Obsessive Hope Disorder

Reflections on 30 Years of Mental Health Reform in Australia and Visions for the Future

Technical Report

ConNetica
The image is a computer generated art image. It shows an individual attempting to push a sphere over undulating terrain. The terrain is certainly uneven and turbulent and possibly liquid in form.

This image has been selected for the Obsessive Hope Disorder Report to represent the assembled evidence that mental health reform has been undertaken without solid foundations. Its base is continually shifting, unstable and outside the control of those moving the sphere. The turmoil of our current federal system of government, the failure to agree on national service frameworks and models of care all contribute to the constant turmoil within the mental health system. The sphere represents the reform agenda. The solitary figure pushing or trying to influence the sphere is unable to control it or necessarily push in a given direction. The solitary individual on one level is representative of the bureaucracy acting in isolation. Clearly more individuals, and a diversity of individuals, would help but they would still expend more energy than if the terrain was more stable and uniform. The lack of light in the image is representative of the lack of accountability and clear line of sight to roles and responsibilities in mental health. The uncertain policy basis, inadequate resources, poor accountability and measurement mean that progress toward a clear goal is never assured - we simply move the sphere somewhere else not necessarily “forward”.

Despite all these hardships, people keep hoping and pushing the sphere because they want better mental health services, and if we acted collectively, then we’d find a better way.

Royalty-free image purchased from SuperStock http://www.superstock.com/search/Sisyphus
Obsessive Hope Disorder

Reflections on 30 Years of Mental Health Reform in Australia and Visions for the Future

Technical Report

John A Mendoza, Amanda Bresnan, Sebastian Rosenberg, Amy Elson, Yvonne Gilbert, Peter Long, Keith Wilson and Janet Hopkins

DISCLAIMER
The Views expressed in this Report are those of the authors unless otherwise indicated. Specific elements of the research were undertaken by research partners: namely the Centre for Mental Health Research at the Australian National University, the Brain and Mind Research Institute, The University of Sydney and the Black Dog Institute at University of New South Wales. Additional work was commissioned from Carers ACT (Dr Doris Kordes), In2It Consulting (Dr Peter Long) and Practical Visionaries (Rajiv Ramanathan).

The project partner organisations played no role in determining research methodologies or in analysing, drafting or editing the findings and conclusions in this Report.

ConNetica and its partners accept no responsibility for the accuracy or completeness of any material contained in this Report.

Additionally, ConNetica and its Partners disclaims all liability to any person in respect of anything, and the consequences of anything, done or omitted to be done by any such person in reliance, whether wholly or partially, upon any information contained in this Report.
Acknowledgements

This Technical Report accompanies the *Obsessive Hope Disorder* Perspectives Report and Summary Reports.

The Technical Report has been prepared and edited by John Mendoza, Amanda Bresnan, Sebastian Rosenberg, Amy Elson, Yve Gilbert, Peter Long, Keith Wilson and Janet Hopkins. The report also includes several chapters and analyses from:

- Dr Doris Kordes – on the era of the Richmond Report
- Professor Brian Burdekin AO – on his reflections on his 1990–1993 inquiry
- Professor Kathleen Griffiths and Bradley Carron-Arthur – for the lead work on the analysis of statutory authority reports
- Tracey Davenport and Professor Ian Hickie AM – the community surveys and analysis
- Rajiv Ramanathan – an analysis of the issues for people from culturally and linguistically diverse backgrounds
- Professor Helen Christensen, Katherine Petrie and Phillip Batterham – on the research agenda.

We thank each of our research partners in this work. Their expertise, counsel and contribution is clearly evident.

We also acknowledge the additional editorial work provided by Mary Hackett and Roslyn Copas and design and publishing from Bevin Neil at BJN Graphic Design.

We wish to thank the authors of the eight-one Perspective Essays contained in this Report who gave their time to write of their experience of the reform journey, of current services and the challenges ahead. We are particularly grateful to the consumers and carers, some who wished to remain anonymous, for sharing their perspective. We commend them for their courage, hope and strength. Their insight provides the basis for real, enduring reform.

We also wish to thank all of our Project Partners for their faith in the ‘vision’ and support in preparing this Report.

- OMC Connect, our project partner for communications and publication, and its great team of Russell Bullen, Kelly Pendlebury and Janna Munn.
- Our principal funding partner Queensland Youth Industry Links (QYIL).
- Our research partners – Centre for Mental Health Research at ANU, Brain & Mind Research Institute at The University of Sydney, the Black Dog Institute at UNSW, Carers ACT and Practical Visionaries.
- The 80+ authors of the Perspective Essays, who have provided a rich and diversity repository of views on the journey of reform, the present state of mental health in Australia and the way forward for reform.
- The 48 partners who responded to this crowdfunded initiative with both funds and in-kind support.

Finally I wish to thank David Richmond, Brian Burdekin and John Feneley for providing Forewords for the Report. David and Brian had no reason to commit their time again to this issue. They have made colossal contributions to mental health reform in the past. We are also grateful to John for putting himself forward as a current statutory office holder with a large responsibility for mental health reform in NSW.

Conventions used in this report

1. Abbreviations are used after the first time a phase is used in full.
2. Referencing is contained within each chapter.
3. Bibliographies of additional sources of data and research are listed at the conclusion of each chapter.
4. Definitions relevant to mental health and mental illness are consistent with those used under the (Australian National Mental Health Policy (see http://www.health.gov.au/internet/main/publishing.nsf/Content/532CBE92A8323E03CA25756E001203BF/$File/pol3txt.pdf)).
Table of Contents

Foreword from David Richmond AO .............................................................. 1
Foreword from Brian Burdekin AO ............................................................ 3
Foreword from John Feneley ................................................................. 5
Preface ...................................................................................................... 7
Executive summary .................................................................................. 11
A summary of obsessive hope disorder: Reflections on 30 years of mental health reform and visions for the future .......................................................... 13
*Obsessive Hope Disorder and A Manifesto for Change* ........................................ 47

PART 1 The journey of mental health reform .............................................. 51
Chapter 1 The dismantling of institutional care: The 'Richmond Report' .............. 55
Chapter 2 The Burdekin Report: Shaming governments to act ......................... 67
Chapter 3 The National Mental Health Strategy – Assessing progress since 1992 .......................................................... 75
Chapter 4 Marching to a different drum? The mental health workforce since Richmond .................................................. 107

PART 2 The present state of mental health services in Australia ................... 117
Chapter 5 A Snapshot of the mental health of Australians ............................. 121
Chapter 6 A systematic review of independent audits of mental health and associated services by statutory and related authorities 2006–12 .......................................................... 149
Chapter 7 Community surveys of experience of care and priorities for reform ............................................................................. 181
Chapter 8 An analysis of the perspectives and visions of Australia’s mental health reform ........................................................................ 191
Chapter 9 The Mental Health Workforce in 2013: Recovery from surgery is long and painful without due care .................................................. 213
Chapter 10 An analysis of governance and accountability in mental health .......... 227

PART 3 A better way to a mentally healthy Australia for all .......................... 235
Chapter 11 Learning from the past… facing new realities ............................ 239
Chapter 12 A better way for multicultural mental health issues in Australia ....... 253
Chapter 13 The past, present and future of mental health research .................. 267
Chapter 14 A Better Way for the mental health workforce: Time to get serious ........ 279
Chapter 15 A Manifesto for Change: Making a better way reality .................. 293

Appendix 1 A summary of the Australian Government’s mental health policy and programs since 2006 .......................................................... 303
Appendix 2 A summary of state and territory mental health policy and programs .......................................................... 317
Introduction ................................................................................................ 319
New South Wales ..................................................................................... 326
Northern Territory .................................................................................... 331
Queensland ............................................................................................... 335
South Australia ......................................................................................... 342
Tasmania .................................................................................................. 346
Victoria .................................................................................................... 350
Western Australia ..................................................................................... 355
Appendix 3  Results from survey of community priorities for reforms ........................................ 361

Appendix 4  Community survey of experiences of care in mental health ........................................ 387

Appendix 5  List of contributors .......................................................................................... 401

Appendix 6  List of 48 project partners ............................................................................. 415
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>ACU</td>
<td>Acute Care Unit</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>AHMAC</td>
<td>Australian Health Ministers Advisory Committee</td>
</tr>
<tr>
<td>AHMC</td>
<td>Australian Health Ministers Council</td>
</tr>
<tr>
<td>AICAFMHA</td>
<td>Australian Infant, Child, Adolescent and Family Mental Health Association</td>
</tr>
<tr>
<td>AIFS</td>
<td>Australian Institute of Family Studies</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
</tr>
<tr>
<td>ANU</td>
<td>Australian National University</td>
</tr>
<tr>
<td>APS</td>
<td>Australian Psychological Society</td>
</tr>
<tr>
<td>ATSI</td>
<td>Aboriginal and Torres Strait Islander (Indigenous)</td>
</tr>
<tr>
<td>ATAPS</td>
<td>Access to Allied Psychological Services</td>
</tr>
<tr>
<td>BEACH</td>
<td>Bettering the Evaluation and Care of Health</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>BOiMHC</td>
<td>Better Outcomes in Mental Health Care Program</td>
</tr>
<tr>
<td>CMMH</td>
<td>Community Managed Mental Health Services (NGOs)</td>
</tr>
<tr>
<td>CMHS</td>
<td>Community Mental Health Team</td>
</tr>
<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
</tr>
<tr>
<td>CDM</td>
<td>Chronic Disease Management Program</td>
</tr>
<tr>
<td>CoAG</td>
<td>Council of Australian Governments</td>
</tr>
<tr>
<td>CoAG NAPMH</td>
<td>Council of Australian Governments' National Action Plan on Mental Health 2006–11</td>
</tr>
<tr>
<td>CoPMI</td>
<td>Children of Parents with a Mental illness</td>
</tr>
<tr>
<td>CSTDA</td>
<td>Commonwealth State/Territory Disability Agreement</td>
</tr>
<tr>
<td>CTO</td>
<td>Compulsory Treatment Order</td>
</tr>
<tr>
<td>DEEWR</td>
<td>(Commonwealth) Department of Education, Employment and Workplace Relations</td>
</tr>
<tr>
<td>DES</td>
<td>Disability Employment Services</td>
</tr>
<tr>
<td>Divisions or DGP</td>
<td>Divisions of General Practice</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health (with jurisdiction added)</td>
</tr>
<tr>
<td>DoHA</td>
<td>(Commonwealth) Department of Health and Ageing</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EPPIC</td>
<td>Early Psychosis Prevention and Intervention Centre</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>Department of Families and Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GPs</td>
<td>General Practitioners</td>
</tr>
<tr>
<td>HASI</td>
<td>Housing and Supported Accommodation Initiative (NSW and ACT)</td>
</tr>
<tr>
<td>HASP</td>
<td>Housing and Support Program (Qld)</td>
</tr>
<tr>
<td>HEROC</td>
<td>Human Rights and Equal Opportunity Commission</td>
</tr>
<tr>
<td>KPIs</td>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>LGBTQI</td>
<td>Lesbian, Gay, Bisexual and Transsexual Queer Individuals</td>
</tr>
<tr>
<td>MBS</td>
<td>Medicare Benefits Schedule</td>
</tr>
<tr>
<td>MHCA</td>
<td>Mental Health Council of Australia</td>
</tr>
<tr>
<td>MHDAO</td>
<td>Mental Health Drug and Alcohol Organisation</td>
</tr>
<tr>
<td>MHNIP</td>
<td>Mental Health Nurse Incentive Program</td>
</tr>
<tr>
<td>MHN</td>
<td>Mental Health Nurse</td>
</tr>
<tr>
<td>MHS</td>
<td>Mental Health Services (Public)</td>
</tr>
<tr>
<td>MHSRRA</td>
<td>Mental Health Services in Rural and Remote Areas</td>
</tr>
<tr>
<td>MJA</td>
<td>Medical Journal of Australia</td>
</tr>
<tr>
<td>NACMH</td>
<td>National Advisory Council on Mental Health</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NHA</td>
<td>National Healthcare Agreement</td>
</tr>
<tr>
<td>NHRA</td>
<td>National Health Reform Agreement</td>
</tr>
<tr>
<td>NHHRC</td>
<td>National Health and Hospitals Reform Commission</td>
</tr>
<tr>
<td>NMDS</td>
<td>National Minimum Data Set</td>
</tr>
<tr>
<td>NMHC</td>
<td>National Mental Health Commission</td>
</tr>
<tr>
<td>NMHS</td>
<td>National Mental Health Strategy</td>
</tr>
<tr>
<td>NMHP or Plan</td>
<td>National Mental Health Plan (with number)</td>
</tr>
<tr>
<td>NSPS</td>
<td>National Suicide Prevention Strategy</td>
</tr>
<tr>
<td>NT</td>
<td>Northern Territory</td>
</tr>
<tr>
<td>OT</td>
<td>Occupation Therapist</td>
</tr>
<tr>
<td>PARC</td>
<td>Prevention and Recovery Centre</td>
</tr>
<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
</tr>
<tr>
<td>PDRS</td>
<td>Psychiatric Disability Rehabilitation Service</td>
</tr>
<tr>
<td>PHaMs</td>
<td>Personal Helpers and Mentors Program</td>
</tr>
<tr>
<td>PM&amp;C</td>
<td>Department of Prime Minister and Cabinet</td>
</tr>
<tr>
<td>PMO</td>
<td>Prime Minister’s Office</td>
</tr>
<tr>
<td>PSU</td>
<td>Psychiatric Services Unit</td>
</tr>
<tr>
<td>ROGS</td>
<td>Report on Government Services (issued by Productivity Commission)</td>
</tr>
<tr>
<td>SAAP</td>
<td>Supported Accommodation Assistance Program</td>
</tr>
<tr>
<td>SPMI</td>
<td>Severe and Persistent Mental Illness</td>
</tr>
<tr>
<td>SSH</td>
<td>Supported Social Housing</td>
</tr>
<tr>
<td>T-CBT</td>
<td>Telephone Cognitive Behavioural Therapy</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Foreword from David Richmond AO

The “Cinderella” of health services was the 1983 description of the then mental health scene as seen through the eyes of the Richmond Report into services in New South Wales. The Report, Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future, clearly demonstrates the continued relevance in 2013 of this comment.

Mental Health is still underfunded and continues to be locked into hospital care albeit often smaller in scale, more localised and more closely aligned with other health services than in the past. This mode of service configuration appears largely provider driven when compared, for example, with client and family priorities.

Obsessive Hope Disorder highlights the challenge of implementing reform and the inability, despite numerous “pockets” of excellent practice, to achieve a coherent, integrated, sustainable and client friendly system. The authors advocate the need for fundamental realignment of governance and funding models at national, state and local level in order to achieve consistency in accessibility to services across Australia.

The authors and contributors are to be congratulated on their diligent documentation and analysis of the events, issues and data over these years. Most importantly, this comprehensive Report also captures personal and professional perspectives from those who have participated in this journey.

An important theme is the need for comprehensive high quality, coordinated and flexible care. This requires greater legibility and visibility of services. In particular, clear entry points and subsequent pathways or “streams of care” within Health and in areas of community services which impact on individual wellbeing and welfare.

The 30 year period reviewed has been one of very significant social, economic and technological change, particularly in medical science and information and communications. Some of this has assisted reform but much has simply made the health services environment more complex and more competitive. On the demand side significant changes have also made services more complex, for example, the growth in consumption of both legal and illegal drugs.

The context and analysis within Obsessive Hope Disorder needs to be placed alongside much of this change, particularly significant changes in urban housing and accommodation markets and in the nature and structure of employment markets. Social attitudes to mental health issues also continued to evolve. It is no coincidence that issues such as housing and accommodation, employment, social inclusion and avoidance of stigma are still highlighted as key challenges.

An important change has been the strengthening of human rights. A complementary trend has been the growth of the consumer movement including consumer participation in services. Devolution of services to local levels and to the non-government sector and attempts at linking services to outcomes through activity based funding, brokerage or purchase models are also relevant themes. These changes can contribute to greater transparency and accountability.

Models of support and care continue to evolve. Enabling people to get as well as they can, and stay well with tailored levels of support and assistance is paramount. Obsessive Hope Disorder provides many useful insights into how an improved system might be fashioned and recommends many of the steps needed to achieve an effective national approach.

The Report’s analysis, based on evidence based research, around the efficacy of specific service delivery elements and their role and place in the continuum of care and support is particularly instructive; as is the discussion about the nature of systems and the need for a paradigm shift in service delivery thinking. Importantly, “systems” thinking is expressed in a broad context recognising both the vital ongoing role that medical science and treatment play and the significance of wider social and economic elements in contributing to individual wellbeing.
This meshing of scientific advances, improvements in social infrastructure, greater focus on evidence based service outcomes, governance reform, and consumer participation is a way forward. The ability, however, to analyse and synthesise the economic, political, social, scientific and systems knowledge and experience we possess and then to mobilise reform through advocacy appears currently beyond our fragmented system of mental health services.

This is a void waiting and needing to be filled – perhaps by entities such as recently established Mental Health Commissions and Commissioners. *Obsessive Hope Disorder* throws up challenges which urgently require vigorous advocacy and broadly based community and political leadership.

David Richmond AO
Sydney, July 2013
Chair of the Richmond Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled, 1983
Foreword from Brian Burdekin AO

The extensive and widely sourced research assembled in this report, *Obsessive Hope Disorder, Reflections on 30 years of mental health reform in Australia and visions for the Future*, is a very important and timely contribution to informing efforts to more adequately protect the rights of Australians affected by mental illness.

Good research is always important to formulating realistic recommendations for effective policies and programs and dispelling ignorance and prejudice. It is also absolutely essential in facilitating effective advocacy by or on behalf of a group or groups who have been routinely ignored, politically disempowered, ostracised, marginalised and even victimised for centuries – as those affected by mental illness have been in virtually every society – including Australia.

Our report on "Human Rights and Mental Illness" 20 years ago, based on evidence from those directly affected and their families and carers, documented appalling violations of human rights affecting hundreds of thousands of our fellow Australians – and sometimes their families and carers as well. The evidence we heard in every State and Territory was an unanswerable indictment of inhumanity and official omission and neglect.

There were many reasons for this. They included the deficiencies of our legal system (the much vaunted common law system – fine in theory, but an abysmal failure in reality) inadequate training for our doctors widespread ignorance in our community associated with irrational fear; discrimination; stereotypes and myths; chronic underfunding, and the indifference of our major political parties compounded by the vagaries of our Federal system and the inadequacies of "democratic systems" in protecting the rights of vulnerable minorities.

But Australia is one of the wealthiest counties in the world – so while there were reasons, there were no justifications.

Shamefully our Federal Government had solemnly ratified international treaties prescribing equality and proscribing discrimination – but abdicated virtually all responsibility for assisting those affected by mental illness. In summary, the evidence from carers, consumers, clinicians, concerned health workers and community organisations clearly established that the abuse, discrimination and neglect suffered by mentally ill Australians was both systemic and systematic.

The national inquiry we conducted had results – including many legal, policy and programmatic reforms, an injection of substantial resources – and for the first time, in response to the evidence, the Australian Government produced a National Mental Health Plan. But, as this current report attests, the follow-up was inadequate and under-resourced. We still have a long way to go.

Recommendations in this report are directed to narrowing the gap between the rhetoric of commitment and the reality of delivery. I sincerely hope they will receive the support they deserve but that will require sustained advocacy – from all of us!

Prof. Brian Burdekin AO
Sydney, July 2013
Federal Human Rights Commissioner, and
Inquiry Head, Human Rights and Mental Illness
Inquiry, 1990–1993
Foreword from John Feneley

Some of the most powerful chapters in this extraordinary report are the individual testimonies from people who live with mental illness, in their own lives or as carers.

They show how people may miss out on finding the support they need if services that do not join up properly, or are made available in arbitrary or inconsistent ways. And they reveal the consequences for individuals of such service failures: sometimes tragedy; more often lives lived on the margins, with reduced opportunity to pursue personal, relationship or career goals.

Three decades ago, Australia began in earnest to reform mental health care, recognising that isolating unwell people in secure facilities could not be justified in a humane society.

But reform to date has focused on systems. We jettisoned one mental health system built around institutions, and patched together another out of hospital wards, hardworking community teams and non-government service providers, medication and wishful thinking.

For those responsible for them, systems can be a comfort. We can debate interminably whether it is the responsibility of the Commonwealth or the states to fix particular system problems. We can measure who goes into the system, what drugs they take, how long they stay and how many times they return. We can see how much a system costs, and adjust it by applying or withholding money. But monitoring the system tells us almost nothing about whether it is meeting the real needs of the people it should serve. Does an episode of mental health care help someone find or keep a job? Does it improve how they relate to their child, or make it easier for them to make an important phone call or greet a neighbour? Does it support people to look after their own physical health?

To take reform to the next level we must remain mindful of organisational issues, but we must also develop much deeper knowledge about how systems work for people, keeping at heart the values of respect for individuals and their right to choose how they wish to live – including the right to choose what care and support they use.

We must also extend our watch beyond government, and take responsibility for educating and supporting everyone – employers, insurers, librarians, sports coaches – to promote good mental health and respond constructively and kindly to people who experience mental illness.

The creation in Australia of mental health commissions nationally and in three states is an acknowledgement that there is something special about mental health, that it does not sit neatly within a broader health system focused on acute illness. Effective mental health care is not about administering treatment and hoping for a response; it needs to recognise the entire context of people’s lives.

The NSW Mental Health Commission has been given explicit responsibility to recommend improvements to the support offered to people who experience mental illness, not just within the health portfolio but encompassing housing, justice, family and community services, education. People tell us these things may be as important as health care, or even more so, in their ability to live a fulfilling life in which mental illness is not the dominant theme but just another circumstance.

We must also look beyond the boundaries of state government and recognise that the supports people seek may be provided by the Commonwealth, community-managed organisations or the private sector.

Our challenge now is to create and maintain momentum for a new generation of changes.

John Feneley

Sydney, July 2013
Mental Health Commissioner of NSW
Obsessive Hope Disorder
Preface

The year 2013 marks the 30th anniversary of the Richmond Report and Inquiry into Health Services for the Psychiatically Ill and Developmentally Disabled. In Australia, 1983 was a big year in many ways – the Ash Wednesday fires ripped through Victoria and South Australia killing 71 people, the Hawke Government was elected in March, Australia II won the ‘Auld Mug’ from the Yanks, the nation’s first case of AIDS was reported and if one could afford a new car, it was often a Holden Kingswood. Perhaps more profound than many realised at the time, was the decision in December 1983 to float the Australian dollar by Treasurer, Paul Keating.

Coincidentally, 2013 also marks the 20th anniversary of the Human Rights and Equal Opportunity Commission (HREOC) Inquiry into The Human Rights of People with a Mental Illness. 1993 was the year Paul Keating won the unwinnable Federal election, Sydney was announced as host city for the 2000 Olympic Games, two great Australians, Edward ‘Weary’ Dunlop and Fred Hollows, passed away, unemployment was nearly at 11% over the full year and again, more fundamental for the nation in many respects, the Native Title Act came into law following the High Court’s Mabo decision.

When the Human Rights Commissioner, Brian Burdekin, commenced his Inquiry in 1990, there was no national approach or strategy in relation to mental health. By the time Burdekin had finished, all Australian Governments had signed off on a National Mental Health Statement of Rights and Responsibilities (1991), a National Mental Health Policy (1992) and a 5-year National Mental Health Plan (January 1993).

The rationale for this Report is simple. The move to deinstitutionalisation is arguably one of the most important public policy ‘decisions’1 of the post-war era in Australia. It has had profound impacts on our society and most particularly those affected by mental illness and their families and the mental health workforce. The Richmond and Burdekin reports did not signal the end of mental health reform. They were more likely to start the reform. The aim of this report is to examine what has followed. There have been dozens of inquiries, reports, plans, policies and strategies since 1993, some national, some by the states and territories. Despite all these plans and even the more recent high level engagement of the Council of Australian Governments (COAG) since 2006, this Report asks “How different things really are from when they were originally reported by Richmond and Burdekin, a generation ago?”

While some positive changes are clear, there are still far too many reports of service issues and failures when it comes to mental health – “Too many people falling through the cracks”. Despite unequivocal commitments by all State governments in 1992 and reaffirmed in 1998, there are still hundreds of people nationally in every state jurisdiction except Victoria, languishing in institutional settings. We estimate this to be costing taxpayers more than $10 million a week. The life expectancy of people with mental illness has not improved. People with schizophrenia have the same life expectancy as remote Indigenous Australians, but there is no ‘Closing the Gap’ strategy for schizophrenia.

As we now reflect on what has changed since Richmond and Burdekin, Australia’s failure to lift the life expectancy of people with a mental illness is arguably the starkest indictment of our public policy failure in relation to mental health care.

1 There was no clear decision or date when the change began as such. The earliest evidence of deinstitutionalisation dates from the mid-1950s in Australia.


Overall structure

Following the Report Summary, this Report is broken into three parts, each of which is supported by a series of chapters as described below.

Part 1 – The journey of reform

In this part of Obsessive Hope Disorder, we track the origins of reform – origins that pre-date Richmond and Burdekin that are very evident in both the journey of reform since 1983 and the state of mental health care in Australia today.

Chapter 1 examines the formal dismantling of institutional or asylum based care and the legacy today.

Chapter 2 includes two short reflections from Brian Burdekin setting out why the Inquiry occurred, what they found and what they learned. The chapter includes a list of recent inquiries into mental health.

Chapter 3 presents an analysis of Australia’s reform through the deployment of the National Mental Health Policy and the five-year plans.

Part 1 concludes with Chapter 4, an analysis of the workforce and its journey through this period.

Part 2 – The present state of mental health services in Australia

Part 2 of this Report is designed to describe the current state of mental health services in Australia. Superficially this appears to be a reasonably simple task. However, on further investigation, the disparate nature of our so-called ‘system’ in fact makes this complicated. We have used a variety of means and approaches to give a clearer, deeper picture.

Chapter 5 provides a ‘snapshot report’ on the mental health of Australians, particularly what we know about prevalence and epidemiology and service use of those in need. There are also two Appendices that provide a summary of Commonwealth (Appendix 1) and State and Territory (Appendix 2) policies and programs since 2006.

Chapter 6 presents a systematic review and synthesis of the findings of National and State audits of mental health and related services undertaken by independent statutory authorities such as the Ombudsman, Auditors, Public Advocates, Guardians and Child Safety Commissioners. Unsurprisingly, given the frequency of these types of reports, there was no shortage of material here with some 32 reports reviewed from July 2006 to December 2012.

Chapter 7 provides the results from two large-scale community surveys conducted in April–May 2013. The surveys examined community priorities for mental health reform and consumer, care and provider experiences of care. The results from the 2013 surveys are also compared with an almost identical pair of surveys conducted in early 2004.

Chapter 8 provides an analysis of nearly eighty perspective essays: contributions by a diverse group of experts, observers and participants in Australia’s mental health reform ‘project’.

Chapter 9 examines the present state of the mental health workforce and Chapter 10 provides a brief overview of the present governance and accountability arrangements.

Part 3 – A better way

Part 3 is our attempt to learn from this journey and present “a better way” forward. As one expert author of a perspective essays succinctly says – “More of the same: no thanks”. The elements of reform towards a contemporary and respectful national response to mental illness have been clear for years. What are missing are the will and the resources to make this reform occur.

Chapter 11 briefly addresses some of the legacy issues from reform, discusses some broader policy initiatives like DisabilityCare Australia (the NDIS) and activity based funding and their relevance to mental health reform, and concludes with a number of innovative solutions for replacing hope with real reform.
Chapter 12 focuses on multicultural mental health issues in Australia. It identifies a context for multicultural mental health reform and the key areas for reform.

Given its importance to "a better way", it is fitting that an overview is provided of the nature of mental health research in Australia in Chapter 13.

Chapter 14 returns to one of the key themes in this Report – the workforce. In spite of the best intentions of government, there seems to have been only limited and patchy improvement in workforce capacity, capability, deployment and sustainability.

Finally, in Chapter 15, we set out a Manifesto for Change and A Better Way.

Obsessive Hope Disorder has been around for 30 years, since Richmond, since Burdekin. There is a cure.
Obsessive Hope Disorder
Executive summary

Introduction

Mental health services have had a long and controversial history in Australia. While most of the states established asylums in the mid-1800s, significant public debate and concern was apparent by as early as 1870, evidenced by the establishment of two Royal Commissions in 1870 and again in the early part of the 20th Century. These commissions were ordered to qualify the existing management structures, which had been suggested to be ‘unaccountable and arbitrary’.

Over the past thirty years since David Richmond’s landmark report in 1983, there has been a continuation of many more controversies relating to mental health and mental health care in Australia. Just this year, a prominent controversy has been the release of the Diagnostic and Statistical Manual of Mental Disorders-V (DSM 5) – its very validity openly questioned from within and beyond the mental health profession. We continue to see reports, almost daily, of system failures – from the demand on Police service resources, to personal tragedies involving suicide or Police shootings of people with mental illness, to reports from statutory authorities of systemic problems. “People falling through the cracks” is almost a new euphemism for reporting “situation normal” with our mental health care “system”.

A common and prominent theme over the past three decades is the lack of accountability and outcomes data. Astonishingly, attributes identified as systemic problems over 100 years ago are still evident today.

More concerning than this representing a failure of basic governance, is that, in examining the origins of mental health reform, one can uncover the same findings and recommendations in Dr Allan Stoller’s report from 1954, David Richmond’s 1983 report, Professor Brian Burdekin’s report in 1993 and the NSW Ombudsman’s report in December 2012.

This Report, Obsessive Hope Disorder, sets out to document aspects of the journey of reform since David Richmond’s report. It provides an assessment of where we are now on that reform journey. Finally, it sets out a better way to go about reform from this point.

It is also evident that there are examples of real reform and progress in developing effective and efficient models of mental health care. The example set by the Australian Capital Territory, as a somewhat discreet system, clearly shows that with strong and sustained political leadership, new investment, effective public administration and genuine engagement with the community, transformation of services can advance well within two terms of government.

Clearly, Australia cannot wait another generation before attitudes and beliefs about mental health are on par with those evident for our common physical health conditions and disabilities. Clearly we cannot continue with the institutional discrimination evident in the allocation of resources for mental health care. Why should we accept that a person with a mental illness has lesser rights than a person with cancer, or cardiovascular disease or respiratory disorders? Why is it accepted that they must wait patiently for access to effective care? Clearly, we cannot afford to sit back and repeat the wanton waste evident in many of the reform initiatives over the past three decades and hope that they work. As a nation we cannot afford the cost – in personal, social and economic terms – to continue with ‘business as usual’.

A vision for the future

The history of Australian mental health reform over the past three decades is one of world class policies and strategies let down by inadequate planning, poor implementation and our complex system of government. The results have been disappointing, wasteful of scarce resources and all too often, devastating for the millions of Australians affected by mental illness.

Despite this, many consumers, carers and people working in mental health remain positive. They are afflicted with a condition known as *Obsessive Hope Disorder*, a condition which permits them to understand mistakes of the past and plan a better future for mental health. *Obsessive Hope Disorder* (OHD) is characterised by a willingness to keep hoping, keep dreaming.

We strongly believe that OHD can be cured, that mental health reform is both practically possible and enjoys overwhelming community support. From the evidence and the analysis presented in this Report, the key to curing OHD is immediate attention to five urgent elements of reform: governance; quality of care; our workforce; research and evaluation; and funding.

We will know we have been successfully if in five, ten and 20 years we will see tangible, measurable and defined outcomes including but not limited to:

**In five years** hope is replaced by reality. There will be:

- Robust planning, policy and accountability
- National frameworks and service models
- Increased funding relative to overall health spending
- Alignment between the different levels of Governments and a clear line of sight to services and to service users and communities
- Nationally harmonised laws that will protect the rights of all people affected by mental illness and their families
- A workforce that feels valued and respected and is supported with continuous investment in training and development
- Services that are co-designed and managed by communities
- The infrastructure to support Australia as world leaders in mental health research and development.

**In 10 years:**

- Access to care for high prevalence mental health disorders will approach that of high prevalence physical health conditions (70% overall, 60% for men)
- The quality of care will be in accordance with guidelines for 70% of episodes of care for the sixteen most common mental health disorders.

**In a generation:**

- Life expectancy of people with severe mental illness is greatly improved, narrowing significantly the gap between this and the average life expectancy for the total Australian population.
A summary of obsessive hope disorder: Reflections on 30 years of mental health reform and visions for the future

Our approach: The origins of Obsessive Hope Disorder

This is the story of the origins of this project and the Report you are now reading. It is the culmination of a long journey, one that is far from over.

Still having the same conversation

In late 2011 over a coffee with a colleague in Brisbane, it became apparent we were still having the same conversation namely that we still did not have a cohesive, easily accessible mental health system in Australia. That same conversation was repeated around the country with colleagues: in spite of numerous reports and reviews, mounting evidence about what works and what does not, recent increased attention and investment from multiple governments – we still did not have a ‘system’ as such.

It was approaching thirty years since David Richmond’s landmark report and twenty years since the Burdekin Inquiry. Over that coffee in 2011, the discussion turned to what had changed? The short answer was ‘not enough’. It was clear we were still talking about problems across all spheres of mental health and it was clear that good intentions had not led to effective, sustained improvements. Why else would 130,000 Australians have signed the GetUp! petition for mental health reform in 2010?3 It was clear that this mattered to many, many ordinary Australians.

The GetUp! petition made its mark and the Federal Budget of 2011 included a $2.2 billion package of reforms. But despite this and claims that “the last few years been quite transformational (for) federal mental health policy in particular”4, the challenges in mental health have never been clearer, yet their effective resolution appears to remain far off.

This realisation sparked the beginnings of this Report. It was time to stand back, to take stock, to reflect and to review. We committed in late 2011 to tell the story – the journey of reform and why we were still having too many of these conversations. Yet we knew there were already more than enough books, reports and professional articles chronicling the parlous state of mental health services. This had to be different.

The vision for the Report

It had to be independent. It had to be real. It needed to bring along and speak to the people that matter. Those 130,000 Australians and the many more who appeared to recognise things were not right with mental health care5. Maybe it was and still is ‘crowd wisdom’, but clearly as with Indigenous disadvantage, Australians wanted their governments to do a much better job on mental health.

What we also knew, in scoping this project and report, that for too long the voices of dissent had been squashed, ignored and marginalised. The ‘airbrushing of dissent’ has been a common experience.

The thirty-year anniversary of the Richmond Report in 2013 provided the extra impetus of a deadline. The journey began.

A collective approach

The current state of the mental health system in Australia was not the result of any one individual, government or organisation. Nor could any one individual, government or organisation remedy ‘it’. Rectification will take a collective approach to bring true, lasting reform. An active new ‘movement’ needs

---

3 This response was the strongest GetUp! had received on a single issue up until then.
4 The Hon Mark Butler, Federal Minister for Mental Health, Speech at ORYGEN Youth Health, 13 June 2013.
5 In the same speech Mark Butler states “that for some years now there had been a bubbling sense of unease in the community that mental health services were not hitting the mark in Australia. That, following the deinstitutionalisation of the sector, and then in the early ’90s the finalisation of that process and mainstreaming of acute mental health services into the general hospital system, there had been a distinct lack of follow-up by all state governments across the country, Labor and Liberal alike, in investing in the community services that were supposed to be the flip side of deinstitutionalisation.”
to come into play. Rectification will not be through incremental improvements or ‘business as usual with a cash splash’. For this project to move from conversations to reality, funding was needed. Resources were scarce but interest was strong. The conversations began and the project gathered momentum. By August 2012 there were a core group of 15 partners signed on.

**The scope evolves**

In late August 2012 the first meeting of partners was held in Sydney and scoping started in earnest. There was much to say, a lot of ideas and excitement and an ambitious agenda was developed. The scope grew. Collectively we would do more than create a report; we would seek to enhance the value and impact of the project by taking advantage of the latest digital platforms to engage and involve as many people across Australia as possible. There was a desire to capture the true picture of the mental health reform journey for ordinary Australians across all walks of life. Importantly there was a strong desire to reflect on successes and gather information on what is working and why.

The project scope now included:

- Two national surveys
- Topic reviews, data analysis, research, and historical document reviews
- Purposive sampling and analysis.

These were developed into the:

- Technical Report, detailing the results, conclusions and recommendations
- Perspectives Report, with over 80 individual and group submissions
- Summary Report.

These would be supported and launched through a public campaign to inspire a movement:

- The ‘swYtch the conversation’ website as the hub, offering a place to:
  - Share experiences
  - Share visions
  - Share solutions
- Integrated social media, Facebook, Twitter, Instagram and YouTube
- Television commercial (TVC)

**Crowdfunded**

The partnership group has been actively involved in shaping this project from the very beginning. In fact this report has effectively been ‘crowd funded’ in both capital and material.

As the ambitions of the group took shape, the scale of the project grew. More resources were required. Interest strengthened and word of mouth attracted more partners. The original partnership group gradually expanded and as the Report goes to print now includes 48 diverse partner organisations. It will continue to grow following the release of this Report. It is not an exclusive club; it welcomes new members with passion, drive and a shared vision for a better way.

**Obsessive Hope Disorder**

With support and vision the project has reached an important milestone with the release of this Report, *Obsessive Hope Disorder: Reflections on 30 years of Mental Health Reform and Visions for the Future*. Together with the Perspectives Report, it provides a detailed picture of the Australian mental health reform journey so far.

This Report is just the start of a new conversation. Its release is an opportunity to bring wider attention to the issues it raises. Mental health reform is not ‘done’ yet. Whilst mental health has attracted more funding in recent years, it is still a long way short of what is needed. Importantly we need to recognise that responsibility for future reform extends beyond the Government to all of us. We now see frequently in recent government policy and program documents that “mental health is everyone’s business”. Indeed
it is everyone’s business: governments will never be able to solve the issues alone. It will require collective action to achieve collective impact… and a truly effective and accessible mental health system for all of us.

Figure 2 below shows the story of the project in an infographic.

Overview of the research methodology

This Report has been informed by a mixed method approach to the research. Triangulation of data, methods, sources and researchers has been used to provide a more comprehensive and deeper understanding of the state of mental health and mental health services in Australia. Five key analyses have been undertaken to inform the findings and recommendations in this Report:

- A systematic review of the National Mental Health Strategy and the commitments made under each Plan, the results reported by government agencies and the results of the evaluation.
- A systemic review of 32 independent, statutory authority reports specifically dealing with mental health service issues. These cover the years from July 2006 until December 2012.
- Community surveying on recent consumer and carer experiences of service, community assessments of the implementation of reforms and a comparison with replica surveys from 2004.
- An analysis of a purposive sample of seventy-nine individual perspectives on reform, the current state of mental health and the future needs.
- Commissioned analyses and reviews – a review of the Richmond era changes; a review of the mental health needs of people from culturally and linguistically diverse backgrounds; a review of the research agenda; and a review of the mental health workforce – its past, present and future.

The research team also undertook a review of the prevalence and impacts of mental illness in Australia and the policy and program initiatives of all Australian nine governments focusing on the period since July 2006. All states and territory governments were sent summaries for comment.

Details regarding the methodology of each research component can be found within the methodology and findings section of this report.

Figure 1 provides a schema for the research methodology.
Figure 1: Research methodology
Figure 2: The project journey
Methodology and findings

Systematic analysis of national mental health strategy and plans

Since 1992, Australia has had a National Mental Health Strategy (NMHS) agreed to by all governments and tied to the national healthcare agreements. This has consisted of:

- Two National Mental Health Policies
- Four National Mental Health Plans (NMHP or the Plan/s)
- The Mental Health Statement of Rights and Responsibilities (issued twice)
- One Five-year Council of Australian Government (COAG) National Action Plan
- The CoAG Road Map for National Mental Health Reform 2012–22.

In addition there are also dozens of various state and territory plans and strategies relating to mental health. For example, New South Wales has six specific plans relating to mental health, plus the NSW State Plan and the NSW State Health Plan. Added to this, are the National Health Reform Agreement (NHRA) 2011 and the National Healthcare Agreement (NHA) 2012, both of which include a mental health stream.

The NMHS was first endorsed by the Australian Health Ministers’ Conference (AHMC) in 1992 as a framework to guide mental health reform in Australia. The four plans cover the following periods:

- Third National Mental Health Plan 2003–2008

The development of the NMHS in 1992 was the first attempt to coordinate mental health services nationally, in an area which had been the responsibility of states and territories. Reviews have been undertaken of each of the national plans, except the fourth which is still current.

The current policy environment for mental health has led to the situation where, despite the proliferation of plans, report cards, and strategies at a national and state/territory levels, there has been little progress in determining the outcome of the investments made in mental health services and reform. Simply put, we cannot tell if people with a mental illness are better off than they were ten or twenty years ago.

The method

The analysis for this Report draws upon the Plans, the subordinate implementation plans, the commissioned reviews or evaluations and other government data sources such as the Report on Government Services (ROGS) prepared by the Productivity Commission.

In order to analyse the impact of the NMHPs over the past twenty years, six key areas in mental health have been examined to look at what progress there has been made, and whether the Federal and the state and territory governments have implemented the commitments they have collectively and individually made under the National Plans.

---

The areas analysed are:

- Housing and accommodation
- Employment
- Social inclusion
- Stigma
- Provision of and access to services
- Measureable targets and accountability.

The findings

The result is disturbing if not alarming. Repeatedly the same issues are identified as priorities for action and repeatedly the reviews and available data point to policy implementation failure, or partial or inconsistent implementation.

Measurement and accountability – a case example

In this Report Summary, we have taken just one of the six themes to illustrate the problem evident in the development, deployment and evaluation of National Mental Health Policy since 1992.

The 4th National Mental Health Plan (the Plan) released in 2009 states that “Improving accountability for both mental health reform and service delivery are central to the Fourth Plan”. It goes on to state the priorities in relation to accountability, namely:

- Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.
- Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.
- Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting.
- Conduct a rigorous evaluation of the Fourth National Mental Health Plan.

However, the 1st Plan and Policy twenty years ago states in relation to monitoring and accountability:

There needs to be greater accountability and visibility in reporting progress in implementing the new national approach to mental health services. Currently mental health data collection is inconsistent and would not be adequate to enable an assessment to be made of the relative stage of development of the Commonwealth and each State/Territory Government in achieving the objectives outlined in the National mental health policy. …. It is essential that such a consistent system of monitoring and accountability be created. In developing such a system, it needs to be recognised that each State and Territory will be at a different stage as a result of the historical development of its mental health system. The central approach should be to measure progress in each State and Territory.

The 1st Plan goes on to list specific objectives in this area, namely:

- To develop nationally agreed measures of performance in relation to each of the objectives in this policy and others which the Commonwealth, States and Territories regard as indications of performance in relation to this policy.
- To report annually and publicly, in a timely fashion, on the progress of the Commonwealth and each State and Territory in relation to these performance indicators and to compare them to their previous performance.

---

9 Extract from the National Mental Health Policy, Canberra, 1992.
In each of the subsequent Plans and evaluations since 1992, the issue of meaningful, timely measures is revisited and ‘the need to develop, agree and implement’ identified. The 3rd Plan (2003) acknowledged national monitoring as important and stated that measurable indicators ‘should’ be agreed on early in the life of the Plan. Then in 2008, the 4th Plan again makes improving accountability “as central to the Plan”.

The 1st Plan Evaluation in 1998 noted that measurement and monitoring of service quality remained a challenge and progress in implementing standards for mental health care had not met expectations. Despite significant developments in the availability of mental health data, it was not possible to monitor changes over time or the levels of unmet need. With regards to the National Standards for Mental Health Services, progress in implementing them had been slower than expected and consumers, carers and service providers thought it was unsatisfactory. It stated that achieving a commitment from all jurisdictions would extend well beyond the Second Plan, and that the challenge was to embed continuous quality improvements rather than just the review of services against the standards.

Mental health workforce practice standards are also discussed and it was anticipated these would promote clinical best practice, and potentially promote a ‘human’ approach to service delivery. However, the implementation of initiatives had been hampered by the attitudes and practices of the mental health (MH) workforce and until the sector itself championed them, progress would continue to be unacceptable.

The 3rd Plan in 2003 acknowledges that a major issue from the 2nd Plan Evaluation was accountability regarding resource use and service quality and that mechanisms are required to ensure accountability on funds spent on services for service development and achieving outcomes.

In the priority area of the 3rd Plan “Strengthening quality” standards and monitoring is highlighted, with the need to move from an emphasis on service input and structure to impacts and outcomes. The Evaluation five years later in 2008 states that frustrations expressed by stakeholders included that the 3rd Plan did not give specific guidance towards actionable and measurable items. The 3rd Plan was too broad by trying to ‘be all things to all people’ and the Key Directions or Outcomes could not be identified as accomplished since the actions required were not clearly defined.

Data and evidence for better mental health outcomes was identified in the 3rd Plan Evaluation. This was a “Group One Priority Recommendation”: namely a national performance management framework. There was a need expressed for establishing and measuring clearly defined targets at the national level (e.g. reducing and eliminating seclusion and restraint). Yet we know that as of June 2013, there is still no national available data on restraint and seclusion. Reporting on matters related to basic human rights are not routinely collected or reported.

The 3rd Plan Evaluation completed in 2008, recommended performance arrangements should also include the national standards for care providers and agreed incentives and sanctions for service providers who do not agree to or meet the standards. The evaluation goes on to list in some detail the features of such a performance system. One could be forgiven for thinking the authors were somewhat frustrated with having to repeat themselves and therefore decided to spell it out.

The following figure depicts the cyclical nature of the mental health plans and the recommendations expressed in the commissioned evaluation reports.
The most recent ROGS Report (2013) points to one of the key factors in the difficulties in delivering the intentions of mental health policy where it repeats many of the same recommendations on the need for robust measures on efficiency and effectiveness of mental health services.\(^{10}\)

Twenty years of the National Mental Health Strategy and the five-year Plans and other strategies, such as the COAG National Action Plan, has delivered information, monitoring and reporting which tells very little about the state of mental health and mental illness in Australia. Despite the national collaborative framework, there is a lack of real accountability and a reliance on limited mental health service (MHS) systems data.\(^{11}\)

Current payment arrangements are historical (you get what you got last year plus or minus something) or based on the number of services provided. These approaches are straightforward in comparison to measuring outcomes or performance. Less than a third of required key performance measures for public mental health services were available for recent government reporting. Even the reports prepared for COAG and First Ministers,\(^{12}\) has been dogged by delays and incomplete data. As at 30 June 2013, the report for the final year (2010–11) of the COAG National Action Plan is still not available.

The failure to collect outcome data points to the need to have such data collected and reported on by a dedicated research body or appropriately empowered statutory body.\(^{13}\)

Assessing the progress of the state and territory jurisdictions against the National Strategy was beyond the scope of this project. Nonetheless from the analysis of all jurisdictions’ policy and programs, it is clear that there is and has been throughout the past 20 years, an almost complete lack of alignment in timeframes, strategies or priorities between the national and state/territory planning documentation. Without nationally agreed incentives or sanctions, jurisdictions have largely done whatever they want, whenever they want.

**The systematic analysis of the statutory authority reports**

*The method*

The Centre for Mental Health Research at the ANU led this aspect of the research for this Report. The results are presented from a systematic review and synthesis of the findings of National and State audits of mental health and related services undertaken by independent statutory authorities such as Ombudsman, Auditors, Public Advocates, Guardians and Commissioners.

---

12 ‘First Ministers’ is the term given to refer to the Prime Minister, Premiers and Chief Ministers – the heads of Australia’s nine Governments.
13 Op Cit, Crosbie.
A total of thirty-two (32) reports were reviewed from the period July 2006 to December 2012. In some cases, the reports on which the review is based were initiated by the office undertaking the review; others were prompted by public complaints, requests by a government, Parliament or Legislative Assembly or constituted part of the office’s statutory functions (e.g. annual review of child deaths). In all cases the resulting report was undertaken independently of the government and the departments or agencies responsible for program management and/or program implementation. There were additional reports (19) identified in the initial stages of this review but were not retained for detailed analysis.

These statutory authority audits and reviews do not analyse all aspects of the mental health care system. Nor, in the case of State and Territory focused audits, do they investigate the system outside a particular jurisdiction. Moreover, unless policy makers act quickly to implement the recommendations of these reports, their findings can quickly lose currency. Nevertheless, the reports represent the culmination of careful and systematic investigation of important questions by trained, independent investigators and the outcomes may be informative both as they apply to the jurisdiction and topic evaluated and for their potential applicability to other jurisdictions and topics.

It was determined to commence this systematic review from the year 2006. This was a relevant ‘start line’ as it was the beginning of what could be termed the ‘CoAG intervention’ following the release of the Not for Service Report in October 2005. To our knowledge a systematic review of the independent reports from statutory offices relating to mental health services has never been previously done.

The findings

The findings from our analysis are presented and relate to the different points of the mental health service spectrum. Although many of the reports identified positive achievements of the agencies and staff they reviewed, every report found problems with the current system and recognised areas requiring change. Areas requiring improvement in one or more jurisdictions included:

- **Mental health awareness** in the community, particularly with respect to awareness that young people can experience mental illness and need to treat threats to suicide seriously.
- **Prevention** services for young people in schools and the prevention of mental illness in particular groups.
- **Community based mental health care** where there is a particular need for improved access to services in the community and for an increased focus on early intervention and rehabilitation and appropriate planning to ensure the mix of services meet consumer need. The need to improve continuity of care and interagency cooperation in the community sector was another strong theme to emerge from the reviews.
- **Crisis response** where dignity and respect are paramount. There is a need to improve the adherence to the protocol that states that consumers should be transferred to hospital by ambulance and not Police van unless this is not possible for safety reasons.
- **Emergency unit responsiveness**: There was little consideration of care in hospital emergency units.
- **Inpatient care** where inadequate access to inpatient care was a significant issue for young people, those from rural and remote regions and those in forensic settings. There was also inappropriately lengthy waits in emergency units pending admission to a ward, poor practices with respect to informing consumers about their rights, ensuring privacy, and with respect to the use of restraint, seclusion and search.

14 In addition to a need for improved access to the general community, particular groups requiring improved access include children with mild to moderate mental health problems, adults and young people in justice settings (and those with behavioural problems that place them at risk of entering the justice setting), women during the perinatal period, people living in rural and remote regions, Australians of Indigenous background, young people from culturally and linguistically diverse backgrounds and young people who are homeless.
- **Housing** where there is a need to increase the availability of supported accommodation for consumers, and to thereby reduce the number of consumers who are inappropriately accommodated in hospital beds for extended periods.

- **Social security** where there is a need to reduce barriers to consumer engagement and communication, to undertake training to assist staff to recognise mental illness and to create an environment in which clients are comfortable disclosing a mental illness.

- **Immigration detention processes** to protect against wrongful detention of Australian citizens.

- **Veteran’s program** administration which requires improvement.

- **Child Protection services and children at risk.** Better targeted mental health and risk assessment, more timely access to therapy, better care planning, improved training, and improved interagency cooperation is required for children requiring child protection.

- **Restraint through Taser use:** Although overall Taser use was reviewed positively.

One further observation from this review is that all too often there are no reports from the responsible government departments, or agencies on the implementation, or progress reports, following the statutory office review. It is abundantly clear that the accountability requirements on governments, Ministers, departments and agencies are inadequate given the frequent reoccurrences of the same recommendations. Repeatedly, statutory authorities are finding the same systemic problems.

In summary, the key themes to emerge from this systematic review are that:

- Consumers currently have **inadequate access** to mental health services across the health care spectrum ranging from prevention to recovery

- Care for consumers is frequently compromised by **inadequate interagency cooperation**

- Quality supported accommodation is inadequate

- Consumers are not always treated with dignity and respect and in some instances subject to discrimination

- There are **gaps in the training** of mental health, health and non-health staff providing services to people with a mental illness

- There is a need to improve data collection and service monitoring

- **Groups have particular unmet needs** including those in the forensic/justice system, those in rural regions, young people, people of Indigenous heritage or from culturally and linguistically diverse backgrounds, and children at risk.

**Analysis of the community surveys**

**The method**

Two community surveys were conducted during April and May 2013 to gather the views of the sector (providers, consumers, carers, family members and other interested stakeholders) regarding experiences with mental health services. We wanted to particularly focus on experiences of mental health service or care in the past 12 months. The community surveys replicated the same surveys conducted by the Mental Health Council of Australia (MHCA) and the Brain & Mind Research Institute (BMRI) in 2004\(^\text{15}\). Again in association with the BMRI, ConNetica replicated these surveys in order to review mental health services in Australia at present and to compare how national and community priorities and experiences of care have changed since 2004.

This first survey ("Community Review of Mental Health Services in Australia") evaluated the extent to which national and community priorities have been implemented at the local, regional and state/territory level. It asked the respondent to rate how the national and community priorities have been implemented or supported within their local area and then how the national and community priorities have been

implemented or supported at a state/territory level. The second survey ("Consumers and Carers Direct Experiences of Mental Health Care in Australia") assessed direct experiences of care against internationally developed benchmarks for quality health care. It asked the respondents about their experiences with mental health services as well as some demographic information. For those respondents who identified as consumers, it then asked more specific questions about their experiences with mental health services.

The two surveys were predominantly conducted online and constructed in LimeSurvey and then securely hosted by the BMRI on The University of Sydney’s server. This study had institutional ethics committee approval from The University of Sydney Human Research Ethics Committee.

The findings

Results of Survey 1: Community review of mental health services in Australia

A total of 477 surveys were received with 86% from individuals and 14% from organisations. The majority of respondents described their role in the mental health sector as consumer of mental health services (31%), followed by non-government community service providers (19%), public providers of specialist treatment (11%) and carers (11%).

First, respondents rated the extent to which national priorities have been implemented or supported in their local area. Of the priorities surveyed, respondents indicated that a total of 60% were currently not as implemented or supported as they were in 2004. That is, respondents rated the implementation and/or support lower than in 2004. Most importantly, these included “provision of early intervention services”, “genuine consumer participation”, “genuine carer participation” and “clear accountability for expenditure of mental health strategy funds”.

Next, respondents rated the extent to which priorities have been implemented or supported within their state/territory. Again, results for all respondents indicated that 75% of priorities were currently not as implemented or supported as well they were in 2004. These included “development of specific inter-governmental service agreements”, “direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health”, “support for enhanced role of non-government organisations in all aspects of care”, “clear accountability for expenditure of mental health strategy funds” and “development of datasets for monitoring the quality of local services”.

Results of Survey 2: Consumers and carers direct experiences of mental health care in Australia

A total of 561 surveys were received with 87% being from people who had received treatment (directly or indirectly) in the previous 12 months. Of these, 64% were from consumers, 14% were from carers, 18% were from family members or close friends, and 4% were from other sources. Forty-three per cent of those who had received treatment (directly or indirectly) had contact with private health services, 29% with public health services, and the remaining 28% a mixture of the two.

Key results were:

- More than two thirds of respondents (mostly consumers) reported that they were treated with dignity ‘nearly always’ or ‘always’ (69%).
- Less than half (43%) of respondents felt that they were able to access adequate services for their mental health problem ‘always’ or ‘nearly always’. However, the results were more favourable for consumers (48% of consumers felt they were able to access adequate services always’ or ‘nearly always’ compared with only 29% of carers and 28% of family or close friends).
- The majority of respondents (86%) were able to find a health professional to talk about their concerns.
Further:

- Most respondents (70%) felt that they were given the ‘right amount’ or at least ‘some’ information about their condition or treatment.
- Of those respondents who wanted information given to family and friends, more than half (54%) felt that not enough information was given.
- In situations where medication was prescribed for the mental health problem, 55% responded that the purpose, benefits and side effects were fully explained.
- Thirty per cent said that the health professionals involved agreed ‘always’ or ‘nearly always’ with one another. Fourteen per cent reported that the health professionals ‘never’ agreed with one another.
- Thirty per cent of respondents did not feel they had enough say in decisions about care and treatment. However, a higher proportion of consumers (78%) felt that they had adequate say in decisions about care and treatment than carers (48%) or family/close friends (38%).
- One in five respondents had not had their diagnosis discussed with them. However, the results were more favourable for consumers (15% of consumers had not had the diagnosis discussed with them compared with 33% of carers and 30% of family members).

When comparing data from this survey with that from the same survey run in 2004, the results show there has been significant improvements in three domains:

1. The extent to which they were able to access adequate services (28% were not able to access adequate services in the current survey compared with 39% in 2004).
2. The information people are given about their condition or treatment (44% of respondents felt they were given the right amount of information in the current study compared to only 32% in 2004).
3. Decisions about care and treatment (70% felt they had enough say in decisions in the current study compared to 62% in 2004).

Consumers then answered more detailed questions regarding their care and treatment. The majority had seen a general practitioner (98%), psychologist (60%), and/or psychiatrist (62%) in the previous 12 months. Fewer consumers had seen a mental health nurse (25%), social worker (15%) or other mental health professional (22%) in the previous 12 months. A number of consumers reported they had no trust or confidence in the social worker (37%), mental health nurse (27%) or psychiatrist (20%). Most consumers (88%) had taken medications for mental health problems in the last 12 months and 71% had received a talking therapy. Close to half of the consumers had an afterhours contact in a mental health service, and of these people 40% had used this form of crisis care in the previous 12 months.

As with any survey of this type, care needs to be taken when comparing the results from the earlier survey – while the 2013 sample size was considerably greater than the 2004 study, the gender and locality information was remarkably similar. This similarity in demographics gives more confidence to any assertion that the results do reflect an overall improvement in the three domains regarding access to adequate services, provision of information and decisions about care and treatment.

Notwithstanding this result, a larger representative sample of consumer, carer and provider experiences of service is required routinely for one to be confident the results are a true reflection of improvements in service experience.

The thematic analysis of the Perspective Essays

To facilitate diversity and depth of input, consumers, carers (paid and unpaid), frontline professionals, political leaders, former bureaucrats, provider organisations leaders, media professionals, researchers and policy advisors from a range of settings were identified as potential contributors to this Report.
The method

A diverse group of individuals was invited to contribute a 1000–2000 word written perspective piece. A staged purposive approach was used to ‘recruit’ contributors from February to late May 2013. An initial list of 130 individuals and organisational leaders were identified using a matrix of settings and expertise with a further 120 individuals and organisations added to ensure there were sufficient numbers of contributors and adequate diversity of perspectives (figure 8.2).

Partner organisations and individuals identified as potential perspective contributors were sent an overview of the project and a brief outline stating that the report was going to examine mental health reform in Australia with particular focus on three key areas:

1. What has been the journey of reform to date since David Richmond and Brian Burdekin's reports 30 and 20 years ago respectively?
2. Where are we now – what is the contemporary experience of care?
3. What should be the future – is there a better way?

Contributors were given freedom to write on either all three key areas or one or two of their choice. All perspectives essays were loaded into a qualitative data analysis tool – hyperResearch. Investigator triangulation, (i.e. the use of several different researchers to interpret a set of data) was utilised to evaluate and analyse the majority of perspectives.

The findings

A rich pool of perspectives

The eighty-one perspectives essays contained within the Obsessive Hope Disorder Report are an incredibly rich pool of experiences and analyses spanning the last thirty years. The authors include some eminent Australians who have served in some of the most important roles in our society. Other contributions come from professionals with decades of experience in mental health services in almost every setting.

There are ‘lived experience’ perspectives on the current mental health care system from those who are using mental health care services in 2013. Some of their stories are distressing, pointing to the continuing systemic issues identified in the statutory authority reports, other data presented in the
Technical Report, and the need to rethink efforts on reform. Other stories however, are reassuring, demonstrating that some real improvements have occurred in the way people get help for their illness and that reforms have occurred.

Many of the authors are not ‘in’ the mental health system and bring an observer or participant observer\textsuperscript{16} perspective. Others have been front and centre of the government policy making and stewardship processes over the past two decades. Almost all of them identify the structural and political barriers and challenges to reform and why it’s just so hard to achieve real national reform for consumers and families.

A number of the authors come from roles as lawmakers and custodians, drawing attention to the ongoing discrimination and failure of present laws to protect some of those with mental illness. Others have led major inquiries into aspects of mental health care and human rights.

There are four perspectives specifically addressing mental health and Aboriginal and Torres Strait Islander peoples. The authors all ask in their own way if we are focused on the right issues to improve indigenous mental wellbeing. Other authors detail the journey, the present and the future for lesbian gay, bisexual, transgender and intersex (LGBTI) communities and there are those that draw our attention to the issues confronting Australians living in rural and remote communities with mental health needs and how we can better meet their needs.

In a year which has seen the commencement of the Royal Commission into sexual abuse of childhood in institutions, there is another essay highlighting the need for mental health services to recognise and be sensitive to the very high rates of sexual abuse suffered by people with mental illnesses.

Importantly, there are many contributions about what a 21\textsuperscript{st} Century mental health care system looks like and what we need to do to bring about reform within a decade – from a systems level down to models of service, to service delivery and own individual attitudes and practices. A number of authors outline the potential of new technologies to reach more people, reach them earlier and at relatively low cost. And as it has been almost a constant theme for decades, many authors stress the need to get beyond the rhetoric on early mental health promotion, prevention and early intervention.

There are also international perspectives that draw on decades of experience working in the UK and New Zealand and elsewhere, and identify the key elements missing in our reform efforts in Australia. In particular, these authors draw attention to the need for investment in a national workforce strategy, culture change and capability development.

There are also some unique perspectives – most notably that from the ACT Chief Minister and Health Minister Katy Gallagher. Katy Gallagher is Australia’s longest serving Health Minister in office. During her six-year tenure as Health Minister, the ACT Government with the support of the ACT Greens, has

\textsuperscript{16} ‘Participant observer’ is a form of sociological research methodology in which the researcher takes on a role in the social situation under observation. The researcher is immersed in the social setting under study, getting to know key actors in that location, adapted from Pearson Education 2005: http://wps.pearsoned.co.uk/ema_uk_he_plummer_sociology_3/40/103422647687/cw/content/
developed and implemented fundamental reform of the ACT mental health care services, particularly focusing on the establishment of a range of community-based alternatives to hospitalisation. This is not the first time an Australian jurisdiction has worked to reform its mental health services. Victoria was a leader under the First National Mental Health Plan in the mid-1990s. The issue is not that genuine reform of mental health care is too hard; it is that it is too rare.

Finally there are many perspectives from our Project Partners who provide services in a range of settings and for specific populations – children, young people, culturally and linguistically diverse (CALD) groups, people living in rural and remote areas, workplace settings, employment and housing services, helplines and online platforms, research, primary care, specialist care and community care. Together they represent the diversity of the mental health sector. Together they have highlighted many service innovations and structural reforms which are reflected in the *Manifesto for Change* in this Report.

We deliberately set out to garner a diverse range of experiences and perspectives in undertaking this aspect of the project. We also gave minimal direction to the authors who agreed to undertake the assignment. In that way, it is their reflection and not our construction. The result is an anthology or encyclopaedia – a set of precious insights into mental health in contemporary Australia. It is difficult and perhaps inappropriate to attempt to distil these rich contributions to just a few themes and issues. Nonetheless for the reader short on time, and to add to the other findings, we have attempted this.

Perhaps the one key message from all contributors is that their hope for real reform of mental health care in Australia is undiminished.

**The findings**

There are several key themes evident in the perspective essays relating to challenges and problems confronting mental health in Australia.

While many contributors acknowledge important progress, the vast majority agree that in terms of mental health reform, *Australia still has a long way to go*.

This collection of perspectives documents many continuing manifestations of stigma, discrimination and inequity. People with mental illness still face real problems in relation to their human rights.

There are still far too many stories included here which document service failure at a systemic level, with people either being unable to access the right care at the right time or finding poor quality of care. There remain large service gaps and high levels of unmet need.

Many contributors sheet home this enduring systemic failure to a continuing lack of funding. The overall health budget continues to increase at a faster rate than the mental health budget, meaning mental health’s share of funding is in decline, exacerbating the disparity between the resources available and the burden of disease.

In this highly pressured environment, several contributors highlight what they feel to have been a chronic lack of support for, indeed neglect of, our workforce.

Several authors highlight that this situation has arisen in an environment in which mental health could be characterised outcome blind, lacking meaningful data, particularly outcome measures.
A recurring theme across the essays is the need for better accountability at all levels, permitting quality improvement feedback for service providers and reassurance to the community at large that it has a mental health system on which it can rely.

*Despite dozens of plans and policies, reports, inquiries and mental health commissions, spending between jurisdictions continues to be uncoordinated, lacking both accountability and a focus on patients’ needs. It is impossible to verify whether jurisdictions really do spend what they commit or what they report. Given the huge burden of mental illness and the unmet needs for mental health services, proper accountability for this expenditure is crucial to ensure that it is targeted at the areas of greatest need and is delivering better outcomes for people with mental illness.*

*Dr Lesley Russell, ANU*

**Other issues**

Beyond these key themes, the contributing authors commonly refer to other issues.

Many refer to the fact that the evidence about what was required twenty, and even thirty years ago, has not fundamentally changed. Over time, many point to successful programs or services that have been built and piloted across Australia to deliver new mental health services. The common theme here is that all too often there has been a failure to build these services to scale to meet community needs.

There is a genuine frustration expressed by many contributors regarding the continuing rhetoric–reality gap on promotion, prevention and early intervention. They lament our continued emphasis on late stage or crisis intervention, with the mental health system only kicking into action once a person is already severely unwell and possibly a danger to themselves or others. Equally, the lack of attention to the physical health needs of people with mental illness is another illustration of a lack of whole-person care.

People working in the system report how challenging it can be to attempt to re-gear the system, how complex this kind of change can be at the organisational level.

There are several essays which highlight policy barriers to employment for people with a mental illness. Other contributors highlight the need to address the social determinants of mental illness more broadly. This is particularly the case if we are to have any meaningful positive impact on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.

And there were some issues that lay outside this mix of ‘common’ themes. For example, Stephen Mugford’s challenge on the way progress is viewed and indeed the vagaries of mental health definitions remains a highly contested area and that in a time of apparent resource scarcity, mental health initiatives may continue to struggle to gain funding.

Several contributors highlight themes or strategies which together, represent a way forward, a better way for both future reform efforts and how we conceptualise mental health.

Let us hope that the next thirty years of mental health reform will be informed more fully by the voices of experience, consumers and families, and that services will be more fully engaged with consumer and carer support programs.

*Joe Calleja, CEO Richmond Fellowship WA*

Despite dozens of plans and policies, reports, inquiries and mental health commissions, spending between jurisdictions continues to be uncoordinated, lacking both accountability and a focus on patients’ needs. It is impossible to verify whether jurisdictions really do spend what they commit or what they report. Given the huge burden of mental illness and the unmet needs for mental health services, proper accountability for this expenditure is crucial to ensure that it is targeted at the areas of greatest need and is delivering better outcomes for people with mental illness.

*Dr Lesley Russell, ANU*

Several contributors highlight themes or strategies which together, represent a way forward, a better way for both future reform efforts and how we conceptualise mental health.

Several of these refer to important employment policy and programs based on international and Australian evidence. Others refer to the importance of systems thinking around the concept of integrated care rather than focusing just on individual services or providers. Other essays highlight the role to be played by community education, community prevention activities and local planning.

Many contributions call for greater consumer, carer and peer worker participation in co-design, management and monitoring of mental health systems and care. New opportunities to apply technology to assist in more timely, effective and contiguous mental health care are also identified.
From the thematic analysis we have postulated a number of ‘theories’ relating to the journey of mental health reform and the ‘drivers’ for the failure of policy implementation so consistently expressed in the perspective essays. Most see this failure as being the result of inadequate planning, definition and detail. Too often high-falutin reform rhetoric is not matched with concrete implementation. Part of this is about disaggregated and ineffective governance structures, weak stewardship of the process and but surely another factor, as pointed out in several essays, relates to inadequate funding to support reform. Real funding is all too difficult to determine from the “funny money”\textsuperscript{17}, re-labeled and/or re-announced funding that is evident from too many governments. Many authors also make reference to the complexity of funding and service arrangements and the consequent deleterious impact these have on the quality of care available.

There is also inconsistent access and quality of care, partly the result of the failure to define a national service framework and national models of service. Contributors also point to the neglect of the mental health workforce over decades.

Finally, a key driver of mental health reform failure is clearly poor accountability – not being able to tell whether what we are doing is really making any difference to people’s lives.

**Figure 4: Key themes and drivers: A postulated theory on Australia’s mental health “reform gap”**

### The commissioned and specific topic analyses

**The mental health workforce**

The mental health workforce has been a central player in the journey of reform. This analysis was undertaken as a ‘special interest topic’ based on the preliminary project scoping which continually identified the neglect of the workforce as an obstacle to reform.

---

\textsuperscript{17} Dr Lesley Russell coined this term in media interviews following the 2011 Federal Budget when discussing mental health funding.
The history of the mental health workforce shows that in spite of all the change, the remnants of the past remain within the mental health system. Given the tragic history and treatment of the ‘insane’ it is little wonder that the vast majority of mental health consumers, families and professionals want to move as physically far from the old asylums, and to a lesser extent, the new mainstreamed hospital services as possible.

For the workforce the journey has clearly been a wild ride with far too little support and too little attention to much of what David Richmond recommended. If implemented, the Richmond Report’s recommendations would have eased the workforce’s journey from custodial care practices and ordered environments, to moving to practice in contested and open environments, to take on new paradigms of care and to view themselves as part of a national picture in the knowledge era.

A number of themes identified in the historical analysis continue to be evident in the mental health workforce of 2013: federalism continues is an ever-present backdrop; the taxonomy of staff has broadened, and their roles are identified; the location of the workforce has changed and the type of practices they engage in varies across the sector; workforce culture impacts across the system; and three issues continue to plague administrators – staff recruitment, retention and efficient utilisation.

In spite of the best intentions of government and significant investment there seems to have been only limited and patchy improvement in workforce capacity, capability, deployment and sustainability.

Recurring patterns of problems in organisations and even industries may signal embedded processes, which are often unconscious to the parties involved and difficult to change. This appears to be the case in mental health. Breaking this cycle of recurring patterns observed in the mental health workforce for the past 30 years is addressed through a systems approach.

What is clear from numerous reports, we know what to do, but the problem again has been policy deployment. Without diverting attention away from the mantra of recent years, attention needs also to be directed to what, at the risk of using a mechanical metaphor in an organic era, is the ‘system toolbox’ required to make the change happen – in this case a more modest ‘starter kit’.

A number of suggestions for change are offered as a means to break the embedded patterns which seem to cause major change inertia: these mainly relate to culture, planning, information for pro-activity, standards, shared competence, leadership and change management.

**Governance and accountability**

Another of the special topics to be included in the analysis of the state of mental health services is governance and accountability. Like workforce, the issue of governance and accountability was consistently reported as a requirement and an implementation problem evident in the preliminary scoping for this project.

In relation to governance and accountability in mental health, Australia has always talked a good game. We have the neatly articulated plans to prove it. What has been lacking is the willingness to invest in genuine, regular, independent processes of monitoring and assessment of progress towards mental health reform. At the heart of this must be the validated voice of the consumer and carer providing a true picture of the impact of mental illness on their lives.

One of Australia’s most significant achievements, again made possible under the First National Mental Health Plan in 1996, was the establishment of a set of National Mental Health Service Standards. These Standards led the world in laying down markers against which to assess the quality of care provided, giving both service providers and users much clearer expectations. Again due to lack of resources, these Standards, while widely respected, were never really implemented or monitored. In 2010 they were reviewed but again, no resources to enable their effective implementation or monitoring have been allocated. And even more recently, a new recovery standard was developed and issued in 2012 but again no resources were allocated for training or implementation. Fine words again resting on hope as a deployment strategy.

Important for mental health reform are the broader reforms to health and hospital reform. Part of Australia’s recent health reforms has involved rearranging financial relationships between the states and the Commonwealth governments. It is precisely in the area of most concern to mental health reformers;
that part of the service system which aims to avoid hospitalisation and provide as many services as possible designed to keep people living well in the community, where responsibility between the federal government and the states is most unclear. This is the dilemma that lies at the heart of Australia’s governance problems.

Genuine reform mental health in Australia must start with a new commitment and real resources to enable better governance and accountability. The issue is too important and too expensive for us to remain “outcome blind”.

**Special populations and mental health issues**

When the National Health and Hospitals Reform Commission handed its report to the Rudd Government in July 2009, it made the point that the immediate priorities for reform action were in relation to services for people in rural and remote Australia, Indigenous Australians, those with chronic dental health needs and those with mental health needs. As one Commissioner summed up things ‘if you were an indigenous person living in remote Australia then prospects for any care are not good. If you needed mental health or dental health care, forget it’.

In the analysis presented in *Obsessive Hope Disorder*, it is very clearly that special populations – people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander peoples, people living in rural and remote Australia, young people, LGBTI people and those with comorbidities such as deafness or an intellectual disability were all under-served by both mental health policies and programs. All too often it was clear that the ‘mental health policy caravan’ had really not stopped to address these population groups, nor their needs beyond a ‘comfort stop’.

It was beyond the scope of this crowdfunded Report to address each of these groups needs and map out a *Better Way* for the future. One group were selected as a case approach to tackling the needs and providing a way forward -- those people from a culturally and linguistically diverse background and the multicultural mental health issues in Australia.

Drivers for reform in this area include the fact that Australia has for the past 50 years been a diverse nation and we are continuing to grow in our diversity. Serious gaps already exist in terms of the accessibility of mental health services for Australia’s culturally and linguistically diverse populations. Policy, planning and implementation of mental health services cannot ignore this reality.

There are several issues identified in the analysis in relation to CALD peoples and mental illness:

- poor access to timely and culturally appropriate care
- poor understanding of the extent of the needs – not only are we ‘outcome blind’ but also ‘needs blind’ as well
- the need to improve the quality and safety of communications between CALD consumers and mental health practitioners
- improving access to services requires working with CALD communities to reduce shame and stigma
- improving the access, quality and safety of services for CALD populations requires a whole-of-service organisation approach.

Addressing these gaps and planning for Australia’s future requires investment and action in the mental health system. Specifically, we need investment and action to:

- improve our understanding of the extent of the problem with regards to prevalence and access in relation to CALD communities
- improve the safety and quality of communications between CALD consumers and mental health practitioners

---

19 Personal communications of a Commissioner to Chair of the National Advisory Council on Mental Health, 2009
• reduce the shame and stigma around mental illness and improve mental health literacy in CALD communities
• improve the cultural responsiveness of Australia’s mental health system through whole-of-organisation and whole-of-system approaches.

Mental health research

The Black Dog Institute at the University of New South Wales has undertaken a review of mental health research for the Obsessive Hope Disorder Report.

Research in mental health is a critical activity. Without research, the causes of disorders will never be understood. Without research, the effectiveness of new treatments, better health service methods, and new methods to aid recovery will not be forthcoming. Importantly, research forms the basis on which we can reject service models, treatments and programs that are not effective, non-evidence-based, or even harmful. In other words, research tells us on the basis of “effectiveness” which approaches to jettison and which ones to embrace.

Mental health research is one of the key opportunities for achieving breakthroughs in both novel treatments and service innovation. Again, the efforts to date have been mediocre at best and mental health research stays stuck in the slow lane. Despite much ‘noise’ there is little evidence of any increase in the allocation of funding for mental health research. Mental health research when compared with other health areas continues to receive an inequitable share of the cake.

In relation to priorities, the evidence shows a considerable discrepancy between stakeholder priorities and the research that is currently being undertaken and funded. While there was significant publication and funding related to affective disorders in line with priorities, there were clear gaps in research on schizophrenia/psychosis, childhood conditions and suicide. In particular, childhood conditions and suicide received little funding, despite their high priority in the stakeholder rankings. A disproportionate amount of funding and publications goes to substance use disorders compared to their relatively lower ranking in stakeholder priorities.

Although affective disorders now receive a level of funding that is in line with disease burden, current publication output does not yet reflect this. Other disorders that appear to be adequately funded and researched in harmony with degree of disease burden include eating disorders, substance use disorders and schizophrenia and psychosis. However, it appears that there are marked discrepancies between the limited degree of funding and publication output in anxiety disorders, dementia and in particular, personality disorders and suicide, when considering their considerable contribution to burden of disease associated with mental disorders.

In summary, the data reveals that research output is inconsistent with the “burden of disease”. Dementia, anxiety and affective disorders and suicide are all underrepresented in Australian-authored publications, relative to their significant disease burden and costs to society.

The remedies are not rocket science. The return on the investment … potentially enormous for Australia.

New initiatives to align research with national priorities and to embed research within health services may increase health service research20. The development of health research and service hubs, as recommended by the 2012 Wills Review21, has the potential to accelerate the growth of a more vibrant clinical research agenda. If successful, embedding research into service reform will be likely to increase health services research and accelerate health reform, and increase accountability.

A focus on translational research may increase the types of groups who are served by the research targets and ensure the implementation of new treatments and procedures will become a focus of research. The growth and development of philanthropy in Australia might be a consideration. More

philanthropic grants to mental health research will grow the base. The type of research will be changed if philanthropists focus on specific health topics within psychiatry and mental health.

The power of the consumer voice may grow and directly and indirectly influence what topics and settings are covered. Advocacy for research might lead to increases in some research areas.

Hopefully, priority-driven research, translational research and research conducted within and around health systems will lead to increased creativity and research that is more responsive to priorities.

**Assessing the state of mental health in Australia**

In scoping the project, it was clear we needed to assess the overall system. The other methods selected for this project zeroed in through particular pathways. A whole-of-system approach was also necessary.

The research team set out to answer some basic questions, namely:

- What is the prevalence of mental health problems and illnesses in Australia?
- What do we know about the health of people with mental illnesses?
- How well are services responding to mental health needs of Australians?
- What is the current state of mental health services in Australia?
- How many Australians have access to care?
- What is the quality of that care?
- What is the level of awareness and understanding of mental health and illness in the Australian community?
- What are the outcomes achieved from these services?
- What reforms have been implemented by the Australian Government since 2006 to respond to widespread concern about mental health services?

Chapter 5 and Appendices 1 and 2 provide the detailed responses to these questions.

**Prevalence**

Mental illness is one of the most prevalent conditions affecting the Australian population and according to the most recent National Survey of Mental Health and Wellbeing\(^ {22}\) (SMHWB) released by the Australian Bureau of Statistics (ABS), around 45% of Australian adults will experience a mental illness at some time in their life. One in five people reported experiencing symptoms in the 12 months prior to the survey and a further 25.5% of adults had experienced a mental illness at some time in their life, but did not have symptoms in the 12 months before the survey.

Up to 3.2 million adult Australians, nearly 16 per cent of the entire population, are either permanently or transiently affected by depression or other mental illnesses during any twelve month period and over half of them are not responding to standard treatments. The true rate of mental illness in Australia will be higher than the above figures in view of dementia and less common mental disorders (e.g. schizophrenia and other psychotic disorders) being excluded from the national survey. The overall prevalence rates have changed little between 1997 and 2007.

There is some evidence to show that rates of major depression have increased in Australia\(^ {23}\); however, it is more generally believed that rates on severe mental illness (major depression, severe anxiety, psychoses) have not changed and remain at around 3–4% of the adult population.

The proportion of Australians experiencing mild to moderate illnesses has remained relatively stable over the past three National Health Surveys, however the prevalence of particular categories of disorders has changed\(^ {24}\).

---

The prevalence rate of Australians experiencing a mental illness significantly exceeds diabetes (4% of adults) and cancer (2.5% of adults). Importantly the prevalence of severe mental illness exceeds that of all cancers combined.

The highest prevalence rates for mental health conditions occurs from late adolescence until later mid-life years (16–54 years) with the peak rates (nearly 1 in 3 people) in the 16–24 year age groups. The most prevalent disorders are anxiety, depression and substance abuse disorders – these are referred to as High Prevalence Disorders.

According to The burden of disease and injury in Australia 2003 (AIHW 2007), mental illnesses (including suicide) were estimated to be responsible for 15.3% of the total burden of disease in Australia in 2003. Mental illness is also the largest single cause of disability, contributing to 24 per cent of the burden of non-fatal disease. Around 600,000 Australians experience severe mental illness and an estimated 60,00025 have ‘enduring and disabling symptoms with complex and multi-agency service needs’.

The health and wellbeing of people with mental illnesses

Presently in Australia we do not have access to routine health data about people with mental illness. We rely therefore on a patchwork of data sets to build a picture of the overall health and wellbeing of people with mental illness. What this patchwork of data tells us makes for stark reading. People with mental illnesses experience:

- higher death rates (2.5 times the general population)
- higher rates of diabetes and obesity, heart disease26 and some cancers
- much higher rates of tobacco use (nearly three times the rate of the overall population)
- higher rates of poverty, unemployment, social exclusion, and homelessness
- higher rates of imprisonment and violence (more often as victims)
- a 16–25 year reduced life expectancy which appears unchanged in a century27, 28.

Mental illness is the largest single cause of disability, contributing to 24% of the burden of non-fatal disease. This is over 3.5 times the disability burden of all cancers. Mental illnesses were estimated to be responsible for 15.3% of the total burden of disease in Australia in 200329.

Moreover, diseases of the brain and mind (including neurological conditions such as Autism Spectrum Disorders and Dementias) now account for more than 45% of all illnesses. These diseases are devastating for those affected, their families and for society and the cost to the Australian economy has recently been estimated to be in excess of $190 billion a year.30 These costs are expected to grow substantially over the next forty years. Dementias alone are predicted to more than treble from around 330,000 cases today to over a million cases by 2050.

Much of the economic cost of mental illness is in terms of productivity – time out of employment, education and training either due to illness or caring for some affected by a mental illness. The recent report from the Inspire Foundation31 showed that the cost of mental illness among young men alone (16–24 years of age) was a staggering $389,000 per hour, 24 days a day, 365 days a year – equivalent to the cost of an outer suburban house or an CBD apartment every hour.

For adults:

- Life expectancy is between 16–25 years lower, depending on the mental illness. Those with psychoses have the lowest life expectancy and it appears this has not changed for decades.

25 This figure of 60,000 and the definition is given by the Department of Health Ageing in several documents and based on an unpublished report by Harvey Whiteford and Bill Buckingham (2006 and 2011).
31 Inspire Foundation 2012. The cost of young men’s mental illness.
Obsessive Hope Disorder

- Ninety per cent of people with a mental illness have at least one other chronic health condition.
- The rate of obesity is between 55–70% higher than the general population.
- The rate of cardiovascular diseases are 2 to 3 times the general population.
- The rate of stroke is 130% higher than the general population.
- The rate of asthma is estimated to be 50% higher than the general population.
- The rate of diabetes is reported to be three times that of the general population.
- Musculoskeletal conditions are estimated to be twice the rate of the general population.
- For women who are exposed to repeated violence, nearly 90% develop mental illnesses.
- Lower socioeconomic status is both a risk factor and a consequence of mental illness.

For young people:

- The 12-month prevalence of mental illness is more than one in four young people (28%).
- Suicide is leading cause of death for people over 16–25 – nearly one in every four deaths.
- In every Year 12 class in Australia, on average, there will be one student who has attempted suicide.
- Two per cent of young men report a suicide attempt in the previous twelve months.
- Nearly 20% of young men report that ‘life is not worth living’.
- Nearly four out of ten young people binge drink regularly.

For children:

- Fourteen per cent of children are affected with developmental disorders and the majority are not identified or treated appropriately.
- One in 110 children have autism spectrum disorders.
- Over 250,000 child abuse notifications are received annually in Australia and appropriately 50,000 cases are substantiated. (Child abuse is the strongest predictor of mental health problems and suicidal behaviour in later life.)

Figure 6 illustrates some of the health status data of children, young people and adults with mental illnesses and developmental disorders.

The service response

Despite spending of over $6 billion this year on MHS by governments, access to affordable, timely and effective care is a widespread problem for people with any mental health condition. Over two million Australians with a clinical condition did not use any service in the previous 12 months.

The quality of mental health care continues to feature in many independent and media reports. While there is some evidence that the quality of care for people who are known to mental health services has improved, around 40% of those people with a severe level of disability from mental illness have little or no contact with services. For the estimated 700,000 Australians with moderate levels of psychiatric disability (usually with more than one illness, comorbidity substance abuse, poor physical health, long-term unemployment or on disability payments and socially excluded) access to services is even poorer with estimates ranging from 25–30%.

For people with moderate and severe levels of disability from mental illness, access to coordinated care, is critical to recovery. This means, health care working hand-in-glove with housing, transport, employment support, education and training, family support and child support and often with justice and Police. This is very rarely the case and consequently, an individual’s problems manifest and multiply and the road back to wellness, social inclusion and participation is fraught.

32 AIHW 2012
34 Bishop J 2010. Mental Health Services Reform. Presentation to the Mental Health Service Conference (TheMHS) Sydney, August 2010.
A recent major study examined the appropriateness of care for 22 common health conditions. Three of the conditions were mental health disorders, namely, panic disorder, depression and alcohol dependence disorder. The study examined the appropriateness of care with evidence-based or consensus based guidelines. Health care providers volunteered for the study and around 50% were GPs, 22.5% specialist practices and 14.5% hospitals. In general the review found “that the consistent delivery of appropriate care needs improvement. In the three mental health conditions included in the study almost three out of every four encounters for panic disorder were in line with guidelines, while only 55% of encounters for depression met guidelines. The care provided for alcohol dependence was appropriate in only 13% of encounters.

High rates of readmission to acute care (< 28 days), high rates of compulsory treatment orders and high rates of seclusion and restraint are all associated with poor mental health care and a system under stress. These are all features of Australia’s specialist public mental health care system.

Inadequate funding over decades lies at the heart of Australia’s mental health service need gap. Despite the increased attention to mental health at the level of COAG since 2006, the percentage of funding for mental health care is declining as shown here in Figure 5.

**The government response since 2006**

Prime Minister John Howard and NSW Premier Morris Iemma led the COAG response in 2006 to the damming assessments of Australia’s mental health system contained in the Mental Health Council of Australia’s Not for Service report and the Australian Senate’s From Crisis to Community report.

**Figure 5: Mental health vs health spending increases 2006–07 to 2010–11**

A major feature of the Commonwealth’s response package ($1.9 billion over 5 years) was the Better Access Initiative – items under the Medicare Benefit Scheme (MBS) for access to psychiatrists, psychologists and GPs which committed over $500 million under fee-for-service arrangements. In 2008 the Federal Budget increased the estimated expenditure from $538 to $773.5 million over the 5 years to 2010–11. This program is now costing around $10m per week to the Federal Government. Growth has being significantly greater in more affluent areas and metropolitan locations. Debate has been fierce with critics attacking the ‘business as usual’ approach under MBS for the Better Access program.

One of the major programs funded through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is the Personal Helpers and Mentors (PHaMs) program which aims to increase opportunities for recovery for people aged 16 years and over who have a severe functional limitation due to severe mental illness. Eligibility is typically restricted to the around 180 postcode areas allocated to a PHaMs service provider.

---

35 Runciman WB et al. 2012. CareTrack: assessing the appropriateness of health care delivery in Australia. MJA, 197 (2), 100-105.
37 Ibid.
An evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives, commissioned and managed by the Department, found that all stakeholders believed PhaMs was an effective initiative, with high satisfaction levels and support for the recovery model approach. There were concerns about the number of service providersfragmenting the system, the small size of many service organisations, and the short-term contracts having a negative impact on clients.\(^{38}\)

### A brief retrospective on the Rudd–Gillard Governments

The Rudd Government came to power in November 2007 with an ambitious social reform agenda. This included radical proposals for reforming the health and hospital systems and clear commitments to do better on mental health. The new Federal Health Minister Nicola Roxon stated in June 2008:

> As I outlined prior to the election, we are committed to meaningful reform … In particular, we are committed to:
> Putting mental health firmly on the national agenda, working with states and territories on an integrated national approach to service delivery
> Putting in place an evidence-based approach
> Reorienting mental health policy towards prevention and early intervention
> Ensuring mental health services are well integrated with other primary care and specialist services
> Investing in programs such as ATAPS to ensure resources are used to fill gaps in existing service delivery, particularly in rural and remote Australia
> Developing an open, transparent system of evaluation and accountability of existing mental health services

---

Developing a 10 year plan to address homelessness in Australia, with people with severe mental illness sadly prominent in our homeless population
Ensuring that people with a mental illness have every opportunity to gain and maintain meaningful employment without prejudice.

However, the only action on mental health of the Rudd Government was to cut funding to some programs, including the highly effective Mental Health Nurse Incentive Program. Some $300 million was clawed back from the Forward Estimates in the Budget Papers. In response to the chorus of criticism led by key mental health advocates, including the 2010 Australian of the Year, Professor Patrick McGorry, the Rudd Government included a modest package of some $181 million in new funding for mental health in the 2010 Budget and COAG Health and Hospital Reforms. This was less than 2% of the overall amount of new funding committed to health reform and the critical chorus simply amped up. Worse still, when closely examined this was just $31.5 million in real new funding over four years, the remainder being ‘funny money’—redirected, re-announced or re-badged. In real terms, mental health’s share of health funding was declining.

The 2010 Federal Election featured mental health policy as a central issue for all the major parties: the Coalition announced a $1.5 billion package in the campaign focused specifically on key areas of prevention and early intervention. The Gillard Government responded with a $273 million package targeting suicide prevention and the clear pledge that ‘mental health would be a second term priority’. Prime Minister Gillard stated that mental health would clearly be a “second term priority” for her government.

Despite occupying the Treasury benches since November 2007 and the much trumpeted $2.2 billion mental health package in the 2011 Budget, it was only in the last few months of 2012 that tangible progress emerged from decisions made by the Rudd–Gillard Governments on mental health. Finally additional youth mental health (headspace) services opened, the number of clients receiving care through the PHaMS Program increased (up approximately 20%) and there was some belated, limited expansion of the Access to Applied Psychology Services for people on low incomes.

Consistent with broader narratives on the Rudd–Gillard’s Government, the two most significant initiatives announced in both the 2010 and 2011 Federal Budgets, namely the commitment to Early Psychosis Program centres ($245m) and a new care program for people with severe and persistent mental illness (i.e. Partners in Recovery at $550m) are yet to deliver a single service to any individual.

Fourth National Mental Health Plan 2009–2014

The 4th Plan states that “Improving accountability for both mental health reform and service delivery are central to the Fourth Plan. The 4th Plan included several priority areas including, Prevention and early intervention; Service access, coordination and continuity of care; and Social inclusion and recovery. As with the previous NMHPs there was little detail in terms of resources, milestones and measures but again a multitude of possible actions and motherhood statements.

The 4th Plan did acknowledge that despite increased funding to primary and specialist services, treatment rates are low compared to prevalence and that service options need to be informed by population planning specifying the mix and level of services. It also acknowledges that there is a critical need to link between and within sectors, and achieve service coordination.

However, the 4th Plan reflected the same inadequate approach to the policy so evident in earlier National Plans.

41 Of the $2.2 billion, the majority of the funding was re-directed, re-announced or re-badged funds. Independent analysis by Access Economics showed only some $600million as additional funding over five years.
42 The Howard Government committed funding for the establishment and ongoing operation of 30 headspace service sites in 2005–6. While the Rudd Government agreed to increase this to 45 in 2010 and then 90 following the 2010 Election, the 31st headspace service only opened in early 2012.
43 While the NMHP is a inter-governmental agreement, its development is lead by and funded by the Commonwealth.
45 Ibid.
The Roadmap for National Mental Health Reform 2012–22

The final CoAG meeting in 2012 approved and released the 10-year Roadmap for reform. The Roadmap emerged as a policy commitment from the (then) Federal Mental Health Minister, Mark Butler in late 2011 prior to any consultation with states/territories or CoAG imprimatur. Consequently, ownership and acceptance of the document as a blueprint for reform by CoAG was somewhat muted.

...the Roadmap for National Mental Health Reform is the response of our collective governments to the challenge put to them by PM Gillard following her investment of $2.2 billion in new and redirected funds in 2011. As such one would have hoped for a document that clearly defined the destination, set a timetable for reaching landmarks along the road to the destination, defined key measures by which substantive change could be assessed, set real targets that were consistent with our national aspirations and modelled the size of investment that would be necessary to achieve real change.

Professor Ian Hickie AM, 11 December 2012

The initial reactions to the final document reported in professional commentary and national media reflected a sense of déjà vu of previous government blueprints – fine visionary statements with too little detail on what, how, when and by whom.

No specific performance measures were set out. Rather the Roadmap includes a preliminary set of 11 indicators and 3 ‘contextual indicators’. The task of developing an agreed set of measures has been sent to the Ministerial Working Group for report back to CoAG at the end of 2013.

In essence, the Roadmap leads us somewhere we have already been for a long time, not somewhere new.

The National Mental Health Commission

The National Mental Health Commission (NMHC) was established as a policy initiative of the Gillard Government following the 2010 Election. The development and release of an annual report card was its principle function. The National Commission is limited in its powers and constrained by being established as an executive office within the Department of Prime Minister and Cabinet. The NMHC is for all intents and purposes an advisory body within a central policy department answerable to and directed at will by the relevant Minister.

National Mental Health Commission Report Card

In November 2012, the NMHC released the much anticipated report card on mental health. The Report – A Contributing Life – was given considerable coverage in national media and drew attention to the failure of reform. However, it simply restated much of what other reports have said for more than a decade.

The Report points to the lack of any clear, agreed picture of what a good mental health service or model should look like and does not offer such. The Report Card does not propose any indicators or system of accountability but simply calls on governments to do so.

Generally while the Report Card has been welcomed by key stakeholders in the mental health sector, it is seen as ‘business as usual’, a largely rear-view mirror perspective on what has been rather than what is now, as lacking in prevention and promotion and short on discussion on early intervention and young people. While the NMHC remains in its current form, the Report Card is unlikely to drive national mental health reform.

For the NMHC’s Report card to become the game charger that everyone so desperately hopes for, what is needed is a culture change that sees mental health and wellbeing as a key indicator for the nation’s to its citizens.

In summary – The state of mental health services

What is clear from the available data on the health and social and economic wellbeing of those with mental illness, is that they continue to receive inadequate access to health care and that the health care received is too often not appropriate or effective. What is also abundantly clear, is that the cost of not providing access to care or quality mental health care is hurting the nation’s productivity and propensity.

Mental health services in Australia are neither planned on the basis of need (that is to respond to the population’s mental health needs) nor based on evidence of what works best. There are, in short, serious structural imbalances in the system of care compounded by poor and outdated practices.

A better way forward

Within this report, Obsessive Hope Disorder, we endeavour to tackle some of the critical issues for achieving the transformation of mental health and mental health care that for so long has eluded us. This is much more than achieving the vision and goals articulated by David Richmond in 1983 and later reiterated by Brian Burdekin all those years ago. It is all about ensuring that:

1. People with a mental illness have the same parity of access to and quality of care available to Australians with other major health conditions regardless of our origins, our income or postcode.
2. The mental health services and care available are based on evidence – not the legacy of history – and are focused on the earliest intervention and where necessary provide seamless continuity of care and linkage to social supports to enable full recovery with dignity.
3. Australians understand that being mentally healthy is much more than the absence of a mental illness and there are actions they can take to sustain and improve their own mental health and the resilience of their communities.
4. Mental health in Australia is seen and understood in relation to the bigger picture – including the contribution of mental health and wellbeing to schooling, urban planning, workplace relations, national productivity and more – mental health is part of the nation’s mental wealth.

The incremental, incomplete and inconsistent approach to mental health reform over the past twenty years is demonstrably inadequate and unaffordable for the challenges now confronting our nation.

We can and must do better. To do better we have to accept the baggage from the past, identify the barriers to reform and map out strategies for change based on these experiences and those who overseas.

One of most obvious artefacts of Australia’s national mental health reform project is that in every state, except Victoria, we still see stand-alone psychiatric hospitals still operating. These relics of the past in mental health are still very much defining our present service models, facilities, workforce distribution and practices, community attitudes, and so on. These relics are barriers to building a truly 21st century model of mental health services and achieving a mentally healthy Australia for all.

Breaking the bonds with the past requires new thinking and structures which impel the ongoing commitment of governments and others to the task of reform. It requires us to embrace new approaches and rid the system of anachronistic services and facilities.

---

Fix the policy and legal frameworks

In 2009 the World Health Organization (WHO) released guidance documents for the development and deployment of mental health policy. Improving health systems and services for mental health\textsuperscript{52} sets out best practice approaches to developing mental health policy, plans and programs, mental health legislation, planning and budgeting, human resource management and development of mental health information systems. Each of these elements are seen as the foundations for effective and sustained mental health service reform. WHO states:

“by using this strategy as a guide, countries can ensure that their mental health systems are not haphazard, but rather, the products of careful consideration and planning.”

The WHO documentation also provides a simple and practical ‘checklist’ for evaluating each of these critical elements of ‘infrastructure’.

A cursory comparative review of the findings documented in \textit{Obsessive Hope Disorder} and the WHO checklist highlights many basic failings in the approach taken over the past twenty years in Australia.

Robust frameworks for developing and implementing public policy in relation to health and human service systems are not novel. Yet this knowledge has not been applied to mental health policy in Australia over a very long time and there is little evidence from the most recently released planning documents (e.g. \textit{The CoAG Roadmap for Mental Health Reform} released in December 2012) that this is changing.

In fact there is some evidence that there have been actions taken at the most senior levels of bureaucracy to dumb down past mental health planning documents\textsuperscript{53}. It seems the avoidance of real reform and certainly real accountability, has been a ‘sin of commission’ rather than a ‘sin of omission’.

Further, continuing reports\textsuperscript{54} regarding the human rights abuses of people with mental illnesses and widespread discrimination, point to the need to get mental health legislation harmonised across Australian jurisdictions and aligned with international practice.

The rule of law is the basis of Australia’s democracy. It seems a good place to start to right the wrongs of current mental health care.

Figures 7 and 8 contrast the integrated and proportional approach to a system of mental health care proposed by the WHO and the reality of Australia’s array of service elements after twenty years of reform.

\textsuperscript{52} WHO 2009. Improving health systems and services for mental health. WHO Press, Geneva.
\textsuperscript{53} For example, the 2003-8 National Mental Health Plan did have in advanced draft forms specific, measureable goals and measurement methodology. These had been developed by the inter-government working groups. These specific details were removed by more senior officials before the documents were tabled with Health Ministers for agreement.
\textsuperscript{54} For example: Shine, K 2013. Medieval law jails mentally ill indefinitely. The Australian, 24 June 2013. There are dozens of examples of similar reports contained in the statutory office reports examined in Chapter 6 of this Report.
Figure 7: The WHO service organisation pyramid for optimal mix of mental health services

Figure 8: Childs play – A representation of Australia’s mental health ‘system’ and funding percentages and sources

55 The representation here is of a child’s set of building blocks. Unlike the WHO Pyramid, there is no logic or relationship between the service elements. Funding sources and the percentages of funding for each service element are based on AIHW data and are approximations.
Some relevant public policy developments

DisabilityCare Australia and mental health

DisabilityCare Australia is the new national disability insurance scheme (NDIS). This major reform, which will be implemented in stages, began on 1 July, 2013. DisabilityCare will provide individualised support to eligible people with permanent and significant disability, including those with a psychosocial disability associated with a mental illness. It is estimated there are 57,000 Australians with mental illness who would be eligible for DisabilityCare.

DisabilityCare will change the existing funding relationships of many service providers, including those currently providing Psychiatric Disability Rehabilitation Support (or community managed mental health) Services. This will result in changes to the operation of these services.

Many NGO community mental health services receive block funding to do so. Alongside the reform instigated by the NDIS, for some time there has been a general Australia-wide push away from block funding towards individualised support packages which place more emphasis on choice and control. Couple this with new national strategies, new structures such as Medicare Locals and Local Health Networks, new systems and sector reform means that enormous challenges lie ahead.

Subject to the finalisation of details with DisabilityCare, clients of existing community mental health services will continue to receive services under their existing arrangements until their area is transitioned across to DisabilityCare Australia by mid-2016.

The Productivity Commission noted in its report that although the community mental health system shares similar approaches and philosophies to the NDIS, it is placed within a broader mental health system, which, “with its clinical orientation, has been slow to recognise these approaches.” The Commission felt that the extra resources provided through NDIS would strengthen community mental health services. This is however complex reform intersecting with an already complex and fragmented mental health system and there will be many challenges, as well as opportunities ahead.

The ‘lifelong’ approach of the NDIS is very positive, as is the approach of putting people in control of the care and support they receive, based on their needs. This will create a ‘bottom-up’ demand for services, instead of the current, largely ‘top down’, budget driven approach to service provision.

There is however some cause for caution and concern. The predetermined pricing of DisabilityCare Australia may drive many service providers out of the market. There is also a danger that the quality of staffing will suffer with price pressures, increasing casualisation, compromising workforce supply, development and capacity into the future. Some clients will struggle as the services and supports they are used to change shape and evolve. There will be clients who are functionally more able or better supported than others to navigate these changes. Those with severe mental health problems may not fare as well.

The new system already has some well-informed critics:

“The thinking is old fashioned – the architecture of the design is archaic and bureaucratic. Australia is building the equivalent of a 1970s IBM super mainframe computer in an era of mobile devices and the Cloud. Modern systems push control and responsibility out towards citizens, allow for networking, assume capacity and enable open source innovation at every level.”

Simon Duffy Director, Centre for Welfare Reform UK

It will be important to monitor how the episodic nature of mental illness will sit within a structure largely built around functional impairments with far less variability and how DisabilityCare interfaces with the mental health legal system, with clinical services and with programs such as Partners in Recovery.

**Partners in recovery**

The Partners in Recovery (PIR) program is a key element of the current Federal Labour Government’s National Mental Health Reform Plan. With a $550 million dollar investment, it is second only in scale to the Better Access program introduced by the Howard Government in 2006 and approximately doubles the investment in the Personal Helpers and Mentors program. Unlike those two programs, PIR is not designed to deliver services, but coordinate them for a select group of ‘clients’.

Almost all of the investment is in service coordination and ‘system’ development. It aims to reach 24,000 individuals over the three years. It is envisaged that most clients will ‘exit’ the program and therefore will not be a PIR client on an ongoing basis. The cost of PIR care or service coordination will be approximately $23,000 for each client.

On the face of it, it seems consistent with the NDIS ethos of ‘choice and control’. Whilst both PIR and NDIS could be considered client-focused initiatives, they are actually working from quite different directions. PIR is focused on system reform, bringing providers together and creating a more integrated, collaborative approach to service provision, to the benefit of the client. Whilst we can expect a type of care coordination function to continue under DisabilityCare Australia, with significant market forces at play, the possibility is that competition may well drive providers further apart rather than together. System reform within PIR is top-down; system reform under the NDIS is more bottom-up in nature. Briefings from the relevant Commonwealth public servants responsible for the two programs, revealed little coordination or alignment.

**Activity-based funding**

Under the National Health and Hospital Reforms agreed to by CoAG in 2010 and 2011, health care services will move to activity based funding from the 2013–14 financial year.

Prima facie, there is probably no other sector with more to gain from the implementation of activity based funding (ABF) than mental health. Stories of funding originally earmarked for mental health being moved to prop up other areas of the health budget are commonplace. ABF offers new classification and costing technologies to make transparent what resources are being used and where, severely curtailing the capacity of hospital administrators to covertly suck funding out of mental health and put it to use elsewhere.

This same technology offers the prospect of creating a new lingua franca in mental health, national naming conventions which permit practitioners to establish new benchmarks, to compare like with like and improve the quality of the care they provide. There are currently no such benchmarking tools available in mental health in Australia.

While these advantages accruing from ABF are considerable, there is also some immediate problems to overcome. In the absence of more suitable casemix classifications, governments are likely to use stop-gap measures such as diagnostic-related groups (DRGs) by which to classify and fund mental health care. Not only are DRGs not very accurate descriptions for mental health care types, but they are also not very accurate predictors of patient-by-patient resource use. Until new casemix technology is devised, the system will be quite inaccurate.

Perhaps more concerning than this however, is the fact interim ABF arrangements will likely perpetuate the hospital-centric nature of mental health care in Australia, providing new levels of Commonwealth-funded growth to precisely the wrong areas for the purposes of mental health reform.

The urgent task facing Australia in relation to the application of ABF to mental health is to build an approach which not only accurately describes the services we want to see flourish in a contemporary system of care, but one that also has the right financial incentives. Such incentives must properly prioritise the community over the hospital as the focus of care, including the use of appropriate incentives and sanctions to help guide decisions about what services to provide and where. Such an approach would then drive ABF to work consistently with the preceding 20 years of national mental health policies.

---

57 Briefings have been attended by authors of this report on several occasions in the past 12 months.
and plans including, most recently, the Contributing Life Framework issued by the National Mental Health Commission.

**What these policy developments all mean for mental health reform**

The short answer to this is we don’t yet know. However it is important to take note again of history and be aware that the momentum of mental health reform may yet again fall victim to broader health and human service reforms.

Indeed here in Australia, ABF models have operated in Victoria for many years and as was shown in the Not For Service report in 2005, that the access to care and the quality of mental health care (e.g. as it adequate length of time for recovery to commence prior to discharge from acute care) is not necessarily advanced through such funding models.

Equally, the introduction of DisabilityCare, will on the present indications, only provide care for those 50,000–60,000 people most severely disabled by mental illnesses. It offers little if anything for the hundreds of thousands of others with severe mental illness, or the hundreds of thousands of people on welfare and unemployment payments with moderate levels of mental illness or the 20,000–30,000 cases each year of first onset psychosis. Indeed as is becoming evident in the NDIS trial sites, it may reduce access to services for those not deemed eligible for DisabilityCare.

**Scaling innovation and evidence-based practice**

Innovation and the ability to apply evidence routinely is often cited as a key factor in any organisations success. McDonalds, the global fast food giant, has a stunningly simply but seemingly effective business strategy: ‘think big… start small… scale fast’. It means to continue to be successful, the organisation must foster and support innovation and creativity, prove it works (test it, stress it, try to break it) and then move quickly to market ahead of competitors – think big, be brave, be quick.

Delivering effective mental health care is obviously more complex than selling food, but the McDonald’s strategy principles could be applied to overcoming some of the problems evident in mental health care in Australia.

In every area of health care practice, there is a lag time between novel approaches becoming the new standard of appropriate or guideline based care and then a further lag to when they become the routine practice of those delivering care. In mental health, that lag time is too long. The evidence presented in this Report raises many questions regarding the quality of mental health care. A preliminary list of mental health care practices and models where there is robust evidence to support the widespread application and availability in Australia. It is not a definitive list, but illustrative of the problem. We need to have the commitment and strategy to urgently scale these across the nation.

**The Manifesto for Change**

The next section of this Report sets out a Manifesto for Change.

There are five strategic issues addressed in the Manifesto: Governance; quality of care; workforce; research and evaluation; and funding.

There is an urgent requirement for a ‘root and branch’ review of the governance of mental health in Australia, bolstered by new attention to accountability, research and workforce development. Together with a commitment to a fair share of funding allocation, these are the building blocks of real and sustainable mental health reform.
Obsessive Hope Disorder and A Manifesto for Change

The history of Australian mental health reform over the past three decades is one of world class policies and strategies let down by inadequate planning, poor implementation and our complex system of government. The results have been disappointing, wasteful of scarce resources and all too often, devastating for the millions of Australians affected by mental illness.

Despite this, many consumers, carers and people working in mental health remain positive. They are afflicted with a condition known as ‘obsessive hope disorder’ (OHD), a condition which permits them to understand mistakes of the past and plan a better future for mental health. OHD is characterised by a willingness to keep hoping, keep dreaming.

We strongly believe that OHD can be cured, that mental health reform is both practically possible and enjoys overwhelming community support. From the evidence and the analysis presented in this Report, the key to curing OHD is immediate attention to five urgent elements of reform: governance; quality of care; our workforce; research and evaluation; and funding.

Area 1 – Governance

The recent involvement of the Council of Australian Governments in mental health since 2006 has been most welcome. However, a legacy of recent reforms has been to exacerbate role confusion between the states and territories and the Federal Government. The key to a better future for mental health in Australia must be to end this confusion and put in place new, clarified governance arrangements for mental health. We need to get better organised to end waste and duplication and maximise the investment return. This should be done in several interrelated steps:

1. A study to establish cost of mental illness. So as to definitively understand both the scale of the problem and the investment required, the Productivity Commission should conduct an inquiry to develop a complete picture of the cost of mental illness and suicide to the Australian community.

2. A national review of roles. The second task for the Productivity Commission is a formal review of the current roles and responsibilities for mental health across Australia. Current role confusion is both wasteful and unsustainable. It must also answer questions regarding the service mix and scale to be available for a given population as well as issues of national quality standards. The Productivity Commission would be charged with providing clear recommendations about how to drive improvements.

3. National Mental Health Commission as a statutory authority. The next step would be to enhance the role of the National Mental Health Commission. To be to be effective it must become a more genuinely independent body, with statutory powers of inquiry and reporting functions to the Australian Parliament. A revamped Commission must have both the statutory powers and resources necessary to develop, monitor and independently report on national mental health policy, programs and outcomes in Australia.

4. A national audit of mental health programs. An important first task for a revamped National Commission is a nationwide audit of mental health services. The approach to service development over past decades means that the nature and quality of care varies wildly depending on where you live. A national audit would for the first time map the type and quantity of services available across Australia, as well as document any evidence regarding the effectiveness of these services.

5. The National Mental Health Report Card. A further key role for the Commission must be the regular public reporting of our progress towards reform. The National Mental Health Report Card must become the focus of our efforts to provide consumers, carers, service providers, policy-makers, researchers and funders with clear advice about whether what we are doing is really improving the lives of people with a mental illness. The Report Card must include data on life expectancy.
6. **Independent program evaluations.** Program evaluations must be conducted independently of the departments and agencies responsible for the development of policy and the administration of programs. This responsibility, and the funding, should be moved to an appropriate independent body to manage e.g. the National Mental Health Commission, the Australian National Audit etc.

7. **Model legislation and legal processes.** Harmonisation of legislation in mental health care was a goal under the first National Mental Health Plan. Regrettably, we still have significant variations in mental health legislation in Australia. The National Mental Health Commission should work with states and territories to establish an agreed best practice approach for the justice system.

8. **Discrimination law.** Housing, employment and social participation opportunities are frequently denied to people with mental illness. On the basis of the evidence in this report, the Australian Law Reform Commission should be asked to examine the provisions of Australian law and international experience and bring recommendations before the next Parliament for consideration.

9. **Inquiry recommendations.** Recommendations formulated by statutory authorities and government reviews frequently are not addressed or implemented by the respective government departments or agencies. This is a broader whole-of-government governance issue and not unique to mental health services. To address this, recommendations arising from reviews and the resultant actions need to be included in annual reports of government agencies.

**Area 2 – Quality of care**

The quality of mental health care across Australia remains highly dependent on where you live, your capacity to pay for services and your determination and persistence (or that of your loved ones) to get you to care. Astonishingly, we still see hundreds of Australians held indefinitely in stand-alone psychiatric facilities twenty years after all Australian governments agreed to close these relics of the 19th Century. This is indefensible and a continuing violation of human rights.

The lack of a national service framework, agreed models of quality care, particularly community based mental health care, the lack of care guidelines and defined pathways to and from care, means people needing mental health care enter a bizarre lottery. This is possibly a key factor in the reluctance of so many Australians, whilst increasingly aware of mental illness, to seek help.

Real improvements in quality of care rely on the following elements:

10. **A national service framework.** There is no clear and shared understanding as to what community mental health care looks like – the architecture never drawn. This must change. The spectrum of services, the standards of care, the pathways to and from care can be articulated through a National Service Framework agreed to by all governments and the sector. The National Service Framework must clearly articulate and define the mix of services: prevention, early intervention, primary care, specialist care, community based care, acute and sub-acute hospital based services. Leadership for the development of the Framework should be vested in the revamped National Mental Health Commission and co-chaired with one of the new state mental health Commissions.

11. **National models of care.** A clear, progressive National Model of Community Mental Health Care informed by international experience and evidence is the basis for higher levels of consistency in the provision of services. The deployment of a national model of care and the development of pathways to/from care for specific mental health problems supported by national training will improve the quality of care.

---

59 In Australia there are just four Clinical Guidelines relating to mental health conditions issued by the NHMRC. They are all medical in emphasis. In the UK, there are over 30 current and approved care guidelines issued by the equivalent body.
12. **Investment in e-therapy and online services.** In the past few years, governments have begun to invest in universally accessible telephone helplines and online service platforms available 24/7. The deficiencies in current services, the workforce constraints, the maldistribution of Medicare funded services and Australia’s dispersed population make investment in 24/7 telephone and online services a no-brainer. These services can be a pathway into care for some and improve care continuity.

13. **Employment policy.** Another consistent theme in the evidence gathered for this report is the failure of employment policy to address the needs of those with mental illness. Employment is a proven component of recovery from a mental illness for the vast majority of people. Employment policy must be framed on the basis of evidence. This is a very simple proposal. The savings to the government budgets, the improvement in productivity for our nation, the improved quality of life and prospects for recovery for these Australians will be the payoff. It’s that simple and the need is urgent.

**Area 3 – Our workforce**

Mental health needs to be a place people want to work. Thirty years ago David Richmond made numerous recommendations relating to the mental health workforce and its needs to successfully transition to community based care. In the years since, the evidence in this report shows many of his recommendations have been repeated and further developed by other reviewers. Over and over again, one reads of the urgent need to act on workforce reform and development.

Despite the unequivocal message to act urgently and assertively on workforce, the best we have seen is an investment of $287 million over five years (or just $57 million per annum) under the COAG National Action Plan on Mental Health 2006–11. This is too little and it is getting close to being too late. The following key steps must be undertaken:

14. **A National Mental Health Workforce Institute.** Australia needs a National Mental Health Workforce Institute specifically established to nurture the workforce of the future and ensure that mental health is a sector where talented people want to work. The systems approach and ‘starter kit’ presented in this report provide a basis and focus for the Institute.

15. **A national workforce plan.** There are already unsustainable pressures on our mental health workforce. There is no national plan to arrest this situation. The Institute would be charged with developing this plan to address not only the size, make up and competencies needed for a contemporary mental health workforce, but also ways of working, the desired culture and leadership.

16. **New roles.** A core focus for the Institute would be designing new roles for peer workers and strengthening the definition of community mental health workers. Greater involvement of peer workers in the delivery of community and hospital-based mental health care is probably key to making our future workforce sustainable. The same is true of community mental health workers. New e-health services require e-health workers to be trained. We also need to ensure enough staff to make the most of new investments in youth mental health, such as the early psychosis (EPPIC) services.

**Area 4 – Research and evaluation**

Despite the prevalence of mental illness and the burdens of disease (13%) and disability (24%) mental health research remains stuck at less than 8% of total national research funding. This is puzzling at a time when we are looking as a nation for ways to lift our declining productivity. Maybe it's time for a mental health research led recovery, using the following approach:

17. **A National Institute for Translational Research in Mental Health.** Funding for mental health research has unfairly failed to reflect the burden of disease. Where funds have been provided (largely by the NHMRC) they have focused on the laboratory rather than translational or service-focused research. A new National Institute is a priority initiative, to enable greater focus around

---

mental health research, promote collaboration between existing researchers and ensure proper attention on translational research.

18. **Prioritised funding for research.** What is clear is that in Australia, medical research is funded on the basis of demand and not epidemiology or national priority. Putting it bluntly, those with the greatest capacity, get the greatest allocation of public research funds. The new National Mental Health Research Institute would require funds of $100m to be drawn from the existing NHMRC budget (approximately 12% of current funding).

**Area 5 – Funding**

Many of the ideas put forward in this manifesto cost little. However, and as recommended by successive inquiries and reports, real reform of mental health will require more resources as well as more intelligent use of resources. The following steps are necessary.

19. **A fair allocation of funds.** While the financial constraints facing Australia are acknowledged, and even with recent increases in spending on mental health, the rate of overall increase to the annual health budget means mental health’s share is actually declining not increasing. A better future for mental health in Australia rests on a fair allocation of funds. Mental health’s share of the total health budget should be 12% by 2020.

20. **Examine funding models.** At the moment a key driver in mental health is not what works but who pays, an unhelpful legacy of the confused governance arrangements between the states and the Federal government. Another key task to be undertaken by the Productivity Commission therefore must be to examine funding models and options for mental health in Australia, including consideration of alternatives internationally.

21. **Funding directed to evidence-based services.** New funding must be directed to the ‘best buys’ in terms of evidence. Australia still spends more than half a billion dollars a year on stand-alone psychiatric facilities and some states are still spending over 50% of their entire mental health budget on hospital based acute services – This is an inefficient policy choice. The results of the audits and reviews set out earlier and the National Service Framework must drive investment in mental health over the next decade.

**Conclusion**

Obsessive Hope Disorder (OHD) is a serious matter. Given what we know, probably the entire Australian population is afflicted, knowing that mental health care in Australia is not good enough and really wanting things to improve. Some people have been affected by OHD for thirty years, most more recently as their understanding of mental health has developed. It is long past the time to deliver on the intentions of David Richmond’s 1983 report and the promise of community based care for people with mental illness. It is long past the time to end stigma against people with mental illness. It is time to respond with what is required to cure ‘Obsessive Hope Disorder’.

This Manifesto has described key elements of the remedy, the essential steps to be taken in the effective treatment of OHD; to end the cycle of neglect in mental health care.

There is an urgent requirement for a ‘root and branch’ review of the governance of mental health in Australia, bolstered by new attention to accountability, research and workforce development. Together with a commitment to a fair share of funding allocation, these are the building blocks of real and sustainable mental health reform.

This Manifesto will help turn Australia’s inextinguishable hopes and dreams for a better future for mental health into a reality. It’s about time!
PART 1

The journey of mental health reform
Introduction – The journey of reform

“Life can only be understood backwards; but it must be lived forwards.” Søren Kierkegaard

This year, 2013, marks the 30th Anniversary of the Richmond Report and Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled. It also marks the 20th Anniversary since the Human Rights and Equal Opportunity Commission (HREOC) completed its Inquiry into The Human Rights of People with a Mental Illness, known as the Burdekin Report.

When the Human Rights Commissioner, Brian Burdekin commenced his Inquiry in 1990, there was no national approach or strategy in relation to mental health. However, through the course of his Inquiry, governments mobilised to respond to the impeding harsh critique to be issued by the HREOC. Before he completed the Inquiry, all Australian Governments had signed off on a National Mental Health Statement of Rights and Responsibilities (1991), a National Mental Health Policy (1992), a 5-year National Mental Health Plan (January 1993).

In this Part of Obsessive Hope Disorder, we track the origins of reform – origins that pre-date Richmond and Burdekin that are very evident in both the journey of reform since 1983 and the state of mental health care in Australia today.

Mental health services have had a long and controversial history in Australia. While most of the states established asylums in the mid1800s, significant public debate and concern was apparent by the late 1860s, evidenced by the establishment of Royal Commissions in 1870 and again in the early part of the 20th Century1. These commissions were ordered to qualify the existing management structures, which had been suggested to be unaccountable and arbitrary2.

Institutional care continued to grow through the first half of the 20th Century, in part to accommodate a new group – returned service personnel from both World Wars. The numbers in institutional custody peaked in the mid-1950s. Again public concern regarding the conditions within the psychiatric institutions led to the first national inquiry – National Inquiry into Mental Health Facilities and the Needs of Australia by Allan Stoller (the Stoller Report)3.

The Stoller report represented the first real interest of the Federal Government in mental health services and the beginning of funding and other assistance by the Commonwealth, albeit reluctantly:

“I merely repeat that this matter is one which has, ever since the establishment of the Commonwealth, been under the jurisdiction of the States. … I do not propose to hold a conference to ascertain whether the Commonwealth is now to enter the maintenance field on this matter…”

Robert Menzies, Prime Minister, Parliamentary Hansard, 10th May 1955

The Stoller Report observed that the mental health system in each state was inadequate: it confirmed unacceptable overcrowding, an almost complete lack of curative or palliative measures, a chronic shortage of professional staff, and poor facility maintenance and equipment or both in Australian mental health hospitals. He went on to cite services that were restricted to custodial rather than therapeutic treatment and that medical standards needed improvement. His recommendations included:

- the need for large numbers of suitable trained professional staff
- the need for a program of applied and basic research
- the modernisation of facilities to be more therapeutic and less custodial or restrictive
- the need for an increase in community services, including early treatment services, clinics, training centres and community education4.

---

3 Stoller A Arscott KW 1955. Report on Mental Health Facilities and Needs of Australia AGPS ACT.
4 Ibid.
Stoller’s report marked the beginnings of the philosophy and policy of de-institutionalisation in Australia and reflected trends in both the UK and USA in the early 1950s. However, the process of emptying the asylums would not get underway in earnest until the 1960s.

The Menzies Government responded to Stoller’s recommendations with a tied capital grants program to the states in lieu of fees or more direct Commonwealth involvement. Sadly within just six years, another Royal Commission (in NSW) into mental health services was underway in 1961. A pattern of crisis-government commissioned review-report and government response that has been repeated almost without exception since Stoller’s inquiry.

What is evident in looking at the origins of mental health reform, is that much of what Stoller found and recommended, Richmond found and recommended thirty years later and Burdekin similarly, ten years further on.

In this Part 1 of Obsessive Hope Disorder, Chapter 1 from Doris Kordes examines the formal dismantling of institutional or asylum based care. Kordes provides her reflections on the Richmond Report and the history and politics of twentieth-century Australian mental health care. In this she aims to unsettle an assumption attributed to the Richmond Report – the notion of a rupture between two eras of care: institutional and community care.

Chapter Two includes two short reflections from Brian Burdekin setting out why the Inquiry occurred, what they found and what they learned. The Chapter includes a list of all inquiries into mental health

Chapter Three presents an analysis of Australia’s reform through the deployment of the national Mental Health Policy and five-year Plans. The analysis draws upon the Plans, implementation plans, the commissioned reviews or evaluations and other government data sources such as the Report on Government Services prepared by the Productivity Commission.

In this analysis, six key consistent themes across the four National Plans, covering 20 years from 1992, are discussed in terms of commitments made in each plan and the available evidence that the commitments were implemented or achieved.

The result is disturbing if not alarming. Repeatedly the same issues are identified as priorities for action and repeatedly the reviews and available data point to policy implementation failure.

Finally, Part 1 concludes with an analysis of the workforce and its journey through this period of change.

5 The arts of care in an asylum and a community 1925-2004: Kenmore Hospital, New South Wales and Canberra, the Australian Capital Territory, 2009, the Australian National University.
Chapter 1

The dismantling of institutional care: The 'Richmond Report'

*Doris Kordes*
Obsessive Hope Disorder
**Introduction**

In 1982 the NSW Government established the *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*. The Inquiry, led by David Richmond, investigated public mental health services, including ‘Fifth Schedule’ psychiatric hospitals, public hospitals, and non-profit community organisations. A report of the Inquiry’s findings and recommendations (the ‘Richmond Report’) was published in 1983.

The terms of reference for the Inquiry were to:

1. Determine the appropriate nature, extent and distribution of services for the psychiatrically ill, psychogeriatrics and the developmentally disabled in NSW.
2. Review the appropriateness of the existing range of care and services for these groups and examine alternative methods of care and service delivery.
3. Identify priority areas for the development of new services.
4. Assess resource requirements for the psychiatric system in the light of the findings in 1, 2 and 3 above.
5. Review the role of the non-government sector in these areas and to recommend future arrangements for co-operative planning, funding and co-ordination between government and non-government agencies.
6. Identify a broad strategy and mechanisms for implementing recommendations arising from the terms of reference.

While the Inquiry was initiated partly by concerns about the ongoing treatment and care of the ‘developmentally disabled’ in asylum settings, the Richmond Report is now mainly remembered for its schedule of recommendations for emptying and closing down asylums as part of the move towards care in the community. The Inquiry’s recommendations provided the NSW Government with a blueprint for the decentralisation and integration of public mental health services across non-government organisations and psychiatric units of general hospitals:

1. That services be delivered primarily on the basis of a system of integrated community based networks, backed up by specialist hospital or other services as required.
2. That the two prime operational objectives be to 1) fund and/or provide services which maintain clients in their normal community environment and 2) progressively reduce the size and the number of existing Fifth Schedule hospitals by decentralising the services they provide.
3. That priorities for funding in mental health be:
   i. Provision of additional community based crisis teams
   ii. Provision of staffing to provide adequate follow up for mentally ill people in the community
   iii. Provision of psychiatric staff for assessment services in general hospitals
   iv. Provision of linked networks of hostels and satellite housing
   v. Provision for opportunities for training existing Fifth Schedule hospital staff for new roles in community and specialised hospital services.

The following reflections on the Richmond Report are based on my doctoral research findings on the history and politics of twentieth-century Australian mental health care. Throughout, I aim to unsettle an

---

2 By asylum, I refer to an institution variously described over time as lunatic asylum, hospital for the insane, mental hospital, and psychiatric hospital or centre. Asylum is used to discomfort and unsettle the reader in a way reminiscent of Goffman’s ‘challenge’ (Reaume 2002:413), of maintaining the tension of its stigmatised association, and resisting the move – by psychiatry and government policy makers – to drape it in medical terminology.
4 The arts of care in an asylum and a community 1925-2004: Kenmore Hospital, New South Wales and Canberra, the Australian Capital Territory, 2009, the Australian National University.
assumption attributed to the Richmond Report – the notion of a rupture between two care eras: institutional and community care.

The rise of care in the community

While the Richmond Report may be remembered for its list of recommendations that heralded the end of institutional care, a process of deinstitutionalisation was well underway across Australia as well as Western Europe and North America from the 1950s onwards. The outcomes of the Inquiry symbolise the culmination of a series of policy shifts towards care in the community. It may be helpful for the reader to consider some of these policy changes, situated in the particular social, political and psychiatric landscapes of NSW, from the 1960s through the 1980s.

The policy discourse of care in the community was underpinned by the belief that it was feasible to blur the social boundaries between people living with mental illness and their community. It was believed that the blurring of these boundaries would not only facilitate recovery but would also remove the stigma associated with mental illness. Mental health reformers believed that psychological healing should not be confined to the psychiatric ghetto of the asylum, and contrasted its traditional culture of segregation, dependency and paternalism with the potential of normalisation through community programs and activities.

The 1960s was a decade of unrest, of civil rights movements including anti-psychiatry activism, given credence by writers such as Laing, Foucault, Goffman and Szasz. During the 1970s, the moral persuasiveness of consumer rights and freedoms began to merge with fiscal considerations. Policy and psychiatric literature argued for the return to community solutions, but to what degree policy reformers were motivated by political ideals or by economic considerations remains questionable. Reflecting on this historical period of mental health reform in the western world, Hacking observes that:

Local authorities and health services were beginning to be strapped for funds after the initial post-war boom, and in the late 1960s and 1970s were delighted to discover that it was politically incorrect to incarcerate fairly harmless mad people at public expense.

In NSW, the Mental Health Act 1958 superseded the Lunacy Act, signifying a shift in emphasis from custodialism and restraint to medical treatment. It emphasised the desirability of voluntary admissions and created new categories of patients such as the temporary patient, with a more active review of lengths of stay. The introduction of the therapeutic community approach in NSW psychiatric hospitals during the 1960s marked the expansion of a facilitative response by government towards asylum residents, with programs that actively prepared them for their reintegration into community. Pharmaceutical interventions were viewed as more effective and ideologically sound than physical restraints. Open door policies were introduced, giving a large percentage of patients an unprecedented greater freedom of movement.

In 1962, there were fewer than 13,000 patients in NSW asylums. By 1973, resident numbers had dropped to 8,761. In 1981, the NSW Health Commission reported that ‘hospitals for the mentally ill, developmentally disabled and persons admitted by a court order under the Inebriates Act 1912’ had a total of 4,341 residents as at 30 June 1980, 596 of whom resided in Kenmore (Health Commission 1981:77). By 1983, with the publication of the Richmond Report, the number of available beds in NSW psychiatric hospitals was 3,700.

---

6 Pinfold V 2000. ‘Building up safe havens … all around the world’: users’ experiences of living in the community with mental health problems, Health & Place 6, p 202.
7 Ibid p 206.
11 Shea writes that under this Act the concept of the voluntary patient, imbued with the competence to give informed consent was ‘frequently stretched beyond recognition’, describing the observations of an Independent Committee on ‘Total Patient Care in NSW Psychiatric Hospitals’ (1976) that found severely intellectually disabled ‘voluntary’ patients in three NSW psychiatric institutions (Shea 1999:63,72n).
In his final report as Director of NSW State Psychiatric Services, Dr William Barclay noted the continuing decline in asylum residency numbers and associated this with the rise of community mental health services. Barclay offered some advice to the new Health Commission, an organisational entity that was to incorporate the functions of the State Psychiatric Services:

This may be the final report by any Director of State Psychiatric Services for New South Wales, as by the time the next report can be presented the position of Director will have made way for the Health Commission of New South Wales. It is to be hoped that the disappearance of this position with its specific responsibilities will not mean any lessening of the standards of care, protection, and treatment of the mentally ill. The mentally ill are a silent minority whose needs are easily overlooked as the history of our own mental hospitals has shown. It would be sad indeed if in our enthusiasm for the future we were to forget the lessons of the past.

The office of the Director of NSW State Psychiatric Services was abolished by the legislation that established the Commission and ‘absorbed within the structure of the Bureau of Personal Health Services’ (NSW Health Commission 1973:6). Over time psychiatric hospital reports became limited to approximately 150 words, a stark contrast to the lengthy correspondence submitted by the various incarnations of Inspector-General of Mental Hospitals and more recently, Director of NSW State Psychiatric Services. The erasure of psychiatric hospital activities from NSW Government reporting procedures was perhaps reflective of the stigmatisation associated with institutional care, and a sign of things to come.

It was believed that the asylum solution was diametrically opposite to a community model of care:

Two or three decades ago the chronic mentally ill patient often entered hospital early in his adult life, and there he stayed, passing through a sequence of remissions and relapses with little prospect of release. When hope had withered, and nothing was left to strive for he assumed the armour of morbid indifference, he became institutionalised and this condemned him to remain. ... (t)here is now an emphasis on therapeutic and social support for the patient in the community and mental health workers are beginning to concern themselves with genetic, family, social, and environmental factors in the cause and control of mental disorders. Thus mental health care is no longer a purely medical prerogative, but a co-operative responsibility of medical, psychological, social and lay workers.

This progress narrative, written by a psychiatrist and former director of mental health services in the ACT, envisaged the expansion of psychiatric practice in the wider, geographical treatment net of the community. It was believed that the rationalisation of asylums, as proposed by the Richmond Report three years later, would lead to improvements in service provision, increase opportunities for community integration, and result in the reduction of stigma associated with mental illness.

13 Director of NSW State Psychiatric Services, 1971, p. 3.
The Richmond Report

The dismantling of NSW asylums that commenced during the 1960s and the 1970s accelerated after the release of the Richmond Report. Unlike the cheerful and optimistic writings of Annual Reports submitted by the Director of Psychiatric Services during the 1960s, the Richmond Report described asylums as isolated institutions segregated from the community, and fostering client dependence.

A key problem identified in the Report was that a ‘separate system’ of services, as represented by the asylum, gave rise to a particular culture, with the following features:

- An isolated system of service delivery which separates the care of the disadvantaged from the rest of the community.
- The stigma of working in institutions dealing only with a disadvantaged client population.
- Attitudes about lack of community acceptance of clients resulting in attempts to ‘protect’ them by keeping them away from the community.
- A genuine belief that clients will suffer outside of the care and control of a hospital.
- The staff and their unions have become the main advocates for these clients.
- Perceived and actual reductions in resources available, which take away incentives to do anything but ‘basics’ and thus further reinforcing client dependence.
- The training of the mainstream profession (i.e. psychiatric nurses and mental retardation nurses) has been isolated from modern tertiary education and even to some extent from its own mainstream profession.\(^{15}\)

In response to the above issues and concerns, the Inquiry findings were that ‘as far as possible the existing services of psychiatric hospitals be decentralised to the local areas which they service – acute psychiatric services and community mental health services should be managed by local general hospitals. Hostels may be managed by local hospitals or non-government organisations’ (Part 1, p.34). It was believed that decentralisation of services and system integration would lead to stigma reduction; improved advocacy outcomes for people with mental illness; higher quality of clinical services; and continuous co-ordinated, and flexible care (Part 1, p.36).

The Richmond Report noted that the budgets for psychiatric hospitals:

> absorb most of the resources for the services being examined. In the Inquiry’s view the perpetuation of a segregated system ... of service delivery dealing largely with a population of socially and economically disadvantaged clients denies these clients the possibility of access to better treatment and assists in maintaining their disadvantage.\(^{16}\)

The resources of about $200 million of recurrent expenditure were ‘locked’ into institutional care, and therefore did not permit people with mental illness to access other public mental health treatment options. It was estimated that the ‘potential level of savings’ from the rationalisation of asylums would be a ‘low conservative figure of a 10% saving’ to the current operating costs:

> Whether this can be realised will only be known if an effective programme of provision of community based services and rationalisation of hospitals is actually implemented and monitored.\(^{17}\)

While the Report recognised that community care would increase people’s risk of becoming homeless, impoverished, vulnerable to forms of discrimination and violence, and more likely to spend time in police lockups and the prison system, this was regarded as preferable to client dependence on government services. This view was framed by asserting that risk was an inevitable aspect of life and should therefore not be controlled for too vigorously.

---

\(^{15}\) Part 1, pp.30-31.
\(^{16}\) Part 1, p.28.
\(^{17}\) Part 1, p.44.
It should be remembered that the Richmond Report was published during a period that marked the rise of market place rationalities of liberal governments, giving rise to market solutions for social problems and accompanied by a downturn in public spending by government on health and other services.

In this political scenario, risk was re-imagined as a by-product of the freedom, choice and self-empowerment of subjects of government: ‘the dependent subject of welfare-ism, protected from risks, and on whose behalf the state would intervene, is replaced by the juridical subject of neo-liberalism, now granted rationality and responsibility – free to decide for himself/herself, as it were’[^16].

In addition to placing political and fiscal pressures on asylums to increase their rate of deinstitutionalisation, the Richmond Report recommended the organisational separation of the developmentally disabled from the psychiatically dis-ordered. In 1985, Kenmore was segregated into two autonomous administrative bodies now referred to as Kenmore Hospital (providing services for ‘psychiatric disability’) and Strathallan (providing services for ‘developmental disability’). The split included moving funding and administrative responsibility for the developmentally disabled from the Department of Health to the Department of Community Services. The asylum’s buildings and grounds were thus converted into two separate institutions[^18]. It not only divided up the physical landscape; social ties between patients were effectively ended.

**Emptying the asylum**

The Richmond Report recommended that psychiatric beds available at Kenmore Hospital be reduced from 396 to 250 by 1986–87. Nurses’ recollections of the emptying of Kenmore were reminiscent of a technical procedure for moving bodies rather than a process for emancipating patients[^20]. According to the nursing staff who participated in my research, administrators were not looking for complexity and difference but were instead governed by bureaucratic priorities and focused on finding expedient solutions.

Buildings were gradually emptied. The buildings and grounds of the Kenmore campus, as it was now referred to, were gradually allowed to deteriorate and become run down. By the 1990s, the asylum’s services were decentralised and regionalised.

In the course of Kenmore’s depopulation, patients were assessed for their capacity to live in the community:

**Brenda:**[^21] Now a lot of the questions on these assessments just didn’t apply to patients and some of them, I’ll give you an example, Miss M, she could, she had done her own shopping, she had her own furniture, she had her own cooking stuff, everything she owned when she came in here she brought with her. And did her own cooking and everything; her own washing. And, she’d done everything for herself.

**Linda:** She had all these, these real paranoid sort of ideas. I mean, she’d been in for 60 years.

**Brenda:** But when she was living here she could do for herself. But to put her out in the community was ridiculous, it was ridiculous. And when she left here to go into the community she would have gone to one of these ah I’d say nursing homes, because of her age. And she wouldn’t have lasted because she wouldn’t have eaten food, they wouldn’t have understood …

**Linda:** Oh, we had so many arguments, fights, damn near tears, … we battled on, and we kept some of them didn’t we, for a few years, but in the end we lost the battle.

[^19]: In their annual reports to the NSW Legislative Assembly during the twentieth century, various incarnations of the position of Inspector-General of Mental Hospitals were critical of the expectation that asylums accommodate people who were aged and infirm, people with epilepsy, people with intellectual disability, and ‘inebriates’. They argued that people with intellectual disability, referred to in this period as ‘mental defectives’, required specialised institutional care by education authorities. However, the practice for lumping together these diverse population groups together continued to be favoured by government due to the cost-effectiveness of this solution.
[^20]: For most of these former nurses, Kenmore was their main place of employment throughout their working lives. Female research participants tended to arrive at Kenmore in their teens, take time out to have children, and return to Kenmore when family circumstances permitted. Working life at Kenmore spanning three decades was not unusual. Two of the 13 research participants commenced working in the asylum in the 1940s, two in the 1950s and seven in the 1960s. The remainder commenced work in the 1970s and 1980s.
[^21]: The names of research participants have been changed.
Brenda: Because they always thought we were overprotective and possessive. And we weren’t, really, because people who could go into the community and some of them have done really well, haven’t they? … [but] some of the real old ones that had been here for 50–60 years, this was their home and their village and it was, wasn’t it?  

This process, as described by nurses, was not unique to Kenmore or NSW but reflective of an historically widespread, governmental rationality for implementing a policy directive over problematic population groups. For some asylum residents, ‘community’ translated into little more than a transfer into another kind of institution such as the nursing home. Szasz describes this phenomenon as trans-institutionalisation, where former patients are ‘rehoused in para-psychiatric facilities, such as group homes and nursing homes’. These ‘new asylums’ also include shelters and prisons.

In group discussions and interviews with nurses, a theme emerged, of the devastating effect on the frail and the aged of moving to an unfamiliar environment. For the long-term elderly resident, far from being a locus of healing and recovery, the community solution may have represented a death sentence.

Nurses’ recollections of the repercussions of emptying the asylum and the trans-institutionalisation of older asylum residents are consistent with a body of literature that provides evidence of ‘a close correlation between the relocations of chronic patients and sharp increases in their mortality rates’.

Asylum in the community

There is no doubt that the arts of late twentieth and early twenty-first century care may be typified in terms of the greater freedoms available for people with mental illness through a shift in their government, from a disciplinary to a facilitative approach. And it is therefore logical to presume that accounts of mental health reforms tend to trace a linear history punctuated by ruptures in care modalities. In the community care era, for example, care and treatment for people living with mental illness is no longer confined to a landscape separated from the community. This care regime thus marks a physical rupture from the asylum, for care is now provided in the settings in which the recipient resides. Whereas once the asylum embodied the policy of lumping together cultural ‘others’ in a holding institution, the community symbolises a trend of decentralising or splitting the provision of care in accordance with the diverse needs of people with mental illness.

While we may have left behind the built environment of the asylum and allowed its buildings and grounds to deteriorate and to crumble as remnants of a disgraced past, the cultural practices of psychiatric knowledge developed within the social settings of the asylum have entered the community and proliferated. And the move to care in the community has liberated the profession of psychiatry from the asylum, as it did the patient. Not surprisingly, this liberation was also framed in terms of progress, of embracing the new stage of knowledge and practice for a ‘modern’ psychiatry.

---

22 The Richmond Report noted that about 11% of all psychiatric hospital residents were over 65 years of age (p. 16).
23 Similarly, in the 1990s, during the dismantling of ‘Hilltop’, an institution for intellectually disabled women, Johnson observed that: ‘[…] in the interplay of discourses which freed the women from the locked unit, they remained strangely silent and removed. The discourses moved around them. Information was gathered about them. Their lives were talked about by those exercising power over them. Their “subjectivity” was dissected, measured and assessed according to prearranged schedules and check-lists … Their fates were determined by the judgements of others’ (Johnson 1998:165).
29 This title is borrowed from Dylan Tomlinson and John Carrier (eds), 1996, Asylum in the community, London and New York: Routledge; and my thinking is influenced by Andrew Scull, in particular his chapter – The asylum as community or the community as asylum: paradoxes and contradictions of mental health care – in Philip Bean (ed.), Mental Illness: Changes and Trends, Chichester: John Wiley & Sons Ltd, 1983.
30 From an examination of the House of Representatives and Senate Registers, a total of 16 inquiries have been undertaken. This does not include inquiries where mental health may have had a significant component such as those dealing with drug issues, homelessness or foster care (e.g. The Forgotten Australians).
During the 1960s, the shift from asylum to community care solutions was increasingly regarded by psychiatry as a humane and enlightened response to mental illness:

*Now we are on the edge of a more fundamental change. Even in our lifetime we shall see psychiatry move into the community and a new attitude emerge to mental illness, its prevention and its treatment. Perhaps this is the most exciting phase of all, for with support, tolerance and group understanding we may together learn to carry more of the stresses of civilisation within our new community structure.*

In 1963, the Director of State Psychiatric Services provided a rationale for the expansion and extension of the terrains for psychiatric practice:

*We must look more searchingly at the need for adequate community psychiatric services. Physical treatments are only partial treatments. Patients must be treated at the earliest possible moment even before admission is required and, once treatment is initiated, there must be frequent follow up interviews with provision of psychotherapy, occupational therapy, social rehabilitation, family therapy and review of treatment. ... modern psychiatric services place maximum emphasis on early treatment of patients as outpatients, in their own homes or in the outpatients departments close to their homes. As a second step, day hospitals provide more comprehensive supervised treatment in the community in which the patient lives. ... Psychiatric patients and their relatives are often poorly motivated to seek treatment ... psychiatric services cannot wait for people to seek them out. Services must be taken to the people.*

The melting away of the boundaries between asylum and community provided a pathway for psychiatry to extend its influence into areas from which it remained excluded so long as its practice was confined along with its patients to impregnable institutions. Perhaps just as important to understanding the impetus for emptying the asylum, then, is to consider the reconfiguration of the psychiatric profession itself:

*At the professional level, ... what was at stake was not a desegregation of the mentally ill, but a desegregation of psychiatry, a desire of psychiatrists to end their isolation and gain access to the power, careers and status of other medical specialisations.*

Asylum-based nursing staff were also retrained and deployed in the provision of services in the community. Domiciliary nurses provided discharged patients with ‘continuing assistance and supervision’ (NSW State Psychiatric Services, 1969:4).

In addition to support, domiciliary nurses also provided ‘medical scrutiny beyond the hospital and into the home’, representing a widening of the psychiatric lens to engage with family members who had hitherto not come under its surveillance.

The open door policies of asylums from the 1960s onwards thus increased the flow of health professionals and community representatives as well as patients, both into the asylum and out to the community. Staff were mobilised and dispersed within community settings, taking with them the care practices that many had learned in the asylum. In NSW, a process began in the mid to late 1960s whereby accommodation and vocational support services were fragmented and transferred from asylum to community (NSW State Psychiatric Services, 1969 and 1970). Community services delivered programs based on the therapeutic community techniques developed in asylums and run by its staff, such as Activities of Daily Living Skills and outpatient clinics. In 1970 it was reported that Kenmore Hospital had established the Church Street Hostel in Goulburn, providing accommodation in a supported environment and acting as a community drop-in centre during the day. In addition, the trend of moving asylum treatments into the community occurred at the same time as representatives from the community,

---

32 Director, NSW State Psychiatric Services, 1963, emphasis added.
35 Ibid, p 75
including volunteers, social workers, occupational therapists and welfare officers, entered the asylum to run activities and services for patients.

The above trends occurred as part of a four stage plan by government and psychiatry for developing 'comprehensive mental health services', eerily reminiscent of the Richmond Report recommendations, including the geographic regionalisation of responsibility for each mental hospital, the subdivision of each mental hospital into subregional units; the decentralisation of services into local communities; and the creation of inpatient psychiatric services at general hospitals (NSW State Psychiatric Services Report 1967:5).

To what degree, then, can we talk about rupture between modalities of care, given that many of the facilitative and rehabilitative services available in the community were originally developed in the social and psychiatric settings of the asylum? Secondly, to what degree can we talk about rupture when we continue to use the asylum-based methods of seclusion and restraint in the acute care settings of public psychiatric wards? Although we are living in a care era that emphasises the minimisation of involuntary hospitalisation and treatments and the maximisation of freedoms in the community, people with mental illness may continue to experience traumatising and custodial care reminiscent of the most disciplinary arts of the asylum era. Even in these permissive landscapes of choice and freedom, the use of coercion and authoritarian techniques continue to be inscribed within the settings of community care.

**Summary**

In summary, it is timely to reflect on the passage of mental health reforms during this 30 year anniversary of the publication of the Richmond Report. As noted, key premises of the Richmond Report were that asylums represented an isolated system of service delivery that stifled treatment choices and options for people with mental illness, contributed to the stigmatisation of mental illness, and reinforced client dependence. The dismantling of asylum services into integrated community based networks, backed up by specialist hospital or other services, a key recommendation of the Richmond Report, has been realised. To what extent, one may wonder though, do people with mental illness and their families believe they have access to comprehensive mental health treatment choices and options, and high quality, coordinated and flexible care?

Secondly, given that we are no longer living under the shadows of the asylum, why does stigma continue to manifest itself in our communities? Finally, while the governmental anathema of the publicly dependent client may have been erased; people with severe and chronic mental illness may continue to be reliant on the support and services no longer provided by government, through the informal and uncertain care arrangements of private households.
Bibliography for Chapter 1

Archival material
State Library of New South Wales.


Legislation
NSW Mental Health Act 1958.

Policy documents, reports by government, reports for government

Books, chapters, articles, unpublished papers and theses


Chapter 2

The Burdekin Report: Shaming governments to act

*Brian Burdekin and John Mendoza*
Introduction

The Commonwealth Government’s involvement in mental health care began with the Pharmaceutical Benefits Scheme (PBS) introduced by the Chifley Government in 1948. The Menzies Government in 1955 provided tied capital works grants (on a 1:2 basis) for the rebuilding and refurbishment of mental health institutions in the wake of the Stoller Report.

Federal Government involvement was then extended substantially through the introduction of Medibank in 1974 introduced by the Whitlam Government and later Medicare under the Hawke Government in 1984.

The Whitlam Government in 1974 also provided around $8 million toward the development of community support networks and discharge centres, specifically for supporting people living in the community with mental illness. This was the first direct Commonwealth-funded mental health service: different to Medibank/Medicare and PBS which were whole-of-health reforms.

The formal responsibility for mental health care and mental health policy was seen as a state government responsibility until the adoption of the National Mental Health Strategy in 1992.

Indeed up until Brian Burdekin’s National inquiry, which commenced in 1990, there had only been two national inquiries from 1945 – the Stoller and Ascott Report in 1955, Mental health facilities and needs of Australia; and P Eisen and K Wolfenden in 1988, National mental health services policy: the report of the consultancy to advise Commonwealth, State and Territory Health Ministers1.

There had however been many state level inquiries or reviews: some with the status of a Royal Commission. The Burdekin Report itself provides a list what it describes as ‘recent reviews’ into mental health undertaken by the state and territory governments. In total, 26 recent reviews were listed (see Table 2.1).

Since Burdekin, there have been only two reports from independent sources that examine the entire mental health system across Australia, namely: the Not for Service report from the Mental Health Council of Australia in 2005 and A National Approach to Mental Health – from crisis to community from the Australian Senate in 2006.

Despite almost daily reports of mental health service failures or inadequacies in the Australian media, these three reviews were for various reasons also compromised in their ability to look at the system in its entirety. Table 2.2 lists Federal Parliamentary Inquiries on mental health or mental health related issues since 1970. Chapter Six of this report examines 32 reports undertaken by various statutory offices around the country since mid-2006 where mental health services are the focus.

What is a consistent in the findings in these three reports, and even Stoller’s Report six decades ago, is that there is plenty of evidence to challenge the “all is going well” response of successive governments. What is also abundantly clear is that the recommendations from these reviews have only received tacit support and ‘light-touch’ attention by governments. Rhetoric has been strong following the reviews, but sustained attention to the challenge and systemic reform have been weak and compromised by our system of government and confused lines of accountability and responsibility.


Brian Burdekin commenced his inquiry on human rights and mental illness in 1990 in his role as Human Rights Commissioner with the HREOC. It followed an earlier inquiry on youth homelessness where the Commission became aware of the extent of homelessness and vulnerability of people with mental illnesses.

Here, Brian Burdekin reflects on the Inquiry – the rationale, the findings and the resultant changes.

---

The National Inquiry On Human Rights And Mental Illness

Why we did it, what we found and how much has changed?

“In the 8 years I had the privilege to be Federal Human Rights Commissioner I conducted two National Inquiries; the first – on the plight of homeless young people – led directly to the second. I was astonished and appalled to find during the first inquiry that over 50% of homeless people in refuges and shelters had histories of major mental illness. From a human rights perspective, it was alarmingly clear that serious violations of the most basic rights of Australians affected by mental illness were not only increasing – they were almost always ignored.

By the late 1980’s over 500,000 of our fellow Australians were suffering serious mental illness – but our preliminary research indicated that over 250,000 were receiving no treatment or assistance from either the public health system or our private health system. I therefore determined that a comprehensive National Inquiry from a human rights perspective was essential.

During this 3-year inquiry we examined nearly 1,400 witnesses and submissions and conducted public hearings in 20 cities and towns – in every State and Territory. We concluded:

- that notwithstanding the existence of anti-discrimination legislation in most jurisdictions, people with mental illness were routinely discriminated against, in both the public and the private sector
- that legislation relating to Australians affected by mental illness was generally outdated, and that law reform in this area had invariably received a very low priority
- that our court system was generally inaccessible to individuals affected by psychiatric and other disabilities and that while our legal system protected their human rights in theory, it was an abysmal failure in reality
- that this fundamental failure of law and policy was largely being ignored by our Parliaments, policy makers and the legal profession
- that this situation was only possible because of widespread public ignorance concerning the nature and prevalence of mental illness or psychiatric disability
- that this public ignorance generated irrational fear – which was a fundamental cause of discrimination, marginalisation and even victimisation of those with a mental illness
- that the discrimination was so entrenched in public and official attitudes that it was both 'systemic' and 'systematic' – and therefore required sweeping reforms – and a major injection of resources
- that it was precisely those who were most vulnerable and disadvantaged – individuals with dual or multiple disabilities – for whom there were no programmes at all – or for whom the existing programmes were grossly inadequate
- that the allocation of such limited resources as were available clearly discriminated against those living in rural and regional areas (in these areas our youth suicide rate was 300% higher than in our major cities and elderly people frequently received no appropriate care at all)
- that our general practitioners were very poorly trained in the field of mental health and mental illness – and our health system routinely discriminated against Australians with mental health issues. According to expert evidence, approximately 10% of elderly Australians were suffering from serious depression – but most were getting no treatment at all; and up to 10% of young people suffering schizophrenia were taking their own lives
- approximately 20% of women were affected by post-natal depression – but because our doctors were inadequately trained in mental health, up to 70% of these women were undiagnosed and were therefore left untreated
- that law reform was urgently needed – but that many of the human rights violations occurring were caused not by acts which were unlawful – but by omission and by official neglect – problems which in the longer term required fundamental changes in public attitudes and a major injection of resources.
We examined in detail and made specific recommendations concerning the treatment of several groups which, for various reasons, were particularly subject to neglect, abuse, marginalisation, or discrimination. These included:

- Elderly people
- Homeless people
- Women
- Children and adolescents
- People with dual and multiple disabilities
- People in rural and isolated areas
- Indigenous peoples
- People from non-English speaking backgrounds and
- Forensic patients and prisoners

We also examined a great deal of evidence from "carers" – usually the women in the family, but sometimes others who attempted to care for individuals affected by mental illness, give their lives dignity and protect their rights. We managed to convince the government to give them more support.

Perhaps, more importantly I believe, by taking an inclusive approach and listening to those both directly and those more indirectly affected by mental illness, we managed to influence entrenched public attitudes and to some extent "shift the paradigm" from one characterised by discrimination and fear to one more oriented to respect for the rights of each individual.

Under both International and National law, Australians affected by mental illness have exactly the same human rights as the rest of us. Following the tabling of our report 20 years ago (and indeed even before we had finished the public hearings) many reforms were introduced. For the first time the Federal Government agreed to a National Mental Health Plan; there was a substantial injection of funding by both Federal and State Governments – and many laws and policies were changed – and I believe we made a significant contribution to an improved level of public awareness and understanding. However, on the basis of the information currently available to me, I believe we still have a very long way to go.

**Lessons learned**

"We learned many important lessons from this Inquiry.

First, we learned that gross violations of human rights, affecting hundreds of thousands of individuals, can still occur in a modern democracy enjoying freely elected Parliaments, an independent judiciary, free trade unions and the 'rule of law'.

Second, we learned that this was possible because our legal system had never really taken seriously the basic right of individuals with a psychiatric disability to be treated with dignity and enjoy genuine equality. The law itself was not part of the solution – it was part of the problem! Our traditional institutions of justice (the courts) were hopelessly inadequate in addressing and redressing human rights violations.

Third, we learned that discrimination against those with a psychiatric disability was frequently based on fear – and that fear was almost invariably based on ignorance. (Clearly, changing public attitudes was essential if any law reforms were going to be successful).

Fourth, the Inquiry demonstrated the momentum which can be generated when individuals with a disability and their carers are given the opportunity to inform the public of the discrimination they routinely suffer.

Fifth, many of the worst abuses in Australia had accompanied the introduction of policies of 'deinstitutionalisation' – which the public had been told would be more 'humane' and consistent with individual rights and freedoms. The policy, as in several other countries, was fine in theory. It became a disaster in practice because governments failed to provide adequate resources for community-based services. Many individuals with a major psychiatric disability were reduced to lives of squalor and homelessness – thus reinforcing existing community stereotypes rather than dispelling them."
Sixth, the legislation and reforms which were introduced during the Inquiry and following our report demonstrated that it was possible in practice to achieve significant reforms – but that vigorous public advocacy based on reliable research was often necessary.

Seventh, we learned that a National Inquiry (to which the public and media had access) could be a powerful tool in generating pressure for political action – as well as informing public attitudes.

At the beginning of the process, media interest in the subject of mental illness was almost exclusively confined to 'bad news' stories of psychiatric patients causing damage in the community or injury to others. By the end of the process, hundreds of news stories emanating from evidence presented to the Inquiry (frequently informing the public of gross abuse of individuals with a psychiatric disability) had produced significant improvements in public attitudes generally – and a reduction in discriminatory practices.

As a result of our findings, immediately following the Inquiry federal and state governments allocated $600 million in additional funds for programmes and services for those affected by a psychiatric disability. Uniform national standards were introduced – both for the legal protection of individuals and for health care systems. A number of public education programmes were also established.

Eighth, we learned the necessity of applying a "rights-based" approach in any efforts to remedy the discrimination, abuse and neglect suffered by those affected by mental illness.

Ninth, we learned the necessity of listening carefully to the carers and families of those affected by mental illness – to understand the critical role they frequently play – and the support they are entitled to receive.

Finally, what we learned from this Inquiry has been important in our efforts over the last two decades to establish Independent Human Rights Commissions in over 80 other countries – to ensure that the human rights of those affected by mental illness and other vulnerable groups are not only respected, but are better protected."

Brian Burdekin AO, April 2013.
Table 2.1: Mental health service reviews listed in the Burdekin Report 1993

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>Royal Australian and New Zealand College of Psychiatrists, <em>Discrimination Against the Mentally Ill</em>, Sydney 1980.</td>
</tr>
<tr>
<td></td>
<td>D T Richmond (Chairperson), Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (The Richmond Report), Sydney 1983.</td>
</tr>
<tr>
<td></td>
<td>W A Barclay (Chairman), Ministerial Implementation Committee on Mental Health and Developmental Disability Report to the Minister for Health (The Barclay Report), Sydney 1988.</td>
</tr>
<tr>
<td></td>
<td>R Duckmanton, National Health and Medical Research: Role of Community Support Systems in the Rehabilitation of the Chronic Mentally Ill, Larundel Psychiatric Hospital, Melbourne 1987.</td>
</tr>
<tr>
<td>WA</td>
<td>C Campbell and Associates, Health Services for the Mentally Ill in Western Australia: A Plan for their Organisation and Further Development, 5 Volumes, Perth 1982.</td>
</tr>
<tr>
<td></td>
<td>R Kosky, Psychiatry: A New Era, Health Department of Western Australia, Perth 1984.</td>
</tr>
<tr>
<td></td>
<td>G Smith (Chairperson), Report of the Working Party on Care of Patients in Psychiatric Hospitals in Western Australia, Health Department of Western Australia, Perth 1990.</td>
</tr>
<tr>
<td>Qld</td>
<td>Division of Psychiatric Services, Report on Psychiatric Hostels and Other Accommodation in Brisbane and Ipswich, Queensland Department of Health, Brisbane 1977.</td>
</tr>
<tr>
<td></td>
<td>Mental Health Services Commission, Hills/Hammond Report Royal Derwent Hospital, Hobart 1989.</td>
</tr>
<tr>
<td></td>
<td>Mental Health Services Commission, Boss Review: The Interaction of Persons with Severe and Continuing Behaviour Disorders with Community Based Helping Agencies, Hobart 1990.</td>
</tr>
<tr>
<td></td>
<td>ACT Council of Social Services, Out to Lunch: A Survey of Mental Health Services for Young People in the ACT, Canberra 1988.</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of inquiry and committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/5/1971</td>
<td>Mentally and Physically Handicapped Persons in Australia, Standing Committee Health and Welfare (Senate)</td>
</tr>
<tr>
<td>24/11/1988</td>
<td>After the march: Strengthening support for the veterans – Counselling and ancillary services for Vietnam Veterans, Standing Committee on Community Affairs (House)</td>
</tr>
<tr>
<td>05/06/1995</td>
<td>Psychotherapeutic Medication in Australia, Senate Community Affairs References Committee</td>
</tr>
<tr>
<td>2/06/1997</td>
<td>Aspects of youth suicide – Summary report, Standing Committee on Family and Community Affairs (House)</td>
</tr>
<tr>
<td>12/05/2005</td>
<td>Provisions of the Criminal Code Amendment (Suicide Related Material Offences) Bill 2005, Legal and Constitutional Legislation Committee (Senate)</td>
</tr>
<tr>
<td>30/03/2006</td>
<td>A national approach to mental health – From crisis to community: First report, Select Committee on Mental Health (Senate)</td>
</tr>
<tr>
<td>9/05/2006</td>
<td>A national approach to mental health: From crisis to community – Final report Select Committee on Mental Health (Senate)</td>
</tr>
<tr>
<td>19/06/2008</td>
<td>Interim report: Mental health services in Australia Community Affairs, Legislative and General Purpose Standing Committee (Senate)</td>
</tr>
<tr>
<td>25/09/2008</td>
<td>Towards recovery: Mental health services in Australia Community Affairs, Legislative and General Purpose Standing Committee (Senate)</td>
</tr>
<tr>
<td>24/06/2010</td>
<td>The Hidden Toll: Suicide in Australia, Community Affairs References Committee (Senate)</td>
</tr>
<tr>
<td>4/07/2011</td>
<td>Before it's too late: Report on early intervention programs aimed at preventing youth suicide Standing Committee on Health and Ageing (House)</td>
</tr>
<tr>
<td>31/10/2011</td>
<td>Interim report: Funding and administration of mental health services, Community Affairs References Committee (Senate)</td>
</tr>
<tr>
<td>31/10/2011</td>
<td>Second interim report: Funding and administration of mental health services, Community Affairs References Committee (Senate)</td>
</tr>
<tr>
<td>1/11/2011</td>
<td>Commonwealth funding and administration of mental health services, Community Affairs References Committee (Senate)</td>
</tr>
<tr>
<td>28/06/2012</td>
<td>Work wanted: Mental health and workforce participation, Standing Committee on Education and Employment (House)</td>
</tr>
</tbody>
</table>

Sources: House of Representatives Register of Committee Reports, and Register of Senate Committee Reports (1970–2011).

3 From an examination of the House of Representatives and Senate Registers, a total of 16 inquiries have been undertaken. This does not include inquiries where mental health may have had a significant component such as those dealing with drug issues, homelessness or foster care (e.g. The Forgotten Australians).
Chapter 3

The National Mental Health Strategy – Assessing progress since 1992

*Amanda Bresnan, John Mendoza, Sebastian Rosenberg, Keith Wilson and Yve Gilbert*
Obsessive Hope Disorder
The National Mental Health Strategy – Policy and five year plans

Introduction

Since the Burdekin Report in 1993, there have been four National Mental Health Plans, two national policies, one national action plan, the National Mental Health Commission’s Report Card, and the Council of Australian Government’s (CoAG) Road Map for National Mental Health Reform 2012–22.

There are also various state and territory plans and strategies relating to mental health. For example, New South Wales has six specific plans relating to mental health, plus the NSW State Plan and the NSW State Health Plan. Added to this, are the National Health Reform Agreement (NHRA) 2011 and the National Healthcare Agreement (NHA) 2012, both of which include a mental health stream.

The National Mental Health Strategy (NMHS) was first endorsed by the Australian Health Ministers’ Conference (AHMC) in 1992 as a framework to guide mental health reform in Australia. The strategy included the National Mental Health Policy, the National Mental Health Plan, and the Mental Health Statement of Rights and Responsibilities. The strategy has been reaffirmed through subsequent national plans, and the national policy revised in 2008 and the statement of rights and responsibilities in 2012.

The four NMHPs cover the following periods:

- Third National Mental Health Plan 2003–2008

The development of the NMHS in 1992 was the first attempt to coordinate mental health services nationally, in an area which had been the responsibility of states and territories. Reviews have been undertaken for each of the national plans, barring the fourth which is still current.

The current policy environment for mental health has led to the situation where, despite the proliferation of plans, report cards, and strategies at a national and state/territory levels, there has been little progress in determining if people with a mental illness are better off that they were 10 years ago, and what has been the outcome of the investments made in mental health services and reform. Even with more performance indicators being added through the NHRA and the NHA, no new reporting measures or data sources are being developed and there is a reliance on the same data sources, such as national minimum data sets (NMDS).

When Brian Howe, Federal Health Minister in 1992, released the first Plan, he emphasised the need for sound accountability and data. Achieving value for money is a part of national mental health reform that has not been addressed, so we don’t know whether the increase in funding for mental health since 1993 has delivered a comparable return in quantity and quality.

The problem with assessing progress – Stumbling in the dark

The four Plans are not written or presented in a way for comparison. Each Plan has adopted a different approach towards identifying the key issues, outcomes and indicators/directions/strategies. There are common ‘themes’ or priorities that are identified in each plan, including early intervention and prevention and service responsiveness/provision/quality. However, there is a lack of consistency between how each Plan attempts to identify the key issues and how they are outlined. Importantly, there are no targets identified in any of the plans to track or measure progress. The broadness of the strategies (as labelled in Plans 1 and 2), the key directions (in Plan 3) and the indicators (in Plan 4), make it difficult to track progress over the period of the particular plan.

Indeed, a reasonable assessment of the Plans would conclude that the degree of precision in the language surrounding the goals and objectives and priorities reduces with each successive plan.

Determining the progress made by the states and territories against the Plans is, if not possible, unreliable. Firstly, there is no consistency from the Plans to the plans adopted in each state/territory. Again while there are general common themes and priorities, there is no consistency or linkage. Secondly, there are no agreed rules of accounting in how the states and territories report back. In the main, they report on activity through the various reporting fora of officials.

The Evaluation of the 2nd Plan notes consultations highlighted confusion between the array of relevant initiatives and strategies such as in drug and alcohol and suicide prevention, and the links between them was unclear. Despite this, the same problem continued under the period of the 3rd Plan.

An examination of the Evaluations of the Plans finds the same issues and concerns are raised repeatedly. Concerns are consistently raised in relation to housing; employment; stigma and discrimination; underserviced population groups including Aboriginal and Torres Strait Islander (ATSI) peoples, people from culturally and linguistically diverse (CALD) backgrounds, people with dual diagnosis, and prisoners; the availability of data; and, in particular, the mental health workforce.

The majority of these areas also require coordination across different government agencies and non-government organisations, again which is consistently raised as an issue. Table 3.2 shows the issues and recommendations from each of the three Evaluations of the Plans undertaken to date.

The 1st Plan Evaluation notes substantial changes in the structure and mix of mental health services (MHS); that the range and quality of services had improved; and that funds made available under the National Mental Health Strategy had been important in expanding community based MHS. However the Evaluation also notes there was widespread dissatisfaction with many aspects of the system:

A simple conclusion is that the mental health system in Australia at the commencement of the Strategy was in a poor state. While significant gains have been made, these need to be viewed against the historical backdrop. The National Mental Health Strategy has raised awareness of previously hidden problem areas and encouraged an expectation, if not a demand, that ‘things should be better than this’. It is the view of the committee that much work remains to complete the mental health policy agenda commenced five years a Plan go

Going forward ten years from the 1st Plan to the 3rd Plan, and again general comments from the Evaluation of the 3rd Plan provide an indication on the progress of reform:

The National Mental Health Plan 2003–2008 is seen by many as having an aspirational quality and as such, was helpful in sustaining a momentum of the reform of mental health services delivery started in the early 1990’s and provided an important ‘point of reference’ as States and Territories developed their plans and programmes. It also gives consumers, carers and advocates a common ground for pressing for changes in mental health policy and planning.

The frustration expressed in the interviews was that the current Plan did not give specific guidance towards actionable items. Measurable targets with timeframes were not established and there were not models of care identified for priority implementation. These factors contributed to an inconsistency in applying the Plan in a systemic way. The Plan was criticised for being too aspirational and much like a policy document, rather than an action-oriented plan. Many of those interviewed viewed the Plan as exceedingly broad by trying to ‘be all things to all people’.

One of the consistent criticisms of the Plans has been the inability to develop an agreed set of indicators to monitor progress and the lack of available data to monitor progress.

6 The 4th National Mental Health Plan is current and has not been evaluated.
The 1999 Report on Government Services (ROGS), the first year to report on mental health services, noted the limited accurate data for reporting on the efficiency of MHS, particularly those outside of hospitals. Funding was based on historic cost plus or input methods which do not allow for differences in or levels of illness. There was an absence of financial incentives for efficiency, quality, improved consumer outcomes or substitution between different service types.

The 2008 ROGS stated that the key challenges for improving the reporting of mental health management were similar to those of previous years:

- improving the reporting of effectiveness and efficiency indicators for ATSI, rural/remote and other special needs groups
- revising the performance indicator framework to account for the 3rd Plan and the COAG National Action Plan on Mental Health, to ensure reporting remains consistent with policy objectives
- improving the reporting of effectiveness/efficiency indicators for community-based mental health care.

The 2013 ROGS again highlights similar challenges for improving reporting on mental health:

- improving the reporting of effectiveness and efficiency indicators for Indigenous Australians, rural/remote and other selected community groups
- developing an estimate of the number of people who need mental health services so that access to services can be measured in terms of need
- identifying indicators that relate to the performance framework dimensions of quality — safety and sustainability
- improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities
- further developing the measurement and reporting on the clinical mental health outcomes of consumers of specialised public mental health services.

It was argued in many of the submissions to the Senate Inquiry in 2005–6 into mental health services that 15 years of National Mental Health Plans, associated policies, and other mental health strategies, had delivered information, monitoring and reporting, but very little on the state of mental health and mental illness in Australia. Despite having a national collaborative framework, there is a lack of real accountability and a reliance on limited mental health service systems data.

Critical areas, which are not monitored, include:

- the development of mental health disorders
- the impact of disorders on individuals, families and the community
- the rights of people with a mental illness
- the physical health of people with mental illnesses
- no ongoing systemic collection or documentation of what happens to people who experience significant mental illness.

On the key issue of workforce, the 3rd Plan Evaluation states that ongoing challenges in relation to the mental health workforce posed a “major obstacle to mental health reform and sustaining a viable mental health system”. It recommended a plan looking forward up to 10 years specifying the required number of staff with defined skills and competencies, across all mental health service sectors, and a map of the current distribution of state/territory, non-government, private and public resources to show the areas of need. Many stakeholders interviewed as a part of the review, saw the provision of a proper workforce as

---

a fundamental precondition for the successful implementation of a further plan\textsuperscript{13}. Five years after governments received that report, a coherent workforce plan is yet to be developed.

The most recent (4\textsuperscript{th}) Plan includes “Accountability – measuring progress and reporting progress” as a priority with the intended outcome being ‘that the community can make an informed and confident judgment about the progress of reform’ including the 4\textsuperscript{th} Plan. The actions listed are:

- establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs
- build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders
- further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting
- conduct a rigorous evaluation of the 4\textsuperscript{th} National Mental Health Plan\textsuperscript{14}.

There is one indicator for this priority – “Proportion of mental health service organisations reporting performance data”. The Plan ‘notes’ that the indicator requires further development and states that specific targets have not yet been set for any indicators, but that this would be a priority during the first year of the Plan\textsuperscript{15}. As we enter the final year of the 4\textsuperscript{th} Plan, the said indicators and targets have not been developed. Again, a robust assessment framework for the 4\textsuperscript{th} PLAN will be absent. This is the result after 20 years of the national reform strategy:

> Accompanied by a new national mental health policy and revised national mental health services standards, it signaled a further retreat from full consultation of stakeholders and the bureaucratic dilution and downgrading of the national strategy with few specified objectives, goals, targets, or timelines\textsuperscript{16}.

Method for analysing the National Mental Health Plans

In analysing the journey of reform since the inception of the National Mental Health Strategy, we have examined the priorities and commitments for each of the Plans. Comparisons and assessments of the Plans – in terms of analysing the planned commitments versus the actual implementation and the outcomes – is not possible for the reasons stated in the Introduction.

Systems Analysis\textsuperscript{17}, Policy Deployment Assessment\textsuperscript{18}, Program Logic\textsuperscript{19} and other robust methods for analysis of public policy, systems and change were considered for the review of the Plan and Strategy. However, these were discounted due to the lack of definition in the Plans, the gaps in reporting on progress and the absent of measures over time. As a consequence a thematic analysis of the Plans was deemed most appropriate. Some common ‘themes’ or priorities can be identified in each Plan including early intervention and prevention and service responsiveness and quality. Under each Plan the policy commitments to each theme are examined along with the outcomes of the Evaluation Report and the ROGS from the Productivity Commission.

Assessing progress by the jurisdictions against the Plans was beyond the scope of this project. A key factor in that assessment was the lack of alignment in timeframes, strategies or priorities. There is a complete absence of any linkage or cascading architect evident in the documents. For example, NSW has six specific plans relating to mental health, plus a State Plan and a State Health Plan\textsuperscript{20}. The extent of alignment ends with a few general shared themes and priorities.

\textsuperscript{13} Curie C Thomicroft G. Summative Evaluation of the National Mental Health Plan 2003-2008.
\textsuperscript{15} Ibid.
\textsuperscript{18} Sheridan B 1993. Policy Deployment: The TQM approach to long-range planning. ASQC, Wisconsin.
\textsuperscript{19} See University of Wisconsin. Program Logic Resource Centre.
Key themes across the four plans

In order to analyse the impact of the Plans over the past twenty years, six key areas in mental health have been examined to look at what progress there has been made, and whether the Federal and the state and territory governments have implemented the commitments they have collectively and individually made under the National Plans. The areas analysed are:

- housing and accommodation
- employment
- social inclusion
- stigma
- provision of and access to services
- measurable targets and accountability.

Theme 1 – Housing and accommodation

What the National Mental Health Plans say

The 1st and 2nd Plans have only a limited focus on housing. In the 1st Plan, the priority area of Intersectoral Linkages states that ‘providers of services such as housing should ensure they are provided in a non-discriminatory manner’, and includes a strategy for the Commonwealth and States and Territories to establish joint pilot projects stating examples include accommodation. It also lists as a role and responsibility of the Commonwealth Government is to ensure people with a mental illness are not subject to discrimination in accessing accommodation programs or services

The 1st Plan Evaluation notes in the examination of Linkages that state and territory initiatives focused on improving access to public housing, and that the more advanced had extended this to develop joint protocols with other government agencies. It also notes that consultations with consumers had indicated that access to housing and employment were the highest priority for improvement.

The 2nd Plan reaffirms the Commonwealth Government's commitment to ensure people with a mental illness and their carers are not subject to discrimination in accessing services such including accommodation. Under the priority area of Partnerships in Service Reform and Delivery it states that consumers have the same needs as others in areas such as stable housing and makes mention of housing in areas for partnerships.

The 2nd Plan Evaluation discusses housing issues in a number sections, namely: Continuity of Care, Access to Wide Range of Support Services, Intersectoral Coordination, and Rehabilitation, Recovery and Relapse Prevention. Key issues raised included:

- A lack of follow up care after hospitalisation for an acute episode.
- Ongoing difficulties with access to accommodation and community care for people with ‘chronic’ mental illness.
- A lack of general community services for people with a mental illness including poor access to accommodation, employment, education and training, income support, and domiciliary care.
- Intersectoral collaboration had not developed in a systematic or coordinated way.
- A lack of accountability or incentives for different sectors to work across their professional and service boundaries has hindered partnership development. Models of coordinated care that identify the intersectoral linkages required to support the treatment, recovery and rehabilitation of people with a mental illness have been developed in some States and Territories, and particularly with the education, housing and police sectors. However, progress overall was reported as “inadequate”.

The lack of a recovery approach to underpinning service delivery and mental health services that supports the empowerment of consumers and personal capacity building.

The need to eliminate stigmatising attitudes and discriminatory practices in community services as fundamental to achieving equity of access.\textsuperscript{24}

The 3\textsuperscript{rd} Plan notes under Improving Service Responsiveness, that consumers experience persistent inequities accessing services that relate to recovery including accommodation, disability, income support, education and training, and employment services. It includes as one of the outcomes – “Increased access to appropriate, long-term supported accommodation” and as key directions – “Develop and consolidate links with departments of housing” and “Strengthen the capacity to meet the needs of marginalised groups, such as homeless people with mental health problems and mental illness”.\textsuperscript{25}

The 3\textsuperscript{rd} Plan Evaluation includes housing as a recommended area of focus in further Plans. It points to a continuing shortage of accommodation for people with mental illness in all states and territories, and that there was no agreement on the models or range of accommodation. The Evaluation states that a coherent housing plan will require the full participation of relevant departments at the federal, state and territory levels. Included as a Group One Priority Recommendation is ‘That a Housing, Accommodation and Support strategy which includes best practice and innovative models be developed’.\textsuperscript{26}

The current 4\textsuperscript{th} Plan in the priority area of Social Inclusion and Recovery notes the importance of housing including that consumers and carers have emphasised the role of stable housing and meaningful occupation to recovery, self-determination and social inclusion. Included as an indicator is ‘Percentage of mental health consumers living in stable housing’ but noting that it “requires further development”.\textsuperscript{27}

**Evidence of progress: Theme 1 – Housing and accommodation**

In the 2007 National Survey of Mental Health and Wellbeing (NSMHWB), 54% of people who reported ever being homeless had a 12-month mental disorder, more than three times the prevalence of people who reported never being homeless.\textsuperscript{28} The CoAG National Action Plan on Mental Health – Progress Report 2009–10 notes that up until 2009, the Supported Accommodation Assistance Program (SAAP) was the main service at a national level for homeless people and data was collected on SAAP clients through a national minimum dataset.\textsuperscript{29}

In 2009 SAAP was replaced with the National Affordable Housing Agreement (NAHA). Data covering 2008–09 and 2009–10 showed that the number of SAAP clients had increased to 135,700 in 2009–10, with people with mental health problems accounting for 12% and people with mental health and substance use comorbidity 7% – largely unchanged from most recent previous years. A 2008 census of SAAP clients across all jurisdictions showed that 34% of the survey sample identified as having mental health issues, of which 56% had a known diagnosis and 31% identified as current users of specialist mental health services.\textsuperscript{30}

Data from recent studies show substance use and mental health clients of services were the most likely to be in primary homelessness immediately before support in improvised dwellings or sleeping rough in 39% and 24% of support periods respectively. After support, the proportion of support periods where clients experienced primary homelessness fell to 31% for substance use and 15% for mental illness.\textsuperscript{31}

Specific mental health housing initiatives have been introduced in a number of states including the Housing and Accommodation Support Initiative (HASI) in NSW and the ACT, Doorway and Housing and Support Program (HASP) in Victoria, and HASP in Queensland. The number of available places in these


\textsuperscript{26} Currie C Thornicroft G. Summative Evaluation of the National Mental Health Plan 2003-2008.


\textsuperscript{28} 2007 Mental Health and Wellbeing Survey, Australian Bureau of Statistics.


\textsuperscript{30} Ibid.

programs is extremely limited – around 1,100 in NSW and just 200 under HASP in Qld. However, the evaluations of the programs has generally been very positive. The success of many initiatives was due to an ability to respond to local and individual needs. There was a need for meaningful data on the extent to which people with a mental illness could access and maintain appropriate housing, and greater integration and forward planning across portfolios to have a more cohesive approach, such as between national housing and disability agreements and the National Mental Health Strategy\textsuperscript{32}.

**Theme 2 – Employment**

*What the National Mental Health Plans say*

There is a limited discussion on employment in the 1\textsuperscript{st} Plan. The priority area of *Intersectoral Linkages* states that providers of services such as employment and training should ensure they are provided in a non-discriminatory manner and lists as a role and responsibility of the Commonwealth Government is to ensure people with a mental illness are not discriminated against in accessing employment and training programs.

In the 1\textsuperscript{st} Plan Evaluation it notes that initiatives at the Commonwealth level targeted improved access to employment support and tailored social security so people with a mental illness were able to access entitlements. It also notes that consultations with consumers had indicated that access to housing and employment were the highest priority for improvement. The Evaluation notes that between 1991 and 1995, the number of mental health consumers assisted by the Commonwealth Rehabilitation Service increased from 10% to 23% and the total persons assisted by Commonwealth-disability support services focused on open-market employment from 2% to 15%.

The 2\textsuperscript{nd} Plan, like the first, reaffirms the Commonwealth’s commitment to ensure people with a mental illness and their carers are not discriminated against in accessing services such as employment and training. It notes in the priority area of *Partnerships in service reform and delivery* that access to disability support services is an area where people with a psychiatric disability face significant disadvantage and the need for policy decisions translate to actual services. Employment is listed as a further area of ongoing concern.

The 2\textsuperscript{nd} Plan Evaluation also states that a key challenge remained delivering continuity of care across services for people to receive treatment and recover. General services were not available to people with a mental illness to the same extent they were to the wider community and persistent inequities accessing services such as employment, education and training impeded recovery and rehabilitation. Attitudes of service providers was identified as a concern by consumers and carers with the employment sector identified as an area with discriminatory practices. The Evaluation recommended removing inequities in accessing services and stigmatising attitudes will be fundamental and that support services (e.g. employment, education) should be provided within a coordinated system.

The 3\textsuperscript{rd} Plan notes that consumers experience persistent inequities accessing services that relate to recovery including accommodation, disability, income support, education and training, and employment services. It includes as an outcome “Increased access to recovery and rehabilitation programs” and includes as a key direction “Foster evidence-based recovery and rehabilitation programs within and outside clinical frame works, and across the public, private and non-government sectors …”. There is a further outcome of “Equitable access to housing, employment services, disability services, social services, education and justice” and lists key direction that address fostering linkages, clarifying the roles and responsibilities of different sectors and cooperating across sectors.

The 3\textsuperscript{rd} Plan Evaluation includes employment as a focus for future Plans. It notes that employment emerged early in the consultations as a high priority. The Evaluation suggests an extension of consumer consultant and peer work scheme and the expansion of successful models of employment in the paid labor market. It also recommends a whole-of-government approach focused on workforce entry and retention, including the full application of the *Discrimination Act*.

\textsuperscript{32} Supporting the housing of people with complex needs, AHURI Research and Policy Bulletin, Issue 90 November 2007, Australian Housing and Urban Research Institute.
The 4th Plan accordingly under Social Inclusion and Recovery, notes the importance of action to “Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs”.

Evidence of progress: Theme 2 – Employment

The 2013 ROGS includes data on employment for people with a mental illness. In 2010–11 the national figure was 61.7% for people with a mental illness who were employed, compared to 80.3% for those for people without a mental illness. In 2011–12 the national figure for the number of people aged 16–30 years with a mental illness who were employed and/or enrolled for study in either a formal secondary or tertiary qualification was 79.2%, compared to 90.2% for people without a mental illness33.

In the 2007 NSMHWB, of the 413,600 unemployed people 29% had a 12 month mental disorder, and 20% of the 10.4 million people who were employed had a 12 month mental disorder. Unemployed people had almost twice the level of substance use disorders than employed people (11.1% compared to 6%) and almost three times the level of affective disorders (15.9% compared to 5.7%).34 of unemployed women and 26% of unemployed men had a 12 month disorder34.

The CoAG National Action Plan on Mental Health – Progress Report 2009–2010 includes figures on the Disability Support Pension (DSP) with 29% (227,000) of the 792,000 people on the DSP having a psychiatric or psychological condition recorded as their primary condition. This has increased at an annual average rate of 5% since 2001, more than twice the rate of overall growth for DSP recipients35.

A study looking the prevalence of mental disorders among income support recipients in 2007 as compared with 10 years previous, found there were limited differences. Rates of mental illness were elevated in all income support categories, including unemployed, lone parents, partnered parented and people receiving disability payments. The 12-month prevalence of mental disorders in working age recipients was 34% compared to 20% for non-recipients36.

There are a number of new initiatives that the Federal Government has implemented under the National Disability Employment Strategy. No evaluation process is provided. Initiatives funded under the Strategy include:

- new disability employment services for people with a disability (stated funding of $1.2 billion)
- a pilot program funded under the 2009–10 Budget (stated funding $6.8 million) to assist 100 people with a disability receiving the DSP
- development of training by the Australian Public Service Commission for APS agencies
- the Employment Assistance Fund which brings together the Workplace Modifications Scheme and the Auslan for Employment program
- an Innovation Fund to fund innovation projects that address barriers to employment, examples included social firms37.

Theme 3 – Social Inclusion

What the National Mental Health Plans say

A key theme of each of the four Plans is social inclusion including in areas such as service integration, links between different sector and bring mental health services into the ‘mainstream’ of health service delivery. However it is mostly an indirect theme, with the actual concept of ‘social inclusion’ only being

directly addressed in the 4th Plan. The 3rd Plan addresses the issue of the importance of people ‘being connected to their community’.

The 1st Plan does not directly address the issue of social inclusion but focusses on ways to address stigma. In the priority area of Mainstream Services, it states that the aim of strategies is to further the development of MHS through a number of means including reducing stigma. In the priority area Intersectoral Links emphasis is placed on enhancing access to the range of services people with a mental illness need and states that services such as housing, social support, income security, employment and training must be provided in a non-discriminatory way to achieve equity of access. The priority area of Service Development and Microeconomic Reform also has a focus on service integration.

The 1st Plan Evaluation like the Plan itself only addresses dimensions of social inclusion, but does address the benefits to recovery and participation that comes from including consumers and carers in service delivery. The Evaluation notes in the section on Intersectoral Links that services such as housing, employment social support and general health care are essential for people with a mental illness to function in the community. It states that there have been steps to address this such as anti-discrimination legislation and formal agreements between different departments. The Evaluation states that the least amount of progress had been made in linking MHS with other services.

Like the 1st Plan, the 2nd Plan only addresses dimensions of social inclusion. The priority area of Promotion and Prevention focuses on addressing stigma and under Partnerships in Service Reform and Delivery notes that people with a mental illness have the same needs as others for general health care, stable housing, home support, recreation, employment, education and friendship.

The 2nd Plan Evaluation also does not directly address social inclusion. The principles of people with a mental illness being a part of the community is considered under Partnerships in Service Reform and Delivery. As noted earlier, the Evaluation states that a key challenge remained delivering continuity of care across services for people to receive treatment and recover. General services were not available to people with a mental illness to the same extent they were to the wider community and persistent inequities accessing services (e.g. accommodation, employment, education and training, income support and domiciliary care) impeded recovery and rehabilitation.

Attitudes of service providers were identified as a concern by consumers and carers. Intersectoral collaboration had not developed in a systemic or coordinated way and while some progress had been made in some states and territories, progress was patchy and inadequate. The Evaluation recommends that removing inequities in accessing services and stigmatising attitudes will be fundamental, and that support services, such as employment, education and training, should be provided within a coordinated system.

The 3rd Plan states that it adopts a population health framework base on the understanding that mental health is influenced by what occurs every day in someone’s life, and that determinants include income, employment, poverty, education and access to a range of community resources. Under Promoting mental health it states that supportive social, economic, educational, cultural and physical environments develop and maintain mental health, and that “Communities in which people feel involved, included and empowered to influence decisions that affect them are supportive of mental health”. An outcome in this priority theme is “Increase in the extent to which mental health and social and emotional wellbeing is promoted within communities” and a key direction “Work with communities to increase their capacity to support active participation by all members and to foster environments that promote mental health”. The priority them of Improving service responsiveness notes that being unable to access services such as accommodation, income support, education, training and employment impacts on recovery and the ability to manage in the community, and includes the outcome of “Equitable access to housing, employment services, disability services, social services and education and justice”.

The 3rd Plan Evaluation notes the success of federally funded initiatives such as beyondblue, SANE Stigma Watch and headspace for having promoted social inclusion, an suggests that the work of these initiatives be built on to address different population groups and other areas of mental illness. The importance of expanding successful employment programs that give people opportunities in paid employment, and the need for supported accommodation are both highlighted in the 3rd Plan Evaluation. The Evaluation notes there was broad consensus that a whole-of-government approach was required to
achieve the cross-sector changes needed and that there must be partnerships across all agencies responsible for the range of required services including housing, employment and education. Without this, there may be unintended adverse consequences for people with a mental illness from existing arrangements.

The 4th Plan goes on to reflect the recommendations and adopts the population health framework and the priority area “Social inclusion and recovery”. The related actions talk about coordinated and linked health, education and employment sectors and programs; and integrated mental health and housing, justice and aged care programs. The indicators include “Rates of community participation by people with mental illness”, noting this “requires further development”.

Evidence of progress: Theme 3 – Social inclusion

The 2007 NSMHWB looked at contact with family and friends. The prevalence of 12 month mental disorders was very similar for people who did and did not have contact with their family. Twenty per cent of the 15.9 million who had contact with their family had a 12 month mental disorder, and 23% of the 121,800 people who had no contact with their family had a 12 month mental disorder. However, the prevalence of 12 month mental disorders for people who did and did not have contact with friends was different. Twenty per cent of the 15.7 million people who had contact with friends had a mental illness, compared with 38% for the 352,500 people who had no contact with friends or no friends.

There has been criticism of the mental health promotion agenda in Australia, in terms of promoting an holistic approach to mental health and wellbeing. Australia had been considered an international leader in mental health promotion, but it had slipped from the national political agenda and taken a focus on ‘downstream’ treatment outcomes. There had been a lost focus on the relationship between mental and physical health and the way health behaviours are shaped by social conditions, noting that people with a chronic mental illness have some of the worst physical health outcomes of any group. Missing from the 4th Plan are positive indicators for mental health and population level indicators for mental health promotion. It refers to social determinants of health such as housing, education and employment within a recovery approach, however there were greater opportunities for people with a mental illness through social inclusion strategies such as the mental health policy developed by the SA Social Inclusion Board and the disability employment priorities set by the Australian Social Inclusion Board.

Theme 4 – Stigma

What the National Mental Health Plans say

Stigma is not directly addressed or discussed in the 1st Plan. In the priority area of Intersectoral Linkages there are statements about providing services such as housing, social support, income security, employment and training in a non-discriminatory way to achieve equity of access, however that is the closest acknowledgment of stigma associated with mental health.

The 1st Plan Evaluation states “For the community, the mental health system remains relatively feared and unknown and, according to consumers, continues to stigmatise and discriminate against those affected by mental illness. A simple conclusion is that the mental health system in Australia at the commencement of the Strategy was in a poor state”.

Consumers, carers and service providers indicated that the Plan had failed to reduce the high levels of stigma and discrimination directed toward consumers by the community. Consumers identified mental health professionals as the main source of stigma and discrimination that they experienced. In the area of Promotion and Prevention, the Evaluation notes that consultations suggested that very little progress had occurred in promoting mental health in the community and in changing community attitudes and behaviour towards people with a mental illness. Stigma and discrimination remained at the high level that existed before the Plan or Strategy.
In the 2nd Plan promotion and prevention is a priority area and includes mental health promotion, community education, prevention of mental illnesses, and early intervention. A target for community education is clinicians with stigmatising attitudes and increasing mental health literacy in key community groups. A stated outcomes are “improved range, quality and effectiveness of public health strategies which promote mental health among the Australian population” and “The Australian population is more informed about mental health issues, of strategies to maintain their own mental health and to support people with mental illness”. Strategies focus on continuing existing successful community education initiatives; developing and evaluating professional development for providers in consultation with consumers and carers; and targeting key settings and occupational groups with mental health literacy.

The 2nd Plan Evaluation notes that there had been considerable investment in improving mental health knowledge and promoting mental health, particularly through media and school initiatives, and that these should progress further. The media had been a focus for improving public knowledge on mental health and stigma reduction. While there had been achievements, people with a mental illness still experienced stigma, and mental health services needed to also be a target in addressing stigma within service providers. It acknowledges the national media strategy for reporting mental health and illness and suicide, and that reporting of mental health was generally of a higher quality than was reporting of suicide. It states that further data was required to determine the impact of the media initiatives, and notes SANE StigmaWatch.

The Evaluation states there is still a great deal to be done to improve mental health literacy, particularly to reduce stigma. A survey conducted by the MHCA for the Evaluation showed that only 2.7% of those surveyed agreed that the community understands mental illness and recognises that people affected by mental illness have the same rights as others. The attitudes of service providers are again raised as a concern, which needs to be addressed through continuous professional development.

The 3rd Plan under Promoting mental health states that knowledge of mental health is essential in addressing the stigma associated with mental illness, and that all sectors, along with the media, have a role to play. It notes the attitudes of the mental health workforce which can perpetuate stigma and that further improvements in this sector are ‘urgently needed’. A stated outcome is “increased levels of mental health literacy in the general community and in particular settings, and decreased stigma experienced by people with mental health problems and mental illness” with the key directions focusing on building on community awareness raising initiatives; developing new and innovative programs for increasing mental health literacy, delivered in specific settings; and further promotion of accurately portraying mental illness in the media.

The 3rd Plan Evaluation notes a widespread consensus was that there had been an increased awareness of promoting mental health and specific mental health problems, particularly depression, but that attitudes of the public and providers had not changed a great deal around bi-polar and schizophrenia. In looking at directions for future mental health plans, the Evaluation highlights mental health awareness and anti-stigma interventions, noting that for many people with a mental illness the stigma and discrimination they experience is worse that the primary condition. Further work on the attitudes of mental health staff to promote recovery and training service organisations, such as Centrelink, on consumer needs. Other recommendations were extending resource kits for employers and tracking the responsible reporting of mental health in the media.

The 4th Plan under Social and inclusion and recovery acknowledges that consumers and carers highlighted that stigma and discrimination are still prevalent. It notes that discrimination occurs with housing and employment; is evident in the attitudes of the media and community; and still occurs within the health sector. A stated action is “improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy, with an indicator “rates of stigmatising attitudes within the community”, noting this indicator “requires further development”. It notes that national campaigns need to be supported by locally based activities, including in workplaces, and done in partnership with the media.

Evidence of progress: Theme 4 – Stigma

Australia and Ireland are the only English speaking OECD countries without a national anti-stigma campaign. Countries such as New Zealand, Scotland, England, the USA and Canada have recurrent
funding to conduct national anti-discrimination campaigns, informed by evidence. Research shows that shifting public attitudes on mental illness has been difficult, but overseas programs have been evaluated and the evidence shows that where they exist, there is strong agreement on this sort of approach being important\textsuperscript{40}.

A 2011 national survey of mental health literacy and stigma involved a general community survey of people aged 15 years and over and a youth survey of people aged 15 to 25 years. Those being surveyed were presented with a vignette of a person with a mental illness (randomly on depression, depression with suicidal thoughts, early schizophrenia, chronic schizophrenia, social phobia and PTSD) and then asked a series of question related to that vignette such as beliefs about causes, stigmatising attitudes and media exposure\textsuperscript{41}.

The 2011 survey showed that there had been improvements in mental health literacy since the 1995 public survey, particularly for recognition of depression; beliefs about the usefulness of GPs, psychiatrists and counsellors; and beliefs about the usefulness of medications in particular antidepressants and antipsychotics. Beliefs about the outcomes and causes of mental disorders was more realistic and closer to those of researchers and health professionals\textsuperscript{42}.

However, there were limited changes in stigmatising attitudes, most notable being an increase in beliefs of dangerousness and unpredictability and a decrease in the desire for social distance for all vignettes other than chronic schizophrenia. The recommendation was that further monitoring of population mental health was needed to determine if improvements in mental health literacy translate into improvements in population mental health, and that beliefs around dangerousness and unpredictability showed the need for public education to address stigma towards people with mental disorders\textsuperscript{43}.

Theme 5 – Provision of and access to services

What the National Mental Health Plans say

A significant focus of all the Plans is the provision of services, in particular around mainstreaming mental health services.

The 1st Plan has four Priority Areas: mainstream services; integration; intersectoral linkages; and service development and microeconomic reform.

Mainstream services is about delivering and managing specialised mental health services within mainstream services. It includes strategies about locating or co-locating inpatient MHS with mainstream inpatient services and community MHS with general community services. There is also a stated strategy of expanding community based MHS. Integration discusses maintaining a network between all components of MHS again within mainstream health services, incorporating case management to achieve continuity of care for consumers. Intersectoral linkages has the stated aim of having the range of services required across agencies coordinated. Service development and microeconomic reform focuses on putting in place contract arrangements between the Commonwealth and the states and territories to support projects or measures to encourage innovation and drive reform. Workforce issues are included in this priority area to achieve a more equal distribution of the mental health workforce. The Plan also has a priority area Special needs groups outlining the need for access to the culturally sensitive or appropriate services they need.

The 1st Plan Evaluation stated that there had been substantial changes in the structure and mix of MHS; that the range and quality of services had improved; and that funds made available under the NMHS had been important in expanding community based MHS. However, despite positive changes, there was widespread dissatisfaction with many aspects of the MHS system. As the Evaluation states:

\textsuperscript{40} From Discrimination to Social Inclusion: A review of the literature on anti-stigma initiatives in mental health, Queensland Alliance, 2009.
\textsuperscript{41} Reavley N Jorm A 2011. National Survey of Mental Health Literacy and Stigma, University of Melbourne, Department of Health and Ageing, Canberra.
\textsuperscript{42} Ibid.
\textsuperscript{43} Ibid.
A simple conclusion is that the mental health system in Australia at the commencement of the Strategy was in a poor state. While significant gains have been made, these need to be viewed against the historical backdrop. The National Mental Health Strategy has raised awareness of previously hidden problem areas and encouraged an expectation, if not a demand, that ‘things should be better than this’. It is the view of the committee that much work remains to complete the mental health policy agenda commenced five years ago.

The area on Service Mix provides some statistics on what had been some of the changes:

- spending on non-institutional care grew by 55% ($216 million), with the majority going to ambulatory services ($135 million) and acute service in general hospitals ($41 million)
- service providers working in the community increased from around 4,100 to 5,900 and acute beds in general hospitals by 20% (395 beds)
- around 31% (1,800) of beds in psychiatric hospitals were closed in the first 4 years of the strategy
- state and territory spending on MHS increased by 6.5% and 61% for the Commonwealth.

Change was not uniform across jurisdictions, with some being very slow, and there was considerable disparity across regions, particularly in rural areas. For many people the vision of accessible, responsive and integrated services bore little resemblance to reality. Key issues of concern were:

- service gaps
- limited access to acute beds
- community services as gatekeepers
- inadequate case management systems
- insufficient emphasis on rehabilitation and personal recovery
- undeveloped ‘special needs’ services
- lack of skilled workforce
- barriers between the private and public sectors
- inadequate rural services.

In the priority area of Promotion and Prevention, the Evaluation notes that with prevention the feedback from stakeholders was there had been no obvious impact, and the lack of data on the extent of mental illness in the community did not help to refute or validate this.

With early intervention, the key issues in 1997 were: 1) the culture of early intervention was across MHS; 2) use of the term ‘serious mental illness’ had inhibited early intervention as many consumers reported being turned away from services – their illness didn’t meet ‘serious’ mental illness criteria; and 3) extended hours services were only available to a minority of people.

In looking at future directions, the following in service delivery were identified as areas of need:

- defining need – determining the extent of the need and developing a national definition of service priorities taking into account clinical diagnosis, personal functioning and suffering
- defining workforce core competencies – noting that little had been invested in looking at the workforce implications of changes in service delivery
- strengthening rehabilitation and personal recovery – emphasising personal recovery, integration and rehabilitation and not just treating acute episodes
- responding to people with special needs – ATSI people, people from CALD backgrounds, children of parents with mental illness, survivors of trauma, dual disabilities, and homeless youth.
- including the private sector in the reform process
- strengthening the role of primary care, in particular GPs
- rural populations.

With the 2nd Plan, under Promotion and Prevention a guiding framework used with universal, selective and indicative preventative measures. Strategies target high-risk groups and the stated outcomes are: 1)
reduced incidence and prevalence of mental illnesses and associated disability; 2) reduced number of suicides; 3) reduced incidence and prevalence of depression and associated disability; and 4) reduced inappropriate readmissions to inpatient services.

Under **Partnerships in Service Reform and Delivery** the 2nd Plan states the need to formally have in place partnership arrangements at the system and service level, which identify responsibilities and address issues impeding interventions. It mentions linking with other reform agendas and initiatives at the Commonwealth level. ATSI people and rural and remote communities are included as a specific target groups. Strategies focus on developing formal agreements between stakeholders to clarify roles and responsibilities; integration of community and inpatient services for continuity of care; and continuing to develop and evaluate funding models.

The 2nd Plan Evaluation notes that over the period of the Plan mental health expenditure increased slightly averaging 5.7% per year compared to 5.2% during the 1st Plan. It notes continuing and considerable variation between jurisdictions commitment to funding, with the gap between the highest and lowest spending continuing to increase and the level of services available. There had also been no resolution of service mix issues. Support for carers was lacking and their role was disregarded at all levels. The shift from separate psychiatric hospitals to general hospitals and community-based service was still occurring. In 1993, 55% of acute beds were located in general hospitals, increasing to 67% in 1997 and 80% in 2000. All jurisdictions had strengthened community services, with 49% of spending by 2000 going to care in the community. However, growth had slowed during the 2nd Plan and despite progress, community treatment options were seen as unavailable or inadequate.

The Evaluation notes that there had been significant development in early intervention, particularly for psychosis with the development of the Early Psychosis Prevention and Intervention Centre (EPPIC) model. The involvement of GPs had been strengthened through the Better Outcomes in Mental Health Care initiative. However, early intervention had not received the merited emphasis, and consultations with consumers and carers identified a lack of satisfaction and limited capacity for timely access. The system remained focused dealing with illness when it was advanced or at a crisis.

In examining **Partnerships in Service Delivery and Reform** the Evaluation noted “there was still much to do” in developing effective care pathways between primary care, specialist services and other providers and alternative access to private services was unavailable for most people. Continuity of care remained elusive.

The emphasis of the 2nd NMHP on certain population groups had led to some improvements, but there remained groups in need of emphasis. The groups were ATSI people; people from CALD backgrounds; rural and remote communities; people with complex needs; and forensic populations, who were largely neglected. Overall the Evaluation states that in terms of funding, mental health had not significantly increased its position and did not received the level of resources commensurate with burden of disease.

While there had been achievements, there was still widespread dissatisfaction and many of the criticisms with the first plan remained. In identifying future directions, the Evaluation identifies ATSI mental health as a high priority, along with CALD and forensic groups who had unique needs.

Improving services responsiveness was seen as being fundamental to consolidating and progressing structural reform, and this included a focus on the following: 1) access to mental health care in a timely manner; 2) continuity of care across the lifespan; 3) early intervention; 4) integrated systems of care; 5) intersectoral collaboration; 6) rehabilitation, recovery and relapse prevention; and 7) recognition and support for carers and community support services.

Principles of the 3rd Plan include: 1) all people in need of mental health care should have access to timely effective services, irrespective of where they live; 2) mental health care should be responsive to the continuing and differing needs of consumers, families and carers, and communities; 3) a recovery orientation should drive service delivery; and 4) sustainability of effective interventions must be ensured.

Under **Improving service responsiveness** in the 3rd Plan were a range of stated outcomes around access issues, including:

- national agreement on the broad levels and mix of services necessary to align current and future supply of and demand for mental health care across the lifespan
• improved access to acute care and early intervention services
• improved access to a range of community-based care alternatives
• improved access to GPs and other primary care providers and private psychiatrists
• increased access to recovery/rehabilitation programs and long-term supported accommodation
• increased support and recognition of the role of non-government organisations
• improved access to services for Aboriginal and Torres Strait Islander people and for other population groups of all age groups with diverse and complex needs
• enhanced care pathways across the spectrum and access to services across the lifespan
• reduced service system gaps and increased integration between private and public MHS
• improved coordination between the MHS and other areas of health.

The 3rd Plan Evaluation in 2008 states that that there had been progress in all key areas and stated outcomes, but that there was a level of dissatisfaction expressed by a range of constituents with particular parts of the Plan. The Evaluation notes that guidelines and principles around care coordination had been generally accepted by all jurisdictions, and some had worked to develop integrated systems of service. There was widespread concern from associated consultations that particular groups were continuing to be underserviced: children and adolescents, CALD people, ATSI people, forensic populations, and comorbidity.

The 4th Plan endorsed in 2009, under the priority area of Social inclusion and recovery includes in the outcome that services are (to be) delivered in a more coordinated way across health and social areas. It again lists many similar priorities to those in the 2nd Plan in relation to access to care.

**Evidence of progress: Theme 5 – Provision of and access to services**

**Expenditure**

The ROGS provides a guide on spending directed towards MHS over the years of the Plans. The 1999 ROGS is the first year to report on MHS. Targeted spending on mental health and related services was $1.997 billion for 1995–96 – this excluded general hospital services and community support programs. State/Territory Governments contributed $1.158 billion (58%), the Commonwealth $661 million (33.1%) and private funding $178 million (8.9%). The overall level of funding had increased by 24.1% between 1992–93 and 1995–96, the largest increase from the Commonwealth at $250.2 million (61%) 44.

Private hospital funding had increased by $66.1 million (59%) and State/Territory Governments by $68.6 million (6%). The strongest increase was in the NT (18.5%) and Tasmania (17.1%). Nationally, expenditure per capita increased by 2.7% to $63.70 – Victoria was the highest at $74.50; Queensland the lowest at $55. The strongest growth was in Tasmania (up 16.3%). Decreases occurred in SA (-1.2%) and Victoria (-0.3%). The overall size of the workforce did not change greatly between 1992-93 and 1995-96, but there were changes in composition with the ambulatory care increasing by 39% and community residential services increasing by 59%, and staff employed in inpatient facilities falling by 15%. Table 3.1 gives a breakdown of average per capita spending by governments by services type 45.

---

45 Ibid.
Table 3.1. Average per capita government expenditure, by service type

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Stand-alone hospitals</th>
<th>Co-located units</th>
<th>Community services</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>26</td>
<td>23</td>
<td>-10.6</td>
</tr>
<tr>
<td>VIC</td>
<td>40</td>
<td>19</td>
<td>-53.4</td>
</tr>
<tr>
<td>QLD</td>
<td>25</td>
<td>23</td>
<td>-5.3</td>
</tr>
<tr>
<td>WA</td>
<td>32</td>
<td>28</td>
<td>-14.7</td>
</tr>
<tr>
<td>SA</td>
<td>39</td>
<td>36</td>
<td>-8.8</td>
</tr>
<tr>
<td>TAS</td>
<td>30</td>
<td>26</td>
<td>-15.1</td>
</tr>
<tr>
<td>ACT</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>NT</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>AUST</td>
<td>31</td>
<td>23</td>
<td>-24.6</td>
</tr>
</tbody>
</table>

The most recent ROGS report for 2013 provides data for 2010–11. Approximately $6.6 billion in real government expenditure billion was allocated to MHS, with State/Territory Governments accounting for $4.1 billion (62.5%) and the Australian Government $2.5 billion (37.5%). Average expenditure per person on specialised mental health services was $294.2, an increase from $240.9 in 2006–07.

The largest part of the Australian Government’s spending on mental health was under the PBS for medications at $808.8 million, which increased at an average annual rate of 2.2% between 2006–07 and 2010–11. The next largest contributor was Medical Benefits Schedule (MBS) payments for psychologists and other allied health professionals (social workers and OTs) at 14.6%, then spending on consultants psychiatrists at 11.3%.

The amount spent by State/Territory Governments on different areas – hospital inpatient, ambulatory, indirect, community residential and non-government organisations – varies across jurisdictions, however, hospital inpatient and ambulatory receive the most amount of funding. NSW had the highest amount of spending on hospital inpatient, which also accounted for just over half of the states total, and Queensland was the only state to not have expenditure on community residential. Tasmania, Victoria and the ACT spent the most of the jurisdictions on community residential, and the amount spent on community services provided by NGO was a fairly uniform, low level across all jurisdictions.

More critically, the overall percentage of health care spending on mental health services has declined in the past few years as shown in Figure 3.1 and table 3.2.
Figure 3.1: Mental health vs total health budget increases 2006–07 to 2010–11

![Graph showing mental health vs total health budget increases from 2006–07 to 2010–11.]

Data Sources: Mental Health Services in Australia, AIHW
Health Expenditure Australia 2010–11, AIHW

Table 3.2 National mental health and health care spending 2006–07 to 2010–11

<table>
<thead>
<tr>
<th>Year</th>
<th>Mental Health Spend ($ Billion)</th>
<th>% Increase</th>
<th>Total Health Spend ($ Billion)</th>
<th>% Increase</th>
<th>MH Share of Total Budget%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006–07</td>
<td>5.16</td>
<td></td>
<td>94.9</td>
<td></td>
<td>5.48</td>
</tr>
<tr>
<td>2007–08</td>
<td>5.75</td>
<td>11.29</td>
<td>103.6</td>
<td>9.17</td>
<td>5.54</td>
</tr>
<tr>
<td>2008–09</td>
<td>6.14</td>
<td>6.84</td>
<td>113.7</td>
<td>9.75</td>
<td>5.39</td>
</tr>
<tr>
<td>2009–10</td>
<td>6.44</td>
<td>4.86</td>
<td>121.4</td>
<td>6.77</td>
<td>5.30</td>
</tr>
<tr>
<td>2010–11</td>
<td>6.87</td>
<td>6.67</td>
<td>130.3</td>
<td>7.33</td>
<td>5.26</td>
</tr>
</tbody>
</table>

Prevalence and services accessed

As is discussed in Chapter Five of this Report, prevalence rates overall have not changed markedly. Only two national surveys have ever been conducted – 1997 and 2007. In 1997 survey approximately 2.4 million adults (17.7%) experienced the symptoms of a mental disorder at some time in the 12 months before the survey, of which 51.7% were female. The most common disorders were anxiety disorders (e.g. General Anxiety, PTSD) accounting for 54.5%; substance abuse disorders were the second most common; and then affective disorders (such as depression, mania and bipolar disorder) 52.

In the 2007 NSMHWB, 45% or 7.3 million of the 16 million Australians aged 16–85 years had a lifetime mental disorder, and one in five, 20% or 3.2 million, had symptoms in the 12 months prior to the survey. Of the 3.2 million aged 16–85 years who had a 12 month mental disorder 14.4% (3.2 million) had an anxiety disorder, 6.2% an affective disorder, and 5.1% a substance use disorder. Anxiety disorders had the highest prevalence across all age groups 53.

Young people experienced higher rates of disorder, with 26% of people aged 16–24 years and 25% of people aged 25–24 years experiencing a 12-month mental disorder compared with 5.9% of people aged 75–85 years 53.

53 Ibid.
In the 2007 NSMHWB 12% (1.9 million) of the population aged 16–85 years accessed mental health services in the 12 months prior to the survey, of these three in five (59%) had a 12 month disorder, and one in five met the criteria for lifetime diagnosis but had no symptoms in the 12 months prior (20%) or had no lifetime disorder (21%)55.

Of the 3.2 million adults with a 12-month disorder, just 35% accessed services for their mental illness, with women accessing services more than men (41% compared to 28%). Around one in three women (30%) saw a GP and one in six (18%) of men, and were also more likely to see another health professional. People with one disorder were less likely to access services (23%) than people with two or more disorders (52%). Of the people who had only a 12-month affective disorder, 45% used mental health services, with 80% seeing a GP. This is probably attributable to the work of beyondblue in raising awareness of depression and to a small extent bi-polar56.

The CoAG National Action Plan on Mental Health – Progress Report 2009–10 acknowledges that achieving significant improvements in treatment rates will require sustained efforts and investment by government over the long term57.

The poor rates of access to services for mental health care, comes in spite of dozens of new programs introduced in the decade between the two NSMHWB. Rates of access to services provided by the States/Territories has even declined (although only marginally), while rates of access to primary mental health care services (through GPs) has risen with the introduction of the MBS funded initiatives, initially in 2003 and then more significantly with the Better Access program in November 200658.

The introduction of numerous Commonwealth programs from 2006 appears to have provided more services to the same people. That is, instead of accessing just one service, say the state-funded hospital care, the consumer is accessing two, three or more other services like the Mental Health Nurse Incentive Scheme, the Personal Helpers and Mentors program and so on. This conclusion is supported in part by the results of the NSMHWB of low prevalence mental illness in 201159.

The most recent initiative from the Commonwealth Government, Partners in Recovery (PIR) – will see some $549.8 million over 4 years to provide improved care coordination and support for people with severe and persistent mental illness with complex needs. It will not increase the number of people accessing services directly, only possibly through some improved efficiencies. PIR is aimed at 24,000

54 ‘General practitioner only’ does not include an additional 15% in each year who saw both a GP and another health provider.
55 Ibid.
58 Ibid.
people (over the four years, not annually) with a severe and persistent mental illness with complex support needs requiring a response across agencies.\(^\text{60}\)

PIR will be the second largest Commonwealth-funded mental health program (after the Better Access program), but will not actually increase the numbers of people getting access to service.

The last priority area in the 4\textsuperscript{th} Plan is “Accountability – measuring progress and reporting progress” with the stated outcome being that the community can make an informed and confident judgement about the progress of reform including the 4\textsuperscript{th} Plan and that consumers and carers have access to services and can compare theses to national benchmarks.

The one indicator for this priority area is “Proportion of mental health service organisations reporting performance data” noting this indicator requires further development. There is a statement in the Plan that specific targets have not yet been set for any indicators, but that this would be a priority during the first year of the Plan, and that collaboration between governments would be required to fill data gaps and develop appropriate targets.

**Theme 6 – Measurement and accountability**

**What the National Mental Health Plans say**

The 4\textsuperscript{th} Plan released in 2009 states that “Improving accountability for both mental health reform and service delivery are central to the Fourth Plan”. It goes on to state the priorities in relation to accountability, namely:

- Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.
- Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.
- Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting.
- Conduct a rigorous evaluation of the Fourth National Mental Health Plan.

However, the 1\textsuperscript{st} Plan and National Policy (circa 1992) states in relation to monitoring and accountability:

> There needs to be greater accountability and visibility in reporting progress in implementing the new national approach to mental health services. Currently mental health data collection is inconsistent and would not be adequate to enable an assessment to be made of the relative stage of development of the Commonwealth and each State/Territory Government in achieving the objectives outlined in the National mental health policy.

> It is essential that such a consistent system of monitoring and accountability be created. In developing such a system, it needs to be recognised that each State and Territory will be at a different stage as a result of the historical development of its mental health system. The central approach should be to measure progress in each State and Territory.

It goes on to list specific objectives in this area:

- To develop nationally agreed measures of performance in relation to each of the objectives in this policy and others which the Commonwealth, States and Territories regard as indications of performance in relation to this policy.
- To report annually and publicly, in a timely fashion, on the progress of the Commonwealth and each State and Territory in relation to these performance indicators and to compare them to their previous performance.

Extract from the National Mental Health Policy, Canberra, 1992

---

60 Partners in Recovery: coordinated support and flexible funding for people with severe and persistent mental illness with complex needs

Obsessive Hope Disorder

The 1\textsuperscript{st} Plan also makes a commitment to develop and implement in “all public MHS” National Standards. The 2\textsuperscript{nd} Plan Evaluation notes that improving the \textit{quality and effectiveness} of mental health care for all population groups was the third key theme of the 2\textsuperscript{nd} Plan. The 3\textsuperscript{rd} Plan in 2003 acknowledged as important national monitoring and that measurable indicators ‘should’ be agreed on early in the life of the 3\textsuperscript{rd} Plan. Then in 2008, the 4\textsuperscript{th} Plan again makes improving accountability “as central to the Plan”.

The 1\textsuperscript{st} Plan Evaluation noted that measurement and monitoring of service quality remained a challenge and progress in implementing standards for mental health care had not met expectations. Despite significant developments in the availability of mental health data, it was not possible to monitor changes over time or the levels of unmet need.

With regards to the National Standards for Mental Health Services, progress in implementing them had been slower than expected and consumers, carers and service providers thought it was unsatisfactory. It stated that achieving a commitment from all jurisdictions would extend well beyond the 2\textsuperscript{nd} Plan, and that the challenge was to embed continuous quality improvements rather than just the review of services against the Standards.

Workforce practice standards are also discussed and it was anticipated these would promote clinical best practice, and potentially promote a ‘human’ approach to service delivery. However, the implementation of initiatives had been hampered by the attitudes and practices of the MH workforce and until the sector itself championed them, progress would continue to be unacceptable.

The 3\textsuperscript{rd} Plan in 2003 acknowledges notes that a major issue from the 2\textsuperscript{nd} Plan Evaluation was accountability regarding resource use and service quality and that mechanisms are required to ensure accountability on funds spent on services for service development and achieving outcomes.

In the priority area of the 3\textsuperscript{rd} Plan “Strengthening quality” standards and monitoring is highlighted, with the need to move from an emphasis on service input and structure to impacts and outcomes. There are three outcomes listed, namely \textit{Increased service quality and numbers of services that meet specified quality criteria in both the public and private special mental health sectors; Comprehensive implementation and further development of routine consumer outcome measures in mental health; Monitoring of the performance of mental health services regarding emotional and social wellbeing issues, through the collection and sharing of information and data with key directions focusing on information and data collections on ATSI people.}

The 3\textsuperscript{rd} Plan Evaluation in 2008 states that frustrations expressed by stakeholders included that the Plan did not give specific guidance towards actionable and measurable items. The Plan was too broad by trying to ‘be all things to all people’ and the Key Directions or Outcomes could not be identified as accomplished since the actions required were not clearly defined.

The National Standards for MHS were seen as providing a framework for continuous improvements, and there were a number of initiatives supporting quality through data collection and review. From interviews it was the consensus that the Plan informed the development of initiatives for specific populations, but factors such as a lack of professional workforce in those populations, lack of GPs and the remote locations of some groups, was continuing to inhibit progress. The Evaluation points to issues around workforce adversely affecting the quality of services and delivery. Overall, consideration should be given to developing a plan identifying actionable and measurable strategic priorities.

Data and evidence for better mental health outcomes was identified in the 3\textsuperscript{rd} Plan Evaluation. This was a “Group One Priority Recommendation”: namely a national performance management framework. There was a need expressed for more establishing and measuring clearly defined targets at the national level (e.g. reducing and eliminating seclusion and restraint). Performance arrangements should also include the national standards for care providers and agreed incentives and sanctions for service providers who do not agree to or meet the standards. The performance management framework should include a small number of measureable national requirements with a national data strategy, which are consistent with the CoAG Action Plan and important agree priorities.
The 2008 3rd Plan Evaluation sets out that the features of such a system would be:

- applies to all jurisdictions with adequate funding for the regular, accurate, complete and timely reporting, collection and publication of the data
- published and analysed in annual reports to monitor progress
- focus on system outcomes or individual outcomes rather than inputs and process.
- the same across providers, public and private
- better reporting and integration of existing data, such as the Report on Government Services
- monitor equity of service provision
- continued support at all levels for individual outcome assessments
- encourage a learning culture based on health service research and evaluation
- new programs to include measurable targets and regular assessment of progress against targets.

"Information and evidence for better mental health – That the performance of mental health services be monitored through an agreed framework of outcomes, and resources developed to allow comparison and consistency between jurisdictions and over time" 61.

**Evidence of progress: Theme 6 – Measurement and accountability**

One of the consistent criticisms in the professional literature 62 of the Plans, and indeed the entire Strategy, has been the inability to develop an agreed set of indicators to monitor progress and the lack of available impact and outcome data to monitor progress.

Even within government, this is not a recent criticism. Over 13 years ago, the 1999 ROGS (the first year to report on MHS), noted there was limited accurate data for reporting on the efficiency of MHS, particularly those outside of hospitals. Funding was based on historic ‘cost plus’ or input methods which do not allow for differences in or levels of illness. They also did not provide strong financial incentives for efficiency, quality, improved consumer outcomes or substitution between different service types 63.

A decade later, the 2008 ROGS stated that the key challenges for improving the reporting of mental health management were similar to those of previous years:

- improving the reporting of effectiveness and efficiency indicators for ATSI, rural/remote and other special needs groups
- revising the performance indicator framework to account for the 3rd Plan and the CoAG NAPMH to ensure reporting remains consistent with government policy objectives for mental health
- improving the reporting of effectiveness/efficiency indicators for community-based MH care 64.

The most recent ROGS (2013) report again repeats and highlights these main challenges for improving the reporting on MHS:

- improving the reporting of effectiveness and efficiency indicators for Indigenous Australians, rural/remote and other selected community groups
- developing an estimate of the number of people who need MHS so that access to services can be measured in terms of need
- identifying indicators that relate to the performance framework dimensions of quality — safety and sustainability
- improving reporting on outcomes to include indicators that relate to the participation of people with a mental illness in meaningful social and recreational activities

• further developing the measurement and reporting on the clinical MH outcomes of consumers of specialised public MHS\textsuperscript{65}.

Twenty years of the National Mental Health Strategy and four five year Plans, and other strategies, such as the CoAG National Action Plan, has delivered information, monitoring and reporting which tells very little about the state of mental health and mental illness in Australia. Despite the national collaborative framework, there is a lack of real accountability and a reliance on limited MHS systems data\textsuperscript{66}.

Current services have invoicing systems which receive government funding for the services and therefore monitoring activity is a straightforward process, compared with identifying outcome indicators. However, it does note there are gaps in basic monitoring and reporting levels of service, with a report from the Information Strategy Committee of the Australian Health Minister’s Advisory Committee, National Mental Health Workforce Group finding that less than a third of required key performance measures for public MHS were available. The failure to collect outcome data also pointed to the need to have such data collected and reported on by a dedicated research body, rather than governments bringing together separate data\textsuperscript{67}.

Table 3.3 – Summary of key issues and recommendations from evaluations of three National Mental Health Plans

Notes:
1. There has not been an evaluation commissioned or undertaken of the Fourth National MH Plan (2009–14).
2. The statements here are direct quotes from the Review and Evaluation Reports. Abbreviations have been used in places.

<table>
<thead>
<tr>
<th>Service delivery, standards, quality and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review of the 1\textsuperscript{st} National Mental Health Strategy 1992–1997</strong></td>
</tr>
<tr>
<td>Service improvements are uneven, across and within jurisdictions.</td>
</tr>
<tr>
<td>Many areas are yet to experience a tangible benefit from the National MH Strategy reforms, indicating the structural reform agenda is not finished.</td>
</tr>
<tr>
<td>Concerns about poor service quality and client outcomes have only begun to be addressed.</td>
</tr>
<tr>
<td>In a number of critical areas (e.g. workforce training), action is yet to commence.</td>
</tr>
<tr>
<td>The focus of the new Strategy needs to move from the current emphasis on service inputs and structure to service standards, quality and outcomes. Much of the criticism of MHS concerns its alleged failures in these areas.</td>
</tr>
<tr>
<td>Initial steps to develop outcome measures and service standards have been taken that place Australia at the forefront of initiatives in these areas.</td>
</tr>
<tr>
<td>Considerable development work is required to take these to a point where they will be fully accepted and implemented in the field… national leadership is essential.</td>
</tr>
<tr>
<td>Little credit can be taken by the National MH Strategy for any changes in the culture and mix of service provision in Australia’s private psychiatric hospitals. This service sector was not included in the original Strategy… now acknowledged as poor policy and recent efforts have begun…</td>
</tr>
<tr>
<td>Psychiatrists… in the private sector were similarly given little attention… Several reports have been commissioned… that identified a wide range of policy options to resolve chronic problems separating private psychiatrists from public sector practice. Most of these are yet to be implemented, and should be pursued in the next policy period.</td>
</tr>
<tr>
<td>The relationship between GPs and specialist MH services is relatively undeveloped in Australia… by contrast, research (shows) GPs carry the burden of responding to the majority of MH need in the community. Barriers claimed to inhibit stronger links between the specialist MHS and GPs include funding disincentives, lack of training and attitudes of MH providers. A range of shared care and training models has been trialled… that demonstrate these can be overcome… to move from an approach based around isolated pilots to a structured program of change.</td>
</tr>
</tbody>
</table>

\textsuperscript{66} Crosbie, D, Mental health policy – stumbling in the dark?, MJA, Volume 190 Number 4, 16 February 2009.
\textsuperscript{67} Ibid.
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Mental Health care</strong>: Consumers and their carers must be able to access services as and when they need to, both within and beyond the specialist MH sector. Access to acute care is especially problematic and the current practice whereby consumers often cannot access acute care until they have reached a crisis must be redressed. Removing barriers to accessing long-term care in the community and ongoing support services must also be prioritised.</td>
</tr>
<tr>
<td><strong>Continuity of care across the lifespan</strong>: MH care should be responsive to the developmental course of MH problems and illnesses. Some MH problems are more prevalent at particular stages of the lifespan, and some likely to recur. Furthermore, different stages of the lifespan bring varied risks for MH as well as diverse treatment needs. Population trends reveal that children, adolescents and young adults require special emphasis for MH care. Conversely, Australia’s ageing population deems older adulthood to also be a lifestage where service provision is not equipped to meet population needs.</td>
</tr>
<tr>
<td><strong>Early intervention</strong>: Early intervention is only beginning to be understood. The evidence-based early intervention models already developed for psychosis need to be made more widely available, and models for other disorders, esp. high-prevalence disorders, need to be developed. Particular emphasis on the evaluation of early intervention responses is warranted …. Prioritising early intervention responses will help reduce access problems for all MH consumers.</td>
</tr>
<tr>
<td><strong>Integrated systems of care</strong>: Coordinated and seamless transitions between the different levels of care and different types of services needed by consumers should continue to be progressed through national service frameworks. Recent initiatives must be sustained and more widely implemented to ensure effective partnerships between primary care and specialist MH care. Jurisdictions need to examine their population needs and ensure that the required mix of services, along with systems to ensure integrated service planning, takes place. Integrated care and effective partnerships are essential for all consumers, but especially for those with more complex needs… Consumers require individual care pathways that recognise their often complex and changing needs, and that include them and their families and carers in decisions …</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations revealed a broad consensus that a whole of government approach is required to deliver the cross-sector changes that we outline in this evaluation. In addition to health specific ministerial responsibilities, implementation of these recommendations will necessarily include the need for a clear and coordinated partnership across Governments, and their portfolios that have responsibility for aspects of services and support for people with mental illness, including areas such as housing, employment, education, social security, indigenous affairs, corrections/justice.</td>
</tr>
<tr>
<td>Without such careful inter-linkages …, it is conceivable that unanticipated adverse consequences of current arrangements may affect people with mental illness. E.G., work related arrangements can lead to loss of welfare benefits for consumers ‘non-compliant’ with the generic work/disability capacity assessment test, or welfare related payment arrangements to carers and family members that may not sufficiently appreciate the remitting/relapsing nature of some forms of mental illness ….</td>
</tr>
<tr>
<td>A further National MH Plan should recognise the importance of ministerial partnerships and shared responsibilities, together with clear led, funding and reporting arrangements that cannot be delivered by a single portfolio area alone. This would build upon the whole of government opportunities provided by the success of the COAG Action Plan. We envision that putting such a ‘whole of government’ approach into practice will be a progressive and evolutionary process that may require commitments across Ministries.</td>
</tr>
<tr>
<td>The Australian MH system is complex, with different levels of government and multiple sectors involved at the different planning and provider levels. Coordination mechanisms are therefore vital at each level. E.G., potential for improved coordination should include evaluation of pilot programmes to compare models of care integration such as for dual diagnosis consumers, with results shared via the clearinghouse arrangements.</td>
</tr>
<tr>
<td>Furthermore, early clarification on whether specified COAG funds are time limited or continuing funding streams will assist ongoing service planning.</td>
</tr>
</tbody>
</table>
## Consumers and carers


Consumers and carers now have a place at the policy table, yet have only limited influence on local services, even when it concerns their personal treatment. It is essential that a national group of consumers and carers be maintained and extended to signal that the policy agenda is far from complete. Guidelines and assistance to local agencies, public and private, need to be established to accelerate the empowerment of consumers and carers at that level.


Services ought to be fully responsive to the needs of consumers and carers, and this will only be achieved by including consumers and carers in service planning. Providing responsive service delivery will require effort to achieve more timely, more community-focused, and more culturally and developmentally appropriate services. The future direction is towards customised models of care through the provision of individual care pathways.

With the move to more community-focused treatment options for people with mental illness, the enhanced role of carers and community support services and organisations must be sustained. Initiatives to include carers in treatment planning and to increase support for carers must be prioritised, especially better access to respite care. The special needs of some carers, particularly children as carers and carers from diverse cultural and linguistic backgrounds, must be addressed. The roles of organisations that provide support to consumers and carers in the community in terms of community integration, accommodation and employment also demand greater emphasis.

Participation needs to move beyond tokenism to full and meaningful participation for consumers and carers at all levels of planning and service delivery... The focus for consumer rights must address consumer neglect, as well as outright human rights abuses. This will entail monitoring of inpatient care and follow-up on discharge, through the full implementation of consumer outcomes.


Regarding consumer and carer participation, while we heard that some progress has been made during the current National MH Plan, the successful further maturation of these forms of involvement can be further consolidated by ensuring clear and transparent reimbursement structures for consumer and carer participation and appropriate budget allocations and by extended employment opportunities incl. consumer consultants, peer support workers and advocates. Furthermore, there needs to be an overall system focus on recovery and social inclusion.

As the consumer and carer movements mature, more diverse voices and perceptions emerge, more pathways for communication needs to be developed. There is a concern that if the Commonwealth or State and Territory Governments rely on primarily one mechanism to gain a consumer perspective, plans will not have the ‘buy-in’ of a wide range of impacted individuals and groups. A recognition of the expectation of participation at every stage of policy and practice planning and implementation and ensuring that there is an extended focus on the Consumer Experience of Care surveys on a regular basis to track trends and to identify key areas for action.

## Mental Health need


The most common concern raised relates to use of the term ‘serious mental illness’ and its widespread application in restricting access to services. Two steps need to be taken. First, the extent of community need must be determined so that local priorities and service gaps can be properly identified. The national MH population survey commissioned under the strategy will provide a basis for this. It is essential that the implications of the national survey be translated to useable planning tools that can be applied by local services in estimating community need. Second, a national definition of service priorities should be developed that takes into account clinical diagnosis, personal functioning and suffering.


### Evaluation 3rd Plan 2003–2008


<table>
<thead>
<tr>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review of the 1st National Mental Health Strategy 1992–1997</strong></td>
</tr>
</tbody>
</table>

| Evaluation of the 2nd National Mental Health Plan 1998–2003 | There is much still to be achieved in developing the MH workforce. Primarily, the distribution and composition of the MH workforce is not responsive to population needs, and innovative solutions to encourage greater equity of access must be found. The focus of training and development must be on changing the attitudes, orientation, skills and historical practices of the MH workforce to ensure that it no longer perpetuates stigma, but rather works in partnership with consumers and carers to promote recovery and social and emotional wellbeing. |

| Summative 3rd Evaluation of the National Mental Health Plan 2003–2008 | The challenges across the entire MH workforce pose the greatest current challenge to the sustainability of a viable MH system of care. A clear forward looking plan is required in the near future, which specifies the numbers of staff needed, with their defined skills and competences, up to 10 years ahead and across all sectors providing services for people with mental illness. … a sufficient workforce is a fundamental precondition for successful implementation … There is a need to map the current distribution of State, NGO, private hospital, and private practice MH resources to identify areas of greatest need. Further, it is necessary to identify best practice to recruit/ train/ reward/ retain staff and review evidence of what elements are most important to current and potential staff as part of a remuneration package. Consideration also needs to be given to broader education and retention strategies to replace and increase the number of MH nurses, as the average age of MH nurses in several States and Territories is 45–50 years. For the future provision of skills and competences across the MH professions, the following issues need to be addressed in short term: Clarification of key roles in relation to other case manager and direct care staff; Identification of effective methods for staff recruitment and retention in rural and remote areas; Greater provision of funded clinical placements for staff-in-training: Plan to be developed with key partners on strengthening the workforce providing MH care to indigenous groups. The scale, urgency and trends in the issues mean … that a serious healthcare staffing challenge …. The response needed that is … should not be underestimated and we therefore recommend … that a coherent strategy for the MH workforce be developed as a priority. |
### Rehabilitation and recovery, including housing and employment


For many consumers, effective treatment of symptoms needs to be accompanied by approaches that emphasise personal recovery, integration, and rehabilitation. Where the illness is of a long term nature, or recurrently episodic, services are needed to assist the person to restore their lives as much as possible, and find ways to adapt to living with a chronic illness.

The skills required to assist consumers in these ways are under-emphasised in favour of models promoting the treatment of acute symptoms. A better balance of approaches is required to improve long-term consumer outcomes.

In this area, consumers appreciate the roles played by the non-government sector and advocate for their expansion.

The Committee agrees with this view, while recognising that personal recovery and rehabilitation services cannot exist in isolation of treatment services. The challenge in achieving a balance of illness and rehabilitation approaches requires coordination of services rather than segmentation.


Providing a fully integrated system of MH care requires expanding service frameworks beyond the health system, to incorporate the disability, accommodation and wider welfare systems. Moving outside the health system is a daunting task, but it is essential that persistent inequities regarding access to accommodation, employment, education and training, income support, disability services, and domiciliary care are removed for people with MH problems and mental illness, and that these support services are provided within a coordinated system of care.

Greater emphasis on rehabilitation, recovery and relapse prevention will provide a more balanced approach to the needs of consumers. Fundamentally, a recovery orientation must underpin service delivery. MH services must begin to operate within a framework that supports the empowerment of consumers and personal capacity building. This will require better understanding of the factors that impact on rehabilitation and relapse, along with coordinated provision of the support services that are determined to be essential to recovery.

Equitable access to and better coordination of support services must be achieved, particularly for accommodation, disability, employment and health services. The elimination of stigmatising attitudes and discriminatory practices in these services is fundamental to achieving equity of access.


**Employment:** The provision of proper work and employment opportunities for people with mental illness emerged very clearly ... as a high priority across the MH sector. ..., we suggest that there is an extension of consumer consultant, and peer support worker schemes ....

A further whole of government approach should contain a renewed focus on workforce entry and retention, incl. the full application of the Disability Discrimination Act to people with MI.

**Housing:** The shortage of capacity and necessary range of accommodation for people with MI was described across all states and territories. There are no widely agreed models of the range of necessary accommodation, incl. clinically supported housing for people with disabilities related to MI. As up to 40% of homeless people have severe MI, there is a need to implement plans already existing on short and longer term provision of accommodation, along with assertive treatment and care. In addition, dissemination of information and evidence of best practice models on accommodation, ... and action plans with agreed targets, responsibilities, budgets, timescales and review points is recommended. Information exchange on successful partnerships ... would also be of benefit

### Special/specific needs groups


A single approach to MH service delivery cannot meet the diverse MH needs in the Australian community. Since its introduction, the NMHS has argued that there are identifiable groups with special needs, for whom unique programs need to be developed. These include: ATSI peoples; people from CALD backgrounds; children of parents with mental illness; survivors of torture, trauma, or child and sexual abuse; people with dual disabilities; homeless youth; and others.

Service development for these groups is variable, and needs to be strengthened in future years.

This will have workforce training implications and requires incentives to be established for health professionals to pursue specialist interests. The general problems faced by rural
communities in accessing health services are particularly evident when specialised MHS are needed. A range of initiatives have been taken under the NMHS and other . . programs, to improve rural access to MHS.

Most importantly, solutions need to be tied to broader strategies to improve health services to rural Australia, and particularly linked to relevant initiatives in primary care.


Improving the social and emotional wellbeing of ATSI is a complex and challenging task that demands high priority. There is an urgent need for better information on the nature and occurrence of MH problems for ATSI peoples, as well as effective intervention models. ATSI communities must be involved at all stages in the development of interventions to ensure cultural appropriateness and acceptance. Efforts to more effectively integrate Indigenous and mainstream services must continue...

Some population groups within the Australian community require special consideration due to their unique needs. Many initiatives have been put in place to improve access to MH care for rural and remote communities, and these need to be actively pursued along with other innovative solutions to problems such as distance. People from CALD backgrounds have a special need for culturally appropriate service delivery and recognition of the unique factors, such as refugee status, that impact on their social and emotional wellbeing. The development of responses for forensic populations has only just begun, despite being noted as a priority group for some time. Heightened emphasis on this population group is, therefore, warranted.


Indigenous : The views received . . fully support AHMAC’s 2006, ATSI Health Performance Framework Report when it stated that the ‘policy response to social and emotional wellbeing problems needs to be multi-dimensional, and focus not only on MH services. It needs to involve a wide range of stakeholders incl. ATSI communities, the health sector, housing, education, employment and economic development, family services, crime prevention and justice.’

... it may also be useful to conduct a review of international best practice in improving indigenous MH be conducted, and used to guide the formulation of a renewed and practical, consensually agreed action programme.

Prisoners : … there are considerable variations in the quantity and quality of MH care provided to prisoners. . . recommend that a further National MH Plan addresses the following issues: 1) more widespread dissemination of practice innovations such as MH courts, court assessment and diversion schemes, prison in-reach services, and post-release care coordination; 2) active steps are taken to reorient criminal justice staff to the model of therapeutic jurisprudence; 3) to inform system planning, information should be gathered nationally on the levels, nature and trends in mental illness among people in prisons.

Co-occurring ('dual diagnosis') disorders: … people with such multiple disorders are relatively poorly served by MH and AOD services.

Prevention and promotion (P&P), including stigma and discrimination


Marginalisation of MH from the broader health system has contributed to the limited effort made in the area of primary P&P. This has left MH providers to take up the role, but they are unwilling to sacrifice their treatment responsibilities …

The separateness of MH has also isolated it from public health expertise and its broad approaches to improving population health. Initiatives in the area of primary prevention need to integrate MH with general health programs and be based on a partnership between public health and MH experts.

Advances made in the Community Awareness Program also need to be consolidated and extended. Specific groups need to be targeted, for whom the broader campaign was not appropriate. These include those from CALD backgrounds, ATSI peoples and those in rural areas.

To complement the community-wide approach, efforts should also be targeted in areas where new services are being established, which are compromised by local community attitudes.


 Australians are becoming more receptive to MH information and continued effort to provide information should build on this. Necessary MH information incl. understanding of the risk and protective factors for MH, recognition of the early signs and symptoms of MI and awareness of sources of help for oneself and others. It is especially important for this information to effectively reach more vulnerable population groups … and be accessible....

Further progress in P&P needs to build on the impressive and innovative achievements thus far. The evidence base for P&P must grow along with networks to share information .... It is
### Obsessive Hope Disorder

essential to support the relatively recent application of P&P approaches within the MH field by 
continued and improved access to information, knowledge and support networks.

… the goal is for all sectors and levels of Australian society to consider the MH impact of their 
actions, realising that many risk and protective factors exist in the conditions of everyday 
life. …, the MH components of all policies and strategies need to be identified and made 
explicit and this information collated and widely shared.

Much more needs to be done to eliminate the stigma of mental illness. … The role of the MH 
workforce also needs to be highlighted, with greater emphasis on combating stigmatising 
attitudes among those providing services to people with MH problems and MI.

| --- |
| The wider context of the achievement of the NMHP since 1993 is the society within which care and treatment takes place and how far MH is seen as integral to a healthy society. There is strong evidence that many people with MI still experience stigma and discrimination, that in some cases is described as worse than the primary condition.

We have been very impressed by the success of Australian Commonwealth Government initiatives such as beyondblue and Stigma Watch (SANE) and by the promise shown by headspace, which have promoted the social inclusion of people with MI. At the same time, these efforts might in the future build upon their work so far to address differentiated population sub-groups, e.g. in relation to age or ethnicity…

There should also be continued evaluation to assess impact of MH awareness interventions. Work on developing a special focus on attitudes of MH staff that promote recovery and on training staff on needs of consumers in key service organisations such as Centrelink should also be promoted with additional support ‘experts by experience’ for speakers bureaux and MH awareness projects.

Other initiatives that would facilitate better awareness and anti-stigma interventions could include extending resource kits for employers that build on work to date by beyondblue and by developing current media tracking work to monitor how far mass media responsibly report MH matters.

### Planning and performance benchmarks, data and availability of information

| --- |
| The value of the NMHS lies largely in the values it espouses and its broad map of service development. From a planning perspective however, it is short on detail. E.G. while it advocates a change in the balance of services, the Strategy does not prescribe a specific service mix, leaving this to be developed in response to local needs. …, the Strategy advocates monitoring of progress made in particular areas, but does not specify targets.

Lack of planning and evaluation benchmarks creates ambiguity in the field. In seeking a target against which to monitor performance, several states and territories have adopted (their own) goals… The committee does not see these to be sufficient goals to guide a major reform program.

Service development at local level would be facilitated by nationally agreed planning targets. These would … act only as guides to be refined in accordance with local population differences and resource constraints. Similarly, performance benchmarks need to be developed for use in the evaluations of all mental health services at national, state and territory and local levels.

Information in MH is grossly undeveloped. The lack of nationally comparable data on service outputs, costs, quality and outcomes places major limitations on the extent to which the NMHS can achieve its objectives.

A precondition to the changes proposed above is the existence of an information infrastructure built from the clinical services level that contributes to individual consumer care and service quality improvements as well as feeding into higher-level planning and policy review. The models exist elsewhere …. Putting such systems in place needs to be identified as an imperative for the next Strategy period.

| --- |
| To better understand population MH needs, and to monitor trends in MH and mental illness across the Australian population and over time, better information needs to be collected on a more routine basis. At present it is not possible to track changes in the MH status of Australians.

Monitoring change and measuring the effectiveness of interventions requires a well-planned information system that yields useful indicators of a broad range of outcomes.

It is time for benchmarks to be produced for MH care to guide best practice. Considerable progress has been made with the development of national minimum data sets for MH care,
which must be maintained and further developed to ensure their utility for service planning. However, MH information systems are recent developments and information must become routinely available to inform decisions about quality and effectiveness and future directions in MH care.

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>... a need for more clearly identified targets to be set and regularly measured at the national level, to guide and assess the performance of MH services. Such arrangements should include performance targets set in relation to reducing and eliminating seclusion and restraint incidents.</td>
</tr>
<tr>
<td>Regular monitoring and public reporting for both public and private hospitals ... as part of quality improvement plans and moving towards a recovery orientation should also be considered.</td>
</tr>
<tr>
<td>The performance arrangements should include the completion of the current revision of national standards for care providers and agreed incentives and sanctions for service providers who do/do not meet agreed standards.</td>
</tr>
<tr>
<td>A more closely specified performance management framework should include a small number of measurable national requirements framed within a national strategy, consistent with the COAG Action Plan and ... focused on the most important agreed priorities... Such a system of performance measures would have the following hallmarks: 1) Apply to all jurisdictions; 2) Be published and compared in annual reports to track progress to the agreed targets; 3) ...focus more upon system outcomes or individual consumer (life) outcomes ... rather than inputs or processes; 4) Be harmonised across providers (e.g. public and private hospitals; state and NGO providers of care coordinators); 5) Demonstrate simplification and better integration of current centrally collated data incl. Report on Government Services; 6) Track equity of service provision; 7) ... extend individual outcome assessments, and to provide electronic data in formats useful to clinicians and to planners.</td>
</tr>
<tr>
<td>Establishing a mechanism to coordinate and share national MH resources which includes:</td>
</tr>
<tr>
<td>1) A lexicon of key terms to reduce ambiguity and misunderstanding via consensus statements: Care coordination; Recovery and social inclusion; Early intervention and Occasions of service; 2) A very small number of unifying concepts for the revised National Policy e.g. social inclusion, recovery, or civic participation; 3) A repository of guidelines and protocols on treatments, on recommended staffing levels in different treatment and care settings; 4) Technical assistance e.g. evidence-based practice for Dual Diagnosis Consumers, or recovery-orientated approaches for staff; 5) Information on international best practice in key areas e.g. advancing indigenous MH and telemedicine; 6) Information on sources of funds to support applied research and programme evaluation; 7) Coordinated leadership training, for MH clinical and managerial staff and NGO staff; 8) A clearing house for operational information; 9) Central resources to reflect (eg governmental level) the shared responsibility between Commonwealth &amp; state/territory levels and across portfolios; 10) To all sectors the results of relevant applied research and programme evaluation that can inform planning and practice; 11) The dissemination of information and guidelines on best practice in staff recruitment and retention in rural and remote areas, on provision of MH care to offenders, including services in prison; on reducing seclusion and restraint; on respite care; 12) A national research register to inform all of research in progress and reduce duplication 13) Information and operational materials to support consumer-led methods including Self-advocacy; Advanced agreements; Decision aid tools; Consumer consultants; Chronic disease models.</td>
</tr>
</tbody>
</table>
| Review of the 1st National Mental Health Strategy 1992–1997 | Funding policy is the vital force in driving change. Tools need to be developed that fit the requirements of MH services, which both reward efficiency and quality, as well as emphasising continuity of care across hospital and community boundaries. Funding tools designed in the general health sector are widely recognised as inappropriate for mental health. Innovative work has commenced under the Strategy to achieve these ends, but will need to be extended before tangible benefits flow.

A role yet to be developed at national level is provision of training and support to agencies undertaking service innovations. Generally, both the initiative and the momentum are expected to be generated locally. It is clear that knowledge needs to be transferred from place to place to advance the reform agenda. This includes documentation, on-site support and use of new communication tools. The National MH Strategy should take the lead in this field. |
| Evaluation of the 2nd National Mental Health Plan 1998–2003 | **Innovation** … much yet to learn in the treatment of MH problems and MI and P&P. There is currently a high level of burden related to MI that cannot be alleviated and original, creative solutions must be urgently sought. … research .. into new pharmacotherapies and psychotherapies, (and) to reduce risks for MH problems and increase resilience, must be prioritised and resourced (also) better models of service delivery … **Sustainability** … is an issue for all innovations in the MH field, but particularly for pilot projects. Australia is in danger of becoming a nation of pilot projects. To prevent this, funding models must be developed to ensure that innovative ideas and pilot programs that are evaluated as effective are sustained… There must be a strong commitment to ensuring that effective innovations become part of mainstream MH care by being fully integrated and resourced within the MH care system.

**Resourcing.** MH must be afforded greater priority, commensurate with its health impact and the high level of unmet need. Although it maintained its relative position in health funding over the Second Plan, more resources need to be explicitly devoted to MH in the future if expectations for continued reform are to be met. The complex federated system that exists in Australia poses formidable challenges to achieving the major changes that are envisaged for MH care. These challenges are surmountable if funding formula and accountability mechanisms can ensure that money is effectively devoted to mental health. An adequate level of resourcing must provide a balance across the entire spectrum of MH interventions, in order to meet the growing MH needs of Australia’s population. |
| Evaluation 3rd Plan 2003–2008 | See Planning and performance benchmarks, data and availability of information |
Chapter 4

Marching to a different drum? The mental health workforce since Richmond

*Peter Long and John Mendoza*
Introduction – Pre-Richmond history

In can only be speculated how indigenous communities managed the mentally ill before European occupation. Chances are that there would have been an inclusive, family or clan-based approach and that an independent institutional workforce did not exist to care for them as in some indigenous societies today.

An internet search of pre-history or pre-contact information relating to mental illness, failed to reveal any definitive studies. A Northern Territory Justice System court reference document to local culture outlined that mainland groups ‘...had medicine men who were available (to) perform a number of roles including the diagnosis and curing of illnesses (often through magical rituals). Assistance rendered by a medicine man may take the form of “singing”.’ The process is described by one central Australian cultural group (Ngaanyatjarra people) as follows:

“Many medicine men have the power to do magic feats by singing magic songs. They can sing and cause someone to become mad. They can also sing a person’s head and thus make them strong. They can sing over a spear wound, singing as they put their mouth right on the wound, thus causing it to heal up quickly.”

The power to send someone ‘mad’ or ‘strong’ could well be a reference to treatment of mental illness or a psychological disorder.

By the time the European population had spread across the nation, and developed robust societies, which secured independence from New South Wales, it was mid-nineteenth century. The early paradigms from the late nineteenth century to the 1920s1 were based around the early industrial models of that era. It pays to remember that in the industrial paradigm ‘economies of scale’ meant more profit, so craft industries around the world were replaced by monolithic production houses, workers were herded into factories, jobs were cut into manageable pieces, science categorised mundane activities and placed them out of the reach of the average citizen.

The ideal mental health treatment was to provide ‘efficient’ service, sweep the insane, inebriated, and intellectually challenged into an asylum to protect the sane. As a consequence, the mental health workforce was institutionally based, their behaviour was not transparent and community interaction was non-existent. The early asylums were surrounded with high walls or located in somewhat discreet areas. In Sydney, the major institution at Gladesville, was located by the sea.2 Transportation over the “Kings Roads” was not permitted under the 19th Century Lunacy Act. Those ‘patients’ brought to the Gladesville asylum landed at Bedlam Bay3 on Sydney Harbour, and were then taken up a long tunnel to the institution itself: as if they were invisible or non-existent to the good residents of Sydney.

Australian researcher, Doris Kordes4, suggested that the medical and nursing practitioners during this period were practicing a type of ‘Herd Care’, with the focus on keeping the group safe, clean, fed and controlled. Lack of attention to rehabilitation, individual rights or personal treatment meant that ‘custodial models’ were predominant.

In the period 1920s to 1960s the rise of science saw the ascendency of the psychiatric hospital where the ‘medical model’ captured the discourse of mental health and acceptance that the conditions affecting mental health were less social but more illness related. During this period the medical psychiatrist and improved drug therapy underpinned a hierarchical workforce, and the predominance of the psychiatric nurse. Kordes describes this period for psychiatric nurses as ‘therapeutic care’ with ‘a greater emphasis on medical treatment rather than on confinement’.5 Regardless, roles were highly differentiated and allied health workers [e.g. social workers, occupational therapists (OTs)] were seen as an indulgence.

1 The categorization of phases is based on Smith G Williams T Policy in Action: Mental health reform in Australia, WA Mental Health Policy Research, September 2008.(UWA MH Policy & Practice Seminar).
2 The Tarban Creek Lunatic Asylum (later renamed Gladesville Mental Hospital) was established in 1836. It remained operational until 1997.
3 The name Bedlam Bay can still be found on maps of Sydney Harbour. Bedlam is a byname of Bethlem Royal Hospital – the first asylum for the mentally ill in England and opened in 1247. The word bedlam came to be used generically for all psychiatric hospitals.
5 Op Cit. p. 22.
As the clientele numbers for these institutions kept rising (to around 30,000 by the early 1960s from a population of less than 10 million), the workforce became swamped and a lack of requisite variety meant that innovation and public policy atrophied. By 1954 public concern had risen to a point where Prime Minister Robert Menzies instigated a Review into Mental Health Facilities and the Needs of Australians⁶ to investigate reports of “Dickensian conditions in mental hospitals”. Allan Stoller’s Report for the Commonwealth Health Department, confirmed unacceptable overcrowding, an almost complete lack of curative or palliative measures and a chronic shortage of professional staff and equipment or both in Australian mental hospitals⁷.

It also was an early precursor to Commonwealth involvement in mental health in Australia and marks “… the beginning of the State based directive to increase community participation in the care for the mentally ill.”⁸. The toxic environment in most of these institutions and the limited ability to positively impact on clients acted to dissuade potential psychiatrists and mental health workers from choosing that career path, or remaining in it having attained professional status, and staff numbers declined. This is a trend continuing to this day.

From the 1960s there was a shift in paradigm that questioned the role of institutionalisation for people with a physical and developmental disability and for those with mental illness – the emergence of the De-institutionalised Paradigm 1960–80s. Structural discrimination and learned helplessness⁹ were creating a cycle of despair it was argued, which acts in contradiction to the medical treatments and the quality of life of those in care. Calls to close psychiatric hospitals and to move people back into the community were high on the policy reformer’s agenda.

In this period of ‘normalisation’ staff were expected to leave institutional care and to take community care roles, often requiring a different type of emotional intelligence and power relationship with their clients, as well as having to leave clients unsupervised and, in many cases, in a community setting, and be clinically unsupervised themselves. The focus was getting people out of the institution and, for public policy architects, ensuring savings in the public purse through asset sell-off – not the recovery of persons with a mental illness. Lack of training to effectively operate in the new environment meant many mental health workers struggled and many clients slipped out of the network and became homeless or worse, and acute care incidents in general hospitals and community facilities increased, placing stress on staff in these environments. The ageing of the workforce and lack of demand management were already resulting in overloaded and burnt out staff.

**Richmond – a planned approach and the emergence of community psychiatry**

Australia was noticeably behind the paradigms in implementation and it was in this environment that David Richmond, in a 1983 review of services in NSW, raised concerns about the lack of reform in the mental health sector and the toxic work culture that had invaded the public sector elements of the service. It was the largest exposé of public sector mental health inadequacy in Australia and his recommendations provided a blueprint for all States (not just NSW), who constitutionally, have responsibility for health to respond more appropriately to the consequences of ‘normalisation’ (1970 – 80s Community Psychiatry).

Richmond’s 1983 Inquiry into Health Services for the Psychiatically Ill and Developmentally Disabled in NSW¹⁰, possibly created the breakthrough needed to shift the paradigms of mental health in Australia, which had survived since the 19ᵗʰ Century. The major focus of his Inquiry was to examine:

“… the services provided by the public sector (i.e. particularly State run “Fifth Schedule” psychiatric hospitals, public hospitals and the community health programme) and the services provided by non-profit community organisations.”

---

⁷ Hansard, House of Representatives, May 1955.
¹⁰ Richmond D 1983. Inquiry into Health Services for the Psychiatically Ill and Developmentally Disabled in NSW.
His inquiry came to the conclusion that “Fifth Schedule” Hospitals could not compete for attention or resources as equitably as “second” and “third” schedule hospitals, leading to an impoverishment of services to clients in the Fifth Schedule Hospitals; that a move to community-based care has been constrained by inappropriate training (including that for psychiatrists); that a type of ‘paternalism’ was constraining the actual move to community care; that the inebriated, the developmentally disabled and the aged require different support to that required for many of those who are mentally ill and dissipate the service if treated in combination.

As a consequence, the inquiry called for scaling down of Fifth Schedule Hospitals and devolution into community services for mental health care through regional or Area Management Boards. Importantly, separation of the inebriated, the developmentally disabled and the aged from those with a mental illness, training and better treatment of staff, especially as they move to the community sector were key planks of his manifesto for change.

Specifically, in summary and in relation to the workforce, he demanded:

- training for mental health staff in Fifth Schedule Hospitals for new roles in community services and specialised hospitals
- funding for the provision of additional community based crisis teams; staffing to provide adequate follow up for mentally ill people in the community; psychiatric staff for assessment services in general hospitals
- representation of staff through elected employee representatives on hospital and other boards
- development of a program budgeting approach to funding of these areas of health care in order to monitor the level of resources utilised for particular programs or client groups
- budget allocated to fund NGO innovative services and accommodation
- progressive introduction of 8 hour shifts from 12 hour shifts
- greater use of part-time staff to cover excessive workload periods in hospitals
- establishment of a more effective independent grievance procedure for staff against management
- improved co-ordination between GPs and public sector mental health services
- creation of new category of direct care staff be established – titled ‘Residential Care Assistant’ and a ‘Programme Officer’ with TAFE and higher education training to be negotiated and CEO responsible for services to a local board
- admission of acute psychiatric services located in general public hospitals through relocation of staff
- sessional arrangements for use of private practitioners
- expansion of use of enrolled nursing aides in staffing of specialised psychiatric hospitals
- seeking upgrading of psychiatric elements in curriculum of professional courses.

Distressingly for the workforce, many of the Richmond Report recommendations were never implemented. Since Richmond, there has been almost continuous public policy attention given to mental health in Australia.

**Burdekin: The accession of humans rights**

Some seven years later in 1990, Brian Burdekin in his role as Federal Commissioner for Human Rights began an inquiry into the human rights of people with a mental illness11.

Workforce issues that drew the attention of the Inquiry related to: lack of standards of care for patients leading to clinical issues, medication misadministration, physical abuse by and on staff, inappropriate treatment regimens within institutions, inappropriate utilisation of expertise, discontinuity of service, lack of availability of staff in rural and isolated centres, and public/private impervious boundaries, failure of staff training and predominance of the ‘medical model’ as a paradigm.

In summary, apart from uncovering damning evidence that Australia was not attending to its international obligations, the workforce issues arising from the Burdekin Report were as follows:

- The quality of psychiatric care is critical to the welfare of many individuals affected by mental illness.
- Medicare funding is not available for a wide range of services provided in the community.
- The continuing drift of mental health professionals from the public sector to the private sector is seriously restricting access by people with mental illness to appropriate services.
- The needs of mental health professionals and allied staff in terms of primary and continuing education and training are not adequately met.
- GPs have insufficient training in the assessment and treatment of mental illness. This is particularly apparent in specialised areas such as the diagnosis and treatment of psychiatric disorders and mental health problems in the elderly, children and adolescents and other particularly vulnerable groups.
- Mental health professionals and allied staff working both in institutions and the community require education and training in the delivery of community-based services.
- Workers and service providers in other sectors need appropriate training and education to meet the specific needs of people with mental illness.

On workforce, Burdekin was largely about ensuring staff who were once operating in a centralised institutional setting were trained and supported adequately to be able to respond appropriately in both a national context (to meet international obligations) and in a community setting, to better meet the needs of people with a mental illness: the paradigm being that of ‘mainstreaming’ (1980–1990s).

His recommendations involved:

- The establishment of a national standard for treatment
- The continued movement to community-based service
- Medicare funding for community provision
- Clarification of roles between professions and between providers
- Involvement of private sector professionals with treatment of chronic mental illness
- Linking GPs with mental health workers in both public and private sector
- Major attention to training through: specialised curriculum development; university and college offerings at all levels in mental health; continuing education availability for all workers and mandatory attendance for registered professionals; clinical supervision of trainee psychiatrists and hospital registrars; training GPs better for roles in assessment and treatment; greater attention by higher education authorities to mental health content in nurse training.

Burdekin came to the Inquiry with a ‘rights perspective’, quite different to the ‘service’ paradigm which had traditionally guided policy in health. The implications for mental health services in Australia, and for the workforce, were profound.

The reigning ‘service’ model was a ‘push’ model and if there was no service available due to poor public policy, lack of staff in certain geographic areas, or incompetent staff unable to deal with a ‘special’ mental health issue – tough luck. A ‘rights’ model places pressure on the government to supply services in order to ensure citizens have access – it should have accountability implications for non-compliance. Where citizens have a particular need (e.g. to justice), then the state is required to ensure that need is met. To this day, a number of jurisdictions have not fully realised the implications, nor perhaps, have they fully acted to comply with international standards.

Whilst Burdekin was coming from an individual ‘rights’ perspective the public sector was being challenged by its own institutional reforms, roughly translated into ‘economic rationalism’ (“what business should
government be in?
imported from the US, and New Public Management (NPM) imported from Britain. These issues affected all public policy, not merely mental health, and workforce re-engineering issues as government restructured around the nation, created considerable dislocation in a sector more used to conservatism and a ‘steady state’. Burdekin called for Commonwealth intervention and this coincided with an outbreak of ‘co-operative federalism’.

This led to the final stage, the paradigm of ‘social inclusion’ (1990’s to the present).


Table 4.1 summarises the intent of each of the National Plans and CoAG NAP with suggestions for workforce and the subsequent findings of the evaluation of the first three, five-year Plans.

Table 4.1: Australian National Mental Health Plans – Workforce summary

<table>
<thead>
<tr>
<th>Date</th>
<th>Aims</th>
<th>Evaluation findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993–1998</td>
<td>Focus on Public MHS</td>
<td>MH system initially in poor shape</td>
</tr>
<tr>
<td>First Plan</td>
<td>Shift Psychiatric beds to General Hospitals</td>
<td>Strategy needed to improve change process</td>
</tr>
<tr>
<td></td>
<td>Institutional to Community Care</td>
<td>Funds critical for Innovation and growth</td>
</tr>
<tr>
<td></td>
<td>Better Integration</td>
<td>Change public/private structure</td>
</tr>
<tr>
<td></td>
<td>Consumer rights</td>
<td>GPs felt excluded from MH process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Widespread dissatisfaction at focus on serious M Illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need workforce core competencies</td>
</tr>
<tr>
<td>1998–2003</td>
<td>GPs and psychiatrists</td>
<td>Failure to invest and commit</td>
</tr>
<tr>
<td>Second Plan</td>
<td>Depression programs &gt;significance</td>
<td>Workforce practice standards not taken up</td>
</tr>
<tr>
<td></td>
<td>Promotion and prevention</td>
<td>Implementation impeded by MH workforce</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training required to ensure workforce let go their old practices</td>
</tr>
<tr>
<td>2003–2008</td>
<td>Mental health for all Australians</td>
<td>Coherent MH workforce strategy a priority</td>
</tr>
<tr>
<td>Third Plan</td>
<td>34 Outcomes and 113 Key Directions</td>
<td>Need to map distribution of workforce</td>
</tr>
<tr>
<td></td>
<td>No specific Federal Funds</td>
<td>Promotes clinical placements in rural/regional</td>
</tr>
<tr>
<td>2006–2011</td>
<td>30% funds for Medicare rebate to Psych sessions</td>
<td>Improve coordination</td>
</tr>
<tr>
<td>CoAG National Action Plan</td>
<td>Funding for GPs and psychiatrists to employ MH nurses</td>
<td>Needs planning framework and innovative funding models</td>
</tr>
<tr>
<td></td>
<td>650 new respite places</td>
<td>Establish Regional partnerships</td>
</tr>
<tr>
<td></td>
<td>900 new PHaMs</td>
<td>No change in overall size of workforce</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workforce issues (barriers to collaboration; data collection; e-health)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NB – Progress reports have been issued for four of the five years.</td>
</tr>
</tbody>
</table>

NPM was focused on efficiency and effectiveness focus, ‘managerialism’, steering not rowing, linked up government, flat structures for responsiveness.
The McKay Report – Opportunity lost?

In a ‘Key Talent Analysis’ of the mental health workforce, the psychiatrist stands pivotal, and mental health systems have been designed to revolve around them. By 1996 a critical analysis of this limited resource was required and a detailed summary of the findings provided in this paper argued that private and public psychiatrists operated under very different structural conditions.

As McKay identified, a less than optimum use of the psychiatric workforce occurs in Australia in four areas:

- A level of unmet need for psychiatric treatment by people with severe mental disorders, although the extent of the unmet need, along with the definition of ‘severe’, has been subject to considerable debate.
- Lack of incentive to perform the role of specialist consultant to the primary care system, with most emphasis on continuing direct treatment of patients.
- Breaks in the continuity of care arising from the separation of public and private sectors.
- Uneven access to psychiatrists.

Table 4.2 Psychiatrists in public MHS and private practice

<table>
<thead>
<tr>
<th>Funding source</th>
<th>Psychiatrists in public MH services</th>
<th>Private psychiatrists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of reimbursement</td>
<td>State Government</td>
<td>Commonwealth Government</td>
</tr>
<tr>
<td>Limits on funding levels</td>
<td>Capped</td>
<td>Open ended</td>
</tr>
<tr>
<td>Interventions funded</td>
<td>No restrictions – direct client treatment, contact with family and social supports, contact with key agencies in the community on behalf of patient, advice to others in treatment team, community education, etc.</td>
<td>Direct client treatment, limited reimbursement for contact with family and social supports. Consultation with other agencies not directly reimbursed.</td>
</tr>
<tr>
<td>Other services available to patients</td>
<td>Integrated public MH service: Community nursing, psychology, social work, occupational health, disability support</td>
<td>Only by referral, to public mental health service or private allied health practitioner</td>
</tr>
<tr>
<td>Patients</td>
<td>Full range with emphasis on chronic conditions, particularly in need of disability support services.</td>
<td>All referred by GPs or other doctors as being in need of direct treatment by psychiatrist – limited capacity to manage patients with disability support needs.</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Restricted by limited capacity. Larger catchments.</td>
<td>In theory, not restricted. But local availability restricted in some areas.</td>
</tr>
</tbody>
</table>

As an example of the inequitable management, 1.8% of patients receiving 49 or more services in 1993/94 accounted for some 19% of the total benefits paid for psychiatric services. McKay pointed out that access would remain uneven while the incentive is to treat a small number of patients on a continuing basis. Inadequate access to child and adolescent psychiatric services was also identified as a major area of concern. While arguing the need for additional special services, it was noted that ‘200 child psychiatrists have been trained since 1970s but only 100 FTE stayed, and very few outside Melbourne and Sydney.’

The Report argued powerfully for three strategic goals for psychiatrists, namely: promote their specialist consultant role; increase access to psychiatrists for people with severe mental illness; and promote better geographic access to psychiatrists.

---

1. Role – Promote the specialist consultant role of psychiatrists

- Recognition, diagnosis and assessment of mental disorders and associated disability
- Determining and advising others upon the medical management, if any, likely to be most effective
- Providing certain forms of treatment requiring specialist training in psychiatry.

2. Access to psychiatrists for people with severe mental disorders whose assessment and treatment require the experience and skills of psychiatrists.

A multidisciplinary approach may be required: public health can employ clinical psychologists, almost all social workers, mental health nurses and OTs who have essential roles in the fully effective care of many patients with severe mental illness. If private psychiatrists refer to these teams their ongoing involvement ceases (and under the financial payments then and now their income ceases).

There is limited private equivalent to the public approach but McKay argued that the system could change but required “a cultural change, and the necessary financial incentives.” Solo practitioners have no infrastructure or economies of scale, to hire allied health workers so need to form new structures for associating with each other. As a consequence the enquiry suggested that perhaps equivalent of Divisions of GPs, or ‘Associations of Psychiatric Practices’ for psychiatrists, be established and called for funding.

3. Access – better access to psychiatrists in areas with relative undersupply, particularly to redress the shortfall in rural communities.

Mckay noted that in a small community – public psychiatrists are under extreme stress delivering an ‘around the clock’ service, while the public may lack access to allied health support.

“... (the) result is often no resident psychiatric service in communities large enough to sustain 2–3 psychiatrists in total.”

Mckay argued that, clearly, a joint public/private approach to servicing rural communities and the clinical sub-specialties with low supply of psychiatrists (e.g. child and adolescent services) was required. Different approaches were suggested, as follows:

- Visiting psychiatrists in a consulting role to locally based mental health teams
- Initial assessment and setting of treatment plan
- Shared care arrangements with local GPs and community mental health staff, adequately trained and supported
- On-call telephone consultations between the psychiatrists and the local health service (hospital, MH workers, GPs)
- Tele-psychiatry14.

McKay argued that a different MBS reimbursement system was required to encourage psychiatrists to take up roles favouring consultation, assessment, advice, and referral. Finally, he suggested pilot approaches as a methodology to address many issues which appeared insolvable at the time.

Conclusion

The history of the mental health workforce in Australia has travelled from pre-contact practices within the indigenous communities; through the industrial practices and bounded institutions of the late 19th and early 20th Century; to more liberal practices associated with the middle and late 20th Century. In spite of all the change, the remnants of the past remain within the mental health system. Given the tragic history and treatment of the ‘insane’ it is little wonder that the vast majority of mental health consumers, families and professionals want to move as physically far from the old asylums as possible. Why some governments remain beholden to them beggars belief – an act of sheer madness maybe.

For the mental health system a major dislocation and surgery, involving amputations, Federal life support systems, grafting of disconnected organs from various species, all while the system was meant to be fully functional. For the workforce the journey has clearly been a wild one with too little support and too little attention to much of what David Richmond recommended. If implemented, his recommendations would have eased the journey from custodial care practices and ordered environment, to needing to practice in a contested and open environment, to take on new paradigms of care and to view themselves as part of a national picture in the knowledge era.

---

15 Despite government agreements under the First National Mental Health Plan to close all stand alone psychiatric hospitals every state except Victoria has such facilities still operating in 2013. We estimate that over $10million is spent every week by governments on these facilities.
PART 2

The present state of mental health services in Australia
Obsessive Hope Disorder
Introduction

In 1973 when the Whitlam Government brought the Jackson Pollock painting 'Blue Poles' for some $1.4 million, Australians were aghast. ‘How could they pay anything let alone a large fortune for that rubbish?’ summed up the national mood. With 20:20 hindsight we can now probably reach a national consensus it was a bargain and a brilliant acquisition for our National Gallery.

Australians who read this Part 2 of this Report, Obsessive Hope Disorder, may have a similar sense of disbelief – ‘how could we spend so much money on mental health reforms since 1992, and end up with this?’ Part 2 includes six chapters that provide a comprehensive picture of the state of mental health in Australia in 2013. It is not a pretty picture. And unlike Jackson Pollock’s great painting, will not improve in ‘value’ unless resolute and determined political and policy reform is implemented. Part 3 will address what that reform looks like, in very large informed of our understanding of the past and present.

Chapter Five provides a ‘snapshot report’ on the mental health of Australians. The chapter does not seek to replicate in detail the publicly available information on the mental health status of Australians in recent major reports or studies. It seeks to bring the key aspects of what we know about prevalence, the epidemiology of people with mental illness and the service access and use of those in need.

Chapter Five seeks to answer some basic questions, namely:

- What is the prevalence of mental health problems and illnesses in Australia?
- What do we know about the health of people with mental illnesses?
- How well are services responding to mental health needs of Australians?
- What is the current state of mental health services in Australia?
- How many Australians’ have access to care?
- What is the quality of that care?
- What is the level of awareness and understanding of mental health and illness in the Australian community?
- What are the outcomes achieved from these services?
- What reforms have been implemented by the Australian Government since 2006 to respond to widespread concern about mental health services?

Chapter Six reports the results of a systematic review and synthesis of the findings of National and State audits of mental health and related services undertaken by independent statutory authorities such as Ombudsman, Auditors, Public Advocates, Guardians and Commissioners. Some 32 reports were review from the period July 2006 to December 2012. In some cases, the reports on which the review is based were initiated by the office undertaking the review; others were prompted by public complaints, requests by a Government, Parliament or Legislative Assembly or constituted part of the office’s statutory functions (e.g. annual review of child deaths). In all cases the resulting report was undertaken independently of the government and the departments or agencies responsible for program management and/or program implementation.

Chapter Seven provides the results from two large-scale community surveys conducted in April–May 2013. The surveys examined community priorities for mental health reform and consumer, care and provider experiences of care. The results from the 2013 surveys are also compared with an almost identical pair of surveys conducted in early 2004.

Chapter Eight provides an analysis of nearly eighty perspective essays provided by a diverse group of experts, observers and participants in Australia’s mental health reform ‘project’. The chapter the key themes and issues reflected in those essays and what lessons can be drawn for the ‘unfinished business of mental health reform.'
Chapter Nine examines the present state of the mental health workforce across Australia and the issues it confronts. A number of themes identified in the historical analysis continue to be evident in the mental health workforce of 2013: federalism continues is an ever-present backdrop; the taxonomy of staff has broadened, and their roles are identified; the location of the workforce has changed and the type of practices they engage in varies across the sector; workforce culture impacts across the system; and three issues continue to plague administrators – staff recruitment, retention and efficient utilisation.

Chapter Ten aims to provide a brief overview of the current state of these two vital aspects of our mental health system – namely governance and accountability. While Australia is regarded as a worldwide leader in the production of first class mental health strategies and plans, there is overwhelming evidence that the problem has always been and remains implementation.

There are also two Appendices (1 and 2) that provide the reader with a summary of Commonwealth (Appendix 1) and State and Territory (Appendix 2) policy and programs since 2006.

The year 2006 has been selected in this review of the current state of mental health services as it was the beginning of what could be termed the ‘COAG intervention’. Much like the COAG Intervention in indigenous communities, the elevation of mental health policy and program oversight to COAG was unprecedented and directly as a consequence, it can be argued, of policy implementation failure by Health Ministers and their departments.
Chapter 5

A snapshot of the mental health of Australians

John Mendoza, Yve Gilbert and Sebastian Rosenberg
What is the prevalence of mental health illnesses?

**Introduction**

Mental illness is one of the most prevalent conditions affecting the Australian population and according to the most recent National Survey of Mental Health and Wellbeing\(^1\) (SMHWB) released by ABS, around 45% of Australian adults will experience a mental illness at some time in their life. One in five people reported experiencing symptoms in the 12 months prior to the survey and a further 25.5% of adults had experienced a mental illness at some time in their life, but did not have symptoms in the 12 months before the survey.

Up to 3.2 million adult Australians, nearly 16 per cent of the entire population, are either permanently or transiently affected by depression or other mental illnesses during any twelve month period and over half of them are not responding to standard treatments.

The true rate of mental illness in Australia will be higher than the above figures in view of dementia and less common mental disorders (e.g. schizophrenia and other psychotic disorders) being excluded from the national survey. The overall prevalence rates have changed little between 1997 and 2007

**Figure 5.1: Prevalence rates from mental illness among adults, 1997 and 2007**

** 1997 survey age range was 18–99 years; 2007 survey sampled 16 to 85 years.
*** Estimates include alcohol and drug use disorders. If these are excluded, overall prevalence of mental illness in the adult population reduces from 20% to 17%.

There is some evidence to show that rates of major depression have increased in Australia\(^2\) have increased however it is more generally believed that rates on severe mental illness (major depression, severe anxiety, psychoses) have not changed and remain at around 3–4% of the adult population.

The proportion of Australians experiencing mild to moderate illnesses has remained relatively stable over the past three National Health Surveys, however the prevalence of particular categories of disorders has changed\(^3\).

---

The prevalence rate of Australians experiencing a mental illness significantly exceeds diabetes (4% of adults) and cancer (2.5% of adults). Importantly the prevalence of severe mental illness exceeds that of all cancers combined.

The highest prevalence rates for mental health conditions occurs from late adolescence until later mid-life years (16–54 years) with the peak rates (nearly 1 in 3 people) in the 16–24 year age groups. The most prevalent disorders are anxiety, depression and substances abuse disorders – these are referred to as High Prevalence Disorders.

According to The burden of disease and injury in Australia 2003 (AIHW 2007), mental illnesses (including suicide) were estimated to be responsible for 15.3% of the total burden of disease in Australia in 2003. Mental illness is also the largest single cause of disability, contributing to 24 per cent of the burden of non-fatal disease. Around 600,000 Australians experience severe mental illness and an estimated 60,0006 have ‘enduring and disabling symptoms with complex and multi-agency service needs’.

**Prevalence in particular needs groups**

**Children**: Childhood diseases of the brain affect over 3% of Australian children (under 10 years of age). Disruption of early brain development can also give rise to pervasive changes in social and cognitive function.

An estimated 14–20% of children (to age 16) are affected each year with many developmental disorders not identified or treated appropriately.

**Young people**: Young people experienced higher rates of disorder, with 28% of people aged 16–24 years and 25% of people aged 25–34 years experiencing a mental disorder in a 12 month period, compared with 5.9% of people aged 75–85 years. By the age of 19, up to 28% of adolescents have experienced an episode of anxiety or depression. Over 75 percent of mental illness and substance abuse occurs in people before age 25, yet only 29% seek help.

---

5 This figure is used in most Australian Government documents. However higher rates of severe and moderate illness are reported in the literature: namely 4.1% or 650,00 adults with severe mental disorders, 6.6% or over 1 million adults with moderate mental disorders and another 9.3% or 1.5 million with mild disorders. See Slade T et al 2009. The mental health of Australians 2.
6 This figure of 60,000 and the definition is given by the Department of Health Ageing in several documents and based on an unpublished report by Harvey Whiteford and Bill Buckingham (2006 and 2011).
75% of all serious mental health conditions start before the age of 25, and preventatively focused interventions targeted to young people aged 12–25 have the potential to create significant personal, social and economic benefits.7

A 2012 national survey8 of Australian young men aged 16–25 years found in the previous year:

- 15% have ‘high’ to ‘very high’ levels of psychological distress and a further 28% had moderate levels of psychological distress
- nearly one in five in the past 12-months ‘felt that life was not worth living’
- nearly one in ten experienced suicide ideation
- 4% made a suicide plan and 2% attempted suicide.

If extrapolated to the national population that is an estimated 29,406 suicide attempts by young men aged 16–25 years in the previous 12 months.

Aboriginal and Torres Strait Islander peoples: 31.2% of Aboriginal and Torres Strait Islander peoples aged 18 years or over reported high or very high distress levels, which after adjusting for age, is 2.5 times higher than for non-indigenous people.9 There were at least 996 reported suicides of Aboriginal and Torres Strait Islander peoples between 2001 and 2010: twice the rate of other Australians.10 Suicide rates are particularly high among the young.16 In a recent Queensland study, at least one mental health condition was detected in 73% of male and 86% of female Aboriginal and Torres Strait Islander prisoners11.

People from Cultural and Linguistically Diverse Background: People born in Australia had a higher prevalence of mental disorders (19.5% in males and 24.0% in females) compared to those born overseas (17.7% for males and 19.9% for females). However the prevalence of mental disorders was much lower for people from non-English speaking countries (8.4% in males and 16.2% in females). The exact nature of this relationship is difficult to determine and may be explained in part by what is termed the ‘healthy migrant effect’. People who successfully migrate are more likely to be physically healthier than the remainder of the population. This may also be true for mental disorders.12

Rural and Remote: Recent research suggests that one in three people in rural or remote Australia may have a mental health problem in a year (1.4 million)13. Rural and remote areas in every state and territory have a higher rate of suicide and higher comorbidity than in urban areas, with the exception of New South Wales and the ACT14.

Prisoners: 385,100 (41%) of the people who reported ever being incarcerated had experienced a disorder in a 12 month period, which is more than twice the prevalence of people who had never been incarcerated. Prevalence of substance use disorders was 23% compared with 4.1%, affective disorders 19% compared with 5.9%, and anxiety disorders 28% compared with 14.1%.15 A national census of new entrants to Australian prisons conducted in October and November 2010 confirmed the high rates of mental illness in the prison population, with one in three prison entrants being advised by a health professional they had been told they had a mental illness. The rate for women (41%) on entry to prison was higher than males (30%).

---

7 Inspire Foundation and Ernst & Young 2012. Counting the Cost – The Impact of Young Men’s Mental Health on the Australian Economy.
10 ABS Suicides in Australia 2010. ABS cat no. 3309.0 (Accessed 30/4/12).
15 Op Cit. ABS 2008.
Indigenous prison entrants were less likely than non-indigenous entrants to have ever been told they have a mental health disorder. This may be attributed to cultural differences but also is likely to to be linked to poorer access to services for indigenous Australians.\textsuperscript{17}

\textit{Unemployed:} It’s also estimated that half of all people defined as long-term and very long-term unemployed have either a diagnosed or undiagnosed mental illness. The 2013 Report on Government Services (ROGS) includes data on employment for people with a mental illness. In 2010–11 the national figure was 61.7\% for people with a mental illness who were employed, compared to 80.3\% for those for people without a mental illness. In 2011–12 the national figure for the number of people aged 16–30 years with a mental illness who were employed and/or enrolled for study in either a formal secondary or tertiary qualification was 79.2\%, compared to 90.2\% for people without a mental illness.\textsuperscript{18}

In the 2007 SMHWB, among the 413,600 unemployed people at that time, 29\% had a 12 month mental disorder, nearly 50\% higher than people who were employed. Unemployed people had almost twice the level of substance use disorders than employed people (11.1\% compared to 6\%) and almost three times the level of affective disorders (15.9\% compared to 5.7\%). 34\% of unemployed women and 26\% of unemployed men had a 12 month disorder.\textsuperscript{19}

\textit{Disability Support Recipients:} Nearly 30\% of the 820,000 persons on the Disability Support Pension have as their primary disability, a psychological condition. Half of all new DSP recipients in recent years have a psychological disability as their primary condition. People with mental illnesses are now the single largest category of disability and the fastest growing by a considerable factor.

A study looking at the prevalence of mental disorders among income support recipients in 2007 as compared with 10 years previous, found there were limited differences. Rates of mental illness were elevated in all income support categories, including unemployed, lone parents, partnered parented and people receiving disability payments. The 12 month prevalence of mental disorders in working age recipients was 34\% compared to 20\% for non-recipients.\textsuperscript{20}

\textit{Homeless:} The 2007 SMHWB reported that 54\% (or 484,400) of the people who reported ever being homeless had a 12-month mental disorder; more than three times the prevalence of people who reported never being homeless.\textsuperscript{21}

Reports note the difficulty in gaining an accurate picture of the number of people who are homeless overall and the prevalence in this population who have a mental illness. The \textit{COAG NAP 2009–10} notes that up until 2009, the Supported Accommodation Assistance Program (SAAP) was the main service at a national level for homeless people. Data covering 2008–09 and 2009–10 showed that the number of SAAP clients had increased to 135,700 in 2009–10, with people with mental health problems accounting for 12\% and people with mental health and substance use comorbidity 7\%. A 2008 census of SAAP clients across all jurisdictions showed that 34\% of the survey sample identified as having mental health issues, of which 56\% had a known diagnosis and 31\% identified as current users of specialist mental health services.\textsuperscript{22} Surveys by service providers show rates of mental illness of up to 80\%\textsuperscript{23,24}

\textit{Aged Australians:} Currently there are an estimated 250,000 Australians are seriously affected by dementias, and this number is predicted to treble or quadruple in the next 40 years, placing a significant burden on the nation’s health and community services.

\textsuperscript{17} Ibid.
Prevalence of particular disorders

Depression

The 2007 SMHWB found that just under one million (6.2%) adult Australians had an affective disorder in any 12-month period. Over the lifetime, nearly one in five adults will experience at least one episode of depression.

Anxiety disorders

The 2007 SMHWB found that 14.4% (2.3 million) of Australians aged 16–85 years had a 12-month Anxiety disorder – the highest for any mental health condition. Post-traumatic stress disorder had the highest individual statistic of any of the 12-mental illnesses specified – 6.4%. In addition, 10 of the remaining 11 disorders are documented in DSM-IV as symptoms of PTSD.

PTSD prevalence statistics are not clear-cut, as estimates seem to be population specific. 14.4% of Australians age 16–85 years; 56% of Australia’s Vietnam War veterans; 31% of Australia’s Gulf War veterans; and 20% after exposure to severe trauma and resource loss (WHO).

Serious accidents are one of the leading causes of PTSD in Australia. 65% of the men and 46% of the women who had been raped met PTSD criteria in a 1995 international study. Other traumatic events associated with high PTSD rates included combat exposure, childhood neglect and physical abuse, sexual molestation and (for women only) physical attack and being threatened with a weapon, kidnapped or held hostage. Accidents, witnessing death or injury, and fire or natural disasters were associated with lower lifetime PTSD rates. Other research has shown high PTSD rates for torture victims, survivors of the Holocaust and prisoners of war.

Substance use disorders

The 2007 SMHWB identified that one in twenty adult Australians aged 16–85 years (819,800) had a 12 months substance use disorder. Alcohol harmful use disorder was the most common form of substance use disorder with a prevalence of 2.9%. Both harmful use and dependence were more commonly diagnosed for alcohol (2.9% and 1.4% respectively) than for drugs (0.9% and 0.6% respectively). Among the drug use disorders, the prevalence of cannabis and stimulant related disorders were higher than the equivalent sedative and opioid related disorders.

---

26 Ibid.
29 Ibid.
Table 5.1. The breakdown of prevalence of 12-month substance use disorders

<table>
<thead>
<tr>
<th></th>
<th>Males (%)</th>
<th>Females (%)</th>
<th>Persons (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use</td>
<td>3.8</td>
<td>2.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Dependence</td>
<td>2.2</td>
<td>0.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use</td>
<td>0.8</td>
<td>0.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Dependence</td>
<td>0.7</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Stimulants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use</td>
<td>0.5</td>
<td>0.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Dependence</td>
<td>0.4</td>
<td>0.1</td>
<td>0.3</td>
</tr>
<tr>
<td>Sedatives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use</td>
<td>np</td>
<td>np</td>
<td>0.04</td>
</tr>
<tr>
<td>Dependence</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Opioids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use</td>
<td>np</td>
<td>np</td>
<td>0.1</td>
</tr>
<tr>
<td>Dependence</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Any drug</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use</td>
<td>1.3</td>
<td>0.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Dependence</td>
<td>0.9</td>
<td>0.4</td>
<td>0.6</td>
</tr>
<tr>
<td>Any substance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harmful use</td>
<td>4.7</td>
<td>2.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Dependence</td>
<td>2.6</td>
<td>1.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Any substance use disorder</td>
<td>7.0</td>
<td>3.3</td>
<td>5.1</td>
</tr>
</tbody>
</table>

Note: Totals are lower than the sum of disorders as people may have had more than one type of substance use disorder in the 12 months. np Not available for publication, but included in totals where applicable.

Figure 5.3: The prevalence of any substance use disorder declined with age

The proportion of people with each type of substance use disorder, who reported each of the four levels of psychological distress, as measured by the Kessler 10 scale (K10), is presented below:
Table 5.2: Psychological distress by substance use disorder

<table>
<thead>
<tr>
<th></th>
<th>Low (%)</th>
<th>Moderate (%)</th>
<th>High (%)</th>
<th>Very high (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol harmful use</td>
<td>50.6</td>
<td>25.1</td>
<td>13.3</td>
<td>2.0</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>32.7</td>
<td>28.6</td>
<td>24.4</td>
<td>14.3</td>
</tr>
<tr>
<td>Any drug harmful use</td>
<td>44.1</td>
<td>28.4</td>
<td>18.5</td>
<td>8.9</td>
</tr>
<tr>
<td>Any drug dependence</td>
<td>19.9</td>
<td>22.9</td>
<td>41.1</td>
<td>16.1</td>
</tr>
<tr>
<td>Any substance use disorder</td>
<td>48.6</td>
<td>26.7</td>
<td>17.5</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Note: Totals are lower than the sum of disorders as people may have had more than one type of substance use disorder.

**Eating disorders**

In 2012 Deloitte Access Economics was commissioned by the Butterfly Foundation to examine the economic and social costs of eating disorders in Australia. Deloitte Access Economics estimated there were 913,986 people in Australia with eating disorders, 1,829 deaths from eating disorders and a socio-economic cost of eating disorders of $69.7 billion in 2012\(^{32}\).

The peak prevalence for eating disorders is in the 20 to 24 year age group in both males and females. The prevalence of eating disorders may be on the rise. A South Australian study observed a two fold increase in the prevalence of disordered eating behaviours in the community over a ten-year period\(^{33}\).

On current projections, there will be over one million people with eating disorders by mid-2022:

**What is the health of people with mental illness?**

**Physical health**

Presently in Australia we do not have access to routine health data about people with mental illness. We rely therefore on a patchwork of data sets to build a picture of the overall health and wellbeing of people with mental illness. What this patchwork of data tells us makes for stark reading. People with mental illnesses experience:

- higher death rates (2.5 times the general population)
- higher rates of diabetes and obesity, heart disease\(^{34}\) and some cancers
- much higher rates of tobacco use (nearly three times the rate of the overall population) and hence tobacco related diseases
- higher rates of poverty, unemployment, social exclusion and deprivation of liberties
- higher rates of homelessness (between 30–80% of homeless have mental illnesses)
- higher rates of imprisonment and violence (more often as victims) and
- most significant perhaps, is that the life expectancy for people with mental illness does not appear to have improved in a century\(^{35,36}\).

Mental illness is the largest single cause of disability, contributing to 24% of the burden of non-fatal disease. This is over 3.5 times the disability burden of all cancers. Mental illnesses were estimated to be responsible for 15.3% of the total burden of disease in Australia in 2003\(^{37}\).

---

36 Lawrence D Hancock KJ Kisely S 2013. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers, BMJ 2013;346:f2539, 21 May.
Moreover, diseases of the brain and mind (including neurological conditions such as Autism Spectrum Disorders and Dementias) now account for more than 45% of all illnesses. These diseases are devastating for those affected, their families and for society and the cost to the Australian economy, has recently been estimated to be in excess of $190 billion a year. These costs are expected to grow substantially over the next forty years. Dementias alone are predicted to more than treble from around 330,000 cases today to over a million cases by 2050. The cost to Australian business of depression alone is now estimated to be $8 billion a year in lost productivity and other costs. Over half of all sick days are due to conditions such as depression, anxiety and substance abuse.

A new study has found mental illness sufferers in Australia are dying up to 16 years earlier than the general population, with most deaths due to disease rather than accident or suicide. When using active prevalence of disorder (contact with services in previous five years), the life expectancy gap increased from 13.5 to 15.9 years for males and from 10.4 to 12.0 years for females between 1985 and 2005. Additionally, 77.7% of excess deaths were attributed to physical health conditions, including cardiovascular disease (29.9%) and cancer (13.5%). Suicide was the cause of 13.9% of excess deaths. The study concluded that despite knowledge about excess mortality in people with mental illness, the gap in their life expectancy compared with the general population has widened. The report shows that public efforts should be directed towards improving physical health to reduce mortality in people with mental illness, in addition to ongoing efforts to prevent suicide.

Other studies also show significantly higher rates of asthma, hypertension, stroke and diabetes. The association between mental illness and obesity, which was recently reported as the second most significant health cost to the Australian economy (at $120 billion per annum), is also growing. The relationship between obesity and mental illness is two-way. That is, excessive weight affects self-esteem, body image and eating behaviours while promoting the risk of depression and anxiety in particular. The opposite is also true – a significantly higher rate of obesity 55% for depression up to 70% for schizophrenia) is found among people with mental illnesses. Both conditions are the subject of stigma and discrimination compounding the condition and making treatment and recovery more difficult.

The association between musculoskeletal conditions and mental disorders has also been reported recently in Australia. Over 1.5 million adult Australians (aged 16–85 years) reported having at least one musculoskeletal condition and one mental disorder in the previous 12 months. What is important in this, is that nearly a third of these cases were due to the combination or comorbidity – that if the occurrence of the two conditions were independent of one another, there would be around 470,000 were cases. The published studies, in Australia and elsewhere, show that experiencing a musculoskeletal condition is more likely to lead to a mental health disorders, but the pathway can be reversed. Again this evidence suggest that people with a primary health condition other than a mental illness, are not receiving timely and appropriate care to reduce their risk of developing a mental health problem.

Finally, osteoporosis (reduced bone density) has consistently been found at higher prevalence rates in people with schizophrenia and other mental health disorders. This is due to both the effects of antipsychotic medication and lifestyle factors – e.g. lack of exercise, smoking, alcohol and drug use.

40 Op Cit. Lawrence D 2013.
44 Lancy & Gruen 2013. Op Cit.
46 AIHW 2010. When musculoskeletal conditions and mental disorders occur together. Cat No. AUS 129. AIHW Canberra.
47 Mental Illness Fellowship of Australia 2011. Literature review: the physical health of people living with a mental illness. MIFA Marleston, SA.
Social wellbeing

A growing body of evidence has highlighted the associations between untreated mental illness, long-term unemployment and poverty. Not only do Australian’s with severe mental illnesses, such as schizophrenia and other psychoses, have a life expectancy on par with Indigenous Australians, they are also likely to be unemployed, living in vulnerable housing conditions and social deprived. A recent OECD report indicated that the impact of mental illnesses is likely to increase in coming years due to increasing job insecurity and job strain.

The Foresight Mental Capital and Wellbeing Project (2008), commissioned by the Government Office for Science (UK) highlighted the strong link between mental health and wellbeing and the production of capital, the role of mental health in national prosperity and the development of mental wealth. Such findings are especially pertinent in Australia which has seen deterioration in national productivity over the last decade. Whereas Australian labour productivity growth was in line with OECD averages in the 1990’s, in the 2000’s, it has been 0.5% below the OECD average. This reduction in growth has seen Australia fall from ranking 11th out of 25 OECD countries in the 1990’s to 17th out of 34 countries in the 2000’s. Growth in productivity is important as it accounts for the main source of improvement in living standards over time. Labour productivity serves as a key measure of national economic and social wellbeing offering a measure of economic growth, competitiveness and living standards within a country, illustrating the link between good mental health and national productivity.

It is estimated that half of all people defined as long-term and very-long term unemployed have either a diagnosed or undiagnosed mental illness. Nearly 30% of Disability Support Pension (DSP) recipients have a primary psychological disability account – the largest single category. The number of recipients with a primary psychological/psychiatric medical condition has increased by 71% from June 2001 in June 2011. It is important to note eligibility for the DSP was tightened over this period.

49 Eslake S Walsh M Australia’s Productivity Challenge 2011, Grattan Institute, Melbourne.
51 Ibid.
There are differing impacts on social and economic outcomes by tier of mental illness severity. Comorbid depression increases death rates in an underlying physical condition by as much as 4.3 times and when compared with non-depressed patients, those with depression have increased mortality, prolonged hospital stays and more days in hospital on follow up.

The effects of mental illnesses on children and young adults are substantial with the individuals' social, emotional and academic or vocational functioning affected. The impact of youth mental illness on schooling through factors such as increased absenteeism, dropout rates and difficulty learning can compound the potential negative impacts on employment outcomes\textsuperscript{53}. Many young people with mental illness have lower levels of educational qualifications, and when they do gain employment, they tend to obtain lower skilled poorly paid roles. A number of international and Australian studies provide support for the assertion that untreated mental illness impairs employment functioning\textsuperscript{54}.


Children who are mentally healthy are better able to:

- learn
- experience stronger relationships with teachers, family members and peers
- negotiate challenges including the transition into adolescence and then adulthood
- achieve long-term education and career goals
- enjoy a better quality of life.

If left untreated, the effects of common mental illnesses can continue from childhood to adulthood with further occupational, economic and personal difficulties arising. When early signs of difficulty are not addressed, mental health problems can potentially become more serious and possibly extend into mental disorders.

Mental illness in young men aged 12–25 costs the Australian economy $3.27 billion per annum or $387,000 per hour across a year in lost productivity. The Federal Government bears 31% of this cost via direct health costs, disability welfare payments, unemployment benefits and the direct costs of imprisonment. Australia loses over 9 million working days per annum to young men with mental illness. On average they have an additional 9.5 days out of role per year.

Young men with mental illness have much lower rates of educational attainment compared to their peers, further limiting their skills development and long term reduced earning potential by $559 million per year."}

Men and women who experienced common mental disorders spent more time unemployed over the next four years than their more mentally healthy counterparts.56

National expenditure on men’s mental health increases significantly from 15–25 years ($205m) to 25–34 years ($306m) and again for 35–44 years ($268m), before declining until the 75+ group.57 This pattern of expenditure may suggest that the flow on impacts of mental illness, including drug and alcohol disorders, antisocial behaviour, loss of employment and relationship breakdown become increasingly evident the longer mental illness is untreated.

---

Costs of young men’s poor mental health are already being felt throughout Australia’s economy. Failure to act presents a serious threat to Australia’s future productivity and to the individual prosperity of young men affected with poor mental health. Young men have higher rates of completed suicide, antisocial behaviour and drug and alcohol problems than young women.

**Self injury**

Over 30,000 Australians are admitted annually to hospital as a result of self-harm – that’s 80 hospitalisations a day with an average stay of over 4 days. Self-harm is now recognised as a form of behaviour in its own right, distinct from attempted suicide.

The Australian National Epidemiological Study of Self-Injury (ANESSI), the largest self-injury study in the world, and the first to look at self-injury across the entire life span, aimed to establish the prevalence and nature of self-injury in Australia, and explore relationships between self-injury and suicidality, mental health factors, drugs and alcohol, and childhood maltreatment.

The study found the overall lifetime prevalence of self-injury (combination of four week and lifetime self-injury) was 8.1%, with a higher prevalence among females (8.7%) compared with males (7.5%). Self-injury peaked in the 18–24 age group for both sexes (females 22.8%, males 15.9%), followed by the 25–34 age group, after which the prevalence declined with age for both sexes.

**Table 5.3: Lifetime prevalence of self-injury by age and sex**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
<th>Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Count</td>
<td>%</td>
<td>Count</td>
<td>%</td>
<td>Count</td>
</tr>
<tr>
<td>10-17</td>
<td>67</td>
<td>8.8</td>
<td>72</td>
<td>10.1</td>
<td>139</td>
</tr>
<tr>
<td>18-24</td>
<td>110</td>
<td>15.9</td>
<td>152</td>
<td>22.8</td>
<td>262</td>
</tr>
<tr>
<td>25-34</td>
<td>119</td>
<td>12.4</td>
<td>108</td>
<td>11.4</td>
<td>227</td>
</tr>
<tr>
<td>35-44</td>
<td>74</td>
<td>7.4</td>
<td>94</td>
<td>9.2</td>
<td>168</td>
</tr>
<tr>
<td>45-54</td>
<td>51</td>
<td>5.4</td>
<td>64</td>
<td>6.7</td>
<td>115</td>
</tr>
<tr>
<td>55+</td>
<td>26</td>
<td>1.6</td>
<td>39</td>
<td>2.2</td>
<td>65</td>
</tr>
<tr>
<td>All age groups</td>
<td>447</td>
<td>7.5</td>
<td>529</td>
<td>8.7</td>
<td>976</td>
</tr>
</tbody>
</table>

Prevalence of self-injury was no greater in females compared to males although the methods differ. Rates of self-injury peaked for females at 18–24 years and for males at 10–17 years.

The most common motivation for self-injury for males and females was to manage emotions (57.2%), followed by self-punishment (24.7%). These results are consistent with previous research and refute the idea that people primarily self-injure to get attention and manipulate others.

Self-injurers were more likely to have a mental health condition, more likely to misuse substances, more likely to have experienced recent suicidal ideation, and more likely to have attempted suicide in the preceding 12-months. Overall, self-injurers were significantly more psychologically distressed.

Only a small percentage of self-injurers sought medical care. However, when this occurred they were highly likely to be admitted to hospital. Despite small actual numbers, if we accept the study is representative of the Australian population, an estimated 30,000 Australians could have sought medical help in the month prior to survey, and an estimated 4,000 could have been admitted to hospital. If we assume an admission of only one single night, the cost to Australia may be immense.

**Suicide**

One of the most common and significant contributing factors to suicide is mental illness. Official Australian statistics record approximately 2,200 suicide deaths per annum. The most recent National Survey of Mental Health and Wellbeing showed that the number of attempted suicides in Australia is

---

more than 65,000 each year. Evidence suggests the personal and social costs of suicide in Australia are immediate, far-reaching and significant on families, workplaces and communities. Suicide and suicide attempts can cause not only immense distress to individuals, but also vicarious trauma among the wider community.

Tragically, suicide continues to be the leading cause of death for young men (15–24 years) in Australia, accounting for 22% of all deaths; with male youth suicide rates in rural areas double those of metropolitan areas.\(^\text{60}\)

The official suicide data is an estimated 20–30% below the actual number due to a range of factors included the complex and variable processes associated with reporting by state coroners, the legal onus of proof, cultural and societal stigma and deaths attributed to other causes (most notably car accidents, drowning and poisonings).\(^\text{61}\) Given our poor data on suicide, it is likely that more Australians die each year as a result of self-inflicted harm than through motor vehicle accidents and skin cancers combined.

The only estimate of the cost of suicide and self-harm to the Australian community puts the costs at $17.5 billion (in 2007–08 dollars). This estimate was based on a formula applied to road deaths in Australia.

**How well are services responding to mental health needs of Australians?**

Again there is not a clear line of sight in the available data to answer this simple question. To gain some understanding of the access to care and the quality of care for mental illness, an examination of a range of data sets can give a sense of the scale of the problem.

**What is the state of mental health services in Australia?**

**Expenditure**

The Productivity Commission Report on Government Services (ROGS) provides a guide on spending directed towards mental health services. The 1999 ROGS is the first year to report on MHS. Targeted spending on mental health and related services was $1.997 billion for 1995–96 – this excluded general hospital services and community support programs. State and Territory Governments contributed $1.158 billion (58%), the Commonwealth $661 million (33.1%), and private funding $178 million (8.9%). The level of funding had increased by 24.1% between 1992–93 and 1995–96, the largest increase from the Commonwealth at $250.2 million (61%). Private hospital funding had increased by $66.1 million (59%) and State and Territory Governments by $68.6 million (6%). The strongest increase was in the NT (18.5%) and Tasmania (17.1%). Expenditure per capita increased by 2.7% to $63.70 – Victoria was the highest at $74.50, Queensland the lowest at $55.

The overall size of the workforce did not change greatly between 1992–93 and 1995–96, but there were changes in composition with the ambulatory care increasing by 39% and community residential services increasing by 59%, and staff employed in inpatient facilities falling by 15%.\(^\text{63}\)

The most recent ROGS report for 2013 provides data for 2010–11. Approximately $6.6 billion in real government expenditure was allocated to MHS, with State and Territory Governments accounting for $4.1 billion (62.5%) and the Australian Government $2.5 billion (37.5%). Average expenditure per person on specialised mental health services was $294.2, an increase from $240.9 in 2006–07.

The largest part of the Australian Government’s spending on mental health was under the Pharmaceutical Benefits Scheme (PBS) for mental health related medications at $808.8 million, which increased at an average rate of 2.2% between 2006–07 and 2010–11. The next largest contributor was Medical Benefits Schedule (MBS) payments for psychologists and other allied health professionals (social workers and occupational therapists) at 14.6%, then spending on consultants psychiatrists at 11.3%.

---

\(^{60}\) Commonwealth Australia 2011. Social Trends 2011: Health outside major cities, catalogue. 4102.0, 2011, ABS.


Spending per person by State and Territory Governments has increased over time. The amount spent on different areas – hospital inpatient, ambulatory, indirect, community residential and non-government organisations – varies across jurisdictions, however hospital inpatient and ambulatory receive the most amount of funding. NSW had the highest amount of spending on hospital inpatient, which also accounted for just over half of the states total, and Queensland was the only state to not have expenditure on community residential services. Tasmania, Victoria and the ACT spent the most of the jurisdictions on community residential, and the amount spent on non-government organisations was a fairly uniform, low level across all jurisdictions.

How many Australians have access to mental health care?

In the 2007 SMHWB:

- twelve per cent (1.9 million) of the population aged 16–85 years accessed mental health services in the 12 months prior to the survey
- of these, three in five (59%) had a 12-month disorder, and one in five met the criteria for lifetime diagnosis but had no symptoms in the 12 months prior (20%) or had no lifetime disorder (21%)
- of the 3.2 million with a 12-month disorder, 35% accessed services for their mental illness, with women accessing services more than men (41% compared to 28%)
- around one in three women (30%) saw a GP and one in six (18%) of men, and were also more likely to see another health professional
- people with one disorder were less likely to access services (23%) than people with two or more disorders (52%)
- of the people who had only a 12-month affective disorder, 45% used mental health services, with 80% seeing a GP.

The COAG National Action Plan on Mental Health – Progress Report 2009–10 presents the figures of access to services from the 1997 and 2007 Mental Health and Wellbeing surveys which shows that 62% of people received no services in 1997 compared to 2007 where 65% of people accessed no services. While there are some differences in methods of the surveys, this does still demonstrate a largely unchanged and increased level of people not receiving mental health services. The COAG progress report acknowledges that achieving significant improvements in treatment rates will require sustained efforts and investment by government over the long-term.

Young people

Findings from the 2007 Australian National Survey of Mental Health and Wellbeing found that while young people (aged 16–24 years) had the highest prevalence of mental disorders, they also had the lowest rates of receiving services in the 12-month period prior to the survey. The rate of service use was especially low for young men, with only 13.2% accessing help and support services, in spite of a 12 month prevalence rate of 22.8%.

Data from headspace shows that of the 75,000 users of headspace services (centre based) 40% were male.

People from cultural and linguistically diverse background

Australian literature indicates that people from CALD backgrounds experiencing mental health problems tend to:

---

• have lower rates of access to community and inpatient mental health services, compared with Australian-born people
• have higher rates of involuntary and lower rates of voluntary admission to mental health services;
• be hospitalised for longer
• be more likely to present for treatment at the acute, crisis end of an episode.

A key issue is that the previously cited studies were conducted between 12 to 17 years ago. The lack of investment in multicultural mental health research since then has resulted in a dearth of CALD mental health research, thereby making it difficult to make contemporary assessments of the impact of mental health reforms on Australia’s CALD populations.

What is the quality of mental health care? 71

Despite spending of over $6 billion72 this year on MHS by governments, access to affordable, timely and effective care is a widespread problem for people with any mental health condition. Over two million Australians with a clinical condition did not use any service in the previous 12 months.

The quality of mental health care continues to feature in many independent and media reports. While there is some evidence that the quality of care for people who are known to mental health services has improved73, around 40% of those people with a severe level of disability from mental illness have little or no contact with services. For the estimated 700,000 Australians with moderate levels of psychiatric disability (usually with more than one illness, comorbidity substance abuse, poor physical health, long-term unemployment or on disability payments and socially excluded) access to services is even poorer with estimates ranging from 25–30%.74

For people with moderate and severe levels of disability from mental illness, access to coordinated care, is critical to recovery. This means, health care working hand-in-glove with housing, transport, employment support, education and training, family support and child support and often with Justice and Police. This is very rarely the case and consequently, an individual’s problems manifest and multiply and the road back to wellness, social inclusion and participation is fraught.

A recent major study examined the appropriateness of care for 22 common health conditions. Three of the conditions were mental health disorders, namely, panic disorder, depression and alcohol dependence disorder75. The study examined the appropriateness of care with evidence-based or consensus based guidelines. Health care providers volunteered for the study and around 50% were GPs, 22.5% specialist practices and 14.5% hospitals. In general the review found “that the consistent delivery of appropriate care needs improvement. In the three mental health conditions included in the study almost three out of every four encounters for panic disorder were in line with guidelines while only 55% of encounters for depression met guidelines. The care provided for alcohol dependence was appropriate in only 13% of encounters.

High rates of readmission (to an acute care mental health facility) within 28 days, high rates of compulsory treatment orders and high rates of seclusion (or isolation) and restraint (chemical and physical) are all associated with poor mental health care and a system under stress. These are all features of Australia’s specialist public mental health care system.

Readmission to acute care

Data from the most recent progress report on the COAG Action Plan for Mental Health 2006–11 includes community follow-up for people within the first seven days of discharge from an acute inpatient unit and

70 Minas I H et al. 1996. Mental Health Services for NESB Immigrants, Bureau of Immigration, Multicultural and Population Research, Department of Immigration and Ethnic Affairs, Commonwealth of Australia, Canberra; Klimidis S et al. (1999), Mental Health Service Use by Ethnic Communities in Victoria. Part 1: Descriptive Report, Victorian Transcultural Psychiatry Unit, University of Melbourne, Melbourne.
71 Quality mental health care can be defined as right service, right time. It is generally characterised as person-centred, flexible, recovery focused, respectful, coordinated and evidence-based. It should also occur as early as possible in the development of the disorder.
72 AIHW 2012.
74 Bishop J 2010. Mental Health Services Reform. Presentation to the Mental Health Service Conference (TheMHS) Sydney, August 2010.
75 Runciman WB et al. 2012. CareTrack: assessing the appropriateness of health care delivery in Australia. MJA, 197 (2), 100-105.
readmissions to hospital within 28 days of discharge. With regards to community follow-up, the national figure was a little over 50% for 2010–11 and there had been a steady improvement since 2006–07. This was the case for all jurisdictions, where there had been a gradual improvement between 2006–07 and 2010–11. The jurisdiction with the best figures was the Australian ACT followed by Victoria, and the worst was the NT, with NSW also sitting below the national level. The COAG Progress Report notes that states and territories have agreed to a target of 75% or above as an indicator and that only the ACT has achieved the target over the life of the COAG Action Plan.

On readmissions, the national figure had fluctuated slightly between 2006–07 and 2010–11, and there had been a slight increase from 2009–10 to 2010–11 (at around 15%). Queensland and NSW had the highest readmission rates, and the ACT and then South Australia (SA) the lowest. The evaluation of the 3rd NMHP 2003–2008 states that that there had been progress in all key areas and stated outcomes, but that there was a level of dissatisfaction expressed by a range of constituents with particular parts of the Plan. There was widespread concern that particular groups were being underserviced which were children and adolescents, CALD people, Aboriginal and Torres Strait Islander peoples, forensic populations, and comorbidity.

Compulsory treatment

Each jurisdiction in Australia continues to have its own mental health legislation. These laws differ in important aspects including criteria for compulsory treatment. The Commonwealth has no mental health legislation and persons charged under Federal laws, are subject to the provisions of the Mental Health Act in the jurisdiction where the charges have been brought. Compulsory treatment provisions – that is legislative provisions to allow the compulsory treatment of people with a mental illness either in community or inpatient settings – are widely used in Australia. Indeed international comparisons indicate that Australian mental health services using compulsory treatment orders are significantly higher than in the United States or Canada. Importantly, the rate of Community Treatment Orders (CTOs) appears to be rising despite a lack of evidence to support the use of such coercive treatment regimes. A recent study has shown rates increased by 78% in Victoria in seven years.

CTOs can be applied even if the patient has the capacity to make decisions about their treatment. The mere presence of a mental illness can lead to the application of a CTO. No other Australians (except in rare circumstances) can be forced to take medical treatment where they are capable of a competent refusal even when that decision may cause serious harm or even result in death.

Moreover, there are of hundreds of individuals held against their will in long-term psychiatric facilities in every jurisdiction except Victoria. This is largely unreported and unknown to the Australian community. This is probably in contravention of Australia’s international human rights obligations.

Restraint and seclusion

Australian public mental health facilities continue to utilise pharmacological and physical restraints and seclusion as a frontline treatment for people with psychosis or major depression. Rates of these practices are only published for four jurisdictions, despite a 2005 inter-government agreement to do so and reduce use. Internationally, such practices have been eliminated or reduced to being ‘a last resort’ in many jurisdictions including in Europe, many US states and Canada.

76 Ibid.
81 This has been given some recent media coverage in late 2012 due to the report by the NSW Ombudsman on 95 cases in NSW mental health facilities. Queensland is known to have around 300 persons held indefinitely in mental health facilities in Toowoomba and Charters Towers.
**Care provided by general practitioners**

US studies have shown that people with mental illnesses have lower rates of use of primary care services\(^82\): the more severe the mental illness, the lower rates of primary health care usage. This is seen as an explanation of why people with mental illness have lower life expectancy.

A retrospective study of some 204,000 users of public mental health services in WA found that contrary to the US findings, people with severe mental illness had higher rates of GP service use than the remainder of the WA population\(^83\). The only exception to this general finding was in relation to the group of MHS users with no fixed address. What this suggests is that GPs are not attending to the physical health needs of people with mental illness. The authors suggest promoting greater use of GP services by those with severe mental illness may be futile and that policies and programs that focus on improving the quality and preventative value of existing interactions between GPs and these clients may be more fruitful.

The Care Track study\(^84\) also points to poor or inappropriate care for depression and alcohol dependence by GPs.

**Social outcomes**

As stated earlier, people with mental illness have overrepresented in populations of homeless and the unemployed and in the lowest income quintiles. They also report high levels of social isolation. Also the number of Police shootings of people with mental illness is included here. On what data is available there is little to suggest an improvement in trends.

**Companionship**

The 2007 SMHWB looked at contact with family and friends. Whilst the prevalence of 12 month mental disorders was very similar for people who did and did not have contact with their family, contact with friends was markedly different with nearly 40% having had no contact with friends or no friends\(^85\) in the previous 12 months.

**Employment**

The COAG National Action Plan on Mental Health – Progress Report 2009–2010 includes figures on the Disability Support Pension (DSP) with 29% (227,000) of the 792,000 people on the DSP having a psychiatric or psychological condition recorded as their primary condition. This has increased at an annual average rate of 5% since 2001, more than twice the rate of overall growth for DSP recipients. The COAG Progress Report notes for the indicator relating to participation rates of young people in education and employment, that there is little published data that is directly relevant\(^86\).

**Housing**

In looking at current pathways to homelessness and access to services, substance use and mental health clients of services were the most likely to be in primary homelessness immediately before support in improvised dwellings or sleeping rough in 39% and 24% of support periods respectively. After support, the proportion of support periods where clients experienced primary homelessness decreased to 31% for substance use and 15% for mental illness. In looking at boarding houses, mental health clients were one of the most likely groups to be residing in such accommodation at 11%\(^87\).

---

82 Cradock-O'Leary J Young A Yano E et al. 2002. Use of general medical services by VA patients with psychiatric disorders. Psych Services, 53: 874-878.
Income
A report from SANE Australia in mid-2009 found that the majority of respondents to a survey of people with mental illness live on below average incomes with a third surviving on less than $20,000 a year.88

Police shootings
The Australian Institute of Criminology recently reported on the numbers of fatal Police shootings in Australia over a 20 year period (1989–2010–11). In that entire period there were a total 105 fatal Police shootings. Of these 44 or 42% were people with a mental illness. What is also striking, is that while the overall number of Police shootings is showing a downward trend since 2001, the numbers of people with mental illness shot each year in Australia remains roughly the same.89

What is the level of awareness and understanding of mental health and illness in the Australian community?
A 2011 national survey of mental health literacy and stigma involved a general community survey of people aged 15 years and over, and a youth survey of people aged 15 to 25 years. Those being surveyed were asked their attitudes in relation to six mental illnesses – depression, depression with suicidal thoughts, early schizophrenia, chronic schizophrenia, social phobia and PTSD.90

The survey showed that there had been improvements in mental health literacy since the 1995 public survey, particularly for recognition of depression; beliefs about the usefulness of GPs, psychiatrists and counselors; and beliefs about the usefulness of medications in particular antidepressants and antipsychotics. Beliefs about the outcomes and causes of mental disorders were more realistic and closer to those of researchers and health professionals.

However, there were limited changes in stigmatising attitudes, most notable being an increase in beliefs of dangerousness and unpredictability and a decrease in the desire for social distance for all vignettes other than chronic schizophrenia. The recommendation was that further monitoring of population mental health was needed to determine if improvements in mental health literacy translate into improvements in population mental health and that beliefs around dangerousness and unpredictability showed the need for public education to address stigma towards people with mental disorders.91

The evaluation of the 3rd National Mental Health Plan in 2007 also had noted that the widespread consensus was that there had been an increased awareness of promoting mental health and specific mental health problems, particularly depression, but that attitudes of the public and providers had not changed a great deal around bi-polar and schizophrenia.

Australia and Ireland are the only English speaking OECD countries without a national anti-stigma campaign. Countries such as New Zealand, Scotland, England, the USA and Canada have recurrent funding to conduct national anti-discrimination campaigns, informed by evidence. Research shows that shifting public attitudes on mental illness has been difficult, but overseas programs have been evaluated and the evidence from where they exist, is that there is strong agreement on this sort of approach being important.92

Recent results from the WA Mentally Healthy campaign challenge the need for social marketing efforts directed at stigmatising attitudes, but rather that a positive mental health promotion campaign not only attracts mentally health individuals to maintaining their mental health, but also attracts people experiencing mental health issues whilst serving to de-stigmatise mental illness.93

89 Australia Institute of Criminology 2013. Police shootings of people with a mental illness. Research in Practice, No 34 May 2013: Canberra.
91 Ibid.
93 Donovan R Laws A 2012.
The 4th NMHP acknowledges that consumers and careers highlighted that stigma and discrimination are still prevalent. It notes that discrimination occurs with housing and employment; is evident in the attitudes of the media and community; and still occurs within the health sector.

There also has been criticism of the mental health promotion agenda in Australia, in terms of the promoting a holistic approach to mental health and wellbeing. Australia had been considered an international leader in mental health promotion, but it had slipped from the national political agenda and taken a focus on ‘downstream’ treatment outcomes. There had been a lost focus on the relationship between mental and physical health and the way health behaviours are shaped by social conditions, noting that people with a chronic mental illness have some of the worst physical health outcomes of any group. Missing from the 4th NMHP were positive indicators for mental health and population level indicators for mental health promotion. It refers to social determinants of health such as housing, education and employment within a recovery approach, however there were greater opportunities for people with a mental illness through social inclusion strategies such as the mental health policy developed by the SA Social Inclusion Board; and the disability and mental health employment priorities set by the Australian Social Inclusion Board.

**What has the Australian Government done in response to the Senate Report (2006) and the Not For Service Report (2005)?**

Prime Minister John Howard and NSW Premier Morris Iemma led the COAG response to the damming assessments of Australia’s mental health system contained in the Mental Health Council of Australia’s Not for Service report and the Senate’s From Crisis to Community report.

A major feature of the Commonwealth’s response package ($1.9 billion over 5 years) was the Better Access Initiative – items under the MBS for access to psychiatrists, psychologists and GPs which committed over $500 million under fee-for-service arrangements. This initiative changed the structure of the Better Outcomes in Mental Health Care Initiative which focused on collaborative care and GP education and training, and providing preferential access for people with socioeconomic, demographic or geographical barriers.

In 2008 the Federal Budget increased the estimated expenditure from $538 to $773.5 million over the 5 years to 2010–11. From November 2006 to October 2007, the MBS items accounted for 1,209,191 services, with growth being greater in metropolitan locations compared with rural and remote areas. An evaluation of the DOHA Better Access to Mental Health Services, commissioned and managed by the Department, generally found the program was effective. However, debate has been fierce among opponents of the “business as usual” approach under MBS for the Better Access program.

An examination of the uptake of the MBS items has shown access by men, young people, and people living in lower income and rural, remote and some regional centres have generally had poorer access to the program. Further, one study reported that a large proportion of women reporting a history of mental health problems had no mental health MBS claims, which indicated that access issues were not being addressed. It showed that women who were socioeconomically disadvantaged were less likely to access these services, despite having mental health problems, and also a low uptake by older women.

One of the major programs funded through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is the Personal Helpers and Mentors (PHaMs) program which aims to increase opportunities for recovery for people aged 16 years and over who have a severe functional limitation due to severe mental illness. Eligibility is typically restricted to the around 180 postcode areas allocated to a PHaMs service provider.

---


ConNetica 141
An evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives, commissioned and managed by the Department, found that all stakeholders believed PHaMs was an effective initiative, with high satisfaction levels and support for the recovery model approach. There were concerns about the number of service providers fragmenting the system, the small size of many service organisations, and the short term contracts having a negative impact on clients.

A brief retrospective on the Rudd–Gillard Governments

The Rudd Government came to power in November 2007 with an ambitious social reform agenda. This included radical proposals for reforming the health and hospital systems and clear commitments to do better on mental health.

The new Federal Health Minister Nicola Roxon stated in June 2008:

As I outlined prior to the election, we are committed to meaningful reform … In particular, we are committed to:
- Putting mental health firmly on the national agenda, working with states and territories on an integrated national approach to service delivery
- Putting in place an evidence-based approach
- Reorienting mental health policy towards prevention and early intervention
- Ensuring mental health services are well integrated with other primary care and specialist services
- Investing in programs such as ATAPS to ensure resources are used to fill gaps in existing service delivery, particularly in rural and remote Australia
- Developing an open, transparent system of evaluation and accountability of existing mental health services
- Developing a 10 year plan to address homelessness in Australia, with people with severe mental illness sadly prominent in our homeless population
- Ensuring that people with a mental illness have every opportunity to gain and maintain meaningful employment without prejudice.

Nicola Roxon did oversee the establishment of the National Advisory Council on Mental Health and the Council delivered the Government over a dozen major reports and a plethora of advice to inform these commitments. However, the only actions on mental health of the Rudd Government were to cut funding to some programs, including the highly effective Mental Health Nurse Incentive Program. Some $300 million was crawled back from the Forward Estimates in the Budget Papers.

In response to the chorus of criticism led by key mental health advocates, including the 2010 Australian of the Year, Professor Patrick McGorry, the Rudd Government included a modest package of some $181 million in new funding for mental health in the 2010 Budget and COAG Health and Hospital Reforms. This was less than 2% of the overall amount of new funding committed to health reform and the critical chorus simply amped up. Worse still, when closely examined this was just $31.5 million in real new funding over four years, the remainder being ‘funny money’ – redirected, re-announced or re-badged. In real terms, mental health’s share of health funding was declining.

The 2010 Federal Election featured mental health policy as a central issue. The Coalition announced a major investment of $1.5 billion in the campaign and this was focussed specifically on key areas of prevention and early intervention. The Gillard Government responded with a $273 million package targeting suicide prevention and that pledge – ‘mental health a second term priority’.

Despite being on the Treasury benches since November 2007 and the much trumpeted $2.2 billion mental health package in the 2011 Budget, it is only in the past few months of 2012 that tangible progress has emerged from decisions made by the Rudd–Gillard Governments on mental health (aside from the program cuts referred to earlier). Finally additional headspace (youth primary mental health)

101 Of the $2.2 billion, the majority of the funding was re-directed, re-announced or re-badged funds. Independent analysis by Access Economics showed only some $600 million as additional funding over five years.
services opened\(^{102}\); the number of clients receiving care through the Personal Helpers and Mentors Program increased by about 20% (on the original commitments of the Howard Government) and there was some limited expansion of the Access to Applied Psychology Services (ATAPS – initiative in 2002–3).

Consistent with the broader narrative on the Gillard’s Government inability to deliver on commitments, the two most significant initiatives announced in both the 2010 and 2011 Federal Budgets, namely the commitment to 16 Early Psychosis Program centres ($245m) and a new care program for people with severe and persistent mental illness (tagged Partners in Recovery at $540m) are yet to materialise.

To give credit where it's due, the Gillard Government implemented two potentially important structural initiatives – the first national mental health report card from the National Mental Health Commission (NMHC) and the Ten Year Roadmap for National Mental Health Reform.

**Commonwealth reform agenda**

**National Health Reform Agreement**

Alongside the various mental health plans and strategies, the other relevant agreement is the National Health Reform Agreement (NHRA) which was agreed to by the Australian and State and Territory Governments in August 2011. The National Healthcare Agreement (NHA) also includes several indicators relevant to mental health. The NHRA contains a specific mental health stream which focuses on five areas:

- Better care for people with severe and debilitating mental illness
- Strengthened primary mental care services
- Prevention and early intervention for children and young people
- Encouraging economic and social participation for people with a mental illness
- Improving quality, accountability and innovation in mental health services\(^{103}\).

Services included in the funding of the NHRA process are stated as being an expansion of headspace, Access to Allied Psychological Services (ATAPS), PHaMS, and Family and Mental Health Support Services; access to new services such as the Early Psychosis Prevention and Intervention Centres (EPPIC); and the National Mental Health Commission. In the 2011 implementation and progress report there are a range of ‘Next Steps’ outlined in the NHRA listing dates for various activities; related budget measures; and milestones. The following are listed as having occurred under the health reform process since April 2010:

- April 2011 – ten new headspace sites announced with anticipated start dates by the end of 2011, and planning underway for the next 15 sites.
- Negotiations conducted in 2010 and early 2011 on the expansion of the EPPIC model with roll-out of the sites included in the 2011–12 Budget for 16 EPPICS around the country.
- Expansion of the Mental Health Nurse Incentive program successfully implemented with funding having commenced in July 2010, which would employ 136 additional mental health nurses by the end of 2011–12.
- Seven of 15 original Taking Action to Tackle Suicide packages implemented in 2011\(^{104}\).

---

102The Howard Government committed funding for the establishment and ongoing operation of 30 headspace service sites in 2005-6. While the Rudd Government agreed to increase this to 45 in 2010 and then 90 following the 2010 Election, the 31\(^{st}\) headspace service only opened in early 2012.


Fourth National Mental Health Plan 2009–2014

The 4th NMHP states that “Improving accountability for both mental health reform and service delivery are central to the Fourth Plan”. Principles of the Plan include:

- services delivered with a commitment to a recovery approach
- recognition of social, cultural and geographic diversity and experience
- recognition that the focus of care may be different across the life span
- services delivered to support continuity and coordination of care
- service equity across areas, communities and age groups
- consideration of the spectrum of mental health, mental health problems and mental illness.

The 4th Plan included several priority areas, including Prevention and early intervention; Service access, coordination and continuity of care; and Social inclusion and recovery. As with the previous National Mental Health Plans there was little detail in terms of resources, milestones and measures but again a multitude of possible actions and motherhood statements.

The Plan did acknowledge that despite increased funding to primary and specialist services, treatment rates are low compared to prevalence and that service options need to be informed by population planning specifying the mix and level of services. It also acknowledges that there is a critical need to link between and within sectors, and achieve service coordination.

The Roadmap for National Mental Health Reform 2012–22

After more than twelve months of consultations and three draft versions, the final Council of Australian Government’s (COAG) meeting in 2012 approved and released the 10-year Roadmap for reform.

The Roadmap emerged as a policy commitment from the Federal Mental Health Minister The Hon. Mark Butler MP in late 2011 prior to consultation with states/territories or the endorsement of COAG. Consequently, ownership of the document and acceptance of it as a blueprint for reform by COAG was delayed and somewhat muted.

…the Roadmap for National Mental Health Reform, is the response of our collective governments to the challenge put to them by PM Gillard following her investment of $2.2 billion in new and redirected funds in 2011. As such one would have hoped for a document that clearly defined the destination, set a timetable for reaching landmarks along the road to the destination, defined key measures by which substantive change could be assessed, set real targets that were consistent with our national aspirations and modelled the size of investment that would be necessary to achieve real change.

The initial reactions to the final document reported in professional commentary and national media reflected a sense of déjà vu of previous government blueprints – fine visionary statements with too little detail on what, how, when and by whom. Prior to the COAG meeting an Open Letter from nearly 100 organisations was published calling for governments to set real mental health targets.

The Roadmap identifies six priority areas with 45 strategies in all. However, the strategies use passive language and lack any clear commitments on resources, timing and targets or milestones. The Roadmap also points to the creation of a fifth 5-year National Mental Health Plan to succeed the current plan which lapses in 2014.

The proposed governance arrangements for the Roadmap include a new national working group with some 27 Ministers and each with their own senior officials (i.e. 3 Ministers per government) and chaired by the Federal Minister for Mental Health. An Expert Reference Group chaired by the National Mental

---

105While the NMHP is a inter-governmental agreement, its development is lead by and funded by the Commonwealth.
107ibid
109Professor Ian Hickie AM, University of Sydney, 11 December 2012
Health Commission with one representative from each jurisdiction (a member of the state commission or a consumer, carer or representative of a peak NGO) will support the Ministerial Working Group.

No specific performance measures have been adopted. Rather the Roadmap includes a preliminary set of 11 indicators and 3 ‘contextual indicators’, with the task of developing an agreed set of measures has been set to the Ministerial Working Group for report back to COAG at the end of 2013.

The Roadmap states that 6 measures have been identified as provisionally suitable for targets on the basis that these have a robust evidence base that supports the setting of specific benchmarks, which allow “government to set well-defined policy directions that will help us achieve these benchmarks”.

In summary, the Roadmap is vacuous at best and at worst it might represent a ten-year prison sentence from which mental health may struggle to free itself, particularly in the light of other priority governmental agendas such as education reform, dental health and the national disability insurance scheme (NDIS). In essence, the Roadmap leads us somewhere we have already been for a long time, not somewhere new.

The National Mental Health Commission

Commentary to date has largely focussed on the product (the Report Card) and not the form of the National Commission. The NMHC was established as a policy initiative of the Gillard Government following the 2010 Election. The development and release of an annual report card was its principle function.

The National Commission is limited in its powers and unduly constrained by being established as an executive office within the Department of Prime Minister and Cabinet. It has no legislative base and a charter letter to the Chairperson from the Prime Minister defines its remit. The National Mental Health Commission is for all intents and purposes an advisory body within a central agency.

National Mental Health Commission Report Card

In November 2012, the National Mental Health Commission released the much anticipated report card on mental health. The Report – A Contributing Life – was given considerable coverage in national media and drew attention to the failure of reform. However, it simply restated much of what other reports have said for more than a decade.

The Report points to the lack of any clear, agreed picture of what a good mental health service or model should look like and does not offer such. Nor does the Report Card propose any indicators or system of accountability but simply calls on governments to do so.

The Report Card identifies four priority areas:

1. Mental health must be a high national priority for all governments and the community.
2. We need to provide a complete picture of what is happening and closely monitor and evaluate change.
3. We need to agree on the best ways to encourage improvement and get better results.
4. We need to analyse where the gaps and barriers are to achieving a contributing life and agree on the direction for Australia.

Generally while the Report Card has been welcomed by key stakeholders in the mental health sector it is seen as ‘business as usual’, a largely rear-view mirror perspective on what has been rather than what is now, as lacking in prevention and promotion and short on discussion on early intervention and young people. It is also unclear as to whether the Report Card is designed for mental health services or whether it proposes a national approach to improving mental health and ameliorating the impact of mental illness.

While the NMHC remains in its current form, the Report Card is unlikely to drive national mental health reform.

For the NMHC’s Report card to become the game charger that everyone so desperately hopes for, what is needed is a culture change that sees mental health and wellbeing as a key indicator for the nation’s to its citizens\textsuperscript{113}.

**Social inclusion**

In 2008 the Rudd Government established the Australian Social Inclusion Board (the Board) as the primary body to provide advice to the Government on achieving improved outcomes for disadvantaged groups in the community, which has included people with a mental illness. In 2008 Board representatives met with peak national bodies in the mental and disability sector to discuss the Board’s priority areas: jobless families with children, children at greatest risk of disadvantage, and adopting a locational approach. Key findings of that consultation included:

- Government funding models for non-government organisations should be based on outcomes for individuals not on the provision of units
- Services should be flexible to respond appropriately to each individuals needs and deliver a level of control
- Indicators and measures should be based on outcomes for individuals rather than units of service
- Need specific data breakdowns for indicators to be useful\textsuperscript{114}.

The ASIB has issued numerous reports since 2008, however it is difficult with the context of this report to examine its ‘value’ to policy and programs.

**Housing**

In 2008 the Australian Government released the white paper on homelessness *The Road Home – A National Approach to Reducing Homelessness*. The two ‘head line’ goals of the White paper were to ‘halve overall homelessness by 2020 and offer supported accommodation to all rough sleepers who need it by 2020’. The response was to be implemented through three strategies:

- **Turning off the tap:** services intervening early to prevent homelessness
- **Improving and expanding services:** more connected and responsive services to achieve sustainable housing, improve economic and social participation, and end homelessness
- **Breaking the cycle:** people who become homeless to move quickly through the crisis system to stable housing with support so homelessness does not reoccur\textsuperscript{115}.

The first strategy included mental health related initiatives:

- Increasing support for people in public and private rentals to maintain tenancies
- ‘No exits to homelessness’ from statutory, custodial care, health, mental health and drug and alcohol services
- Delivering community mental health services under the Personal Helpers and Mentors Program (PHaMs) to 1,000 people who are difficult to reach, including people who are homeless.

An appointed Council on Homelessness would monitor the achievement of the goals and targets by 2013 and 2020, and report annually. The COAG Reform Council would monitor progress against outcomes and performance indicators in the NAHA\textsuperscript{116}.

The Australian and state and territory governments committed to a range of service outputs in 2008 through the National Partnership Agreement on Homelessness (NPAH) which include:

- ‘A Place to Call Home’ initiative involving housing and support services
- Street-to-home initiatives for chronic homeless people (rough sleepers)


\textsuperscript{116} Ibid.
• Support for public and private tenants to sustain tenancies
• Assistance for people exiting child protection, correctional and health facilities
• Specialised outputs for substance users and people with mental health issues.

Specific mental health housing initiatives have been introduced in a number of states including the Housing and Accommodation Support Initiative (HASI) in NSW and the ACT, and Doorway and Housing and Support Program (HASP) in Victoria, and HASP in Queensland (roll out of HASP in Queensland has been limited). The states and territories in Australia had varying methods of addressing housing and support needs of people with a mental illness, mostly due to autonomous approaches in each jurisdiction. The success of many initiatives was due to an ability to respond to local and individual needs, which also limited replication in other areas. There was a need for meaningful data on the extent to which people with a mental illness could access and maintain appropriate housing, and greater integration and forward planning across portfolios to have a more cohesive approach, such as between national housing and disability agreements and the National Mental Health Strategy.\textsuperscript{117}

\textbf{Employment}

As a part of the Australian Government’s Social Inclusion Agenda, the Australian Government developed the National Mental Health and Disability Employment Strategy, which was released in 2009. The Strategy itself acknowledges that the rate of employment for people with a mental illness and disability is well below that for people without a disability and that in recent years, employment prospects declined. It notes that an important aspect of social inclusion is having employment. It also notes that people with a mental illness have some of the worst employment rates. The Strategy includes six actions:

1. Engaging people with disability
2. Improving disability employment services
3. Providing better access to education and training
4. Supporting and encouraging employers
5. Improving public sector employment of people with disability
6. Pursuing innovative strategies.

No evaluation process of the Strategy is mentioned\textsuperscript{118}. Initiatives funded under the Strategy include:

• New disability employment services for people with a disability (stated funding of $1.2 billion)
• A pilot program funded under the 2009–10 Budget (stated funding $6.8 million) to assist 100 people with a disability receiving the DSP
• Development of training by the Australian Public Service Commission for APS agencies
• The Employment Assistance Fund which brings together the Workplace Modifications Scheme and the Auslan for Employment program
• An Innovation Fund to fund innovation projects that address barriers to employment, examples included social firms\textsuperscript{119}.

\textsuperscript{117} Australian Housing and Urban Research Institute 2007. Supporting the housing of people with complex needs, AHURI Research and Policy Bulletin, Issue 90.
Conclusion

What is clear from the available data on the health and social and economic wellbeing of those with mental illness, is that they continue to receive inadequate access to health care and that the health care received is too often not appropriate or effective. What is also abundantly clear, is that the cost of not providing access to care or quality mental health care is hurting the nation’s productivity and propensity.

Mental health services in Australia are neither planned on the basis of need (that is to respond to the population’s mental health needs) nor based on evidence of what works best. There are, in short, serious structural imbalances\textsuperscript{120} in the system of care compounded by poor and outdated practices\textsuperscript{121}.

\textsuperscript{120} Doessel D Williams R Whiteford H 2010. Structural imbalance and resource shortage in the Australian mental health sector. J. of Mental Health Policy and Economics, 13 1: 3-12.

\textsuperscript{121} Runciman WB et al 2012. Op Cit.
Chapter 6

A systematic review of independent audits of mental health and associated services by statutory and related authorities 2006–12

*Kathleen M. Griffiths, Bradley Carron-Arthur and John Mendoza*
Obsessive Hope Disorder
1. Introduction

This chapter reports the results of a systematic review and synthesis of the findings of National and State audits of mental health and related services undertaken by independent statutory authorities such as Ombudsman, Auditors, Public Advocates, Guardians and Commissioners. In some cases, the reports on which the review is based were initiated by the office undertaking the review; others were prompted by public complaints, requests by a Government, Parliament or Legislative Assembly or constituted part of the office’s statutory functions (e.g. annual review of child deaths). In all cases the resulting report was undertaken independently of the government and the departments or agencies responsible for program management and/or program implementation.

The limitations of these audits and reviews are that they do not systematically analyse all aspects of the mental health care system. Nor, in the case of State and Territory focused audits do they investigate the system outside a particular jurisdiction. Moreover, when policy makers act quickly to implement the recommendations of these reports, their findings can quickly lose currency. Nevertheless, the reports represent the culmination of careful and systematic investigation of important questions by trained, independent investigators and the outcomes may be informative both as they apply to the jurisdiction and topic evaluated and for their potential applicability to other jurisdictions and topics.

The impetus for this review came following a meeting involving one of the authors and state and territory Guardians, Public Trustees and Advocates in 2011.

To date the findings of these reports have not been synthesised by government or researchers. To address this gap, the current chapter analyses 32 reports systematically identified by a search of audits and reviews and published by relevant statutory authorities since mid-2006. This date was selected as the ‘start line’ for this review as it was the commencement of the COAG National Action Plan on Mental Health 2006–11. The COAG NAPMH was a direct response to damming assessments of the state of mental health care released by the Mental Health of Australia in October 20051 and the Australian Senate in March 20062.

2. Methodology

Source

The reports incorporated in this review were obtained via a multi-stage systematic search of the publications posted on the websites of each of the following Australian (National), State and Territory statutory authorities:

1. Auditor
2. Ombudsman
3. Public Advocate/Guardian
4. Public Trustee

Search methodology

Websites for each of the relevant statutory authorities were located through a Google search of their title and a term that specified the jurisdiction in which the authority operates (National/Commonwealth or a specific State/Territory). This search yielded 51 relevant websites comprising 483 State or Territory and three national website including the National Audit-Office, the Commonwealth Ombudsman and the Australian Human Rights Commission.

---

1 Mental Health Council of Australia 2005 Not for Service: Experiences of Injustice and Despair in Mental Health Services in Australia.. Canberra.
2 Australian Senate 2006 From Crisis to Community: Inquiry into Mental Health Services in Australia. Community Affairs Committee, Canberra.
3 The Northern Territory Public Guardian website was confined to a contact information page on the Department of Health Website.
Report identification

Within each website, the relevant reports were typically located in a section labelled “Publications” or synonym. Potentially relevant reports were identified in a multistep process as follows:

Stage 1: The titles of all the investigative/parliamentary reports since 30 June 2006 and the most recent annual reports were screened for their relevance to the topic of mental health. If the title contained any one of the words “health”, “hospital”, “psychological/psychiatric services”, “mental health”, “mental illness”, “death” or “disability”; or if the reviewer considered it plausible from the title that the report might contain relevant content (e.g. “The use of Taser weapons by New South Wales Police Force”), the report was retrieved.

Stage 2: The retrieved reports were briefly screened by examining the Contents page of the document and by searching for the terms “mental health” and “mental illness” using the Adobe “find” function. If the report appeared to contain sections relevant to mental health issues, it was retained. This process yielded a total of 51 reports.

Stage 3: The reports identified in Stage 2 were examined in more depth by two reviewers who independently rated each as to whether they contained at least one demarcated subsection specifically relevant to mental health. Where the document was an Annual Report, only the most recent report was included. Any disagreements were resolved through discussion between the reviewers at the end of this process. A total of the 32 reports satisfied this inclusion criterion and were thus included in the review.

Included reports

Tables 6.1 and 6.2 provide a summary of the distribution of the source of the included reports and a listing of each report. Fourteen of the reports focused on children and young people. The greatest number of documents were generated in NSW and by the Ombudsman and Child Safety Commission offices. There were no relevant reports published in Tasmania, the Northern Territory or by the Public Trustee.

Table 6.1: Distribution of the included reports

<table>
<thead>
<tr>
<th>Source of Reports</th>
<th>National</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditor General</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Ombudsman</td>
<td>2</td>
<td></td>
<td></td>
<td>6</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Public Advocate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Child Safety Commission</td>
<td>1</td>
<td></td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Human Rights Commission</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Public Trustee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>32</td>
</tr>
</tbody>
</table>

Table 6.2: Reports included in the present review

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Auditor-General’s Office 2010 [1]</td>
<td></td>
</tr>
</tbody>
</table>

4 All report details are given at the conclusion of this Chapter.
<table>
<thead>
<tr>
<th>Source</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commonwealth Ombudsman 2010 [8]</td>
<td>Falling through the cracks: Centrelink, DEEWR and FAHCSIA: Engaging with</td>
</tr>
<tr>
<td>NSW Ombudsman 2009 [10]</td>
<td>The implementation of the Joint Guarantee of Service for People with Mental</td>
</tr>
<tr>
<td>NSW Ombudsman 2012 [12]</td>
<td>How are Taser weapons used by the NSW Police Force?</td>
</tr>
<tr>
<td>Ombudsman SA 2012 [14]</td>
<td>Ombudsman investigation into the Department for Correctional Services in</td>
</tr>
<tr>
<td>Victorian Ombudsman 2011 [18]</td>
<td>Investigation into prisoner access to health care.</td>
</tr>
<tr>
<td>Children and Young People</td>
<td></td>
</tr>
<tr>
<td>Commission for Children and Young People and Child Guardian</td>
<td>Children of Parents with Mental Health Issues.</td>
</tr>
<tr>
<td>Commission for Children and Young People and Child Guardian</td>
<td>Follow up review of children of parents with mental health issues.</td>
</tr>
<tr>
<td>Commission for Children and Young People and Child Guardian</td>
<td>Reducing Youth Suicide in Queensland Final Report</td>
</tr>
<tr>
<td>Commissioner for Children and Young People Western Australia</td>
<td>Report of the Inquiry into the mental health and wellbeing of children and</td>
</tr>
<tr>
<td>Commissioner for Children and Young People Western Australia</td>
<td>Report to children, young people and the community: Inquiry into the mental</td>
</tr>
<tr>
<td>Commissioner for Children and Young People Western Australia</td>
<td>Speaking out about mental health – The views of Western Australian children</td>
</tr>
<tr>
<td>Guardian for Children and Young People 2011 [28]</td>
<td>Report of the Case File Audit of Mental Health Services for Children and</td>
</tr>
<tr>
<td>Commissioner for Children and Young People Western</td>
<td>Annual report 2011–2012.</td>
</tr>
</tbody>
</table>
3. Findings

The findings from the included reports are presented for the different points of the mental health service spectrum including: (1) mental health and suicide awareness; (2) prevention; (3) community mental health services; (4) community crisis services; (5) hospital emergency services; and (6) hospital inpatient treatment. This is followed by a summary of findings associated with (7) Other relevant services and special topics including (i) housing; (ii) social security services; (iii) wrongful immigration detention; (iv) abuse of consumers in psychiatric institutions; (v) Veterans Program Administration; (vi) Protection services and children at risk; and (vii) Taser restraint in the community.

3.1 Community mental health awareness and training

Overall, there was little focus in the included reports on community mental health awareness and training. However, three of the reports did address the importance of community education with respect to the mental health of young people. In particular, the Inquiry into the mental health and wellbeing of children and young people in Western Australia [25] concluded that it is likely that many people in the community are unaware that children and young people can experience mental illness. It recommended the implementation of a community education campaign to increase public awareness of mental illness in young people (p. 142). Citing the high level of unmet need among CALD communities of mental health services this Inquiry also called for culturally sensitive mental health education and destigmatisation programs to improve access by young people from a CALD background (p, 90, [25]).

Secondly, noting that many young people who completed suicide signalled their intention to do so prior to the act [24], a 2012 review of deaths in children and young people in Queensland emphasised the importance of taking seriously a child’s threat to suicide and advised that families and others should be made aware that children, even when they may not understand its finality, are capable of completing suicide (p. 69, [24]).

Further, a report on death among children in NSW concluded that the young people who died by suicide often used electronic media including mobile phone and blog to inform others, particularly their peers, of their intent to suicide [29]. The Report concluded that in implementing the community education strategy outlined in the NSW’s suicide prevention strategy, consideration should be given to these electronic forms of communication and that young people be encouraged to advise others when their friends express intent to suicide (p. XXV, [29]).

A number of reports also called mental health awareness training for those providing non-health services to people with a mental illness (e.g., [25], [16]); see further details below.

3.2 Prevention of mental illness

There was not a strong focus on preventive service among audits and enquiries considered. However, WA Inquiry into the mental and wellbeing of children and young people strongly emphasised the importance of introducing programs for preventing mental illness in children and young people. The Inquiry concluded that such services were inadequate at the time of the review (p. 13, [25]). Specific recommendations included:

- The funding and roll out of KidsMatter Early Childhood and KidsMatter and MindMatters programs across WA Early Childhood services, primary and secondary schools respectively (p. 109, p. 121, p. 140). Programs such as KidsMatter provide a framework for the roll out of evidence-based mental health prevention programs designed to prevent depression and anxiety and enhance self-esteem (p. 125).
- Increasing the provision of evidence-based parenting programs and establishing a mechanism for integrating parenting programs across the State (p. 15., p. 107) given the current programs are fragmented and interagency linkages are absent.

---

5 In her subsequent 2012 Annual Report the Commissioner reported that these programs had increased (p. 14).
• Continued provision of evidence-based anti-bullying programs (p. 124). Finally, she detailed evidence-based mental health prevention programs designed to prevent depression and anxiety and enhance self-esteem (p. 125), although she made no recommendations with respect to them.

**Prevention programs for particular groups**

An unmet need for prevention programs was noted for a number of different groups and settings:

- **Peri-natal:** The WA Inquiry argued that the mental health of children is shaped by their environment in utero and the subsequent family environment to which they are exposed (p. 97–98) including the mental health status of the mother [25]. The Commissioner recommended to the Commonwealth that GPs be trained to recognise mental health problems in women during pregnancy and that longer consultations be allowed to enable GPs to increase mental health knowledge in women who are pregnant (p. 99). The Inquiry also recommended that the number of community child health nurses, currently inadequate, be increased (p. 103, [25]) The Commissioner subsequently noted in her 2012 Annual report that 100 additional child health nurses had been employed [31].

- Children of a parent with a mental illness: The WA Inquiry asserted that the children of consumers with a mental illness may be at increased risk and recommended that adult mental health services routinely ask if a consumer has children and take appropriate steps to ensure any children have appropriate support and access to services if needed (p. 87, [25]).

- Culturally and linguistically diverse background. The WA Inquiry pointed to the importance of providing prevention programs that specifically addressed issues for children from CALD backgrounds [25].

- Rural and remote: The WA Inquiry also recommended that a number of agencies work together to increase children’s access to “arts, cultural, sport and recreation opportunities . . . particularly in regional and remote areas”. (p. 146)

- Indigenous background: The SA Advocate pointed to the lack of preventive services for people of Aboriginal background.

### 3.3 Community-based mental health care

A number of reports addressed issues relevant to community-based mental health care. Issues raised included access, service information, referral management.

**Access, availability and equity**

An audit of community mental health teams in WA found that consumers frequently did not receive the services or information they required about services [4]. It also reported that the available services focused on crisis rather than rehabilitation services (p. 17, [4]) with consumers often unable to access a service until they are in crisis and the delays in accessing services increasing the risk of crisis (p. 23). The audit also concluded that access was diagnosis driven rather than needs driven with consumers being denied entry to services while they wait for a formal diagnosis even when their need for a service is clear (p. 26). For example, the report described the case of a consumer who had received a number of differing diagnoses with the result that she unable to access necessary services (p. 27). The review found that assessment and treatment services were available in most areas of the State but that the mix of services has developed without planning, and was not based on an analysis of community needs (p. 17, [4]) leading to gaps in services. The auditor recommended that services should be planned and based on the needs of consumers in the region in which the service is provided.

The review of Access to Allied Psychological Services Program (ATAPS) by the ANAO concluded that funding to services was not needs-based leading to inequitable access to ATAPS resources across communities (p. 17, [5]). ATAPS funding is capped and the report cited a number of demand management strategies used by general practice Divisions, all of which are designed to reduce access to the program but which compromise the consistency and equitable access to care and in some cases the quality of care. These demand management strategies varied across Divisions but included: placing
limits on the number of referrals allowed by a single GP, the number of GPs permitted to refer, the number of sessions provided to consumers or the imposition of demographic criteria to qualify for the program (e.g. low income); delivering group rather than individual therapy; requiring co-payments; introducing waiting lists; or suspending referrals for some periods of the year; referral to less qualified professionals to reduce service costs (p. 73–74, [5]).

The ANAO review also noted that the case management and referral under the ATAPS program is typically undertaken by a GP. This can be a barrier to service for groups without links to a GP (e.g. young people, the homeless or Indigenous people (p. 43, [5]). The review also reported that some Divisions place a limit on the number of sessions that can be provided under the scheme, which in turn may compromise clinical care [5].

These reports also noted access issues for particular groups as follows:

**Children**

The WA Inquiry into the mental health and wellbeing of children and young people found that children and young people of all ages had inadequate access to mental health services [25]. Specialist mental health services for severely ill children were under resourced, and characterised by long waiting lists. Child and adolescent mental health services were found to be primarily accessible only by children in crisis. As a result children with mild to moderate disorders were not seen until their condition deteriorated to the point that it is sufficiently severe that they qualified for treatment (p. 113). The problem with this approach was illustrated by a statement from a young 18 year old consumer:

“Telling someone who has an eating disorder [ED] that they have not yet lost enough weight to be seen by an ED clinic is BAAAAAAAD”. (p. 50, [25]).

The WA Inquiry recommended that the Department of Education employ more psychologists to expand the care available to young people with mild to moderate mental health problems (p. 139, [25]). It also recommended the establishment of youth service centres across the State (e.g. Headspace) (p. 148), pilot integrated comprehensive mental health services at schools (p. 131), and a dedicated Specialist Infant Mental Health Service for treating very young children (p. 114, [25]).

**Justice**

A number of reports pointed to difficulties accessing appropriate treatment or services within a number of justice settings around Australia.

The NSW Ombudsman cited cases of prisoners with a mental illness on remand or in jail being subject to substantial delays before being provided with their usual medications (p. 58, [19]). For example, the Ombudsman described the case of a female prisoner with schizophrenia who reported that after 12 days in prison she had not been provided with her usual medication.

The Ombudsman was advised by NSW Justice Health that medication could not be provided until the woman had been seen by a Psychiatrist (p. 58).

The Victorian Ombudsman found that Victorian male prisoners had inadequate access to mental health services [18]. Victorian Justice Health figures provided to the Ombudsman in late 2010, indicated that a total of 1585 prisoners required access to psychiatric treatment, care or assessment. However, the Ombudsman found that currently the system has the capacity to provide access to 30-minute consultations for only 132 prisoners. The Ombudsman recommended that the Department increase the number of psychiatry consultation hours available to men (p. 19, [18]).

A report issued by the ACT Human Rights Commission found that 20% of young people in a youth justice centre in the ACT reported a lack of support for mental health problems (p. 283, [19]). For example, the Commission described the case of a young person in the remand Centre being initially denied access to a medication prescribed by a psychiatrist for urgent use through a mental health nurse from the Crisis Assessment and Treatment Team (CATT) (p. 286). A Manager in the Centre had questioned the appropriateness of the medication and threatened to bring a legal action against the CATT team nurse for allegedly bringing contraband into the Justice Centre. The Commission expressed concern that a health
professional's judgment had been questioned (p. 286) and recommended that Bimberi staff accept the treatment recommendations of healthcare staff.

The SA Public Advocate pointed to the importance of establishing a permanent in-reach team to provide mental health services to consumers in prison and assist staff to respond appropriately to consumers (p. 33). This team would be employees of the mental health service rather than the corrections system.

The WA Inquiry in the mental health and wellbeing of children and young people noted that despite the high level of mental illness among young people in the juvenile justice system, there were no programs for young offenders with a mental illness in Western Australia [25, 33]. The Inquiry Commissioner considered that with appropriate mental health services, these young people could be 'diverted' from the justice system (p. 69, [25]). The Commissioner recommended that such services be made available to young people appearing before the court (p. 80). In her subsequent 2012 report the Commissioner commended the WA government’s decision to fund the establishment of a pilot forensic mental health service for children and young people at the Children's Court.

**Perinatal**

The WA Inquiry into the mental health of children and young people found a lack of services for perinatal women who required mental health treatment (p. 101, [25]).

**Rural and remote**

According to the WA Inquiry into the mental health of young people, children in rural and remote areas frequently do not have access to any mental health services (p. 13, [25]). The Inquiry also pointed to the concerns among youth in rural regions about confidentiality and stigma, noting the importance of addressing these concerns in developing new services (p. 77, [25]). WA currently supplements the regular government budget to regional areas with additional funds from mining royalties (the “Royalties for Regions” program). The Inquiry Commissioner recommended that the State direct funding from the Royalties for Regions program into mental health services for children and young people in rural and remote areas (p. 78, [25]).

**Indigenous**

The SA Advocate pointed to the lack of culturally safe mental health services for people of Aboriginal and Torres Strait Islander background, suggesting that Aboriginal-controlled services might appropriately be involved in their planning and delivery and that an Audit might ‘be a catalyst for immediate action’ (p. 44, [16]). He also argued that Indigenous mental health should be a priority in the next mental health plan and that funding be provided to Aboriginal controlled organisations to address the gaps in services and in regions in which Indigenous peoples reside (p. 45).

The WA Inquiry into the mental health of young people found that children from an Indigenous background lacked access to culturally safe and appropriate services [25]

**Culturally and linguistically diverse**

The WA Inquiry into the mental health of young people found that children also pointed to the gap in culturally appropriate services for people from a CALD background (p. 90, [25]).

**Other groups**

The WA Inquiry found gaps in services for young people with ‘a disability’ such as a developmental disability and those with a dual diagnosis that the delays in access to appropriate service for young people who are homeless are a barrier to care (p. 154, [25]).

**Service information**

The WA Audit of Community Mental Health Teams found that although the specialist services provided by each team differed, information was not available to guide the service choices of consumers and carers (p. 29, [4]). Similarly, in a review of Older Persons Mental Health Services (OPMHS) in the ACT, the Auditor General found insufficient communication to consumers, carers, GPs and other agencies about OPMHS’s role, nature and entry criteria (p. 19, [1]). A low level awareness among GPs of the service
was seen as of particular concern and service were advised to target awareness programs at new general practitioners (p. 32).

Referral management

Two reports identified inadequacies in service referral management, particularly with respect to identifying entry criteria and referring consumer to additional services.

Entry

The WA Audit of Community Mental Health Services reported varying entry criteria across regions which were not always documented and/or available to consumers (p. 25, [4]).

An audit of Older Persons Mental Health Services in the ACT [1] also found a lack of clarity concerning entry and exit criteria for the service. The Auditor cited a case in which an older person attempted to self-refer to the OPMHS which instructed him to contact the CATT team who in turn instructed him to contact the OPMHS (p. 21). The Auditor also found that there was insufficient clarity as to what defines ‘urgent’ and no formal system for prioritising referrals (p 30, [1]). Further he reported that OPMHS provided ‘little’ feedback to referral agencies for their use in providing ongoing care to the client (p. 31). This issue relates in large part to privacy issues. The Auditor recommended that OPMHS develop a mechanism to provide feedback to referral agencies, and that they clarify that information which can and cannot be communicated (p. 31).

Referral on

The WA Audit of Community Mental Health Services found that consumers often do not obtain all the services they require because the Community Mental Health Team lacks knowledge about other relevant services due to the large number of services involved (p. 29, [4]). Similarly, the audit of the OPMHS found the service did not maintain a consolidated list of services to inform referral of consumers on to other agencies, resulting in inconsistent referral practice. The Auditor recommended that such a list be compiled and kept up-to-date (p. 50, [1]).

Assessment

The WA Audit of Community Mental Health Teams found that clinical risk was not uniformly assessed across mental health teams as the service had no agreed standardised clinical risk assessment tool for use by staff (p.30, [4]). There was also evidence of a failure to consistently conduct suicide risk assessments of consumers referred to the Older Persons Mental Health Service in the ACT (p. 53, [1]). According to the audit of this service, only 52% of the cases sampled had evidence of a complete assessment.

There was also evidence in inadequate assessment of the mental health status of young offenders within juvenile justice settings, despite the high prevalence of mental illness in the juvenile justice system. In particular, the WA Inquiry into mental health among young people found that there were no mechanisms for ensuring that young offenders with a mental illness are identified [25]. Moreover, due to a lack of resources and the potential for referrals to increase the time a child is detained, the Court restricts its requests for mental health assessments (p. 80). The Commissioner recommended that children appearing before Court be provided with access to mental health assessments (p 80, [25]).

Treatment quality

Outcomes

There was little focus in the reviews on the assessment of health outcomes following the delivery of mental health services, although as noted below, some reviews commented on the absence of available outcome data or reporting (see Monitoring and Evaluation section below).

The report on the ATAPS program [5] noted that most of the emphasis on ATAPs assessment has been on activity and expenditure levels. It found some pre-post data suggesting that ATAPs produce good mental health outcomes. However, this data was available for only 15% of consumers, the collection of outcome data by Divisions being optional (p. 60). Commenting on the ATAPS telephone counselling trial
which sought to formally evaluate the benefits of an ATAPS telephone counselling pilot service, the Auditor pointed to substantial problems with recruiting participants to the trial and with the implementation of a data collection technology. Despite the resulting lack of outcome data, the program was approved for delivery (p. 85–6, [5]).

**Care plans**

The WA Audit of Community Mental Health Teams [4] found that 22% of consumers were not provided with a care plan, that the majority of care plans (77%) omitted key information and that there was no agreed definition of the required content of a care plan. Moreover, it concluded that consumers and carers were often not sufficiently involved in the development and review of care plans (p. 30, [4]) with only 23% of consumers recorded as having been involved in the care plan development and only 5% being provided with a copy of the plan (p. 31, [4]). Carer involvement was even less evident. Accordingly, the audit concluded that Carers Recognition Act 2004 was not consistently adhered to by the WA Mental Health Teams (p. 32).

**Continuity of care and interagency cooperation**

The Audit of Community Mental Health Teams in WA [4] reported poor information sharing and coordination between services leading to a lack of continuity of care, the necessity for consumers to repeatedly ‘tell their story’ and delays in receiving care. Only 19% of care plans had been shared with other professionals such as GPs. The audit concluded that there was a need for agencies to work together to ensure appropriate information sharing (p. 30, [4]).

The audit of the NSW mental health workforce [3] also found that continuity of care was compromised by poor communication between mental health service and referral sources and a failure to agree on the division of responsibilities. NSW Health attributed some of the communication barriers to privacy and technical issues. The Auditor recommended that mental health services be integrated, and linkages established with other health and non-government service providers and mental health consumers and carers (p. 4, p. 19).

The audit of Community Mental Health Teams in Western Australia observed that the variability in entry criteria to different services across regions in WA compromised continuity of care for some consumers when they moved between regions (p. 25, [4]). It also found that the service did not meet WA Health’s own policy and targets for follow-up of consumers after their discharge from inpatient mental health services [4]. Further, the Review noted that the time and benchmarks in the WA policy (70% follow up within 2 weeks) fell short of the National Mental Health Service Standard of 90% follow-up within 1 week (p. 28).

The audit of the NSW mental health workforce [3] concluded that a lack of community based mental health clinicians compromises the capacity of the community mental health service sector to follow-up consumers discharged from acute settings, with contacts being recorded for 52% (p. 26), a figure that falls short of their target of 70% (p. 27).

Inadequate continuity of care and interagency coordination was also reported for young people and children. The WA Inquiry into the mental health of young people emphasised the vulnerability of young people during the transition from adolescence to adulthood and recommended that strategies be developed for ensuing continuity of care (p. 160, [25]). The Inquiry also called attention to the lack of interagency collaboration for children with complex needs (p. 56, [25]). In reporting on the suicide of an adolescent with an alleged background of parental abuse and drug use and a history of contact with juvenile justice, the WA Ombudsman pointed to ‘missed opportunities for interagency communication and collaboration’ (p. 77,[15]) The WA Inquiry recommended that a demonstration collaborative care service be established to cater for young people with complex needs who require input from a range of agencies and sources (p. 56, [25]). Further, the Inquiry recommended that a collaborative approach be established across a range of government agencies (e.g. health, education, child protection, sport and recreation) to improve identification of mental health problems and their appropriate treatment (p. 63). In her 2012 Annual Report the WA Commissioner for Children and Young People reported some progress on improving inter-agency collaboration [25].
The NSW Child Death Review Team recommended increasing school capacity to identify risk of suicide and improve the linkages between schools and mental health services (p XXV–VI, p 149, [29]).

In a review of the ACT Juvenile Justice system and the Bimberi Juvenile Justice Centre [19], the ACT Human Rights Commissioner pointed to problems caused by lack of information sharing between agencies dealing with the young people in the juvenile justice system, particularly citing risks to the young person arising from lack of sharing, between the juvenile justice staff, the health workers, the forensic mental health service and the juvenile justice staff providing care to the young people and recommended that the relevant agencies develop a protocol to overcome this problem (p. 297, [19]). The Commissioner also pointed to substantial differences in the philosophies of the forensic mental health service model operating at Bimberi and the ACT Child and Adolescent Mental Health Services (CAMHS). The former emphasised early intervention with medication and the use of involuntary treatment orders whereas CAMHS focused on counselling approaches and did not impose treatments orders on clients referred from the Bimberi forensic service. The Commissioner concluded that this disparity of models and practices undermined continuity of care and recommended that the situation be reviewed with the aim of developing a consistent treatment model to ensure continuity of care (p. 295).

**Timeliness**

The ACT audit of OPMHS [1] found that the service typically met its own services standards but there was evidence of some cases of delayed responsiveness with inadequate management by the service during the delay (p. 40).

**Consumer and stakeholder input into services**

The WA Inquiry into the mental health of children and young people [25] recommended that young people should participate in mental health reform by sharing their perspectives on how to improve services for this age group (P. 61). The ACT audit found that the service did not engage sufficiently with the external stakeholders in the community and recommended that ACT Health undertake regular consultation with community agencies involved with older people (p. 42, [1]).

**Monitoring, analysis, evaluation and reporting**

A number of reports highlighted gaps in the routine monitoring of and reporting on community mental health services.

**Collection**

The WA Audit of Community Mental Health Teams found that WA Health did not audit the number of consumers waiting for mental health services or the delays in receiving such care (p. 26, [4]). Nor did it assess the community mental health teams’ performance or effectiveness (p. 33). It recommended that WA Health introduce a framework and procedures for such monitoring. The Auditor also noted that complaints (nature, number) were not monitored at the level of Mental Health Division (p. 37). As noted earlier, the ANAO review of DoHA’s administration of ATAPS program also found a paucity of pre-post ATAPS outcome data, its collection by general practice Divisions being optional (see above).

In his audit of mental health services for older people, the ACT Auditor General [1] found that processes for monitoring consumers were in place, and that process information (e.g. usage levels) were collected. However, staff were not fully compliant in entering outcome data into the data collection system or in conducting 3-month reviews according to National Mental Health Service Standards (p. 58). This particularly occurred when the Team Leader position was vacant or the team Psychiatrist was away. As a result, overall, outcome measurements were collected in only 55% of cases over a 2½ year period. The Auditor General recommended that ACT Health monitor these case reviews and compliance with suicide risk assessment protocols, both of which were currently inadequate (p. 64). The audit also revealed that...

---

6 In her subsequent 2012 Annual Report the Commissioner reported that the WA Mental Health Commission had involved consumers in planning services (p. 14).

160
there was no process for monitoring cases where responses to referrals were delayed. Finally, there was no mechanism for systematically monitoring complaints about the MHS for older people.

The audit of NSW mental health workforce could not determine its size due to the poor quality of the data collected by NSW Health. The Auditor-General recommended that data collection be improved to enable future workforce planning and reporting (p. 4, [3]).

**Analysis**

The ACT Auditor General [1] found that there was no formal analysis of unmet need among older people with mental health problems and that there was no analysis of staffing and discipline mix of the OPMHS that might inform workforce planning and recruitment.

**Reporting**

The most recent Annual Report of the Queensland Child Death Case Review Committee [20] considered whether previous recommendations by the Commission for Children and Young People and Child Guardian to improve the accuracy of the reporting of suicides among children and young people had been implemented (p. 101), now that deaths from suicide are no longer designated as accidental when a statement of intent is missing (p. 101, [20]). In addition, the Australian Bureau of Statistics now reports suicide statistics (aggregated across years) for children younger than 15 years (p. 101, [20]), which in turn provides data for considering the need for prevention programs for children and young people.

The ACT Auditor General concluded that the reporting of outcomes measures for the OPMHS was inadequate (p. 57, [1]).

**Staff training and orientation procedures**

A need for staff specialised, operational and mental health literacy training was highlighted in a number of the reports.

**Specialised training**

A review of ACT OPMHS noted a lack of any plan for keeping staff up-to-date with the mental health of older people and recommended that arrangements be made to rectify this (p47, [1]).

WA Mental Health Community Teams incorporated Indigenous support workers but there is a lack of specific training for these staff (p. 24, [4]).

**Operational procedure and administrative training**

The Auditor General concluded that training in and documentation of administrative procedures such as the monitoring of consumers and use of the information collection system required strengthening in the ACT OPMHS [1].

The review of the Psychiatric Services Unit (PSU) in the ACT also noted that Staff at PSU were not trained in the policies and procedures of the unit (p. 31, [2]). The review recommended that formal in-service training be instituted to rectify this problem (p. 8, p. 31).

The ATAPS review revealed a lack of training among DoHA program administrators on specifics aspects of ATAPS program delivery. There was also a lack of documentation of key policies for use in induction of program administrators, a significant problem in the context of a small team with high staff turnover (p. 66, [5]).

**Mental health literacy training for non-health service providers**

The Victorian Ombudsman recommended that prison staff be trained to identify mental health problems among prisoners and draw any mental health concerns to the attention of health practitioners (p. 19, [18]).

The SA Public Advocate called for training of prison staff in mental health first aid and support from in-reach workers so that they better assist and respond prisoners with a mental illness. (p. 32, [16]).
Obsessive Hope Disorder

The Inquiry into the mental and wellbeing of children and young people in Western Australia suggested that school teachers in pastoral care roles receive training to increase their mental health knowledge (p. 20, p. 99, [25]).

**Quality of administrative oversight**

The review of the government oversight of the ATAPS program [5] identified a lack of active management of the programs and a failure to intervene to correct problems and to establish success indicators. The report found that DoHA staff were unable to locate important documentation about the program, noting that this may compromise the delivery of the programs according to the government’s policy parameters. The audit stated:

“Across a number of areas the department was not well placed to make informed program design decisions, primarily due to the lack of: retained information on funding approaches; program guidance materials, or evidence on which policy decisions were based” (p. 36).

Service monitoring of ATAPS was based on self-assessment and report with no particular focus on providers at greatest risk of non-compliance. Service providers reported inadequate guidance about new enhancements to the program. In addition, the audit noted there was no explicit description of the ATAPS program objective, with different government documents providing differing descriptions of ATAPS. Further, there was no centralised record of decisions made about individual programs, the latter being kept on record by the general practice Divisions not DoHA[5]. Finally, there was no mechanism for identifying if, in contravention of ATAPS guidelines, consumers were using services in more than one region (i.e. different Divisions) or program (e.g. ATAPS and the Better Access Program through Medicare).

**Workforce**

An audit in NSW showed that the NSW mental health workforce was primarily distributed in the acute services sector rather than in the community (p.3, [3]). Further, the audit found that the workforce was distributed unevenly across the State [3] and NSW spent less per capital on mental health services than other states. However, the auditor noted a problem with the reliability of the workforce statistics. He also described an example of a service apparently providing data that led to inflated estimates, including non-clinical staff and facility costs such as food in their clinical staff figures (p. 17). The auditor observed that following the allocation by the NSW Government of funding to increase the mental health workforce, new positions were filled but, as part of broader budgetary restraints, existing positions were frozen when staff departed with the result that ‘only 38% to 62% of the intended workforce growth was achieved’ in the community sector. The audit also found that funds allocated to community mental health ‘were not adequately protected from the pressure from Area Health Services to support other areas of health’ (p. 23, [3]). The Auditor recommended that a system of accountability be introduced with “health networks required to report against agreed benchmarks for the distribution of their workforce between community and hospital based services” (p. 4).

The NSW audit also concluded that there were insufficient staff with expertise in caring for older and younger consumers despite a small increase in such staff between 2006 and 2009 (p. 3, p. 22). Without suitable services in the community, a substantial percentage of children and older people remain in acute hospital beds for lengthy periods in the NSW system (p.3, [3]).

The ACT audit of OPMHS reported that staff were ‘over-stretched’ with respect to client load [1].

Noting the absence of skilled child and adolescent mental health professionals in Western Australia, the WA Inquiry into the mental health of children and young people called for the WA Mental Health Commission to develop a mental health workforce strategy for the State. Given the high level of mental health problems among Indigenous young people and the need to provide them with a culturally safe service that they will access, the Inquiry particularly emphasised the importance of training, recruitment and retention of Aboriginal mental health workers (p. 71, [25]).

Finally, the review of the ATAPs service concluded that the establishment of the Better Access initiative had attracted some rural allied health professionals away from providing ATAPS services in rural and
remote regions (p. 70, [5]). A clear case of programs administered by the same department, working in opposition to the intended program goals.

**Policy**

The WA Audit reported that the aims of community MHS were defined by each team rather than by WA MHS and there was no agreed framework for evaluating service effectiveness (p. 7, [4]).

**Complaints and responsiveness to reviews**

The WA Audit of Community MHS found that a large number of the recommendations made by the Chief Psychiatrist in a review of CMHTs were either not implemented or were only partially implemented (p. 36, [4]). In addition, the mechanism available to consumers and carers for submitting complaints was considered problematic (p. 36).

The audit of the ATAPS program found that there was no formal process for managing complaints about the program at the Departmental level and no requirement that such a mechanism be established at the Division level (p. 69, [5]).

**3.4. Crisis response**

This section incorporates findings from audits of crisis services in the community

**Access, availability and equity**

The WA Inquiry into the mental health of young people found that there was no Emergency Psychiatric Services Team for children and young people [25]. The Inquiry described Police reports of conveying young people to hospital for mental health assessment and/or care, the young people being sent home without admission or follow-up mental health service involvement and the cycle being repeated until the problem escalated into criminal behaviour (p. 132).

The Inquiry stated:

“The implications of this are profound. That children with a mental illness needing specialist support should instead find themselves in the criminal justice system demonstrates the response being offered is totally inadequate” (p. 133).

The Inquiry recommended that a special 24-hour emergency service be established for assessment of young people in the community”.

**Assessment**

An audit of emergency service responses to mental health crises in Victoria reported a trend towards more mental health assessments undertaken in the emergency departments and less in the person’s own environment (p. 32, [17]).

**Quality of care**

**Dignity and respect**

The Victorian audit [17] reported that the experiences of consumers varied markedly depending on the staff attending an incident but could include ‘indifference and degrading treatment’ (p. 22). The audit noted inconsistent application of the protocol that people in mental health crisis should be transported to hospital in an ambulance and not a Police van unless unsafe to do so (p. 26).

Consumers detained under the Mental Health Act can be lawfully held in Police cells if and while they are behaving violently. However, the Victorian audit reported cases of consumers with a mental illness being held in Police cells at the request of CAT team members because they are intoxicated with alcohol. The Auditor pointed out that failing to provide access to appropriate health care to these consumers violates

---

7 In her subsequent 2012 Annual Report the Inquiry Commissioner reported that the Assertive Community Intervention program had been extended to provide 24/7 services to children and adolescents in mental health crisis (p. 14, [25])
the Victorian Charter of Human Rights and Responsibilities, 2006, the Mental Health Act, 1986, and the interagency and the Chief Psychiatrist’s protocols (p. 33, [17]).

Timeliness
The Victorian audit [17] reported significant dissatisfaction with the time taken for a CAT Team to attend mental health crises in the community (resulting in Police transporting consumers to hospital) (p. 30). Further, stakeholders were not provided with information about the likely response time by the CAT team. The audit found that most responses to mental health crises by the ambulance service in metropolitan areas met the services’ standards for response time (p. 16). Quantitative data for the ambulance service specific to mental health crises were not available in rural regions. However, in the area audited, mental health staff reported that mental crises were not prioritised and both mental health staff and Police reported lengthy waiting times for ambulances.

Interagency cooperation and continuity of care
The Victorian audit recommended the consumer-centred Police Ambulance and CAT team Emergency Response (PACER) model for mental health crises which has demonstrated the value of interagency cooperation (p. 18, [17]). However, it described as unfortunate, the discontinuation of joint training between Police, mental health staff and paramedics since it fosters better coordination between the agencies.

The Audit demonstrated the problems that can arise when appropriate cooperation is not forthcoming with the example of a consumer requiring admission to a hospital outside of the Police patrol region in a circumstance in which the Police officer in charge refused to permit the Police vehicle to leave the region:

“The sergeant told his staff to take the patient to the border of their area in the divisional van and call an ambulance and Police from the neighbouring Police area to take the patient to hospital”.

An ambulance attended but in the absence of a Police escort left without the consumer. This resulted in a two-hour delay in transporting the consumer to hospital.

The audit found that Police were not typically aware of the interagency protocol for guiding Police and mental health staff interactions and that while the latter were more likely to be aware of the protocol they did not always comply with it (p. 37, [17]). Further there was a lack of involvement of consumers in the review of the protocol (p. 38). The audit found that staff in ambulance services lack clarity concerning when to engage Police in providing an escort when transporting consumers in crisis.

At the time of the review neither the ambulance service nor consumers were included in the Interdepartmental liaison (IDLC) committee established to enhance strategic planning and facilitate communication between senior Police and Department of Health staff (p. 38–39). Ambulance staff were represented on local Emergency Services Liaison Committees (ESLCs) but the effectiveness of these committees varied across regions due to low frequency or poor attendance, or little membership continuity at meetings, failure to develop protocols and absence of wider input from colleagues not on the committee (p. 39). Consumers were typically not represented on these committees in contravention of the protocol for ESLCs. The Auditor recommended that consumers be represented on both IDLC and ESLC committees (p. 40, [17]).

Monitoring, analysis, evaluation and reporting
At the time of the Victorian crisis service audit, the Department of Health did not consistently measure outcome of triage or urgent calls to the CAT Team (e.g. hospital admission), response time for the delivery of CAT services, or where urgent assessments were undertaken (p. 12, [17]).

Staff training and orientation procedures
The Victorian audit found that the mental health crisis training provided to CAT Team staff and ambulance officers in some practical skills such as de-escalation strategies and in knowledge of and working with other emergency services (p. ix, p. 21, [17]) was inadequate. While acknowledging the positive work undertaken to date, it also reported a need for further mental health education among Police (p. 14). The Audit recommended that training in each service should incorporate exposure to consumer perspectives (p. 21). It also recommended services undertake joint training (p. 25).
3.5. Emergency hospital units

There was little consideration of care in hospital emergency units among the included reports. Findings related to referral management, and the timeliness and continuity of care.

Referral management

The SA Public Advocate cited instances in which families have advised that emergency staff had failed to refer young people newly presenting with mental illness for appropriate follow up (p. 28). This may in part be due to inadequate assessment. However, the Advocate also pointed to the difficulty of diagnosing psychosis in the early stages of the illness and the importance of specialist ongoing monitoring and early intervention as well as the provision of treatment for alcohol and drug misuse (p. 29 [16]).

Timeliness of care

Delays may also occur at accident and emergency units. The Victorian audit of crisis services [17] found that Police reported lengthy delays (up to four hours) in transferring consumers into emergency hospital care while they waited for an assessment of the consumer to be undertaken and duty of care accepted. This has the potential to lead to stigma, cause distress to the consumer and precludes the Police from responding to other calls (pp. 32–33). The Auditor noted an example of a service where delays had been reduced through an interagency protocol and recommended that it should be a priority to improve the process across other jurisdictions.

Continuity of care

Lack of access to diagnoses from other agencies can compromise continuity of care in Emergency units. The SA Public Advocate ([16]) described a case in which a diagnosis from a forensic psychiatrist was not available to those undertaking an assessment in a hospital emergency unit. In response, SA Health stated that electronic health care records would facilitate information sharing between the prison and external agencies (p. 27). The Advocate responded that although it is currently possible to determine if a consumer has been seen by a forensic psychiatrist currently, the details of consultations are not electronically available.

3.6. Inpatient hospital care

Access, availability and equity

Access to inpatient care was identified in the included reports as a problem for a number of specific groups and settings.

Young people

The WA audit of the mental health of young people reported that the inpatient facility for 12 to 18 year olds in the State (Bentley Adolescent Unit) was unable to meet the demand for places (p. 152, [4]) and that there was an urgent need for additional acute mental health services [25].

Rural

The WA Audit of community MHS found that since most of inpatient services were focused in metropolitan areas, it was necessary for rural consumers to travel away from their support network to receive inpatient treatment (p. 21, [4]).

Forensic

The SA Public Advocate [16] pointed to a lack of access for prisoners to specialist mental health services (p. 31) and forensic psychiatric beds in South Australia (p. 21), stating that based on their enquiries there were typically ‘at least 20 people on the waiting list’ for one of the 40 forensic psychiatry beds in South Australia, some of whom are in prison (p. 24). The advocate concluded that the system did not meet the relevant standards of the National Statement of Principles for Forensic Mental Health (p. 31). The Public Advocate recommended the introduction of more beds beyond the additional 10 planned already (p. 37).
The Victorian Ombudsman also found that ‘the level of mental health services available for the male prison population is grossly inadequate.’ and recommended that the Department increase the number of beds for these prisoners (p. 19).

Finally, the WA Inquiry in the mental health of young people, reported that young people who require treatment in a secure forensic service were admitted to an adult forensic facility which was ‘entirely inappropriate’ to the needs of these young people (p. 81, [25]). The Inquiry cited a submission from the Magistrates of the Children’s Court which stated that children were being kept ‘often in an isolation ward, restrained and sedated’ (p. 82). The Inquiry recommended that a dedicated mental health forensic facility be established for children and young people (p. 83, [25]).

**Older people**

An audit of Older Persons MHS in the ACT [1] reported ‘admission blocks’ due to high occupancy in the older person’s inpatient unit and to long term inpatient placement for consumers who ‘could not be referred on’, the latter occasioned by a lack of GPs ‘who can, or are willing’ to attend the older person at a nursing home and by delays in guardianship proceedings (p. 55). The consequence of this block is that other consumers are unable to access the bed. The Auditor found ‘no evidence of ACT Health developing strategies to effectively address these issues’ and recommended that the department rectify this (p. 56).

**Referral and admission processes**

A review of the inpatient Psychiatric Services Unit (PSU) in the ACT, identified that ACT Mental Health staff in the community were unsure of the admission processes for the unit, a situation that was exacerbated by differing admission processes depending on the time of the day (p. 45, [2]). The review recommended that for the benefit of referring staff, the admission processes be clarified in a clear flowchart or similar. Further, finding lengthy waits for admission to PSU after the decision to admit a consumer, the review recommended that the steps in the admission process be tracked in order to identify processes that required further internal review.

The SA Public Advocate [16] also reported lengthy waits in the Emergency Unit for a bed in psychiatry. The SA Government has established a community-based Intermediate Care Centre (ICC) by reducing the number of expensive acute beds and generating new less expensive and therefore more ICC beds. However, the Advocate noted that that long waiting times remained and the effectiveness of the new ICC system was yet to be demonstrated (p. 46–47).

**Assessment**

The review of ACT PSU found that although it is mandatory to assess the physical status of all consumers on PSU, there is no mechanism to trigger an assessment if it cannot be undertaken at the time of admission. Moreover, some staff reported that the physical assessments which are completed are not always clinically adequate. The review recommended that ACT Mental Health audit the ‘presence, timeliness and clinical adequacy’ of these assessments (p. 53, [2]).

**Quality of care**

None of the 32 reviews examined by the authors considered the outcomes of inpatient care. However, at least one report addressed issues of appropriateness of care, dignity and respect, continuity of care, staff responsiveness.

** Appropriateness of care**

The ACT review of PSU [2] noted that some children under 16 years were admitted to the Adult Psychiatry Unit. Such admissions were undertaken as ‘an option of last resort’ (p. 62) and under the policy that these young people receive one-to-one support (‘specialling’). However, the review reported that contrary to policy, such specialling was not always provided, depending on the assessment of the staff as to the needs of the child. However, citing the international standards for protection of children under 18 years, the review recommended that unless clear documentation is in place to justify removal of specialling it should be undertaken.
Finally, the PSU review found that some adult consumers reported that they were bored in the Unit and the review concluded there was a need for greater access to recreational, educational and diversion activities in the Unit, particularly at weekends (p. 55)[2].

The WA Inquiry into the mental health of young people reported that the care provided by Bentley Adolescent Unit was ‘inadequate in terms of age-appropriate care’ and recommended that ‘it be upgraded to provide a more therapeutic service for children and young people’ (p. 153, [25]). Noting that children in the unit are immediately moved to the adult ward regardless of their needs or readiness when they turn 18, the Commissioner also recommended that a planned new service at the Children’s Hospital cater for young people up to 25 years (p. 153, p. 158).

**Dignity and respect**

*Information on rights*

The ACT PSU review [2] noted that the Unit has a package of information for consumers that includes information about their rights. However, it is not clear to what extent this information is made available for consumers. Consumers variously reported not receiving the package at all or on the current admission, being too unwell at the time of admission to recall if they had been provided with the material, and finding that the large amount of information reduced the salience of information about consumer rights. The review noted that some key information important to the rights of consumers, had not been updated (e.g. information about the Public Advocate). The review concluded that checks be made to ensure a consumer receives the information, that the publications in the package are reviewed and updated and that a separate document be provided detailing the consumer’s rights. The review also suggested that consideration be given to reiterating information later in the stay in PSU in cases where consumers were not well enough to process the information on admission (p. 58).

*Privacy*

The PSU review observed that some consumers shared rooms without privacy screens and recommended that this be rectified (p. 64, [2]). It also observed that in the absence of separate rooms for consultation, clinical interactions (e.g. assessments) in the High Dependency Unit occurred between staff and consumers in common areas within hearing of others, thereby violating the National Standards for Mental Health and privacy legislation. The review team recommended that the planned new Psychiatry Unit include separate consultation area for the HDU (p. 64). The new Unit has since been built.

*Restraint, seclusion, search*

A number of reports identified problems or made recommendations with respect to restraint, seclusion or the searching of consumers.

The ACT PSU review reported that Unit was locked limiting the freedom of consumers voluntarily admitted to the service to leave. It recommended that a ‘thorough risk assessment and human rights compliance assessment’ be undertaken to assess whether the low dependency areas of the planned new mental health service building should be locked (p.8., p. 35, [2]).

The ACT review observed a lack of policy framework around restraint and around searches of consumers. It recommended that ACT Mental Health develop a documentation structure, consider ‘contemporaneous recording’ of restraint episodes and include a policy that consumers should be debriefed following a restraint episode (p. 38). Similarly, it recommended that a policy for searching consumers be developed, outlining in what circumstances search may be undertaken, principles and practices for ensuring the search respects the dignity of the consumer (e.g. presence of a second person), and the documentation of a search where it occurs in the consumer’s medical file and in a unit registry (p. 42). The review also suggested that a review of the relevant legislative framework should consider the issue of search.

By contrast, the review considered the policies and practices with respect to restraint were ‘robust’ within PSU. However, it raised questions about the practice at PSU for two of the three staff in the High Dependency Unit to monitor at 5 or 10 minutes intervals a consumer in seclusion. The review considered that this might place the remaining staff member and the consumers in the High Dependency Unit in a
difficult position should an incident occur in the HDU and concluded that a risk assessment be undertaken to review this practice (p. 40).

The SA Public Advocate pointed to the shackling of prisoners with a mental illness while in general hospitals as evidence that the National Forensic Mental Health Principles were not met in all circumstances with respect to Ethical issues (p. 31).

The SA Ombudsman [14] also investigated the shackling of six prisoners in hospital – three of whom had a mental illness – in accordance with the Department of Correctional Services rule (2011) that prisoners in hospital were required to be hand chained and leg cuffed to the bed with legs shackled regardless of the level of their security risk. The investigation related to shackling in general wards only. The Ombudsman recorded instances of distress following the application of restraint to people with a mental illness (p. 47). He concluded that the Department of Correctional services had ‘acted in a way that was wrong within the meaning of Section 25 (1) (g) of the Ombudsman Act’ (p. 38). The Ombudsman recommended that level of risk should determine whether a person is restrained, that such restraint should never involve chains and that use of restraints should be recorded. He also recommended that guards not be present during clinical consultations, unless required for safety reasons.

**Discrimination**

The ACT PSU review reported that some staff perceived that forensic consumers were subject to discrimination within the PSU. The review recommended that the Mental Health ACT evaluate ‘organisational bias’ against forensic consumers and that PSU staff be provided in-service training with respect to such perceived difficulties (p. 44, [2]).

**Continuity of care**

The SA Public Advocate described a case in which a consumer was imprisoned on multiple occasions and in between diagnosed with schizophrenia. However, the diagnosis was known to the forensic psychiatrists when the consumer was subsequently re-incarcerated. Currently, prison psychiatrists in South Australia are unable to access the electronic health record system. To avoid this, the Advocate emphasised the importance of rolling out this system and to ensure ‘people in mental health facilities and prisons are covered by this system” (p. 27–29, [16]).

A submission from the WA Coroner to the inquiry into the mental health and wellbeing of young people in WA identified a problem in identifying suitable supported accommodation, step-down or a community adolescent mental health service to which to discharge a child from hospital, linking the resulting lack of continuity of care to suicide (p. 150–154, [25]). The Commissioner recommended the establishment of a step-down facility for young people.

**Discharge planning**

The PSU review concluded that consumers could be discharged due to a need for their bed for another consumer at greater risk rather than on the basis of their readiness for discharge, noting that it often ‘the least unwell’ consumer who is discharged (p. 46, [2]). In such cases, preparations for the consumer’s return to the community may be inadequate.

The audit of the mental health workforce in NSW [3] noted that some mental health consumers were discharged from hospitals without recovery plans; 3.7% of those discharged were homeless (this equates to almost 1,600 persons per year).

**Information for carers**

The PSU review [2] also indicated that carers frequently complain that they do not receive timely advice that the consumer for whom they care has been discharged. The review team pointed to the complexity of the privacy laws but recommended that information sharing be facilitated (eg, by staff proactively taking action to enable information to be shared legally; for example through seeking consent from a consumer to do so currently and in the future). They also recommended that a clear guide for carers be developed to explain issues of confidentiality and privacy. (p. 61).
Staff responsiveness

The ACT PSU review of the High Dependency Unit noted the low level of one-to-one interaction between consumers and staff, with staff primarily located in the staff station rather than with consumers leading to an ‘us and them’ situation and that this practice be changed (p. 52, [2]). The review also criticised the delays experienced by visitors, consumers and others in gaining the attention of staff in order to enter or exit the Unit or to otherwise obtain assistance. It recommended that staff be responsive at reception and the staff station window and that the Unit be aware of these issues and the need to improve interactions (p. 50).

Physical infrastructure

The review of ACT PSU [2] concluded that the physical state of the unit was below the standard available to people with other medical conditions. The review stated:

“It is unlikely that a mainstream hospital would tolerate such conditions on an ongoing basis” (p. 49).

It recommended that a number of actions be taken to maintain the physical state and cleanliness of the Unit (p. 9). In addition, the review found that the design of the PSU restricted consumer access to sunlight and clean air8.

The Inquiry into mental health of young people in WA cited the Council of Official Visitors which stated that the 12-bed inpatient unit (Bentley Adolescent Unit) ‘looks and feels like a prison’ with inadequate outdoor space (p. 152, [25]). It was recommended that this service be upgraded.9

Consumer participation in service design

The same WA Inquiry recommended the participation of children and young people in designing new in-patient services for the new Children's hospital. (p. 61, p. 153 [25]).

Workforce

The PSU review noted that the Unit was unable to fill all allied staff positions, thereby reducing consumers’ access to key services. It recommended that ACT Health note and address their obligations under the National Standards for Mental Health (p. 54, [2]).

Policies

The report on the ACT PSU [2] found that policies, guidelines and protocols specific to the Unit were out of date and mutually inconsistent. This included an incorrect number for summoning emergency assistance during an incident of violence (Code Black) in the High Dependency Unit. The review recommended that the Unit guidelines be overhauled (p. 8, p. 30–31, [2]).

The PSU report pointed to the differing views held about the policy that smoking was permitted in two courtyards at PSU, noting the tension between the legislative requirements that ACT Health is required to provide a safe environment and concerns that a ban on smoking might increase the anxiety levels of consumers when they are already very unwell and potentially discourage them from admitting themselves to care when they need it. The review concluded that if smoking is allowed in the new PSU facility, the building should be designed to ensure that consumers have access to non-smoking as well as smoking outdoor areas (p. 56, [2]).

8 Authors’ Note: This problem has subsequently been addressed by the replacement of PSU in 2012 with a new building
9 In her subsequent 2012 Annual Report the Commissioner reported that the Unit had been refurbished (p. 14).
3.7. Other relevant services and special topics

(i) Housing

Access

In his report entitled “Denial of Rights: the need to improve accommodation and support for people with psychiatric disability” the NSW Ombudsman [11] investigated the impact of inadequate housing options for people with a mental illness. He concluded that:

“Many people are being denied fundamental rights under mental health and disability legislation, including the right to live in the community and to receive support in the least restrictive environment possible.” (Foreword, [11]).

The Ombudsman noted NSW Government estimates that approximately one-third of current long-term inpatients in NSW mental health facilities could be discharged if they had access to suitable accommodation and support services (p.2, p. 47, [11]; p. 92, [13]). He also reported that mental health staff consulted in his review estimated that between 30–60% of current inpatients could be discharged if suitable support services were available. However, there were insufficient supported accommodation options in the community to enable this. A secondary effect was that this situation created a bottleneck within the hospital system, reducing the beds available for consumers requiring admission and intensive treatment.

Barriers to the discharge of patients included a lack of discharge planning and knowledge about accommodation options and failure by mental health service staff to follow up referrals for accommodation support (p. 2, p. 43–45, [11]), and inadequate access to ‘highly supported accommodation’ and mental health clinical support. Community mental health teams were perceived by staff as already overloaded, inadequately staffed, time poor and with insufficient time to form a relationship with the client. Concern was expressed about the safety of consumers discharged into the community due to this of lack of support (p. 47, [11]).

The Ombudsman criticised the NSW Department of Family and Community Services (FACS) Ageing Disability and Home Care’s (ADHC) Allocation of Places in Supported Accommodation policy (2009). This policy denied most people with a primary diagnosis of mental disorder supported accommodation funded under the Disability Service Act (1993). The Ombudsman pointed to the inequitable treatment of consumers with physical and psychiatric disability, emphasising the inequity of relying on a primary diagnosis rather than functional impairment to determine eligibility for disability support (p. 51, [11]). Noting that this is contrary to the Disability Services Act 1993, the Ombudsman concluded that the ADHC should work with NSW Health to address the accommodation needs of consumers with a mental illness. (p. 92, [13]). Citing disagreements and demarcations disputes between Health and ADHC he concluded:

“It is unacceptable that these individuals are substantially disadvantaged by inadequate agency cooperation” (Foreword, [11]).

FACS responded that if people with psychiatric disorders were allocated disability accommodation, other people with disabilities would experience problems in obtaining accommodation. In reply, the Ombudsman stated: ‘It is unacceptable to trade-off the rights of people with psychiatric disability against those of others’ (p. 68, [11]), recommending that the policy be amended immediately and that assessment criteria be employed that focus on function and need rather than diagnosis. He continued:

“Our review has identified people aged 24 and 25 years who have already been in hospital for over 5 years. It is unacceptable that these individuals may be facing a similar future to others in our file review who were admitted to hospital as teenagers and only left when they were discharged to aged care facilities over 40 years later.” (p. 68, [11])

The Ombudsman endorsed the Productivity Commission’s conclusion that the mental health sector should be responsible for clinical care and that disability services should attend to accommodation and ‘disability support needs’ (p. 52, [11]).

The Ombudsman indicated that the Health and Accommodation Support Initiative (HASI) provided by the NSW Departments of Health and Housing provided a good model for accommodation support for people
with a mental illness, but was not sufficient to meet demand. He also concluded that people with a mental illness require a wide range of accommodation options to meet the diverse preferences and needs (p. 64–65, [11]). He noted the difficulty experienced by older consumers with complex needs in accessing residential care (p. 59) and concluded the Commonwealth Government’s Partners in Recovery option might provide a mechanism to assist the integration of these older people into residential care (p. 60).

**Risk assessment**

The NSW Ombudsman recommended that housing workers use a standardised risk assessment tool to identify individuals whose tenancies may be at risk (p. 75, [10]).

**Interagency cooperation**

As noted above, the NSW Ombudsman found that there was a need to improve interagency relationships between the Department of Health and ADHC. In a separate investigation, The NSW Ombudsman [10] also examined the utility of the Joint Guarantee of Service (JGOS), an interagency framework involving the NSW Department of Housing and the Department of Health. JGOS was designed to assist consumers living in Aboriginal, community or public housing. The Ombudsman concluded that JGOS had not resulted in systemic improvements (p. V, [10]). He found that JGOS was not adequately implemented and did not fulfill the needs of the partners involved (p. V, [10]). He also concluded that there were inconsistencies in the JGOS documentation (p. 20) and a lack of accountability mechanisms including inadequate specification of the aims of JGOS and the lack of appropriate collection of data to support the work of staff and to document outcomes against JGOS aims[10]. The Ombudsman recommended that JGOS be replaced with the Housing and Human Services Accord [10].

The Ombudsman observed that the crisis nature of the work of mental health workers and the fact that some behaviours that place a tenancy at risk were not areas in which the mental health staff could intervene created friction with other agencies. There was evidence that in contravention of their own policies and JGOS, the public housing provider in NSW issued some tenants with mental illness ‘notices of termination’ as method of ‘coercing a tenant …to remedy a tenancy breach or to prompt other services to provide support to tenants’ (p. 43) rather than to pursue other avenues first.

The Ombudsman found that housing workers had difficulty negotiating the MHS system (vii, [10]). They experienced frustration when people with a mental illness were discharged from hospital without notification to them or discussion as to what supports they might require ‘to sustain their tenancy’ (p. 63, [10]). Similarly, failure by the health service to advise housing workers that a tenant with a mental illness had been hospitalised, could place the tenancy at risk due to rent arrears or presumed abandonment of the property. Practices with respect to informing Housing of hospitalisation were found to vary with some health workers believing this would be a violation of privacy and others that it was acceptable practice. The Ombudsman [10] pointed out that there were circumstances in which an exchange of information could occur in the absence of consent but that these circumstances were not well known to staff. He recommended that MHS review their discharge planning and that legislation be changed to enable a more streamlined method for sharing of information between agencies if needed to protect the wellbeing/safety of clients. He also recommended that a specialist tenancy support service be established by the Department of Health and Human Services to assist consumers to maintain their tenancies (p. vii, [10]).

The Ombudsman concluded the JGOS has not successfully engaged key stakeholders outside the Housing and Health departments including Aboriginal housing providers, Aboriginal health services, Supported Accommodation Assistance Providers (SAAP) or advocates. SAAP workers reported that they were unable to obtain adequate case management support for the people they attempted to place. SAAP workers also indicated that there was a lack of accommodation to which they could refer their clients and a particular paucity of options for exit accommodation for young people. The Ombudsman concluded that the relationship between SAAP providers and mental health services was strained with a ‘disconnect’ between the two sectors and limited strategic collaboration (p. 32–35, [10]).

---

10 This recommendation has since been implemented. Nevertheless it is instructive to consider the Ombudsman’s findings.
Staff training

Housing staff emphasised their need to receive training that was not limited to passive information about ‘mental illness’ but rather would enable them to work with mental health services and acquire the practical skills and strategies necessary to support clients with mental illness (p. 65, [10]). Conversely health workers indicated a need for training that would assist them to negotiate the housing system [10].

(ii) The social security system

The Commonwealth Ombudsman reported that complaints to his office suggest that ‘interactions with the social security system can be difficult and distressing’ for many people with a mental illness (p. 3, [8]). The Ombudsman identified two areas of risk: 1) interaction of a person with a mental illness with the social security system and 2) identification that the client has a mental illness.

While emphasising that it was not a systemic problem, the Ombudsman found that Centrelink and Employment Service Providers (ESP) with whom clients must interact in order to continue to receive social security payments, sometimes imposed conditions or created arrangements that failed to take into account the barriers posed by the individual’s mental disorder, particularly where the mental illness affected the person’s capacity to ‘communicate effectively’. For example, conditions such as agoraphobia may preclude attendance at a face-to-face interview and an individual with symptoms of paranoia may be unwilling to answer the telephone (p. 8).

The Ombudsman found that although Centrelink had produced guidelines for interacting with clients with a mental illness, the guidelines lacked specific information as to how to determine the best means for communicating with clients (p. 8). Secondly, access to a service may be denied because the staff or a client of the social security system was unaware of the mental disorder or that it caused them a disability (p. 9). Not all consumers disclose their mental illness, either due to lack of awareness or embarrassment and a lack of information that to do so may be beneficial with respect to obtaining their social security entitlements (p. 18). Due to the many staff at Centrelink, individuals with mental may be required to repeatedly re-tell their ‘story’, resulting in distress or embarrassment (p. 21).

The report [8] recommended that social security services take into account barriers to communication and engagement and consider the most appropriate methods of outgoing and incoming communications between Centrelink/the Employment Service Provider and each individual with a mental illness. For example, for client with particular needs, it might be appropriate to appoint a single reference person for contact with that client. Such arrangements are currently available for some clients of Centrelink. The report recommended extending the arrangements to people with a mental illness and notifying client that these arrangements are intended to benefit them but can be altered if the client prefers (p. 8–10, 24).

The report also recommended that consumers should be provided with additional support to ensure they receive their entitlements. Since there were no special arrangements in place to support clients with mental illness targeted for Centrelink’s debt recovery processes, the report recommended such procedures be modified to accommodate the needs of people with a mental illness (p. 11, 16, 24–25).

The Ombudsman also concluded that there was a need to create an environment in which clients feel comfortable disclosing a mental illness and are aware that it will be treated with respect and that disclosure may be of benefit to them (p. 18). In addition, the report recommended that Centrelink ensure staff record a client’s mental health status and associated barriers and flag these to inform future, tailored communications with that person (p. 23–26).

Staff training

To ensure these recommendations are implemented the Ombudsman recommended that existing staff training be improved to enhance staff capacity to identify individuals with a mental illness and to increase their awareness of policies and procedures designed to improve engagement with individuals with a mental illness (p. 23, 26).

The relevant agencies agreed to implement most of these recommendations.
(iii) Wrongful immigration detention

A 2006 report described the Commonwealth’s Ombudsman’s findings in nine cases where Australians or people with a valid visa with a mental illness or incapacity had been detained under the Migration Act (S189). The Ombudsman concluded that in these cases there had been ‘wrongful detention’ under the Migration Act (S189) due to a ‘lapse in good administration’ associated with poor recognition of mental health issues by Department of Immigration and Multicultural Affairs (DIMA) staff (p. 3, [7]).

The Ombudsman recommended that ‘persons of interest who are suspected of being delusional or medically incapacitated’ should be ‘medically assessed before any action is taken in respect of their immigration status’ (p. 6, [7]). He also recommended staff be trained to recognise mental illness. Further, the Ombudsman stated that DIMA should ensure that people with a mental illness are linked to appropriate support when they are released from detention. He did however note that that recent cases illustrated increased sensitivity by DIMA to this need (p. 12).

The Ombudsman also pointed to instances of inadequate record-keeping by DIMA. In contravention of Immigration Detention Standard 7.3 the ‘detention dossiers’ of several of the cases reviewed were absent (p. 14–15). The Ombudsman indicated that the DIMA should ensure record keeping is undertaken and that records included a documentation of the detainee’s health and wellbeing. In addition, the Ombudsman recommended that Police procedures for referral to DIMA be reviewed to ensure they are appropriate (p. 16). DIMA responded positively to the suggestions indicating that reforms have been planned or actioned.

On a related but separate matter, the WA Inquiry into the mental health of young people [25] reported concerns by the Federal Human Rights Commissioner about the mental health of young people in immigration detention centres (p. 91) and suggested that particular attention be directed to the needs of this group.

(iv) Consumer abuse by the mental health system

The SA Public Advocate[16] elicited consumer reports of past systemic abuse by the mental health system of consumers, its subsequent impact on their lives and consumer perspectives on how they would like the Government to respond now. Consumers’ views on the latter ranged from no action, to a letter of apology to financial compensation. The Advocate noted that the problem is likely to be one of national relevance and has referred it to both the National Mental Health Commission and the Australian Human Rights Commission. The Advocate emphasised the importance of ‘righting these past wrongs’, thereby affording ‘the victims the respect and value of which they were deprived in the past’ (p. 42). He cautioned that there are lessons to be learned and asks how future generations will judge the subjecting of people with mental illness to physical restraint in situations where this would not be necessary were there a place available on a psychiatric ward.

(v) Veterans’ program administration

The Commonwealth Auditor-General reviewed the effectiveness of Department of Veterans’ Affairs (DVA) administration of its mental health programs for younger members of the Australian Defence Forces (ADF) discharged from service. This audit focused on the framework within which the programs are provided, the extent to which the programs are promoted and veterans engaged with them, the availability of programs to support complex needs, and the monitoring and reporting of program performance (p. 16–17, [6]).

The audit found that although a new Mental and Social Health Branch had been established within DVA, mental health policies, programs and service were managed across many areas of DVA and methods for coordinating these activities were in need of review (p. 18). Further, the audit noted that there was confusion in the use of terms such as ‘younger veterans’ (originally applied to Vietnam Veterans) and recommended that the terminology be clarified. The Auditor reported that veterans interviewed for the audit unanimously reported that they felt abandoned by the ADF when they were discharged on mental health grounds citing a lack of compassion for their situation (p. 26). Veterans also criticised the mental

---

11 DIMA responded that they were working on introducing training programs for the identification and management of people with a mental illness.
health screening assessments undertaken when they return from overseas service, noting that these may be answered inaccurately due to stigma and a concern for their jobs and to ensure they ‘get home’ (p. 71).

Overall, the Auditor concluded that the DVA’s programs and initiatives were ‘small’ and ‘disparate’ and of limited effectiveness (p. 19) and that there was low awareness and access of these programs. For example, the Auditor observed a low level of use of the DVA’s mental health-related websites, noting that this observation was consistent with research from the Australian Centre for Posttraumatic Mental Health which had found a low level of awareness among veterans of the sites (p. 88). The Auditor suggested that DVA review its Internet strategy for mental health literacy (p. 89). There was also low use of the DVA’s programs for assisting transition to civilian life with one program recruiting only 15% of the participants budgeted (p. 20). The Auditor recommended that the DVA develop a targeted communication strategy to increase awareness of the DVA mental health programs among younger veterans (p. 36, p.77).

**Data monitoring**

The report found that the DVA’s mental health data lacked reliability and recommended that responsibility for data collection be assigned to the new Mental and Social Health Branch (p. 18). The Audit noted that there was no framework for evaluating transition services.

**(vi) Child protection services and children at risk**

A number of jurisdictions including NSW, Queensland, Victoria and South Australia published investigations of deaths of children in contact with protection services and/or at risk. The WA Commissioner for Children and Young People also made recommendations for this group.

**Access**

In reviewing the deaths from suicide of children and young people with prior or current contact with child protection services, The Queensland Child Death Case Review Committee (CDCRC) pointed to a lack of access to suitable therapeutic services in the region in which the child was located, particularly for complex cases (p. 49, [20]).

The SA Guardian for Children and Young People [28] undertook an audit of 60 children to investigate the extent to which the system met the mental health treatment needs of children in care. Mental health assessments had been conducted for 90% of the children of whom 80% were recommended to receive treatment. Although the majority (88%) received treatment, 39% of these involved a delay in excess of 4 months before treatment was provided. The average time to receive treatment for children who were not seeing a MHS at the time of the assessment was 7 months.

**Assessment**

The Queensland CDCRC review found that although there were cases of good practice in assessing children known to Child Safety Services, the risk assessment for children with a mental health problem was inadequate in other cases (p. 47, [20]).

The SA Guardian for Children and Young People found initial assessments of children placed in care may not be sufficiently focused on mental health care and recommended that consideration be given in case reviews as to whether a more specific assessment is required (p. 21, [28]).

The WA Inquiry into the mental health of children and young people commended the Department of Child Protection on introducing routine mental health assessment on admission to the program but recommended that this practice be subject to an audit (p. 84, [25]).

The NSW Ombudsman pointed to the need to incorporate a review of child care responsibilities as part of the psychiatric assessment of adults in mental health services (p. 50, [32]).

**Quality of care**

The Queensland CDCRC reported cases of inadequate response by the system to a child’s suicidal ideation and attempts (p. 48, [20]). The review team also reported the case of a child who died two
weeks after a change in medication. One of the three medications prescribed to the child was not recommended for children below 18 years (p. 50). The team referred the case to the Health Quality and Complaints Commissioner.

Case planning and continuity of care: The CDCRC reported inadequate case planning as a service system issue in three of the six young people who completed suicide in 2011–12 (p. 61).

The SA Guardian for Children and Young People [28] found discontinuity in care for almost half of the children seeing a therapist (p. 12).

Interagency cooperation: The Queensland CDCRC identified cases where the system failed to institute "appropriate support options for the child and the family" including a failure to facilitate interagency communication and information (p. 48, [20]). The CDCRC also reported that contrary to guidelines there was a lack of liaison with Recognised Entities for children of Aboriginal and Torres Strait Islander background (p. 61).

Similarly, in review of deaths by suicide of an at risk adolescent who completed suicide, the Western Australian Ombudsman [15] pointed to ‘missed opportunities for interagency collaboration and communication’ in the context of efforts by agencies to assist the young person independent of each other (p. 77).

The SA Guardian for Children and Young People [28] did not systematically collect information about interagency collaboration. However, he noted ‘evidence of very poor communication, limited information exchange and service coordination’ between MHS and Families SA in 10% of cases and very good collaboration in 33% of cases (p. 15).

Risks may arise for children and young people when a parent’s behaviour is adversely affected by mental illness, particularly in the context of other risk factors. The Victorian Child Safety Commissioner [30] reviewed 41 deaths of children with parents with co-existing family violence, substance misuse and mental illness. The majority of the deaths were due to acquired illness, accident and SIDS; two involved non-accidental trauma. The Commissioner found “little evidence of integrated multiservice response” and recommended that steps be taken to instigate a multi-sectoral response in children at risk and to recognise that it was necessary to “look beyond their individual specialisms” (p. 4). He emphasised the need for all sectors to recognise the potential impact of multiple risk factors on children. It was seen that this required strong leadership and resourcing, polices in each sector for multi-sectoral collaboration and shared knowledge and skills between sectors. The cross-sectoral capacity building strategies suggested included embedding child experts in adult services and vice-versa (p. 5). The Commissioner emphasised that with respect to mental illness, the relevant factors in assessing risk were the symptoms or behaviour of the parent rather than the diagnosis that had been applied to them (p. 14).

The Queensland Commission for Children and Young People and Child Guardian also highlighted the absence of a framework for cross-agency reporting to secure a 10 year old child’s welfare in a case where the father had recently received involuntary treatment for a mental health issues and subsequently allegedly murdered his child (p. 7, [21]). The review found that there was no formal policies or guidelines in place to ensure Queensland Health staff assess, act upon or report foreseeable risk of harm to children of parents with mental health issues: (p. 14, [21])12.

Staff training

The Victorian Child Safety Commissioner recommended shared staff training across sectors (p. 40, [30]). In a follow up review of the safety of children of parents with a mental illness, the Qld Commission for Children and Young People and Child Guardian found that mental health staff required training in the procedures involved in assessing and acting to ensure the safety of the children of clients with a mental illness. The report identified that mental health staff and child safety officers were unaware of the available guidelines (p. 5–6, [22]). The Guardian recommended that staff should receive training in these matters at induction and in an ongoing fashion.

---

12 According to the review, procedures have since been introduced.
In his review of deaths of children in care and by neglect or abuse, the NSW Ombudsman also pointed to the need to ensure mental health and other health and emergency staff are aware of the needs of the children of parents with a mental illness (p. 50, [32]).

**Data collection and research**

The follow up review undertaken by Qld Commission for Children and Young People and Child Guardian on the safety of children of parents with a mental illness recommended that data be collected on the number of staff attending training sessions and the number of staff aware of resources for addressing the safety of children of people with a mental illness (p. 6–7, [22]).

The NSW Ombudsman recommended that adherence to the *Children of Parents with Mental Illness (COMPMI) and Safe Start Guidelines*, particularly with respect to referral to support and resources, should be monitored within Local Health Districts (p. 50, [32]).

The Victorian Child Safety Commissioner called for more research to investigate the combined effect of the multiple risk factors of violence, substance misuse and mental illness [30].

**(vii) Restraint in the community: Police Taser use**

The NSW Ombudsman published the results of reviews of Taser use in 2008 [9] and 2012 [12]. At the time of the 2008 report the use of Tasers was confined to specialist units attending critical incidents. Subsequently, Tasers were issued to general duties Police officers.

The 2008 report [9], identified 50 people between 2002 and 2008 who had been subject to Taser application of whom 68% were identified as experiencing ‘mental health issues’ and 35% involved suicide attempts (p. II, p. 52). One man with schizophrenia and chronic heart disease died of a heart attack 12 days after the application of the Taser; it is not known if there was any link between the Taser application and the death. The Ombudsman found no evidence of improper use of Tasers by the Police. However, noting the high percentage of those Tasered had a mental illness, he recommended that officers using Tasers receive training about mental illness (p. 70). He suggested that such training should include:

‘Training about mental health issues, including the most effective ways to communicate with people thought to be experiencing mental illness, and the most effective ways to de-escalate situations involving mentally ill people who are behaving in an an aggressive or violent manner.” (p. 71, [9])

The Ombudsman also recommended that officers be trained specifically about “if and when it is appropriate” to apply a Taser to a person with a mental illness (p. 80, [9]). He noted that despite the prevalence of mental illness among those subject to Tasers, there was no information in the relevant standard operating procedures about these matters (p. 78). Further given the potential health risks of Taser application, the Ombudsman recommended that a person subject to Taser be informed of the possible health risk, and offered medical attention. Where a person is being attended to by medical personnel. Police should inform the practitioner of the Taser application and record that they have done so.

In the 2012 report the NSW Ombudsman [12] assessed that 14% of Taser incidents involved a breach of criteria for use. Overall 31.3% of the drawing or use of a Taser involved a person with a mental illness (or suspected mental illness) (p. 103, [12]). The Ombudsman does not report what percentage of the incidents that involved a breach of use criteria involved people with a known or suspected mental illness. However, 5 of the 23 case studies illustrating inappropriate use in the report involved people with a mental illness. This included an ‘unreasonable discharge of Taser to arrest [an] intoxicated man’ (Case study 3, p. 112), repeated Taser use as a result of failure to restrain a man after he had been first Tasered (Case 5, p. 117), repeated Taser use with “not enough time to comply with instructions” between additional cycles (Case 6, p. 118), Taser use on a man who was ignoring police directions (Case 12, p.128) and “hazardous use of a Taser in a Police cell” (Case 17, p. 136). [12]. The Ombudsman recommended that Taser training incorporate scenarios involving de-escalation techniques for use with vulnerable people. He also recommended that ‘all general duty officers should receive mental health training as a matter of priority’. (p. 15). Overall, he concluded that there were few cases of serious misuse, and that the ‘accountability framework was strong and in most cases worked well’ (p. 1).
4. Summary and conclusions

This chapter has presented the findings of a systematic synthesis of reports relevant to mental health and published since June 2006 by the Ombudsman, Auditor, Public Advocate/Guardian, Human Rights and Child Guardian/Child Safety authorities.

Although many of the reports identified positive achievements of the agencies and staff they reviewed, every report found problems with the current system and areas requiring change. Areas requiring improvement in one or more jurisdictions included:

- **Mental health awareness** in the community, particularly with respect to awareness that young people can experience mental illness and the importance of treating threats to suicide seriously.
- **Prevention** services for young people in schools and the prevention of mental illness in particular groups (e.g. perinatal, culturally and linguistically diverse, rural and remote, Indigenous).
- **Community based mental health care** where there is a particular need for improved access to services in the community and for an increased focus on early intervention and rehabilitation and appropriate planning to ensure the mix of services meet consumer needs. The need to improve continuity of care and interagency cooperation in the community sector was another strong theme to emerge from the reviews. Other areas requiring attention are access to service information, the transparency of entry criteria for services, referral management, the institution of appropriate assessments, reviews and care plans, staff training and the routine monitoring and reporting of services.
- **Crisis** response where dignity and respect are paramount. There is a need to improve the adherence to the protocol that states that consumers should be transferred to hospital by ambulance and not Police van unless this is not possible for safety reasons. There is also a need for improved mental health crisis training for CAT team members, ambulance officers and Police officers. Other areas requiring attention include the time for attendance at a crisis by CAT team members, monitoring and reporting of services.
- **Emergency unit responsiveness**: There was little consideration of care in hospital emergency units. Delays in receiving care in the emergency may be considerable and create lengthy delays where Police are required to remain in attendance until a formal handover can occur.
- **Inpatient care** where inadequate access to inpatient care was a significant issue for young people, those from rural and remote regions and those in forensic settings. There was also evidence of inappropriately lengthy waits in emergency units pending admission to a ward. There is a need to improve practice with respect to informing consumers about their rights, ensuring privacy, and with respect to the use of restraint, seclusion and search. Other areas requiring improvement include the assessment of consumer’s physical status, continuity of care, discharge planning and staff responsiveness to consumers and their visitors.
- **Housing** where there is a need to increase the availability of supported accommodation for consumers, and to thereby reduce the number of consumers who are inappropriately accommodated in hospital beds for extended periods. Currently consumers are denied access to disability accommodation in NSW on the basis of their primary diagnosis in what the NSW Ombudsman has described as a fundamental denial of their rights. In NSW, there is a need to improve interagency cooperation and staff training.

---

13 In addition to a need for improved access to the general community, particular groups requiring improved access include children with mild to moderate mental health problems, adults and young people in justice settings (and those with behavioural problems that place them at risk of entering the justice setting), women during the perinatal period, people living in rural and remote regions, Australians of Indigenous background, young people from culturally and linguistically diverse backgrounds and young people who are homeless.
• **Social security** where there is a need to reduce barriers to consumer engagement and communication, to undertake training to assist staff to recognise mental illness and to create an environment in which clients are comfortable disclosing a mental illness.

• **Immigration detention processes** to protect against wrongful detention of Australian citizens immigration staff should ensure detainees whom they believe may be delusional receive appropriate medical assessment.

• **Veterans’ program administration** which requires improvement. There is also a need for a targeted communication strategy to increase awareness among young veterans of DVA programs, a framework for evaluation, and a reliable data collection system.

• **Child protection services and children at risk:** Better targeted mental health and risk assessment, more timely access to therapy, better care planning, improved training, and improved interagency cooperation is required for children requiring child protection. Services should review the child care responsibilities of adults with a mental illness.

• **Restraint through Taser use:** Although overall Taser use was reviewed positively, mental health training and instruction on strategies for de-escalation should be incorporated in Taser training.

One further observation from this review, is that all too often there is no report from the responsible government departments or agencies on the implementation or progress reports following the statutory office review. There are some instances were the statutory authority returns to the issue and conducts a follow up review, as we found with Child Safety Commissioners in both WA and Qld. It may also be that there is some reporting mechanisms within government not known to this review.

However, it is abundant clear that the accountability requirements on governments, Ministers, departments and agencies are not adequate given the frequent reoccurrences of the same recommendations. Over and over again, the statutory authorities are finding systemic problems not addressed.

In summary, the key themes to emerge from this review are that:

• Consumers currently have **inadequate access** to mental health services across the health care spectrum ranging from prevention to recovery.

• Care for consumers is frequently compromised by **inadequate interagency cooperation**.

• **Quality supported accommodation** is inadequate.

• Consumers are not always treated with **dignity and respect** and in some instances **subject to discrimination**.

• There are gaps in the **training** of mental health, health and non-health staff providing services to people with a mental illness.

• There is a need to improve data collection and service monitoring.

• **Groups with particular unmet need** include those in the forensic/justice system, those in rural regions, and young people as well as people of Indigenous, culturally and linguistically diverse backgrounds and children at risk.

Viewed together with feedback collected from the other sources in Chapters 3, 7, 8 and 9 of this Report, the findings suggest areas that require urgent national consideration, review and action.

**References for Chapter 6**

1. ACT Auditor-General’s Office, **Delivery of Mental Health Services to Older Persons**, 2010, ACT Auditor-General’s Office: Canberra.

27. Commissioner for Children and Young People Western Australia, Speaking out about mental health – The views of Western Australian children and young people, 2011, Commissioner for Children and Young People Western Australia: Perth.


Chapter 7

Community surveys of experience of care and priorities for reform

Tracey Davenport, Ian Hickie, and John Mendoza
Obsessive Hope Disorder
Community surveys

Introduction

In this section of the Obsessive Hope Disorder Report, the method used to conduct and results from a national review of mental health experiences and reform are described.

A number of mechanisms were utilised to gather the views of the sector and the general community to inform the development of this Report. One of these mechanisms was the conduct of two community surveys of providers, consumers, carers and interested stakeholders regarding experiences with mental health services. We wanted to particularly focus on experiences of mental health service or care in the past 12 months.

Methodology

In April 2003, the Mental Health Council of Australia (MHCA) launched its national review of mental health services in Australia: Out of Hospital, Out of Mind! (Groom et al. 2003). The report highlighted the obvious deficiencies in care and developed community priorities for action. As a consequence, the MHCA, with academic support from the Brain & Mind Research Institute (BMRI), undertook a state-by-state review of services in 2004 gathering data from government agencies about what really happens in mental health at local, regional and state/territory levels. The results of these surveys comprised the basis of the report: Investing in Australia’s Future (Hickie et al. 2004), which detailed the personal, social and economic benefits of good mental health at that time. Ten years on, the BMRI in association with ConNetica have replicated these surveys in order to review mental health services in Australia at present and to compare how national and community priorities and experiences of care have changed over time.

This first survey (“Community Review of Mental Health Services in Australia”) evaluated the extent to which national and community priorities have been implemented at the local, regional and state/territory level (Appendix 3.1). It was designed to be completed by both providers and users of mental health services and was divided into three sections:

- The first asked some demographic information about the respondent and the service they used.
- The second asked the respondent to rate how the national and community priorities have been implemented or supported within their local area.
- The third asked respondents to rate how the national and community priorities have been implemented or supported at a state/territory level.

The second survey (“Consumers and Carers Direct Experiences of Mental Health Care in Australia”) assessed direct experiences of care against internationally developed benchmarks for quality health care and was divided into two sections (Appendix 3.2).

- The first asked consumers, carers and family members about their experiences with mental health services as well as some demographic information. Its basic domains are drawn from those identified by the Picker Institute Europe as critical elements of quality health care.
- The second asked consumers only more specific questions about their experiences with mental health services.

The two surveys were conducted online. They were constructed in LimeSurvey and then securely hosted by the BMRI on The University of Sydney’s server. Hard copies of the surveys were also available upon request. ConNetica initially distributed the electronic links to these surveys via email to the project partners and ConNetica’s own extensive networks of mental health providers, consumers, carers and other interested stakeholders. Efforts were made to reach out to specific population groups, e.g. refugee, CALD, ATSI and youth. This was supplemented by advertisements posted on the project website “swYtch” as well as ConNetica’s pages on the social networking websites LinkedIn and Facebook. Importantly, the ease of access to these surveys provided a unique opportunity for genuine input from the broader mental health sector.
Ethics
This study had institutional ethics committee approval from The University of Sydney Human Research Ethics Committee (Protocol No. 2013/215).

Limitations
In making comparisons with the 2004 surveys, caution should be applied as the numbers of respondents in the 2004 survey was significantly different – Survey 1 “Priorities” 714 in 2004 and 477 in 2013 while with Survey 2 “Experiences of Care” 228 in 2004 and 561 in 2013). Nonetheless, the samples in the Survey 2 were remarkably similar in gender and type of locality.

The surveys also were constrained by coinciding with other surveys being conducted during the same period, in particular the National Mental Health Commission survey.

Data analysis
All statistical analyses utilised the IBM SPSS Statistics for Windows, Version 19.0 (IBM Corp., Armonk, NY). It should be noted that some denominators vary with missing data.

Results of Survey 1: Community review of mental health services in Australia
As of 3rd June 2013, a total of 477 surveys were received including 392 (86%) from individuals and 64 (14%) from organisations. The majority of respondents described their role in the mental health sector as consumer of mental health services (n=139, 30.5%). This was followed by non-government community service providers (n=85, 19%), then public providers of specialist treatment (n=52, 11%) and carers (n=48, 10.5%). Across Australia, most respondents were located in Queensland and New South Wales (Table 7.1).

Table 7.1: Total number of respondents by jurisdiction; N=477.

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales and Australian Capital Territory</td>
<td>151 (33)</td>
</tr>
<tr>
<td>Victoria</td>
<td>75 (17)</td>
</tr>
<tr>
<td>Queensland</td>
<td>158 (35)</td>
</tr>
<tr>
<td>South Australia and Northern Territory</td>
<td>33 (7)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>17 (4)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>19 (4)</td>
</tr>
</tbody>
</table>

First, respondents rated the extent to which national priorities have been implemented or supported in their local area. Results for all respondents are shown in Table A 3.1, and by jurisdiction in Tables A 3.3 (NSW & ACT), A 3.5 (Victoria), A 3.7 (Qld), A 3.9 (SA & NT), A 3.11 (WA) and A 3.13 (Tas). Of the priorities surveyed, respondents indicated that a total of 60% (n=9/15) were currently not as implemented or supported as they were in 2004 (Table 7.2). Most importantly, these included “provision of early intervention services”, “genuine consumer participation”, “genuine carer participation” and “clear accountability for expenditure of mental health strategy funds”.

Next, respondents rated the extent to which priorities have been implemented or supported within their state/territory. Again, results for all respondents are shown in Table A3.2, and by jurisdiction in Tables A 3.4 (NSW & ACT), A 3.6 (Victoria), A 3.8 (Qld), A 3.10 (SA & NT), A 3.12 (WA) and A 3.14 (Tas). At the state/territory level, respondents indicated that 75% (n=12/16) of priorities were currently not as implemented or supported as they were in 2004 (Table 7.3). These included “development of specific inter-governmental service agreements”, “direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health”, “support for enhanced role of non-government organisations in all aspects of care”, “clear accountability for expenditure of mental health strategy funds” and “development of datasets for monitoring the quality of local services”.

184
Table 7.2: Implementation or support of priorities at a LOCAL level, 2004 vs 2013

<table>
<thead>
<tr>
<th>Priority</th>
<th>2004 Survey</th>
<th>2013 Survey</th>
<th>Chi-square</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Provision of early intervention services</td>
<td>17% (125/750)</td>
<td>7% (25/338)</td>
<td>16.85</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>7. Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>11% (81/748)</td>
<td>9% (29/337)</td>
<td>1.26</td>
<td>0.26</td>
</tr>
<tr>
<td>8. Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>12% (88/749)</td>
<td>8% (27/336)</td>
<td>3.38</td>
<td>0.07</td>
</tr>
<tr>
<td>9. Implementation of the national standards for mental health services</td>
<td>15% (115/748)</td>
<td>11% (37/334)</td>
<td>3.53</td>
<td>0.06</td>
</tr>
<tr>
<td>10. Programs that promote attitudinal change among mental health workers</td>
<td>10% (72/748)</td>
<td>9% (30/334)</td>
<td>0.11</td>
<td>0.74</td>
</tr>
<tr>
<td>11. Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns/initiatives)</td>
<td>10% (75/748)</td>
<td>10% (33/332)</td>
<td>0.002</td>
<td>0.96</td>
</tr>
<tr>
<td>12. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>14% (106/750)</td>
<td>9% (29/332)</td>
<td>6.14</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>13. Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>14% (106/750)</td>
<td>7% (24/332)</td>
<td>10.38</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>14. Genuine consumer participation</td>
<td>16% (120/749)</td>
<td>8% (25/331)</td>
<td>14.16</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>15. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>11% (85/750)</td>
<td>6% (21/331)</td>
<td>6.46</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>16. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>12% (89/749)</td>
<td>6% (21/331)</td>
<td>7.70</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>17. Genuine carer participation</td>
<td>17% (130/750)</td>
<td>8% (26/305)</td>
<td>16.71</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>18. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>10% (73/750)</td>
<td>10% (32/331)</td>
<td>0.001</td>
<td>0.97</td>
</tr>
<tr>
<td>19. Clear accountability for expenditure of mental health strategy funds</td>
<td>11% (84/748)</td>
<td>5% (18/331)</td>
<td>8.99</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>20. Clearly defined roles for the primary care, community care and specialist workforces</td>
<td>13% (98/749)</td>
<td>8% (26/331)</td>
<td>6.18</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>21. Devolution of service planning to local level*</td>
<td>-</td>
<td>3% (11/331)</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Finally, respondents living and/or working in regional, rural and poorly-resourced areas were asked to rate the extent to which such factors have been implemented or supported within their state/ territory. In 2013, just 1% reported any high-level support. For regional or rural areas, this was significantly less than 2004, while no difference was observed for poorly resourced areas.
Table 7.3: Implementation or support of priorities at a STATE level, 2004 vs 2013

<table>
<thead>
<tr>
<th>Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE</th>
<th>Nearly complete OR high support PLUS Fully implemented OR full support</th>
<th>Chi-square</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>13% (96/749)</td>
<td>6% (16/282)</td>
<td>10.80</td>
</tr>
<tr>
<td>23. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>10% (78/750)</td>
<td>4% (12/282)</td>
<td>9.72</td>
</tr>
<tr>
<td>24. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>10% (72/748)</td>
<td>5% (14/282)</td>
<td>5.81</td>
</tr>
<tr>
<td>25. Support for specific disease prevention initiatives (e.g. in anxiety, depression, alcohol or other substance misuse)</td>
<td>11% (84/749)</td>
<td>7% (20/282)</td>
<td>3.84</td>
</tr>
<tr>
<td>26. Support for general mental health promotion</td>
<td>11% (86/750)</td>
<td>7% (19/282)</td>
<td>5.02</td>
</tr>
<tr>
<td>27. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>11% (86/750)</td>
<td>6% (16/281)</td>
<td>7.64</td>
</tr>
<tr>
<td>28. Clear accountability for expenditure of mental health strategy funds</td>
<td>11% (80/750)</td>
<td>5% (14/282)</td>
<td>8.05</td>
</tr>
<tr>
<td>29. Ongoing support for suicide prevention campaigns</td>
<td>14% (102/749)</td>
<td>9% (26/282)</td>
<td>3.65</td>
</tr>
<tr>
<td>30. Development of datasets for monitoring the quality of local services</td>
<td>14% (105/750)</td>
<td>8% (23/282)</td>
<td>6.44</td>
</tr>
<tr>
<td>31. Service development for those in forensic (i.e. prison-based) services</td>
<td>12% (87/748)</td>
<td>5% (15/282)</td>
<td>9.14</td>
</tr>
<tr>
<td>32. Specification of clear primary care, community care and specialist workforces</td>
<td>10% (74/748)</td>
<td>5% (14/282)</td>
<td>6.37</td>
</tr>
<tr>
<td>33. Service enhancement for persons from CALD backgrounds</td>
<td>12% (90/749)</td>
<td>6% (15/281)</td>
<td>9.95</td>
</tr>
<tr>
<td>34. Support for community leadership in mental health</td>
<td>9% (71/749)</td>
<td>4% (10/281)</td>
<td>9.89</td>
</tr>
<tr>
<td>35. Support for professional leadership in mental health</td>
<td>9% (68/750)</td>
<td>7% (20/281)</td>
<td>1.00</td>
</tr>
<tr>
<td>36. Development of specific procedures for reporting Human Rights abuses or neglect</td>
<td>10% (77/750)</td>
<td>8% (23/281)</td>
<td>1.01</td>
</tr>
<tr>
<td>37. Increased support for stigma reduction campaigns</td>
<td>11% (82/750)</td>
<td>6% (16/281)</td>
<td>6.52</td>
</tr>
<tr>
<td>38. What is the level of support for service development in rural and regional areas?</td>
<td>7% (27/392)</td>
<td>1% (2/163)</td>
<td>7.45</td>
</tr>
<tr>
<td>39. What is the level of support for service development in poorly resourced areas?</td>
<td>2% (8/394)</td>
<td>1% (2/151)</td>
<td>0.30</td>
</tr>
</tbody>
</table>

Results of Survey 2: Consumers and carers direct experiences of mental health care in Australia

As of 3rd June 2013, a total of 561 surveys were received with 486 (87%) from people who had received treatment (directly or indirectly) in the previous 12-months. Of these, 310 (64%) were from consumers, 69 (14%) were from carers, 87 (18%) were from family members or close friends, and 20 were from other sources (4%). Forty-three per cent (n=206/486) of those who had received treatment (directly or indirectly) had contact with private health services, 29% (n=142/486) with public health services, and the remaining 28% (n=137/486) a mixture of the two.
Eighty one per cent (n=396/486) of the total sample was female with an average age of 41 years. Participation varied across Australian States and Territories (Table 7.4), and the majority of respondents (60%, n=291/486) resided in major urban areas (greater than 100,000 people), with fewer respondents living in regional centres (30%, n=147/486) or rural areas (10%, n=48/486). Most respondents were born in Australia (86%, n=417/486), with 14% born overseas (n=69/486).

Table 7.4: Total number of respondents by jurisdiction; N=482

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales and Australian Capital Territory</td>
<td>202 (42)</td>
</tr>
<tr>
<td>Victoria</td>
<td>81 (17)</td>
</tr>
<tr>
<td>Queensland</td>
<td>112 (23)</td>
</tr>
<tr>
<td>South Australia and Northern Territory</td>
<td>41 (9)</td>
</tr>
<tr>
<td>Western Australia</td>
<td>36 (7)</td>
</tr>
<tr>
<td>Tasmania</td>
<td>10 (2)</td>
</tr>
</tbody>
</table>

More than two thirds of respondents (mostly consumers) reported that they were treated with dignity ‘nearly always’ or ‘always’ (69%, n=304/441) (Table 7.5).

Table 7.5: The extent to which the consumer or someone close to them was treated with respect and dignity by health professionals; N=441

<table>
<thead>
<tr>
<th></th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consumer</td>
</tr>
<tr>
<td>n</td>
<td>288</td>
</tr>
<tr>
<td>Always</td>
<td>41.7</td>
</tr>
<tr>
<td>Nearly always</td>
<td>30.9</td>
</tr>
<tr>
<td>Sometimes</td>
<td>14.6</td>
</tr>
<tr>
<td>Not often</td>
<td>10.2</td>
</tr>
<tr>
<td>Never</td>
<td>2.8</td>
</tr>
</tbody>
</table>

Less than half (43%, n=186/437) of respondents felt that they were able to access adequate services for their mental health problem ‘always’ or ‘nearly always’ (Table 7.6). However, the results were more favourable for consumers (48% of consumers felt they were able to access adequate services always’ or ‘nearly always’ compared with only 29% of carers and 28% of family or close friends).

Table 7.6: The extent to which access to adequate services for mental health problems was achieved; N=437

<table>
<thead>
<tr>
<th></th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Consumer</td>
</tr>
<tr>
<td>n</td>
<td>288</td>
</tr>
<tr>
<td>Always</td>
<td>21.2</td>
</tr>
<tr>
<td>Nearly always</td>
<td>27.1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>27.8</td>
</tr>
<tr>
<td>Not often</td>
<td>19.4</td>
</tr>
<tr>
<td>Never</td>
<td>4.5</td>
</tr>
</tbody>
</table>

The majority of respondents (86%, n=373/434) were able to find a health professional to talk about their concerns. Further, most respondents (70%, n=308/441) felt that they were given the ‘right amount’ or at least ‘some’ information about their condition or treatment. Of those respondents who wanted information given to family and friends, more than half (54%, n=152/283) felt that not enough information was given.
In situations where medication was prescribed for the mental health problem, 55% (n=222/405) responded that the purpose, benefits and side effects were fully explained (Table 7.7).

Table 7.7: The extent to which medications prescribed for a mental health problem was explained in terms of purpose, benefits and/or side effects; N=405

<table>
<thead>
<tr>
<th>Percentage (%)</th>
<th>Consumer</th>
<th>Carer</th>
<th>Family or close friend</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>266</td>
<td>53</td>
<td>69</td>
<td>405</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>31.6</td>
<td>22.6</td>
<td>27.5</td>
<td>29.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>24.8</td>
<td>30.2</td>
<td>24.6</td>
<td>25.2</td>
</tr>
<tr>
<td>Yes, a little</td>
<td>15.4</td>
<td>20.8</td>
<td>15.9</td>
<td>16.8</td>
</tr>
<tr>
<td>No</td>
<td>28.2</td>
<td>26.4</td>
<td>31.9</td>
<td>28.4</td>
</tr>
</tbody>
</table>

Less than one third of respondents (30%, n=131/435) said that the health professionals involved agreed ‘always’ or ‘nearly always’ with one another. Fourteen per cent (n=60/435) reported that the health professionals ‘never’ agreed with one another.

Thirty per cent of respondents (n=129/430) did not feel they had enough say in decisions about care and treatment (Table 7.8). However, a higher proportion of consumers (78%, n=224/288) felt that they had adequate say in decisions about care and treatment than carers (48%, n=28/58) or family/close friends (38%, n=42/74).

One in five respondents (20%, n=84/430) had not had their diagnosis discussed with them. However, the results were more favourable for consumers (15% of consumers had not had the diagnosis discussed with them compared with 33% of carers and 30% of family members).

Table 7.8: Whether the consumer, carer or family member/ close friend felt they had enough say in decisions about care and treatment; N=430

<table>
<thead>
<tr>
<th>Percentage (%)</th>
<th>Consumer</th>
<th>Carer</th>
<th>Family or close friend</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>288</td>
<td>58</td>
<td>74</td>
<td>430</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>43.1</td>
<td>15.5</td>
<td>18.9</td>
<td>35.1</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>34.7</td>
<td>32.8</td>
<td>37.8</td>
<td>34.9</td>
</tr>
<tr>
<td>No</td>
<td>22.2</td>
<td>51.7</td>
<td>43.2</td>
<td>30.0</td>
</tr>
</tbody>
</table>

When comparing data from this survey with those from the same survey run in 2004, the results show there has been significant improvements in three domains: (1) the extent to which they were able to access adequate services (28% were not able to access adequate services in the current survey compared with 39% in 2004); (2) the information people are given about their condition or treatment (44% of respondents felt they were given the right amount of information in the current study compared to only 32% in 2004); and, (3) decisions about care and treatment (70% felt they had enough say in decisions in the current study compared to 62% in 2004) (see Table 7.9).
Table 7.9: Changes in consumer and carer direct experiences of mental health care in Australia, 2004 vs 2013

<table>
<thead>
<tr>
<th>Experience</th>
<th>2004 survey</th>
<th>2013 survey</th>
<th>Chi-Square</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. To what extent were you/ they treated with respect and dignity by health professionals? (always/ nearly always)</td>
<td>78% (142/181)</td>
<td>83% (304/365)</td>
<td>1.89</td>
<td>0.17</td>
</tr>
<tr>
<td>6. How much information about your/ their condition or treatment was given to you? (right amount/ some)</td>
<td>60% (148/246)</td>
<td>70% (308/441)</td>
<td>6.63</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>7. To what extent were you able to access adequate services for your/ their mental health problems? (always/ nearly always)</td>
<td>43% (74/171)</td>
<td>60% (186/310)</td>
<td>12.41</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>8. Did you find a health professional to talk to about your concerns? (definitely/ to some extent/ a little)</td>
<td>81% (196/243)</td>
<td>86% (373/434)</td>
<td>3.25</td>
<td>0.07</td>
</tr>
<tr>
<td>9. If your family or someone else close to you wanted to talk to a health professional, did they have enough opportunity to do so? (definitely/ to some extent)</td>
<td>71% (139/197)</td>
<td>75% (258/346)</td>
<td>1.03</td>
<td>0.31</td>
</tr>
<tr>
<td>10. How much information about your condition or treatment was given to your family or someone else close to you? (right amount)</td>
<td>37% (66/177)</td>
<td>45% (126/283)</td>
<td>2.34</td>
<td>0.13</td>
</tr>
<tr>
<td>11. If you/ they were prescribed any medication for a mental health problem, was its purpose, benefits and/or side effects fully explained? (definitely/ to some extent/ a little)</td>
<td>73% (169/233)</td>
<td>72% (290/405)</td>
<td>0.06</td>
<td>0.80</td>
</tr>
<tr>
<td>12. If you/ they were admitted as a hospital inpatient for treatment of a mental health problem, did staff attend to your/ their physical health needs in a timely manner? (definitely/ to some extent/ a little)</td>
<td>64% (85/132)</td>
<td>71% (143/201)</td>
<td>1.68</td>
<td>0.20</td>
</tr>
<tr>
<td>13. Sometimes, one health professional will say one thing and another health professional will say something quite different. Did this happen to you? (always/ nearly always)</td>
<td>55% (84/153)</td>
<td>48% (131/273)</td>
<td>1.88</td>
<td>0.17</td>
</tr>
<tr>
<td>14. Did you have enough say in decisions about your/ their care and treatment? (definitely/ to some extent)</td>
<td>62% (153/246)</td>
<td>70% (301/430)</td>
<td>4.32</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>15. Has your/ their diagnosis been discussed with you? (definitely/ to some extent)</td>
<td>81% (199/246)</td>
<td>80% (346/430)</td>
<td>0.02</td>
<td>0.89</td>
</tr>
</tbody>
</table>

Consumers then answered more detailed questions regarding their care and treatment. The majority had seen a general practitioner (98%, n=294/301), psychologist (60%, n=180/301), and/or psychiatrist (62%, n=187/301) in the previous 12 months (see Table 7.9 for ratings). Fewer consumers had seen a mental health nurse (25%, n=74/301), social worker (15%, n=46/301) or other mental health professional (22%, n=67/301) in the previous 12 months. A number of consumers reported they had no trust or confidence in the social worker (37%, n=17/46), mental health nurse (27%, n=20/74) or psychiatrist (20%, n=37/187) they saw.

Most consumers (88%, n=259/295) had taken medications for mental health problems in the last 12 months and 71% (n=209/294) had received a talking therapy. Close to half of the consumers (47%, n=135/286) had an after hours contact in a mental health service, and of these people 40% had used this form of crisis care in the previous 12 months.
Table 7.10. The extent to which the consumer or someone close to them was treated with respect and dignity by health professionals; N=441

<table>
<thead>
<tr>
<th></th>
<th>Listened carefully to you</th>
<th>Trust and confidence in this person</th>
<th>Treated you with respect and dignity</th>
<th>Given enough time to discuss condition and treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General practitioner</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>59.5</td>
<td>56.8</td>
<td>74.5</td>
<td>49.3</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>29.9</td>
<td>31.3</td>
<td>20.4</td>
<td>30.3</td>
</tr>
<tr>
<td>No</td>
<td>10.5</td>
<td>11.9</td>
<td>5.1</td>
<td>20.4</td>
</tr>
<tr>
<td><strong>Psychologist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>77.2</td>
<td>64.4</td>
<td>81.7</td>
<td>57.8</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>14.4</td>
<td>22.2</td>
<td>14.4</td>
<td>28.9</td>
</tr>
<tr>
<td>No</td>
<td>8.3</td>
<td>13.3</td>
<td>3.9</td>
<td>13.3</td>
</tr>
<tr>
<td><strong>Psychiatrist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>62.6</td>
<td>55.1</td>
<td>72.7</td>
<td>55.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>24.6</td>
<td>25.1</td>
<td>19.3</td>
<td>21.9</td>
</tr>
<tr>
<td>No</td>
<td>12.8</td>
<td>19.8</td>
<td>8.0</td>
<td>22.5</td>
</tr>
<tr>
<td><strong>Mental health nurse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>48.6</td>
<td>47.3</td>
<td>59.5</td>
<td>39.2</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>35.1</td>
<td>25.7</td>
<td>27.0</td>
<td>36.5</td>
</tr>
<tr>
<td>No</td>
<td>16.2</td>
<td>27.0</td>
<td>13.5</td>
<td>24.3</td>
</tr>
<tr>
<td><strong>Social worker</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>58.7</td>
<td>50.0</td>
<td>63.0</td>
<td>53.3</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>23.9</td>
<td>13.0</td>
<td>26.1</td>
<td>22.2</td>
</tr>
<tr>
<td>No</td>
<td>17.4</td>
<td>37.0</td>
<td>10.9</td>
<td>24.4</td>
</tr>
</tbody>
</table>
Chapter 8

An analysis of the perspectives and visions of Australia’s mental health reform

John Mendoza, Amy Elson, Yve Gilbert and Amanda Bresnan
Obsessive Hope Disorder
Introduction

This Chapter provides an analysis of eighty-one perspectives essays provided by a diverse group of experts, observers and participants in Australia’s mental health reform ‘project’. The Chapter outlines the key themes and issues reflected in those essays and what lessons can be drawn for the ‘unfinished business of mental health reform.

A rich pool of perspectives

The eighty-one perspectives essays contained within this volume of the Obsessive Hope Disorder Report are an incredibly rich pool of experiences and analyses spanning the last thirty years. Each author has volunteered to describe their view of the current state of mental health care, the way forward and the solutions for a better mental health care system.

The authors include eminent Australians who have served in some of the most important roles in our society – leading our Governments as First Ministers1, serving as Cabinet members, Chief of Defence Forces, Police Commissioners, community leaders and Chancellors and leaders from our Universities. Other contributions come from professionals with decades of experience in mental health services – from the old institutions, to mainstreamed services in general hospitals, to community managed service providers, to consumer and carer organisations.

There are ‘lived experience’ perspectives on the current mental health care system from those who are using mental health care services in 2013. Some of their stories are distressing pointing to the continuing systemic issues identified in the statutory authority reports and other data presented in the Technical Report and the need to re-think efforts on reform. Other stories however, are reassuring, demonstrating that some real improvements have occurred in the way people get help for their illness and that reforms have occurred.

Many of the authors are not ‘in’ the mental health system and bring an observer or participant observer perspective. Others, including Harvey Whiteford, Leanne Durrington, Lesley Russell and Ivan Frkovic, have been front and centre of the government policy making and stewardship processes over the past two decades. Almost all of them identify the structural and political barriers and challenges to reform and why it’s just so hard to achieve real national reform for consumers and families.

Others like the three current members of the Australian Senate from across the political landscape – Senators Claire Moore, Concetta Fierravanti-Wells and Penny Wright – view the mental health system from their positions within the Australian Senate and have advocated long and loud for a better deal for mental health. They are but a small representative sample of Federal Parliamentarians from across the political spectrum who want real mental health reform for their constituents.

A number of the authors come from roles as law makers and custodians – Anita Phillips and John Brayley (both in their present statutory authority roles). They, along with Penny Wright, who reflects on her time as a member of the South Australian Guardianship Board, Quentin McDermott as a national investigative journalist, and others, draw attention to the ongoing discrimination and failure of present law to protect some of those with mental illness. Others like Peter Baume, Mick Palmer and Brian Burdekin have all led major inquiries into aspects of mental health care and human rights. Their insights into what they found and what we need to do to achieve our intentions in reform are invaluable.

There are four perspectives specifically addressing mental health and Aboriginal and Torres Strait Islander peoples. The authors, Colin Tatz, Melissa Sweet and Pat Dudgeon, Rachelle Irving and Ernest Hunter all ask in their own way, if we are focussed on the right issues to improve indigenous mental wellbeing. Other authors such as Alan Brotherton and William Leonard detail the journey, the present and the future for LGBTI communities while Jennifer Bowers draws our attention to the issues confronting Australians living in rural and remote communities with mental health needs and how we can better meet their needs.

1 ‘First Ministers’ is the collective term given to Prime Minister, State Premiers and Territory Chief Ministers in Australia.
In a year which has seen the commencement of the Royal Commission into sexual abuse of childhood in institutions, Jack Heath highlights the need for our services to recognise and be sensitive to the very high rates of sexual abuse suffered by people with mental illnesses.

Importantly, there are many contributions about what a 21st Century mental health care system looks like and what we need to do to bring about reform within a decade – from a systems level down to models of service, to service delivery and own individual attitudes and practices. A number of authors, including Jane Burns, Dawn O’Neill and Aram Hosie, outline the potential of new technologies to reach more people, reach them earlier and at relatively low cost. Just as it has been almost a constant theme for decades, many authors stress the need to get beyond the rhetoric on early mental health promotion, prevention and early intervention.

There are also international perspectives – Stephen Niemiec, Paul O’Halloran, Nick O’Connor and Alan Rosen. They draw from their decades of experience working in the UK and New Zealand, travels to Italy, the USA and elsewhere, and identify the key elements missing in our reform efforts in Australia. In particular, they draw attention to the need for investment in a national workforce strategy, culture change and capability development.

There are also some unique perspectives – most notably that from the ACT Chief Minister and Health Minister Katy Gallagher. Katy Gallagher is Australia’s longest serving Health Minister in office. During her six year tenure as Health Minister, the ACT Government with the support of the ACT Greens, has developed and implemented fundamental reform of the ACT mental health care services, particularly focusing on the establishment of a range of community-based alternatives to hospitalisation. This is not the first time an Australian jurisdiction has worked to reform its mental health services. Victoria was a leader under the First National Mental Health Strategy in the mid-1990s. The issue is not that genuine reform of mental health care is too hard, it is that it is too rare.

Finally there are many perspectives from our Project Partners who provide services in a range of settings and for specific populations – children, young people, CALD, people living in rural and remote areas, workplace settings, employment and housing services, helplines and online platforms, research, primary care, specialist care and community care. Together they represent the diversity of the mental health sector. Together they have highlighted many service innovations and structural reforms which are reflected in the Manifesto for Change in this Report.

We deliberately set out to garner a diverse range of experiences and perspectives in undertaking this aspect of the project. We also gave minimal direction to the authors who agreed to undertake the assignment. In that way, it is their reflection and not our construction. The result is an anthology or encyclopaedia – a set of precious insights into mental health in contemporary Australia. It is difficult and perhaps inappropriate to attempt to distil these rich contributions to just a few themes and issues. Nonetheless for the reader short on time, and to add to the other findings, we have attempted this: faithfully we hope. We commence this volume then with a brief analysis of the key themes from the essays. Perhaps the one key message from all contributors is that their hope for real reform of mental health care in Australia is undiminished.

Method

To facilitate diversity and depth of input, consumers across the lifespan, carers/natural supports, frontline professionals, political leaders, former bureaucrats, leaders of provider organisations, journalists and media professionals, researchers and policy advisors from a range of settings and expertise were identified as potential contributors (Figure 8.2).

The expertise of invited contributors was determined from public sources including via Google search, LinkedIn and other social media groups. The settings included public administration, acute hospital-based care, community mental health services, rural and remote, employment, education and training, accommodation and housing, human rights and justice, youth, indigenous, culturally and linguistically diverse (CALD) and men. A number of contributors had diverse careers in a range of settings and these are listed in the ‘General’ sub-sector.

This diverse group of individuals were invited to contribute a 1000–2000 word written perspective piece. A staged purposive approach was used to ‘recruit’ contributors from February to late May 2013. An initial
list of 130 individuals and organisational leaders were identified using the matrix shown in Figure 8.2. Over time another 120 individuals and organisations were added to the list, to ensure there were sufficient numbers of contributors and adequate diversity of perspectives. We have included all the received submissions, choosing to represent the full breadth of the voluntary contributions given, rather than conduct any kind of selection or culling process.

Additional contributions were received from the Project’s integrated digital platform – the swYtch Australia website-Facebook page-Twitter account-Instagram sites. Contributors on these platforms provided short personal perspectives, program solutions and interventions, uploaded short videos and photos and comments. These contributions were not included in this analysis.

**Invited Perspective Essays**

<table>
<thead>
<tr>
<th>SECTOR &gt;</th>
<th>Psych hospitals &amp; General Hospital</th>
<th>MH Community services &amp; Clinical Outreach</th>
<th>Rural &amp; remote</th>
<th>Employment &amp; Education</th>
<th>Accommodation/Housing</th>
<th>Corrections/Justice/Human Rights</th>
<th>Young people</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer/lived experiences</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer/support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Academic/researcher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Law/human rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Politician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police/Magistrates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Categories:**

| Consumers | Media |
| Carers | Politicians |
| Service providers/NGO | Law/human rights |
| Researchers | Police/Magistrates |
| Health professionals | CALD |
| General community | Aboriginal and Torres Strait Islander |
| Refugee | Business community |
| Funding agencies | |

**Figure 8.2: Perspective Essays were invited from those in the highlighted cells.**

Individuals identified as potential perspective contributors were sent an overview of the project and a brief outline of the perspective essay scope. Partner organisations were given a similar brief. A brief was provided that the report was going to examine mental health reform in Australia with particular focus on three key areas:

1. What has been the journey of reform to date since David Richmond and Brian Burdekin's reports 30 and 20 years ago respectively?
2. Where are we now – what is the contemporary experience of care?
3. What should be the future – is there a better way?

Contributors were unconstrained providing a wide scope to write on either all three key areas or one or two of their choice.

A total of eighty-one perspectives were received within the timeframe for analysis. A full list of contributors in listed in Appendix 5 of the Technical Report. Partner organisations are listed in Appendix 6 of the Technical Report.
All perspective essays were loaded into a qualitative data analysis tool – hyperResearch. Investigator triangulation, described by Patton\(^2\) as the use of several different researchers to interpret a set of data, was utilised to evaluate and analyse the purposive sample of perspectives. The investigators then used open coding, selected coding and theoretical sampling individually. They then combined their findings to develop a single set of themes and findings from the essays. Only the key themes and issues are discussed here.

**Summary of the findings**

There are several key themes evident in the perspective essays relating to challenges and problems confronting mental health in Australia.

While many contributors acknowledge important progress, the vast majority agree that in terms of mental health reform, Australia still has a long way to go.

This volume documents many continuing manifestations of stigma, discrimination and inequity. People with mental illness still face real problems in relation to their human rights.

There are still far too many stories included here which document service failure at a systemic level, with people either being unable to access the right care at the right time or finding poor quality of care. There remain large service gaps and high levels of unmet need.

Many contributors sheet home this enduring systemic failure to a continuing lack of funding. The overall health budget continues to increase at a faster rate than the mental health budget, meaning mental health’s share of funding is in decline, exacerbating the disparity between the resources available and the burden of disease.

In this highly pressured environment, several contributors highlight what they feel to have been a chronic lack of support for, indeed neglect of, our workforce.

Several authors highlight that this situation has arisen in an environment in which mental health could be characterised outcome blind, lacking meaningful data, particularly outcome measures.

Beyond these key themes, other issues are commonly referred to by the contributing authors.

Many refer to the fact that the evidence about what was required twenty, and even thirty years ago, has not fundamentally changed. Over time, many point to successful programs or services that have been built and piloted across Australia to deliver new mental health services. The common theme here is that all too often there has been a failure to build these services to scale to meet community needs.

There is a genuine frustration expressed by many contributors regarding the continuing rhetoric–reality gap on promotion, prevention and early intervention. They lament our continued emphasis on late stage or crisis intervention, with the mental health system only kicking into action once a person is already severely unwell and possibly a danger to themselves or others. Equally, the lack of attention to the physical health needs of people with mental illness is another illustration of a lack of whole-person care.

People working in the system report how challenging it can be to attempt to re-gear the system, how complex this kind of change can be at the organisational level.

There are several essays which highlight policy barriers to employment for people with a mental illness.

Other contributors highlight the need to address the social determinants of mental illness more broadly. This is particularly the case if we are to have any meaningful positive impact on the social and emotional wellbeing of Aboriginal and Torres Strait islander peoples.

And there were some issues that lay outside this mix of ‘common’ themes. For example, Stephen Mugford’s challenge on the way progress is viewed and indeed the vagaries of mental health definitions remains a highly contested area and that, in a time of apparent resource scarcity, mental health initiatives may continue to struggle to gain funding.

---

Several contributors highlight themes or strategies which together, represent a way forward, a better way for both future reform efforts and how we conceptualise mental health.

Several of these refer to important employment policy and programs based on international and Australian evidence. Others refer to the importance of systems thinking around the concept of integrated care rather than focusing just on individual services or providers. Other essays highlight the role to be played by community education, community prevention activities and local planning.

Many of the contributions call for greater consumer, carer and peer worker participation in co-design, management and monitoring of mental health systems and care. New opportunities to apply technology to assist in more timely, more effective and contiguous mental health care are also identified.

A recurring theme across the essays is the need for better accountability at all levels, permitting quality improvement feedback for service providers and reassurance to the community at large that it has a mental health system on which it can rely.

From the thematic analysis we have postulated a number of ‘theories’ relating to the journey of mental health reform and the ‘drivers’ for the failure of policy implementation so consistently expressed in the perspective essays. Most see this failure as being the result of inadequate planning, definition and detail. Too often highfalutin reform rhetoric is not matched with concrete implementation. Part of this is about disaggregated and ineffective governance structures, weak stewardship of the process and but surely another factor, as pointed out in several essays, relates to inadequate funding to support reform. Real funding is all too difficult to determine from the “funny money”3, re-labeled and/or re-announced funding that is evident from too many governments. Many authors also make reference to the complexity of funding and service arrangements and the consequent deleterious impact these have on the quality of care available.

There is also inconsistent access and quality of care, partly the result of the failure to define a national service framework and national models of service. Contributors also point to the neglect of the mental health workforce over decades.

Finally, a key driver of mental health reform failure is clearly poor accountability – not being able to tell whether what we are doing is really making any difference to people’s lives.

3 Dr Lesley Russell coined this term in media interviews following the 2011 Federal Budget when discussing mental health funding.
The key themes from the Perspectives Essays

**Hope**

Hope was a consistent theme in many essays expressed from divergent perspectives. Some were disillusioned by the disappointing outcomes anticipated from previous reforms and hoped that someday there would be justice and equality of care for people with mental illness. Most remained stoically optimistic about the future and others expressed the view that genuine reform is underway. Others hope that new approaches to mental health would enable an improved life for their loved ones or other people with mental illnesses.

I value the wonderful people I have met over the past years – their courage, resilience, passion and humour have maintained the struggle for real inclusion. I have shared the frustration of promise and the celebration of every success … The hope of the first National Mental Health Plan must be maintained and bolstered by the development of clear outcomes with agreed assessment… We cannot afford to lose the engagement of the people who have invested so much energy and hope, and who have the genuine experience of mental illness. If we only have plans and rhetoric we will betray the people whose rights and responsibilities were defined in 1992 and reinforced over the years.

*Senator Claire Moore, ALP, Qld.*

We hope to see many more diverse approaches emerge and different ways of being are understood and accepted and new ways of enabling recovery become the new mainstream

*Joe Calleja, CEO Richmond Fellowship WA*
Heartened by the lessons of the NDIS, our best hope is for a dramatically stronger Federal government stake in the leadership, design, funding and governance of community mental health care, which should be linked conceptually and operationally to primary care, with the States retaining responsibility for hospital care. It would allow them to concentrate on fixing a serious problem. Inpatient care is in a parlous state Australia-wide with very negative experiences for staff and patients alike.

**Professor Patrick McGorry, AO, ORYGEN**

There are many new opportunities to achieve great reforms. If we expect mental health services to achieve significantly more of the better outcomes to which we aspire, perhaps we could do worse than emulate successful businesses (large and small), which remain relevant principally because they pay attention to what their customers tell them.

**Jan Kealton, Carer and Carer Advocate**

Within a few days of starting at SANE, I met inspiring people living with severe mental illness. I didn’t appreciate just how much stigma I myself had been carrying around severe mental illness. I came to learn that recovery rates were far higher than I ever realised. Sure, life wasn’t easy but there was so much more hope than I ever imagined.

**Jack Heath, CEO SANE**

There is a long road ahead before the structural factors and environments which have had such a profound influence on our (LGBTI) communities’ mental health and wellbeing are fully addressed, but the journey is well and truly underway.

**Alan Brotherston and William Leonard, ACON**

As the sector becomes more sophisticated, and the stigma and discrimination that surrounds mental illness lessens, the sector should emphasise its successes, identify the deficiencies and highlight the benefits that will accrue to consumers and their families from innovative solutions. Governments like to be associated with success, not only the hope of success and not always the compulsion to intervene in a crisis.

**Professor Harvey Whiteford, University of Qld.**

The relief and emotional gratitude shown by people with mental and other disabilities and their families, when the National Disability Insurance Scheme was very recently announced, graphically provided evidence of this. To many it heralds the beginning of a whole new world. Let us hope the promise is delivered.

**Mick Palmer AO**

**Stigma**

While there was general agreement that community understanding of mental illness has changed considerably over the last 30 years, stigma is still a daily reality for people with mental illnesses. Stigma is seen as manifesting in reluctance to seek help, the general quality of care provided, the state of facilities, the attitudes and behaviours of mental health services staff. It was also evident in continuing general social exclusion – people with mental illness have fewer friends and fewer social networks. Stigma was also seen as evident in employment and housing exclusion and the continuing gross inequity of resources for mental health services.

The persistence of stigma not just in the community generally but also in the minds of those who are ill and needing treatment. In fact it can become the major barrier for people who need to present themselves for treatment.

**Professor Geoff Gallop AC, University of Sydney**

The stigma of mental illness also pervades the responsiveness of general practices to support those people with severe mental illness.

**Learne Durrington, CEO, Perth Central East Medicare Local**
This is 2013; we should be more enlightened, sometimes we pretend we are over certain politically correct subjects that once did have a stigma; mental illness is still up there as an unsexy, stigmatized, uncomfortable topic in our homes, families, schools, workplaces. .... We don't want to know how people really are. We have the Aussie vernacular “Hi, How are you?” – the reality is we don't want to hear the answer the real answer, that could be too negative, and we don’t have the skills to respond if some actually does answer us honestly that they are not well.

Ingrid Ozols, Managing Director, mentalhealth@work

Stigma sets individuals apart from society. Unfortunately, the stigma and fear surrounding mental illness continues to impede the human rights of many people. Stigma can be debilitating for someone experiencing mental illness as it can increase isolation and hinder the drive to seek help when needed. The analysis of the perspective essays revealed that the prevalence of stigma surrounding mental illness is the primary concern of many individuals in Australia.

Stigma presents itself in many forms and will be experienced by most people at some stage of their life. Belonging to a certain cultural group, race, sexual orientation or just having a point of difference can expose an individual to stigma from people who may be seeking to exalt their self for any number of reasons. Stigma is not an affliction of the uneducated, it can be projected by anyone on anyone, regardless of profession, education or standing in the community.

Rachelle Irving, Community Mental Health Worker, Kununurra

Every person who lives with a mental illness is unique, but I witnessed the commonalities. Loneliness and stigma were frequent companions for the people who came before me. Labeled “mentally ill,” it often takes great courage to get up each day and face the world.

Senator Penny Wright, Aust Greens, SA

Stigma is an even greater issue for those people from lesbian, gay, bisexual, trans/gender and intersex (LGBTI) communities or those living with another illness or disability when stigma is evident from the broader community such as those individuals with obesity problems or an intellectual disability.

.. there is growing agreement among both researchers and community that the mental health disparities seen among LGBTI communities are in large part a consequence of homophobic/heterosexist or transphobic/cisgenderist discourses and their cultural consequences. While most mental health researchers, clinicians and services have long abandoned the pathologisation of sexual diversity, cultural norms have taken longer to shift. Many researchers attribute high levels of anxiety, depression and suicidality to ‘minority stress’, noting the still high rates of verbal and physical abuse directed at our communities.

Alan Brotherton and William Leonard, ACON

Most perspective piece authors discussed the impact of stigma on an individual’s family life, employment, mental health, physical health, and the level of care they could receive.

Symptoms of mental illness are often misread as signs of laziness or incompetence ... This stigma of mental illness can discourage people from disclosing due to concern about how the disclosure would impact on employment opportunities.

WISE Employment

Some authors also pointed to the effect of stigma in funding and decision making within government.

State and federal governments and large companies bear ultimate responsibility for those living and working in [rural] areas. However, due to the stigma attached to mental illness and the disaggregated population in rural and remote Australia, the mental health challenges are often not recognised so they attract disproportionately limited resources.

Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health
Many authors proposed that improved awareness of mental illness through education is important for successful mental health reform. They suggested that the stigma of mental illness permeates the Australian community including the people who experience mental illness, their carers, and professionals within the mental health workforce.

They play it safe and governments are left delivering a morass of rhetorical road maps and good intentions. …. Key issues lie fallow, like mental health promotion. … Governments have never properly funded a mental health anti-stigma campaign. I’ve sat in meetings where the argument put is that there is no one single message to impart in an anti-stigma campaign, so the worth of a major investment is not understood, and consequently not delivered.

Simon Tatz, former Communications Manager MHCA

**Discrimination/human rights**

In an endeavour to improve the rights of people who experience mental illness, David Richmond in 1983, and Brian Burdekin in 1993, released reports advocating for the equal rights of people who experience mental illness and outlined the need for a planned and formal approach of deinstitutionalisation to replace the haphazard one they found.

In 2009, Mick Palmer was a member of the National Human Rights Consultative Committee appointed by the Rudd Government under the chairpersonship of Father Frank Brennan. The committee met with over 6,000 people and received a staggering 35,000 submissions. Many of those who attended consultation forums and made submissions to the Committee raised issues of human rights of people living with mental illness. Many of the submissions to the Committee could have been mixed up with those received by Brian Burdekin nearly twenty years earlier.

Many perspective authors questioned whether the human rights of people experiencing mental illness have changed since these reports, or whether individuals continue to be institutionalised in homes, hostels and boarding houses, on the streets and in our correctional system.

In (a) second case a well-educated and more mature man with a long history of similar mental health issues, was arrested for allegedly loitering near a women’s shelter, becoming abusive and refusing to leave on demand. In conversations with his father, who was deeply concerned for his son’s health and well-being, and at his court appearance, (which his father attended) the son refused to acknowledge that he had any health problems. Due to the son’s mature age, his father was not able to access his son’s lawyer or otherwise be heard during the court proceedings. As a consequence, the matter was heard and resolved without the court becoming aware of the mental health issues which, in all probability, directly caused the man’s unacceptable behaviour, including his behaviour in court.

Mick Palmer AO

An alternative view is that despite the major community and political efforts to kick-start reform, the general scope and quality of services is little changed on the ground from the late 1980s.

Professor Ian Hickie AM, University of Sydney

Living in an underfunded boarding house can limit a person’s privacy, personal safety, and rehabilitation. A cycle of homelessness and incarceration can have devastating effects on a persons’ health and longevity, as can lack of access to good general health care.

Dr John Brayley, Public Advocate South Aust.
Obsessive Hope Disorder

My parents as volunteer lobbyists fought for change to the system, became involved in the first NSW peak body, and set up a parent support group in their area in Sydney. They even contributed submissions to the Richmond report in the hope of fundamental change to the institutional system. They didn’t bargain on the fact that the government would “throw the baby out with the bath water” so that in effect deinstitutionalisation was not backed up with sufficient supported, adequate, caring accommodation for people suffering from mental illness but who were not at high risk, and many were left homeless.

Carer “C”

The realisation of the policy of deinstitutionalisation has created the contemporary reality of transinstitutionalisation—from the asylum to homeless shelters and the prison system—while the fragmentation and inadequacy of services remains a persistent theme of community debate. It is also timely to remember that one of the repercussions of an underfunded ‘community care’ solution has been the outsourcing of mental health care onto the family; and many carers continue to struggle in their daily lives for recognition and appropriate supports.

Carers ACT

Somehow the years of policies, statements and strategies had not ensured that people received the rights identified as “fair and equitable”.

Senator Claire Moore, ALP Qld.

A number of contributors, namely carers and consumers, openly expressed their concern for a failing mental health system in Australia; with others stating that services have plateaued. Discrimination is a key issue within the current mental health system; rights are still being stripped from those with a mental illness.

Eight months locked up! That’s how long I have been in the Public Mental Health Wards. That’s been over nine years, having been admitted or committed. Three times with Police arrest.


During my seven years in working in this field (disability employment), I have seen and experienced a system which quite frankly fails and discriminates against the very people it is designed to assist!

Regional Manager of DES Service Provider

That the discrimination was so entrenched in public and official attitudes that it was both ‘systemic’ and ‘systematic’ – and therefore required sweeping reforms – and a major injection of resources.

Professor Brian Burdekin AO

People experiencing mental ill health are entitled to the same protection of their human rights that can be taken for granted by all of us, however a number of contributors highlighted the breadth of discrimination that still occurs and described the ramifications.

Public ignorance generated irrational fear – which was a fundamental cause of discrimination, marginalization and even victimisation of those with a mental illness.

Professor Brian Burdekin AO

Despite such initiatives and advancements in anti-discrimination legislation (such as the Disability Discrimination Act 1992) and employment support provided through the National Disability Agreement, people with mental illness are less likely to be working than other Australians.

WISE Employment

Police in Australia continue to shoot dead men who are mentally unwell. Sometimes, as in the case of Adam Salter, shot dead by a police officer in western Sydney on 18 November 2009 as he attempted to stab himself, a cover-up ensues, and the police force closes ranks, instead of opening
up to constructive criticism, and to an acceptance that – like all of us – police officers sometimes make dreadful mistakes.

Quentin McDermott, ABC 4 Corners

Service failure/unmet need

The perceived lack of mental health services and the subsequent failure of the mental health system in Australia were strong themes underlying many of the perspective essays. Carers, consumers, providers, educators, and academics all voiced their concern for individuals unassisted by current Australian mental health models of care.

Although repairing the current mental health system would be complex and multifaceted, many authors expressed that improvement could include the need for a national approach to cease the fragmentation of care between the states, increased accountability and more outcomes based evaluations of existing care models.

Greater awareness has been fostered, especially by beyondblue and SANE, and repeated National Mental Health Surveys reveal substantial unmet need, and a shameful gap in access and quality of care between physical and mental health care. This results in so much unnecessary suffering and wasted potential.

Professor Patrick McGorry AO, ORYGEN

The mental health system is fragmented and under-resourced. It separates mental from physical health and often attempts to treat the mental illness independent of social, economic, inter-personal and cultural environments.

Sue Murray, CEO, Suicide Prevention Australia

Failure to meet the needs of people with mental ill health across various service sectors was described by contributors from a range of backgrounds. Examples were provided of how this failure continues to impact our vulnerable citizens.

The Commonwealth Government needs to ensure that funding for the provision of Intensive Placement and Support interventions in the Job Services Australia program is included in the next service contract likely to commence from 2015. Failure to implement such interventions will result in people with high mental health barriers to securing employment being locked into chronic cycles of poverty and unemployment.

BoysTown

Susan overdosed twice in a week. She thinks she is beyond help. She can’t wait any more for a solution. No one can help her! Her survival instinct has gone. The first overdose we arrive at the Hospital to sit in ED with no help or concern for Susan and then to be discharged with no follow up. The second time I take Susan by ambulance to the Children’s Hospital. Here she is looked after and admitted for observation. We fight with all our heart to ask an out of area hospital to look after our daughter. … Lots of politics and phone calls and Susan is in a specialist unit at the Children’s Hospital at present trying to understand where help will come from and in what from.

Carer “D” and daughter Susan, Melbourne, 2013

We cannot however, rest on our laurels. With nearly one in five Queenslanders experiencing mental ill health in any given year and far too many falling through the silos in the service delivery system, we must find ways for better engaging with many more consumers, carers and families to assist them in their journey and help them achieve their life goals. It is estimated that approximately only 46% of those experiencing mental ill health are seeking or receiving treatment.

Ivan Frkovic, State Manager, AfterCare Qld.

Serial state governments have failed to build enough housing for mental health consumers in need.

Carer “J”
In the past, I had always been reluctant to bring forward my own experience of sexual abuse and didn’t want to project on to others but when I started at SANE I gently enquired of people with severe mental illness whether they had been sexually abused as a child. I was staggered by how many responded in the affirmative ....Trauma-informed care needs to become commonplace practice throughout the mental health sector and funding for work in this area needs to increase.

Jack Heath, CEO SANE

A number of perspective piece authors articulated that an integrated individually tailored model of care is required in a national mental health plan for Australia.

Collaboration and partnerships within the mental health sector are at the core of changing the service experience for people with a mental illness and their families. Collaboration and partnership is at the core of improving life expectancy for those with a mental illness – something we have as a nation failed to do for the past half century.

Lydia Najlepszy, CEO, Qld Youth Industry Links

Being a menopausal, professional woman who has worked in wellness for 30 years, who has had relatives who are alcoholics, others diagnosed with mental 'illness' and put onto drugs, written a book on joy, experienced the impact of hormonal imbalances on mood, and seen the effects of an online learning program to teach the skills that help us rediscover our own joy, I see clearly the need for integrated wellness centres – physical and online. These centres need broadly educated individuals to provide a 'one stop shop' approach to educating NOT JUST TREATING people. When we treat someone you take away the locus of control from them and make it external – they are merely pawns in their lives.

Amanda Gore

Important international reviews of the mechanisms for improving the quality of mental health care services (such as that conducted by the US-based Institute of Medicine) emphasise the need for all funding bodies to purchase preferentially a new style of integrated and collaborative services that are effective and person-centric.

Professor Ian Hickie AM, University of Sydney

To respond simplistically in a complex business world invites costly failure, even collapse.

Dawn O’Neill AM

Inconsistency of services

Many authors refer to the inconsistency of service quality and access to a spectrum of services (rather than the acute care bed as the only resort) is due to the lack of an agreed national service framework, an agreed model or models of service and agreed mix of care or spectrum of services. Services – be it spectrum of, capacity or quality – varies across the nation, across jurisdictions and even across regions and localities. In many instances authors highlighted:

- service complexity and fragmentation
- the lack of quality assurance standards for professionals within the industry
- the deficiency of an intensive and short term alternative to hospitalisation for people with acute mental illness
- that services for mental health and illness fall far below physical health services in terms of facilities and high technology equipment
- the dearth of consistency of services across the states and territories
- the ongoing uncertainty surrounding funding and sustainability for many innovative programs.
There is a lack of quality assurance standards by which individuals, professionals, workplaces and communities can assess programs against needs.

*Sue Murray, CEO, Suicide Prevention Australia*

Mental health and illness fall far below physical health services, facilities and high-technology equipment in terms of governments’ (and medical professionals’) priorities.

*Professor Rob Donovan, Curtin University*

Australian Governments politicise their attempts at health service reform so much that they often turn out to be an unworkable mess or uncoordinated tangle of fragmented services, sometimes duplicating each other, and failing to plan or work together.

*Professor Alan Rosen, University of Sydney*

While many may argue there is real benefit in a National approach, the Plan is applied in a unique way in each state; the jurisdictional issues are a key weakness. While each state has ‘signed up’ nomenclature varies, counting rules differ, service types are modified and each system a reflection of the historical and political idiosyncrasies of the jurisdiction. While it can be argued that each state should localise the service system to its unique characteristics and population needs this would appear to be to the detriment of a modern system of care. More critically though the National Plan/s has not addressed the structural and system issues which impede reform.

*Learne Durrington, CEO, Perth Central East Medicare Local*

There is an urgent need to strengthen the provision of mental health care to people with physical illness and the quality of physical health care provided to people with mental health problems in both acute and primary care.

*Dr Lesley Russell, ANU*

One of the most telling perspectives on the quality of mental health care (in NSW) over the past thirty years came from a carer whose sister has had a severe mental illness since the late 1970s:

> Since the 70s, there has been the gradual decline of available relevant services to those people who are in the category of “needing constant recovery support” but not classified as “high risk”, those people like my sister who need continuous care and support from case managers and nurses to monitor physical and psychological condition and are symptomatic on a regular basis but not necessarily at harm to others or themselves.

*Carer “C”*

Another from Paul O’Halloran and Nick O’Connor, draws on their experiences in developing the UK service frameworks over the past ten years and comparisons with the Australian story of reform.

> While good policy abounds, there is an apparent lack of an evidence-based and recovery oriented model of care or service framework for community mental health, making effective implementation of any policy difficult as well as creating variability and lack of standardization at all levels of the system. In this context, without clear articulation of a community-based model of care and despite the fact that the vast majority of consumers and their families live in the community, the centre of gravity for mental health care provision defaults to the hospital.

*Paul O’Halloran and Dr. Nick O’Connor*

**Expenditure**

Every five years since 1993, the Australian Government has released a national mental health plan co-created and signed off with every state and territory government of the time. These plans are implemented to varying degrees of ‘good faith’ by each government. Each government decides where its own priorities will be under the so-called National Plan. As there are no agreed service models or definitions on the service type and mix, each jurisdiction effectively does whatever it wants. There are no penalties or incentives to be gained by implementing the “Plan”.

ConNetica
The result is that mental health services are fragmented if not fractured, the level of care that is provided per state differs and there is little evidence to show that investment is actually driving improved health outcomes.

Despite dozens of plans and policies, reports, inquiries and mental health commissions, spending between jurisdictions continues to be uncoordinated, lacking both accountability and a focus on patients’ needs. It is impossible to verify whether jurisdictions really do spend what they commit or what they report. Given the huge burden of mental illness and the unmet needs for mental health services, proper accountability for this expenditure is crucial to ensure that it is targeted at the areas of greatest need and is delivering better outcomes for people with mental illness.

Dr Lesley Russell, ANU

The recent increases in community-based services has been much anticipated and greatly appreciated by both consumer and service provider. Though there remains the ongoing uncertainty around funding and sustainability, as it has not had cross party Government support. There is also evidence that current State Governments are reducing funding in areas that are receiving Federal funding. The end effect being that there is not a net increase in services rather a shift in the funder and models being offered. This limits choice as well as the chance for a wide diversity of services to best meet the needs of our community.

Regional Manager, Community Mental Health Service Provider

Unfortunately mental health continues to receive little funding in comparison to physical health, even though mental illness is documented to directly affect nearly one in five Australians. Currently there is no comprehensive, publicly available analysis of how much the Australian Government spends on mental health treatment and prevention strategies. Funding models or streams and the reporting requirements complex and a barrier to innovation.

… it’s not easy to stay afloat so we continue to cobble together funds from month to month through a hybrid model of our Medicare rebates, fundraising, private donations and philanthropic grants. While this is enough to support our two wages we really struggle to pay the rent and can’t afford a receptionist or practice manager position which makes coordination difficult.

Toby Raeburn, ROAM Communities

The ROAM Communities program is Australia’s first mental health nursing charity dedicated to helping people overcome mental illness in the community, avoiding hospitals, jails and homelessness. The program includes a nurse practitioner led mental health recovery centre, which is made possible by generous donations from family, friends and the local community. The centre is located in NSW fastest growing local government area, Camden, South West Sydney. ROAM is the only bulk billing mental health service outside hospital in the Local Government Area (LGA).

What is different in 2013, internationally, is that mental health is not simply a limited health or welfare issue – but rather a large economic and social policy issue for developed nations. Ineffective policies and practices, which are still the norm in most countries, cost our societies greatly and impose unnecessary harm and suffering on those who are directly affected by mental ill-health. There is now much debate as to whether the mental health field is held back by key structural deficits such as lack of investment relative to the scale and scope of actual needs or whether it just doesn’t lend itself to the types of assessments and effective interventions that make other areas of health care (e.g. cancer care, cardiovascular health) such natural magnets for sustained improvements in health services delivery.

Professor Ian Hickie AM, University of Sydney
Katy Gallagher, as ACT Health Minister and now Chief Minister, makes the case for investment but also doing the co-design and service development in partnership with the community.

However, the reform and development of the ACT’s mental health system is not all about dollars. There has been a clear focus during my time as health minister to deliver new infrastructure as well as forging better partnerships with the mental health industry to inform policy development and lead public debate.

*Katy Gallagher, ACT Chief Minister and Minister for Health*

**Lack of support for the mental health workforce**

While recent changes to Medicare has seen the exponential rise in private psychology services, many authors expressed a view that many mental health workplaces were understaffed, leaving remaining workers overworked. On this basis, the pace of reform has slowed since deinstitutionalisation. This trend appears in many professional settings within the mental health system including: Carers, nurses, psychologists, and psychiatrists. Many authors who work in the mental health sector expressed that they do not feel supported in their role.

There has been some improvement in many institutions and practices over years and it is to be hoped that more improvements will occur. Nevertheless, the clinical staff are pushed enormously and some consideration needs to be given to how to reduce the load that staff carries.

*Professor Peter Baume AO*

Investment is needed to ensure our frontline workforce is sustainable and effective.

*Sue Murray, CEO, Suicide Prevention Australia*

Social isolation and the loss of social identity resulting from caring responsibilities but also from the prevailing stigma of mental illness, is not uncommon. Not surprisingly, carers for a person with a mental illness are at particular risk for developing mental health disorders. While the role of carers is vital to support the recovery of people with mental illness and their ongoing wellbeing, it is unclear what role and meaning, if any, the concept of ‘recovery’ has in carers’ everyday lives.

*Carers ACT*

Herein lies an interesting contradiction, most intensive treatment units house the most highly trained nurses e.g. ICU, CCU, to facilitate the best possible care whereas in psychiatric units there is no specific requirements for trained nursing staff within this speciality. … but often the acute wards have registered but untrained specialist mental health/psychiatric nurses. This is a serious indictment on local service providers. One thing is for sure if there were insufficient specialist staff on ICUs, paediatric wards or CCU trained staff there would be a huge outcry. The absence of this united chorus from health service providers is a sad reminder of the stigma associated with mental illness. Where does the idea emerge that it is okay not to have specialist trained staff for people with mental illness?

*Adj Associate Professor Stephen Niemiec, University of the Sunshine Coast*
Policy framework

Policy frameworks regarding mental health are large and complex. Although Australia has a national plan, implemented at a state level, laws regarding the care and rights of people who experience mental illness differ within the jurisdictions. A number of authors articulated the need for a national framework that is outcomes based and evaluated periodically. Furthermore, some authors stated that reform will not succeed without the involvement of consumers, carers and their families.

Related to the present complex and confused policy arrangements is the lack of clear roles and responsibilities of Federal and State governments. The need for a clean 'line of sight' through policy, funding and program or service delivery was regularly identified as an urgent area for reform.

Organisations, services and programs must be assessed, not in terms of their size or cost but rather, in terms of their specific outcomes. The national targets need to be ambitious, set for the long term, and secure support across all political parties and governments. Thankfully, the mental health sector is now uniting around these targets with the National Mental Health Commission, the Mental Health Council of Australia and others playing critical roles in the setting of these targets. It is essential that Governments do not water down the targets called for by the mental health sector.

SANE

Reforming mental health responses in Australia to provide technologically-literate, integrated services is not a one-time policy gear change. Each technological advance will bring new possibilities and new challenges – but those possibilities can’t be seized, those challenges can’t be addressed, unless we make the decision now to invest in the future of mental health: to engage, to build networks and partnerships, to embrace innovation, and to rethink online and virtual health services as an indispensable part of a 21st century mental health care system.

Aram Hosie, Inspire Foundation

The Commonwealth should rightly set the policy and be a funder. The State and Territory governments should also be a funder/purchaser of services deemed within the National Framework.

Learne Durrington, CEO, Perth Central East Medicare Local

Structural reform of mental health services is easier to achieve than improvements in service quality; support of clinicians, consumers and care-providers is a critical factor in the success of mental health reforms. Mental health reform in Australia looks good on paper, and has been heading broadly in an appropriate, more community focused and recovery oriented direction. However, these reforms are often fragmentary and keep losing momentum. Core local public community mental health services lack adequate investment, are being eroded by plundering by their custodian Local Health Networks or have never developed sufficient breadth.

Professor Alan Rosen, University of Sydney

The poor quality of data and a lack of outcomes data was identified by many authors as a key factor in the failure of policy implementation. Without access to timely, relevant or meaningful outcomes data on the health of people with mental illness, we have little way of knowing if the policy framework is appropriate.

While the search for cures and improvements in treatment of mental illness remain as important as ever, people affected by mental illness and their families want action to address their risks of earlier death from diabetes, coronary heart disease, stroke and respiratory diseases.

David Meldrum, CEO Mental Illness Fellowship of Australia
**Other issues**

*The evidence about what was required twenty, and even thirty years ago, has not fundamentally changed*

Jane Burns reflecting on her early career in suicide prevention in the 1990s makes this point.

In 1998 the NHMRC funded a series of systematic literature reviews aimed at understanding the evidence base around the epidemiology of suicide, risk and protective factors, and the interventions that could be deployed to reduce rates of youth suicide. The evidence across Burdekin and NHMRC was strong. First, that adolescence and early adulthood is recognised as the primary age for the onset of psychiatric disorders; second, that young people are generally poorly served by current mental health services; and third, that certain population groups are more vulnerable to mental health problems. Twenty years on that evidence has not changed.

*Associate Professor Jane Burns, CEO, Young and Well CRC*

Similarly, several authors point to the evidence known and available for a long time in relation to employment, housing, community based care and early intervention and the time passed to bring these forward as services.

**We have many successful programs/services, but these are not scaled to meet needs**

There are many essays which include references to successful programs in almost every setting and context. It's clear there has not been a shortage of innovation and adaption to local needs – what has been lacking is smart investment, robust evaluation, scaling of programs and bureaucratic leadership.

*By Deadly Thinking and the Creative Livelihoods programs, ACRRMH delivers a consistent message that will inspire, promote and achieve active change. Building awareness and understanding through Deadly Thinking is a critical first step in fostering social and emotional wellbeing and in individuals and communities. Creating sustainable ongoing programs through Creative Livelihoods are essential second steps that bring the community together, builds on the awareness, and fosters long term changes in attitudes and beliefs.*

*Australasian Centre for Rural and Remote Mental Health*

The emergence and development of the Australian Government's initial significant commitment to postvention shows foresight and is heartening, yet until all communities and sufficient services are coordinated to provide a community based integrated response, the challenge for postvention services will remain.

*United Synergies, StandBy Response Service*

A number of authors point to the need for investment in mental health as a means to improving productivity for the nation and through the improved investment scaling programs and services to meet the needs. There is also the need to ensure that existing investment is actually addressing needs and not ‘non-needs’.

*Australia’s mental health services sector is subject to several long-standing economic problems. The resource shortages are a well-known economic problem…. Other problems of this sector are not solved by ‘throwing dollars’ as those types of problems are not about resource shortages. (e.g.) …we have some empirical evidence of a tendency for resources in this sector to be misaligned with need… The term that we apply here to this misallocation problem is ‘structural imbalance’. … result in some of the people in need of services not being served adequately by the system; … and involves unmet need (people with a mental disorder not consuming mental health resources), which is well-known, which exists alongside met non-need (some consumers of mental health resources having no mental disorder).*

*Dr. Ruth Williams and Dr. Darrel Doessel, Latrobe University and Qld University*
The continuing rhetoric-reality gap on promotion, prevention and early intervention

A number of authors point to the continuing rhetoric around (mental health) promotion, prevention and early intervention and the gap with reality.

While it is true that mental health promotion (usually followed by ‘prevention and early intervention’) is talked about a lot more right around the globe than a few decades ago, the reality is that with one exception …, there appear to be no comprehensive, population-wide mental health promotion programs in the … world. … there appear to be no comprehensive programs designed to enhance and maintain mental health at a population level other than the Act-Belong-Commit program which originated in WA….

Professor Rob Donovan Curtin University

Youth mental health is a growing area of interest from both an economic and social perspective due to the high rates of mental illness that once identified, have their ‘origins’ in adolescence. … Many organisations such as Inspire Foundation, Headspace and ReachOut.com have already made great headway in providing online mental health support specifically to young people. However, often these services are accessed once a problem or potential problem is identified. Smiling Mind believes there is a step prior to this that the Australian mental health sector has not accessed well – that of the school environment.

Sarah Hardy and Jane Martino, Smiling Minds

Ernest Hunter points to the lessening in support for population health initiatives and the immediate impact in Indigenous communities.

… across Australia there has been a lessening in enthusiasm for population health approaches that will have greatest impact on those least politically visible, amongst whom the Aboriginal and Islander residents of remote Australia stand out. For instance in Queensland, State funded public health nutrition, population level sexual health, and health promotion programs to these areas have either been severely compromised or have, functionally, disappeared. The Cape York Welfare Reform trial was defunded and refunded within the space of one day, and repeal of alcohol restrictions through the Alcohol Management Plan has been muted on the basis of a ‘rights’ argument.

Professor Ernest Hunter, James Cook University

The scale and complexity of change at the organisational level

A number of the essays that outline organisational change over the period since Richmond bring the policy agenda down to the application within services.

As a service provider in the mental health sector it is easy to feel like the sands are continually shifting rather rapidly beneath us. This is particularly true of the last 12 months …. We must not lose sight of how this rapidly changing environment is affecting service users and their families who are constantly hearing about all these proposed changes and new initiatives but knowing little about how exactly they will help them. As a service provider we hear time and time again from people with mental health issues that they just want secure accommodation, meaningful employment, to feel a valued and contributing member of their community and have access to treatment services. For many people there remains a sense that the system still has yet to coordinate these basic services in a cohesive and meaningful way.

Open Minds

Choice Support Services talk about the complexity and extent of change necessary to instil a recovery philosophy and practice in their organisation. The need to move to outcomes reporting is seen by one of the peak community mental health bodies as particularly challenging for the NGO services.

The sector must come to grips with the challenge of agreed outcome measures that demonstrate service effectiveness, while simultaneously becoming peripheral rather than central to the lives of the people who use our services. The emergence of Partners in Recovery, with its mandate for system
transformation, can provide the support and practice model for this vision, but it will take strong national capacity building to begin to seed these changes at local and regional levels.

Qld Alliance Mental Health

The policy barriers to employment

Repeatedly through the essays from the employment sector partners and some of those from consumers and carers, the issues around Australia’s employment policy in the way they work against engaging people with mental illness is highlighted. The policy barriers work hand-in-hand with stigma and discrimination from some employers.

NESA believes that to effectively and positively improve the level of workforce participation and inclusion of people with mental illness we need to develop a more holistic assessment framework at the front end of the social security and employment services system. There is a need for a framework which is can identify and accommodate the servicing needs of both clients with diagnosed conditions and those who have undiagnosed and/or undisclosed mental ill-health as too often it is not until individuals are connected to employment services that issues such as mental illness are identified.

Sally Sinclair, NESA

It takes specialist skills and experience to provide effective employment services to those with mental health issues. Often job seekers with psychological symptoms are poorly assessed, undiagnosed or misdiagnosed. Sometimes they do not even fully acknowledge their own condition.

WorkFocus Group

This point from WorkFocus emphasises the need for tailored and specialised support and not the one size fits all approach of Job Services Australia. In discussing more effective responses to long-term unemployed for 45+ year old men, Anthony Smith makes a similar point:

One of the most effective measures to ensure the on-going mental health and well being of mature-aged men who are unemployed or facing redundancy is to support them back into meaningful employment. This can only be done through a quality ‘men-friendly’ program that supports the men to re-envision not just their future career, but their future life. A significant leadership role is needed to facilitate a broad collaboration between Government, Industry and the labour movement to implement a full-scale, national, comprehensive approach to this issue.

Anthony Smith, Male Health Consultant

The need to address the social determinants of mental illness, particularly along Aboriginal and Torres Strait islander peoples

Four perspective essays specifically address issues relating to Aboriginal and Torres Strait islander peoples. Common within these essays is the need to look beyond mental health services to address the social determinants of Indigenous disadvantage. Indeed to continue to define Indigenous mental ill-health and suicide in particular through a service deficit paradigm will be of little benefit and maybe harmful. Even large scale interventions, such as ‘Closing the Gap’, Colin Tatz argues, are yet to yield any reductions in Aboriginal deaths due to suicide.

There is urgent need of public and professional education which explains that not all suicides are due to mental illness, that many, even most, of the causative factors are to be found in the social, historical, sometimes geographic, sometimes cultural, and economic environments. ....‘Closing the Gap’ and similar programs have yet to show any signs that self-harming, parasuicide and actual suicide are reducing in Aboriginal communities.

Professor Colin Tatz AO

This view is supported by Ernest Hunter, a psychiatrist with four decades experience of working with Indigenous peoples in the Kimberley and Cape York. He notes the impact of public policy on the intergenerational ‘waves’ of indigenous mental health problems:
The increasing burden of mental health problems has been complex and occurred in a series of ‘waves’ that may be considered as a cascade of precedent-setting issues and policy/service priorities. From a baseline in the first half of the last century in which mental disorders and problems were little seen and less commented on, there were dramatic rises in alcohol problems through the 1970s, accidents and violence (associated with the former) through the 1980s, adult suicide in the 1980s and 1990s, disabilities associated with compromised intrauterine development (including alcohol effects) in the 1990s and 2000s, child suicide in the 2000s, cannabis use and dependence in through that decade and, recently, psychotic disorders.

Professor Ernest Hunter, James Cook University

The importance of addressing racism as one of the key social determinants of indigenous mental ill-health is addressed by Rachelle Irving, currently working in the Kimberley and by Melissa Sweet and Professor Pat Dudgeon.

But it seems that in most mental health policy documents and statements, discrimination more broadly is framed largely as a consequence of mental illness, rather than as a determinant of mental health and wellbeing. .... Reducing the mental health toll of racism requires leadership and action across all levels of society, including community education campaigns to make the full extent of the problem more visible and widely understood.

Melissa Sweet and Professor Pat Dudgeon, Macquarie University
Chapter 9

The Mental Health Workforce in 2013: Recovery from surgery is long and painful without due care

Peter Long, John Mendoza and Amy Elson
Introduction

This Chapter seeks to paint a picture of the present workforce and the issues it confronts. It is as if painting it through a frosted window because there is moving data and in some cases limited or no data to use upon the canvas.

A number of themes identified in the historical analysis continue to be evident in the mental health workforce of 2013: federalism continues is an ever-present backdrop; the taxonomy of staff has broadened, and their roles are identified; the location of the workforce has changed and the type of practices they engage in varies across the sector; workforce culture impacts across the system; and three issues continue to plague administrators – staff recruitment, retention and efficient utilisation.

Federalism

Australian federalism is an ongoing backdrop to policy development and provision of services in the health field. In 1901 the Commonwealth was not given any powers to deal with health matters, yet today it is firmly astride the matter in response to community concerns with access, cost and quality of health and subsequently, mental health.

There is no doubt that cooperative federalism through COAG, has paid dividends for mental health in terms of raised consciousness of mental health matters, suasion on the states and territories to pay attention through tied grants, billions of dollars of investment, attempts to improve reporting and standard data collection, to name a few.

Despite this, it is clear there are serious and persistent inequities with access to mental health services across our nation and federalism is implicated as an obstruction.

National implications of our federal system of government for the mental health workforce include:

- Hundreds of employers – limiting focus and creating inertia to and complexity with change.  
- Numerous employment awards – pay and conditions vary both vertically and horizontally.  
- Various professional accreditation requirements – limiting mobility, training articulation, and time-to-market of graduates.  
- Various provision or service standards – limiting workforce mobility, integration, outcomes.  
- Political ‘duck-shoving’ on accountability – creating governance and workforce leadership issues, destroying in-full-on-time performance, lowering morale and causing distress.  
- Lack of transparency regarding the assignment and utilisation of funds directed to mental health – limiting investment in workforce.  
- Focus on inputs at expense of outcomes – failing to achieve a return-on-Investment (ROI).

Consequently, it is difficult to get any clear ‘line-of-sight’ on outcomes or progress toward intentions.

Taxonomy of mental health workforce in Australia: who’s who?

The contemporary mental health workforce in Australia has broadened in recent years from those roles discussed earlier. This is largely because the paradigm of care has altered as a consequence of a better understanding of the epidemiology and aetiology of mental health. The World Health Organisation provides a diagrammatic explanation of the new regime (Figure 9.1) and this has been adapted for this discussion.
What this highlights, as we ascend the pyramid, is that many who report a mental health problem or illness do not seek treatment from existing services, but find a way to cope and move on (to become self-carers). Effective self-care relies upon sufficient mental health literacy. Something that has shown to be improving but still poor when compared with many common physical illnesses. The aim of a ‘healthy functioning system’ would be to ensure all citizens can ‘self-care’ to the optimal degree.

Some members of the population need, at some point in their lives, some support to manage an ephemeral mental health condition or low intensity but chronic condition and utilise ‘Informal community care’ – perhaps a clergy member or a Pastoral Care teacher, information services, or an NGO. These are very low cost services to meet many of the needs of a large number of clients. Equipping a larger number of gatekeepers and bystanders to provide support and help a person with ongoing needs or someone struggling to comprehend an early episode of mental illness, is known to be effective and therefore an effective ROI on any government investment. Many workers in these settings probably will not identify as mental health workers.

Mental health provision through ‘Primary Health Care (PHC) services’ is led by GPs with guidance from specialist mental health workers supported by numerous ancillary services for early diagnosis, intervention and recovery. Applied psychological therapies (e.g. CBT) and pharmacology can be utilised depending on severity and type of need. This area is one area where there has been considerable workforce turbulence in Australia and, increasingly, workers in this sector recognise themselves as mental health workers.

‘Step up-step down’ models recognise that a relatively smaller group of users may need a range of services from community and general hospital psychiatric care to ‘long stay facility’ support and ‘special’ services. The workforce handling this more acute and, perhaps, enduring mental illness would consider themselves centrally within the mental health workforce.

Traditionally, the pyramid of care has been inverted and the majority of funding and national reform attention has been focussed on acute care and the medical apex, with the resultant limited (and poor) access to support for the majority of Australians.

---

Within this changed service paradigm, it is possible to summarise here the key and emerging roles in the workforce, definitions, roles and issues.

**Psychiatrists** are at, and largely remain, the technical pinnacle of the mental health profession. They work in public hospitals, community mental health services and in private practice but predominately the latter. Issues relating to the psychiatry profession include:

- Poor remuneration (compared to other medical specialists) but high out-of-pocket costs.
- Too few overall, declining (just 12.9 FTE/100,000) and distributed poorly both across the sector and geographically with over 87% located in major cities.
- Ageing – over 41% are over 55 years.
- Utilised too operationally and, therefore, compounding the constraints of scarcity.
- Locked into medical model of training: this impedes national attempts to build extra capacity.
- Complexities for coordination across the system – public/private; hospital/community.

**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 if not the core (50–60%) of the traditional mental health workforce. Issues relating to them include:

- Too few and distributed poorly across the sector and geographically with almost 75% employed in major cities.
- Ageing – in 2011, average age was 47, 61% are over 45 and 3% (approx. 540) are over 65.
- Remuneration not differentiated to account for danger, stress and high demand.
- Training traditionally focussed on institutional setting and inappropriate for community setting
- Hundreds are still employed within stand-alone psychiatric facilities.

**Psychologists** – the last national survey of psychologists was conducted in 2004–05. At that time there were over 22,000 registered psychologists. Psychologists consult with individuals and groups, assess psychological disorders, and administer programs of treatment. They do not prescribe medication, and according to the APS have spearheaded the development of non-pharmacological treatments. Specialisations require additional postgraduate study. Issues relating to the psychology workforce include:

- Overall numbers appropriate but many moving to private sector
- Specialist psychologists relatively underutilised
- High gap fees for private services
- Poor distribution in rural and remote areas
- Considerable disaffection within the profession with regard to accreditation requirements.

**General practitioners** (GPs) are medically trained with a general health focus and are the first point of professional contact for a great majority of people (75%) seeking help with mental health problems. There are approximately 25,000 GPs in Australia. Based on Medicare and BEACH data approximately 12% of all consultations with GPs are mental health related matters. Issues relating to this element of the workforce include:

- Up-skilling GPs to provide improved assessment, early intervention and care

---

4 Ibid, p 123.
6 Ibid, p 124.
7 The Senate Community Affairs Reference Committee 2011. Inquiry into Commonwealth Funding and Administration of Mental Health Services. The Australian Senate, Canberra.
Incentives to enable GPs to lead community support for mental health consumers to divert them from hospital and long-stay institutions and providing leadership for local promotion and prevention campaigns

Incentives to move medical practitioners to mental health as a specialty (Psychiatry).

Social workers are university trained and have capabilities which span the mental health and community support functions. Traditionally, working mainly in the public sector, their capability (as case workers and counsellors) has been increasingly valued in the private and NGO sectors. Issues include competition for recruitment by both other mental health agencies and wider care agencies.

Occupational therapists are university trained with a rehabilitation focus within a medical regime, which has been useful to assist people to adjust to environmental factors in the mental health field.

In addition, there are many other health professions working in mental health and include: art therapists, dieticians, drama therapists, music therapists, physiotherapists and speech and language therapists, who also work across both institutional and community care settings.

Community mental health workers are part of a growing but diverse workforce. There is presently no national, reliable data available for this critical workforce. In the UK formal qualifications for these workers have been required for almost ten years. They are called “Support Time and recovery (or STaR) workers and provide a mix of roles to coordinate care, provide some applied therapies and advocate for clients’ needs. There is no equivalent qualification or classification in Australia. An estimated 34% of this workforce has a VET qualification (Certificate 3 and or 4 in related fields) and 43% a degree or higher qualification. Many have moved from other sectors or industries and ‘learnt on the job”. The vast majority work in small organisations that operate in only one jurisdiction creating significant issues with quality and consistency of care. Without clear models of services, standards of practice and competency framework there is role confusion, pay and condition inequities, and a range of other workforce challenges.

Aboriginal mental health workers have a variety of backgrounds (not necessarily ‘health related’) but an understanding of culturally appropriate treatments and environmental issues is central to their role. These workers are engaged across the spectrum from acute institutional care to community intervention. Issues include growing demand, inequitable remuneration and inadequate support and training.

Carers of people with a mental illness provide individual and sustained support. Traditionally, carers have been family members but, increasingly, paid carers have become part of the landscape. Issues for this group include identifying and ensuring appropriate competencies and ensuring equitable remuneration and conditions (e.g. OH&S).

Consumer consultants are officers in the private sector, a limited number of public sector settings or employed by NGOs to provide advice to consumers on appropriate providers, treatments, rights, redress, and access for participation. Carer consultants are officers in the private sector or employed by NGOs to assist carers in improved methodologies, training, rights, redress, and sustainable practices.
**Evolution of workforce:**

As the focus has moved from an illness to a disability and in some instances a wellness paradigm, more complex forms of expertise and support have been added to the workforce. The figure below provides a snapshot of the range and evolution of the workforce and points, perhaps, towards growth in future requirements.

**Figure 9.2: Evolution of mental health workforce**

![Evolution of mental health workforce](image)

**Figure 9.3: Structural-functional analysis**

A big picture workforce analysis of the roles, training, remuneration, status, employment field and tools used is captured in the following figure (Figure 9.3). This draws attention to the job type (e.g. Mental Health Nurse, Psychologist), the role they play generally (e.g. medical, talking, social rehabilitation) and the tools they might utilise (e.g. drug therapy or advocacy)\(^{11}\). It also adds the demarcation issues (restricted or open entry); the probable source of funding (Government or NGO); the complexity of the competence base; and the comparative status and remuneration. There will be exceptions but this serves as a brief, integrated view of the workforce and supporting structures.

---

\(^{11}\) Adapted from Table 4, P31 Workplace Research Centre, 2009 Mental Health Articulation Research Project Services and Workforce Study, Draft report 4 Feb.
Where is the workforce deployed?

Governments report as if institutionalisation as a mental health practice is a practice of the past, yet this year around 30% of all state and territory funding in mental health will still be allocated to the stand-alone psychiatric hospitals. Given that Victoria, ACT or NT do not have such facilities this is an even higher percentage of resource in the remaining jurisdictions.

Furthermore, in recent years in some jurisdictions, we have seen the development of the “Psychiatric Emergency Care Centre” or PECC separate to, but located on, the campus of a general hospital. This was done without any reference to international evidence. These represent a quasi-form of the old institutional system of care semi-detached from the general hospital system with separate lines of accountability and clinical governance.

Others suggest that psychiatric hospitals have been replaced by long-care options in General Hospitals, or by the overuse of correctional institutions and now the invisible ‘back ward institutionalising process’ of community-based care (hostels, aged care homes).

The implications of this are: first, there is still a long way to go to transition institution-based employees into community settings and to provide the necessary (essential maybe) skills. Second, the culture of such institutions can be antithetical to modern practice and modern workplaces, such that while they exist, disgruntled staff members are more easily enticed into private practice, or alternative careers, contributing further to shortfalls in mental health services. Third, if alternative institutions such as aged care facilities are now having to provide care for residents with mental illnesses, then major requirements for training in mental health and recovery programs, are required for these workforces.

---

12 As a comment, it is inconceivable that a large capital investment would be made in any other area of health care without sound evidence to support a particular model of care. Yet this is precisely what has happened in relation to the PECCs established by the NSW Govt in the 2000’s.

13 See coverage of the ‘staff revolt’ at the Baillie Henderson Hospital in Toowoomba reported in March 2013 at the proposed scaling down of the numbers of units there from 8 to 3 by 2015.
As stated earlier in this chapter mental health workers operating outside the Psychiatric institutional (hospital) are found in an increasingly diverse range of settings. There are an estimated 14 789 – 26 494 employees employed across the NGO sub-sector alone\(^{14}\). The commitment of these NGO service providers to their clients is demonstrably high and governments are often keen to pass the service responsibility to these groups in the hope of an equally high return on investment. Workforce issues that are evident in these settings include: de-professionalisation, unpaid labour, limited training opportunities, OH&S issues, and inadequate supervision and governance.

The diversity of settings however, does not translate to equitable distribution of the workforce across Australia. On the contrary, a continuing problem is the maldistribution of the workforce as shown in the following table. Indeed in some major regional areas, such as Regional WA and Central Queensland, there are virtual no psychiatrists – public or private. This is In spite of recommendations to address the crisis over the past 20 years\(^{15}\).

<table>
<thead>
<tr>
<th></th>
<th>Metropolitan</th>
<th>Inner and outer regional</th>
<th>Rural and remote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>16.4/100,000 pop’n</td>
<td>3.4–5.8/100,000 pop’n</td>
<td>4.6/100,000 pop’n</td>
</tr>
<tr>
<td>MH Nurses</td>
<td>81.7/100,000 pop’n</td>
<td>47.8–78.6/100,000 pop’n</td>
<td>38.8/100,000 pop’n</td>
</tr>
</tbody>
</table>

Table 9.1 Distribution of key mental health staff metropolitan and remote

The vast majority of psychologists and GPs, who make up the core service providers for the provision of primary mental health care, operate in small private practices. It is rare that GPs and psychologists and other mental health professionals, such as mental health nurses, operate as a co-located multi-disciplinary team. Providers are scattered and only modest efforts (such as the Mental Health Nurse Incentive Program) have been undertaken to build more collaborative care despite the abundance of international evidence to support such models of service delivery. This again means it is difficult to roll out models of service, practice guidelines and the like to ensure a consistent quality of care.

**A full complement of staff**

Various reports and evaluations coupled with national plans and numerous state strategies all attest to the fact that there has been a crisis in attracting and retaining staff in mental health across Australia. Yet to know what is needed for sound planning, knowing what you have, knowing what you will lose (through retirements and natural attrition) are basic data – but knowing what you have is the starting point. Presently it is not clear if anyone knows the answer.

It will be noted that the Australian Institute of Health and Welfare reported only psychiatrists and mental health nurse numbers in its 2009 and 2013 mental health workforce reports, as data are not available on other categories as yet.

---

Culture

Many reports on mental health allude to the fact that the workplace culture in many settings is not conducive to attracting and retaining staff. Contributing to this are:

- Demand pressures, both in terms of bed occupancy rates and complexity of needs, in acute care facilities often create feelings of being overwhelmed and that intervention is hopeless.\(^{16}\)
- Recovery results for acute care are compromised and less than ideal (i.e. approximately 1 in seven clients are re-admitted within 28 days)\(^{17}\) leading to feelings of inadequacy among staff.
- Clinical supervision is limited or not available e.g. indigenous, private practice and isolated practitioners, and for some professionals not steeped in the ‘supervision ethic’, leading to emotional and ethical concerns.\(^{16,19}\)
- Leadership in larger teams is often provided by individuals who may be technically competent but who have not been trained in, or able to display, appropriate leadership capability, raising the spectre of low morale, bullying, grievances, performance issues.
- Highly unionised and licence regulated nature of medical workforce leads to major demarcation issues and dissatisfying roles for many.\(^{20}\)
- Paradoxically, isolated workers are often required to undertake roles and display competence outside their designated roles, which is both stimulating but demanding. Leading to possibility of burnout and stress related issues for workers.\(^{21}\)
- Threatening incidents and violence created by clients create a fearful environment and stress related issues for staff.\(^{22}\)
- Long hours and sustained over-commitment, lead to burnout and lack of work-life balance, causing collateral damage in worker’ families, health, fitness and avocational interests.\(^{23}\)
- Pay scales vary but are reported to be lower than other medical areas – psychiatrists are among the lowest paid medical specialist; mental health ancillary workers are paid less than equivalent workforces (e.g. Corrections) – leading to motivational dissatisfaction.\(^{24}\)

In this context, it must be noted that the workforce is providing service during ongoing times of disruption and change, and it would be remiss to paint a picture of the culture which didn’t factor in dedication, concern, care and professionalism. Further research into the culture(s) which prevail in the mental health system would facilitate change, improve support and provide better ‘branding’ for recruitment and retention.

Summarising the structural analysis

The contemporary available evidence on the mental health workforce in Australia suggests that three major challenges have been ongoing for the sector and these are:

- Attracting more workers into the sector
- Retaining those workers attracted and presently engaged
- Improving the efficiency and effectiveness of the workforce – the quality of care.

Each will be discussed briefly here in full recognition that the enormity and complexity of the challenge(s) is beyond the scope of this Report.

\(^{16}\) CSHISC 2009. Western Research Institute, Mental Health Articulation between VET Providers and Universities. P. 10, 18.
\(^{18}\) Op Cit p. 58-62.
\(^{19}\) WA Peak Bodies 2008. Workforce in Crisis: Value our Community Services… value our workforce pp 60.
\(^{20}\) 20 Op Cit. p. 63.
\(^{22}\) Op Cit p. 64.
\(^{24}\) Ibid. p. 25.
Efforts to attract

All jurisdictions have long recognised that having adequate staff to meet the current and emerging needs of the Australian community is a service imperative in mental health reform. It is also apparent that the demand for services will rise given increased mental health literacy, and possibly also due to an ageing population and increasing dementia type conditions, and broadened community penetration of services and assessment.

At the federal level various initiatives have been implemented:

- Increasing the number of places in higher education for some of the specialties (e.g. psychiatrists; GPs; nurses) to stimulate supply.
- Offering incentives to attract GPs to specialties in the mental health field, to boost the national capacity to deal with the acute and complex conditions.
- Increasing the number of Scholarships to study in the field.
- Enabling regional provision of higher education in mental health specialities in the hope of attracting regional students (who also may be more inclined to remain in the region and serve severely under-resourced regional, rural and remote communities).
- Offering regional hospital placements to students during training.
- Targeting special groups (e.g. ATSI).
- International recruitment.

However almost all these initiatives have been too little too late and not scaled on sound data to meet needs. Large workforce gaps remain and will probably increase in critical work groups and areas. Systemic issues (e.g. culture) may need to be addressed to raise the value of the mental health brand.

While major efforts have been taken to attract overseas workers, Western Australia reports the overall outcome for mental health has been minimal. However, should the various services be successful in attracting sufficient workers, it may be to no avail as they may not remain in the mental health system as a result of retention issues.

Efforts to retain

Some jurisdictions report strikingly high turnover rates (e.g. National 14.3% with WA 21%; Victoria up to 22% and Queensland NGO workforce 50% turnover within 2 years). This is serious if not crippling for any organisation or sector. Estimates of the cost of having to replace a key worker can be as high as three times the annual salary of the officer replaced, making the cost of such a workforce attrition rate unsustainable. For those critics who are now asking – ‘where did the billions of dollars allocated to mental health go?’ – retention failure is a part of the answer.

On top of the direct costs, loss of service, loss of expertise, loss of impetus, and loss of direction are significantly linked to low retention ratios and are symptoms displayed by mental health in Australia.

---

29 WA Peak Bodies 2008. op cit pg36.
Why retention difficulties?

First, it is convenient to utilise the WHO experience, which categorise the factors that influence the recruitment and retention of health professionals and organisations as including:

“... adequate remuneration, compensation, purposeful change management, fairness, inclusiveness, interdisciplinary relationships and social support, leadership, management style, open communication, flat organisation structures, access to professional development, worker and effort recognition programs, safety and wellbeing, social responsibility, work organisation, work-life balance and work space and supportive technology.”

In the various reports and assessments accessed for this analysis, issues relating to most, if not all, of these factors, have been reported as inadequate or problematic in many jurisdictions. Added to them, as the mental health workforce spread into the community, there was increased competition for staff from other care agencies and NGO providers.

Second, in rural and remote areas, particular concerns are raised, such as:

- Poor quality of life in small and isolated communities (schooling, friends, safety) failing to encourage all members of a family (especially the spouse) to stay.
- Limited ability to receive adequate professional development, supervision, and community of practice.
- Inadequate differential remuneration for workers in isolated areas to compensate for regional, remote, or isolated high-cost lifestyle.

Initiatives taken to address the inability to retain staff include:

- Restructuring the workforce to spread the load – engaging more GPs into primary care, encouraging more GPs to do more mental health consultations, engaging skilled community workers to support recovery, including psychologists more directly in collaborative primary care teams to reduce burden on medical staff.
- Job broadening to make work more fulfilling – GPs to assessment; Nurses to Nurse Practitioner; Psychiatrists as consultants.
- Part-time and sessional arrangements to deal with over loading in acute care and regional and remote areas.
- Locums for regional areas to assist work-life balance.
- Financial incentives to remunerate more equitably – tax changes and/or incentives, Medicare rebates and timing adjustments and practice bonuses.

After 20 years of reform, and in spite these efforts there appears to be little evidence that the tide has turned. Clearly 20 years of the same is not an option given the staffing limitations and the growing user demand for services.

Efforts to improve efficiencies and effectiveness of workforce

As previously related, the emphasis in Australia in the post-institutional era has been on acute care and hospital based treatment of the mentally ill. Patients requiring acute care are but the dramatic and pointed end of a much larger client group.

Even to treat the acutely ill, those 600,000 Australians identified as ‘severely disabled’ by mental illness, there are too few psychiatrists, even fewer in the correct geographic locations, and chronic shortages within the public sector. Although psychiatrists are sensitive to the criticism that they operate in private

---

33 Victorian DOH op cit 2009, p. 44.
35 Op Cit. p.36.
practice and face too few acute care and crisis intervention clients, overrunning the public sector and general hospitals, demographic studies and international reviews have supported this assessment.37

One recent report concurs on this issue:

“Nationally and internationally, attention is shifting to strategies that maximise the effective use of specialist mental health staff through different workforce configurations and new and amended workforce roles, including expanded scopes of practice (e.g. nurse practitioners).38

Other ways forward include:

- Psychiatrist to act as a specialist consultant over a mental health team comprised of professionals (GPs, nurses, social workers), Allied Health workers, para-professionals, community care workers, and carers.
- GPs to be front line (primary care) and work with support of consultant psychiatrists.
- Integrated ancillary support to deal with physical and environmental stressors.
- Training of the workforce to provide appropriate diagnosis, early diagnosis, early and appropriate treatment, prevention, and rehabilitation, ‘step-up and step down’ approaches to ongoing management, mental health literacy to the broader community and first-aid skills to first responders such as, carers, police, and corrections’ personnel.
- Integration of public sector, NGO and private sector training for quality and effectiveness.
- Development of shared competency sets and team competency sets to further break down professional boundaries.
- Well planned programs to address workforce cultures characterised by outdated work practices and models of treatment, hierarchy, disrespect and bullying, acute-care biases and stigma, constrained innovation and poor governance.

Conclusion

Perhaps it is timely that ‘consumerism’ and evidence of the efficacy of collaborative primary mental health care, early intervention for younger people and community-based recovery services, converged.

Perhaps, given the realities of the workforce, it is the moment for making a ‘virtue out of necessity’ as policy moves to adjust the way mental health is approached in Australia from acute-care hospitalisation to a broader, community-based and recovery-focussed approach. The effort now must surely be to value-add and leverage the efficacy of the specialist knowledge of the mental health professionals through deploying them to support frontline healthcare clinicians, such as GPs and other specialist.

The present workforce is broader and more diverse than it was thirty years ago, and as the system more appropriately defines itself and refines its practices it will further encapsulate workforces from other professions and jurisdictions (community, disabilities, Justice) and attention will be needed to inform and train these groups.

The choice is stark – either we apply what we know from the past 20 years of effort, accept our failures, and crawl our way back to an effective and functioning system or we move from crisis to emergency status in a decade.

As a consequence there is need to explore ways to continue to ‘value add’ to the efforts to mobilise the workforce in the service of Australians with a mental illness.

Obsessive Hope Disorder
Chapter 10

An analysis of governance and accountability in mental health

Sebastian Rosenberg
Introduction

This chapter aims to provide a brief overview of the current state of these two vital aspects of our mental health system.

Governance

Australia is regarded as a worldwide leader in the production of first class mental health strategies and plans. The problem has always been and remains implementation.

Four successive five-year National Mental Health Plans, beginning in 1993, have largely driven governance of Australia’s mental health system. Each Strategy was timed to coincide with the Medicare Agreements which were at the time the main vehicle by which the Commonwealth Government allocated health funding to the states and territories.

It is generally felt that the First National Mental Health Plan had the greatest impact. With some new funding to back it up, this Plan offered some incentives for states and territories to reconsider how they provide mental health care and in particular, commit to the process of closing down the old mental health institutions. In their place was to be a range of new community mental health services, designed to give people a decent shot at living well, in their own homes with support when required. This first strategy also gave new voice to the rights of consumers and carers.

Some states, particularly Victoria took advantage of the incentives offered in the first Strategy and did invest in a range of services offering alternatives to hospitalisation. Here are the seeds of the growth of Victoria’s Psychiatric Disability Rehabilitation Support (PDRS) sector which until recently clearly led the nation in the provision of this range of services.

Other states merely closed their asylums and kept any savings or redirected them to the provision of psychiatric services in the wards of general hospitals. The situation varied from jurisdiction to jurisdiction, the Commonwealth permitted this variation with little or no sanctions to prevent it.

This trend has continued in subsequent national Plans, where general goals are agreed by state, territory and federal governments but without any system of incentives or sanctions to ensure consistent implementation across Australia.

This partly explains why NSW has 2650 mental health beds – more than double the number in Victoria though NSW’s population is less than one-third larger. NSW also directs 53% of its total mental health budget towards services to be provided in psychiatric hospitals or psychiatric wards of public hospitals, the highest proportion of any state. The national average expenditure on these services is 43% and while overall per capita spending on mental health between NSW and Victoria is comparable, this figure is only 32%.

By the time of the fourth Strategy, the mental health sector largely viewed the document as well-intentioned rhetoric but little more. In Australia’s federalist system is really falls to the national government to drive national reforms. In mental health, following the laudable initial efforts under the First National Mental Health Strategy, the Commonwealth has become increasingly disinterested in providing the leadership, incentives or sanctions to drive nationwide reform. As a result, the jurisdictions have largely proceeded on separate tracks, pursuing different types of services and programs.

As a consequence, the nature of the services and care available to a person with mental illness will vary markedly depending on where the person lives. It is a fractured, piecemeal system characterised by inequitable access to care.

Looking specifically at some mechanisms for governance, the responsibility for managing each of the four Strategies fell to a national meeting of departmental officials, the Australian Health Ministers’ Advisory Council’s National Mental Health Working Group (NMHWG). This Group also established the Mental Health Information Strategy Sub-Committee (MHISS) and the Safety and Quality Partnership to manage these areas. In the course of their work, at various times, each of these groups added some members from the community sector, a consumer and a carer. In truth and again in the absence of national leadership, all these groups were dominated by state and territory mental health officials. While some
important projects have occurred under these arrangements, these meetings became increasingly concerned with managing the ever-expanding reporting requirements as the Australian Institute of Health and Welfare, the Department of Health and Ageing, the Productivity Commission and others all sought similar information and different times.

The Working Group engaged overseas consultants on three occasions to evaluate progress under each Strategy (see below and the summary of each evaluation report provided at Table 3.2). The Working Group reported to Health Ministers and the cycle continued for another five years.

These governance arrangements failed to institute regular, independent monitoring and reporting of progress towards mental health reform. The public servants participating, unsurprisingly, became mostly concerned with ensuring the policies their respective governments were seen to be effective.

**The Council of Australian Governments (CoAG)**

These governance arrangements were largely unaltered until 2006 when, first the Mental Health Council of Australia\(^1\) and then the Australian Parliament\(^2\) both published quite damning reports into the crisis affecting mental health care in Australia. These reports were the catalyst to engage a new player in mental health governance, the Council of Australia Governments (CoAG). CoAG effectively elevated governance of mental health, specifically a new National Action Plan for Mental Health 2006–11 out of the province of health ministers and into the realm of first ministers (Premiers, Chief Ministers and the Prime Minister).

CoAG’s intervention brought new funds and scrutiny and added yet another report to the list for departmental officials to manage. CoAG published its own *Roadmap for Mental Health 2012–22*\(^3\) and appeared to establish a competing set of governance arrangements. A new Working Group on Mental Health Reform co-chaired by the Commonwealth Minister for Mental Health and the Victorian Minister for Mental Health was set up to oversee CoAG’s work. Membership of the new Working Group includes one official from each first minister’s department and one from each health department or mental health commission. So as to promote a whole-of-government approach, the Working Group also includes one additional member from each jurisdiction, from portfolios such as early childhood, education, employment, housing, homelessness, indigenous, regional affairs, community services, disability, drug and alcohol and justice. Each jurisdiction is therefore entitled to send up to three officials making a group of twenty-seven members.

CoAG also authorised the establishment of an Expert Reference Group (ERG), headed by Allan Fels, Chair of the National Mental Health Commission. The ERG is comprised mostly of state and territory nominees rather than departmental officials but the extent to which it will have genuine influence over governance is unclear.

CoAG also agreed to revive the National Mental Health Report series of publications\(^4\) despite the 2010 Report having previously been published as the final, pending establishment of new reporting arrangements. CoAG’s Roadmap commits it to three-yearly reporting once the data items have been agreed by the end of 2013. This means the first report on progress under the Roadmap could be reasonably expected by 2017. The Roadmap sets no targets or concrete goals to achieve and, crucially, leaves the states and territories completely autonomous in how they manage their mental health systems, what services they choose to invest in and by when.

**Mental health commissions**

The new kid on the governance block are the three mental health commissions established first by Western Australia, then by the Federal Government and most recently by the NSW. The rhetoric behind each commission is similar, to identify and prosecute mental health reforms. But the models of each

---

organisation are quite distinct. They are set up differently, some with statutory legislation others as executive agencies. Only WA’s model holds the budget for mental health expenditure, operating in fact just like a normal government department in this regard with all the same reporting and budgeting requirements. Both the National and NSW Commission’s will need to exercise their influence if they are to change the way the business of mental health is conducted in their jurisdictions. It will need to be an influence of ideas, solutions and political support if they are to have any sway over the traditionally big players in the system, the various government departments especially Health. There has already been some confusion and tension in that responsibility for key aspects of mental health policy now seems split between the new commissions and other agencies principally Health. In the absence of clear delegation, it is likely that in the short to medium term this confusion will continue and perhaps escalate. Queensland has committed to establish its Commission shortly.

It is too early to tell if the Commissions are delivering more resources, better care or more transparent reporting. Early indications are that the commissions are giving new opportunities to consumer, carer and community organisations to have their say in matters of mental health reform.

**Consumers and carers**

One critical aspect of the national governance of Australia’s mental health system has been the stunted attention and resources allocated to permit the views of consumers and carers to influence policy.

One of the strengths of the first National Plan was the emergence of the National Community Advisory Group (NCAG), comprised of mental health consumers and carers. This national body sat atop a nascent group of state based CAGs established to provide oversight of the first Plan from a consumer and carer perspective.

During the second Plan funding was removed from the CAG structures and the government chose to create the Mental Health Council of Australia (MHCA), a different group with a different purpose. The NSW-CAG is the only remaining of the original organisations. A National Mental Health Consumer and Carer Forum was established under the auspices of the MHCA with nominees provided by each state and territory government. Even with goodwill and emerging consumer and carer policy sophistication, token funding has severely limited the effectiveness of the Forum. Perhaps more importantly, the state and territory consumer carer representative organisation structure has been largely dismantled. While there are active consumer and carer organisations these are generally very poorly resourced.

On this basis, consumers and carers have really struggled to have a significant impact on the governance of Australia’s mental health system. Their epithet “nothing about us without us” too often rings hollow in the face of what remains too often a tokenistic engagement.

From the initial blush of genuine enthusiasm which accompanied the First National Mental Health Plan, the governance arrangements for successive Plans have contributed to waning interest. The focus on the role of departmental officials has alienated many service providers, particularly those working in the community and has marginalised the views of consumers and carers. Prospects under COAG seem little different placing even more pressure on the new mental health commissions to deliver new governance and greater participation.

Perhaps the greatest governance challenge remains ensuring our system is based on the best evidence about what works and what consumers want and that it can deliver regular, independent monitoring and reporting on progress.

---

Accountability

“The Strategy advocates monitoring of progress made in particular areas, but does not specify targets”

Evaluation of First National Mental Health Strategy

“At present it is not possible to track changes in the mental health status of Australians”

Evaluation of the Second National Mental Health Plan

“Many of those we consulted expressed a need for more clearly identified targets to be set and regularly measured at the national level, to guide and assess the performance of mental health services. Such arrangements should include performance targets...”

Summative Evaluation of the Third National Mental Health Plan

A distinguishing feature of all four national mental health plans has been the commitment to develop new systems of accountability for mental health so as to better track the lives of people affected and the impact of mental illness on the community. As can be seen above, Australia has largely failed to develop this system, leaving us outcome blind6.

A recent report calculated that Australia spends more than $28bn each year supporting people with a mental illness7. Given the scale of the problem, it seems remarkable that Australia has chosen to invest so little in better understanding mental illness and the impact of care. There have only been two National Surveys of Mental Health and Wellbeing, one in 1997 the other a decade later. These surveys provide vital insight. It is understood that these surveys cost around $6m which seems a paltry sum in comparison to the cost of mental illness. We need bigger and more regular surveys into different aspects of the community’s mental health.

One of the key consequences of our past approach to governance has been to focus mental health accountability much less around assessing people’s lives and much more on the health and hospital administrative data sets which can fulfil bureaucratic reporting obligations. At last count there were at least eight different mental health indicator sets including:

1. Fourth National Mental Health Plan Measurement Strategy
2. National Healthcare Agreement
3. Report on Government Services (Productivity Commission)
5. Key Performance Indicators for Australian public mental health services
6. COAG Action Plan on Mental Health
7. National Health Performance Authority

It is likely that to this list, the new mental health commissions may well add their own indicator sets as they look to fulfill their remits to provide better community reporting, such as proposed by the National Commission’s Contributing Life Project.

Across these indicator sets are more than 70 individual indicators, some shared between different sets. The volume of reported material is quite staggering. What is even more remarkable is how little of this data finds its way back to service providers for the purposes of quality improvement. This type of feedback is largely absent from routine mental health reporting across Australia.

Australia’s situation is not unique. As demonstrated in a recent report prepared for the National Mental Health Commission, the paucity of international mental health benchmarks is also striking8. There are no regularised processes of data collection and reporting to enable Australia to compare itself with other

countries in relation to mental health and even fewer reliable markers. It is often the case that the only marker deemed worthy of inclusion in benchmarking exercises is suicide but there are problems with data collection even here.

A new approach to accountability means breaking the cycle of merely reporting mental health service administrative data and instead initiating data collections which can more fully reflect the experience of having a mental illness in 21st century Australia.

The establishment of an agreed national process for gathering the validated experience of care of mental health consumers and carers would be a good place to begin. Such processes already exist both overseas\(^9\) and domestically\(^10\).

The voice of consumers and carers is the key performance measure absent from our reporting system. Such a measure would permit service users to not only contribute to mental health service quality improvement but also to provide holistic feedback on their experience of housing, employment, education, transport and the other issues which impact daily on quality of life. As it stands, there is almost no information in Australia on these broader measures of the impact of mental illness on a person’s life.

**Conclusion**

One of Australia’s most significant achievements, again made possible under the First National Mental Health Plan in 1996, was the establishment of a set of National Mental Health Service Standards. These Standards led the world in laying down markers against which to assess the quality of care provided, giving both service providers and users much clearer expectations. Again due to lack of resources, these Standards, while widely respected, were never really implemented or monitored. In 2010 they were reviewed but again, no resources to enable their effective implementation or monitoring have been allocated.

In relation to governance and accountability in mental health, Australia has always talked a good game. We have the glossy brochures and neatly articulated plans to prove it. What has been lacking is the willingness to invest in genuine, regular, independent processes of monitoring and assessment of progress towards mental health reform. At the heart of this must be the validated voice of the consumer and carer providing a true picture of the impact of mental illness on their lives.

Australia has undergone recent health reforms, rearranging financial relationships between the states and the Commonwealth governments. It is precisely in the area of most concern to mental health reformers; that part of the service system which aims to avoid hospitalisation and provide as many services as possible designed to keep people living well in the community, where responsibility between the federal government and the states is most unclear. This is the dilemma that lies at the heart of Australia’s governance problems.

Genuine reform mental health in Australia must start with a new commitment and real resources to enable better governance and accountability. The issue is too important and too expensive for us to be outcome blind.

---

Obsessive Hope Disorder
PART 3

A better way to a mentally healthy Australia for all
Introduction

In this final part of *Obsessive Hope Disorder* we endeavour to tackle some of the critical issues for achieving the transformation of mental health and mental health care that for so long has allured us. This is much more than achieving the vision and goals articulated by David Richmond in 1983 and later reiterated by Brian Burdekin all those years ago. It is all about ensuring that:

1. People with a mental illness have the same parity of access to and quality of care available to Australians with other major health conditions regardless of our origins, our income or postcode.
2. The mental health services and care available are based on evidence – not the legacy of history – and are focussed on the earliest intervention and where necessary provide seamless continuity of care and linkage to social supports to enable full recovery with dignity.
3. Australian’s understand that being mentally healthy is much more than the absence of a mental illness and there are actions they can take to sustain and improve their own mental health and the resilience of their communities.
4. Our mental health is seen and understood in relation to the bigger picture – in relation to the contribution of mental health and wellbeing to schooling, urban planning, workplace relations, national productivity and more – mental health is part of the nation’s mental wealth.

The incremental, incomplete and inconsistent approach to mental health reform over the past twenty years is demonstrably inadequate and unaffordable for the challenges now confronting our nation.

We can and must do better. To do better we have to accept the baggage from the past, identify the barriers to reform and map out strategies for change based on these experiences and those who overseas.

One of most obvious artefacts of Australia’s national mental health reform project is that in every state, except Victoria, we still see stand-alone psychiatric hospitals still operating. Chapter 11 looks at these relics and their continued operation and the message this sends to those ‘retained’ in them, their families and the broader community. The chapter also looks at what we need to apply from good practice in health policy and service reform, scaling innovation and evidence based practice to re-energise reform while critically examining the impact of broader reform agendas such as DisabilityCare.

In the analysis presented in Parts 1 and 2 of *Obsessive Hope Disorder*, it was very clearly that special populations – people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander peoples, people living in rural and remote Australia, young people and LGBTI people were under-served by both mental health policies and programs. It was beyond the scope of this Report to address each of these groups needs and map out a Better Way for the future.

We have selected one of these groups as a case approach to tackling the needs and providing a way forward. Chapter 12 focuses on key multicultural mental health issues in Australia. It identifies a context for multicultural mental health reform and then discusses four key areas for reform: Data and research; Interpreter access and quality; Stigma and mental health literacy; and Whole-of-organisation and whole-of-systems cultural responsiveness.

The chapter is intended as a starting point for reform.

Mental health research is one of the key opportunities for achieving breakthroughs in both novel treatments and service innovation. Again, the efforts to date have been mediocre at best and mental health research stays stuck in the slow lane. Chapter 13 addresses the developments in the mental health research sector over the last 10 years and focuses on three key aspects of the research landscape:

- The extent to which mental health is prioritised relative to other research domains, and whether this has changed in the last decade. Is its share of the cake equitable?
- The research content of mental health publications relative to key stakeholder priorities and disease burden, and whether this has changed in the last 10 years.
• New initiatives in research practice and how this may impact mental health research into the future.

Chapter 14 returns to one of the key themes in this Report – the workforce. In spite of the best intentions of government and significant investment there seems to have been only limited and patchy improvement in workforce capacity, capability, deployment and sustainability.

There is a recurring pattern of problems in relation to the mental health workforce which are seemingly resistant to change. So this Chapter focuses on strategic issues and applications to break the cycle of the recurring patterns observed in the mental health workforce for the past 30 years.

Finally, in Chapter 15, we set out a complete Manifesto for a Better Way. What is clear from the analysis in this Report is that the history of Australian mental health reform over the past three decades is one of world class policies and strategies let down by inadequate planning, poor implementation and our complex system of government. The results have been disappointing, wasteful of scarce resources and all too often, devastating for the millions of Australians affected by mental illness.

There are five strategic issues addressed in the Manifesto:

• Governance
• Quality of care
• Workforce
• Research and evaluation
• Funding.

There is an urgent requirement for a ‘root and branch’ review of the governance of mental health in Australia, bolstered by new attention to accountability, research and workforce development. Together with a commitment to a fair share of funding allocation, these are the building blocks of real and sustainable mental health reform.

The Manifesto outlined here will help turn Australia’s inextinguishable hopes and dreams for a better future for mental health into a reality.
Chapter 11

Learning from the past… facing new realities

John Mendoza, Sebastian Rosenberg, Amanda Bresnan and Janet Hopkins with assistance from Professor Max Bennet AO and Professor Alan Rosen
Obsessive Hope Disorder
Introduction

The past is omni-present

As Parts 1 and 2 of this Report have amply shown, relics of the past in mental health are still very much defining our present – be it the service models, facilities, workforce distribution and practices, community attitudes, and so on. These relics are also seen in the barriers to building a truly 21st Century model of mental health services and achieving a mentally healthy Australia for all.

Breaking the bonds with the past requires new thinking and structures which impel the ongoing commitment of governments and others to the task of reform. It requires us to embrace new approaches and rid the system of anachronistic services and facilities.

Why are these facilities still here?

Every state, except Victoria, has stand-alone psychiatric hospitals still operating in 2013. This year these states, Western Australia, South Australia, Tasmania, New South Wales and Queensland will collectively spend over $500 million on providing over hundreds of beds to the individuals retained in these premises. This is significantly more than all investments made by Federal, state and territory governments in evidence-based early intervention programs for people aged 12–25 years – the years when most mental illnesses have their onset.

Many of those provided with ‘care’ in these facilities are held involuntarily and indefinitely. Unless there is concerted community advocacy or legal action brought against the relevant state (possibly under a challenge to Australia’s obligation to the UN Declaration on the Rights of People with a Disability) nothing will change. These people will be left to languish indefinitely – out of sight, out of mind.

Most of the individuals held in these stand-alone psychiatric hospitals are not there as a result of a criminal conviction. All states, except the ACT2, now have dedicated forensic mental health facilities usually located beside or inside state corrections facilities such as those at Long Bay Jail in Sydney or the Wilfred Lopes Centre, a 35-bed Secure Mental Health Unit located next to (but not in) the Risdon Prison in Tasmania.

This issue was brought to national prominence through the NSW Ombudsman’s report in December 2012 (this was included in the review of statutory office reports in Chapter 6). However the continuation of this model of care is largely hidden from the Australian community. Space does not permit an examination of all of these facilities, but two are shown and discussed briefly here.

The Glenside Hospital campus

The Glenside Hospital opened in 1870 as the Parkside Lunatic Asylum. It is located on a nearly 60 hectare tract of land within 2 kms of the centre of Adelaide – prime real estate.

Glenside has a terrible history of abuse including the use of patients for experiments in malaria control in the 1920s. Despite this history and the stigma associated with the site, both the Rann Government and the then Liberal Opposition supported investment to re-develop the site. Over $300 million has been earmarked for the redevelopment work.

When one considers that large numbers of people with mental illness living today will have known of family members who endured terrible human rights abuses at this same campus, it does raise serious questions over the wisdom of the investment in re-development rather than moving to a ‘greenfield site’ as has been done in almost every other case of deinstitutionalisation in other jurisdictions.

---

1 It may be possible to bring legal action against the relevant State Government and the Australian Government for its failure to uphold the rights of individuals held in these facilities under the UN Declaration on the Rights of People with Disabilities
2 Funding has been allocated in the ACT Budget for a forensic mental health facility.
Baillie Henderson Hospital Toowoomba, Qld

Baillie Henderson Hospital (BHH) is located in a semi-bushland setting just beyond the old industrial precinct in the City of Toowoomba in SE Queensland\(^4\). It is somewhat hidden from the public with few traffic routes in its vicinity. Inside the grounds of BHH are some 200 ‘patients’, with some having been there for more than a generation.

The failure by successive Queensland Governments to close this facility is largely due to sectional interests of some of the mental health professionals working at the facility and local factors. Recent reports on the Newman Government’s plan to close five of the eight remaining wards by 2016 have been met with an outcry from staff and sections of the local community.

It seems that local interests outweigh commitments to national and international obligations. It is unlikely that BHH proves a therapeutic recovery oriented environment for the individuals held there given these images.

---

4 One of the authors to this report spent most of their schooling years in Toowoomba and regularly visits the City.
Even where governments invest significantly in refurbishment of the site, institutions such as Glenside and BHH face possibly insurmountable barriers to developing and implementing recovery based mental health care.

**Below: The main entrance building at Baillie Henderson Hospital:** “206 patients”

![Image of the main entrance building at Baillie Henderson Hospital]

**Below: Stigma on show. Nurses’ station, Baillie Henderson Psychiatric Hospital Toowoomba, Qld.**

*Photo provided by a mental health consumer, early 2013.*

![Image of stigma on the nurses’ station]

**Get the basics right: aspects of Australia’s mental health policy**

In 2009 the World Health Organization released guidance documents for the development and deployment of mental health policy. Improving health systems and services for mental health sets out best practice approaches to developing mental health policy, plans and programs, mental health legislation, planning and budgeting, human resource management and development of mental health information systems. Each of these elements are seen as the foundations for effective and sustained mental health service reform. WHO states:

---

5 Reported in Toowoomba Chronicle, 7 March 2013. Statement by Darling Downs Health & Hospital Service chief executive officer Dr Peter Bristow. There are still 2 stand alone psychiatric hospitals in Queensland – the other is located in Charters Towers. While exact numbers of clients are not reported, it is estimated that at least 300 people are held indefinitely. Some have been in care for decades.

"by using this strategy as a guide, countries can ensure that their mental health systems re not haphazard, but rather, the products of careful consideration and planning."

The WHO documentation also provides a simple and practical ‘checklist’ for evaluating each of these critical elements of ‘infrastructure’.

A cursory comparative review of the findings documented in *Obsessive Hope Disorder* and the WHO Checklist highlights many basic failings in the approach taken over the past twenty years in Australia.

Robust frameworks for developing and implementing public policy in relation to health and human service systems are not novel. Yet this knowledge has not been applied to mental health policy in Australia over a very long time and there is little evidence from the most recently released planning documents (e.g. *The COAG Roadmap for Mental Health Reform* released in December 2012) that this is changing.

In fact there is some evidence, that there has been actions taken at the most senior levels of bureaucracy to dumb down past mental health planning documents. It seems the avoidance of real reform and certainly real accountability, has been a sin of commission rather than omission.

Further, continuing reports regarding the human rights abuses of people with mental illnesses and widespread discrimination, point to the need to get mental health legislation harmonised across Australian jurisdictions and aligned with international practice.

There are growing calls from the legal profession for a fundamental re-think on aspects of mental health laws including compulsory treatment orders – that is treatment without an advance health treatment order or informed consent.

The rule of law is the basis of Australia’s democracy. It seems a good place to start to right the wrongs of current mental health care.

**Some relevant public policy developments**

*DisabilityCare Australia and mental health*

DisabilityCare Australia is the new national disability insurance scheme (NDIS). This major reform, which will be implemented in stages, began on July 1, 2013.

DisabilityCare will provide individualised support to eligible people with permanent and significant disability, including those with a psychosocial disability associated with a mental illness. It is estimated there are 57,000 Australians with mental illness who would be eligible for DisabilityCare.

**Origins of the reform**

In 2010 the Australian Government asked the Productivity Commission to carry out a public inquiry into a long-term disability care and support scheme. The inquiry received over 1000 submissions and its report was released in August 2011. Agreement was reached in July 2012 to proceed with the launch of the NDIS.

During the creation of its report, the Productivity Commission sought feedback on where the boundaries should lie between the mental health sector and the NDIS. The advice received indicated that, “many people with significant and enduring psychiatric disabilities have the same day-to-day or weekly support needs as people with an intellectual disability or acquired brain injury” and NDIS should meet the disability support needs of these people.

---

7 For example, the 2003-8 National Mental Health Plan did have in advanced draft forms specific, measureable goals and measurement methodology. These had been developed by the inter-government working groups. These specific details were removed by more senior officials before the documents were tabled with Health Ministers for agreement.

8 For example: Shine, K 2013. Medieval law jails mentally ill indefinitely. The Australian, 24 June 2013. There are dozens of examples of similar reports contained in the statutory office reports examined in Chapter 6 of this Report.


As such, DisabilityCare will change the existing funding relationships of many service providers across Australia, including those currently providing Psychiatric Disability Rehabilitation Support Services. This will inevitably result in changes to the way these services operate.

Many community mental health services, which currently provide psychosocial support services to those with mental illness, receive block funding to do so. Alongside the reform instigated by the NDIS, for some time there has been a general Australia-wide push away from block funding towards individualised support packages, which, like the NDIS, place more emphasis on choice and control. Couple this with new national strategies, new structures such as Medicare Locals and Local Health Networks, new systems such as the personally controlled e-health record and sector reform and consolidation across multiple States (with a drive towards ‘preferred providers’), and you can appreciate the enormity of the challenges ahead.

Subject to the finalisation of details by the Commonwealth Government with each individual State and Territory Government, clients of existing community mental health services will continue to receive services under their existing arrangements until their area is transitioned across to DisabilityCare Australia. The progressive rollout has begun with specific age groups in four locations, Barwon (Victoria), the Hunter area (NSW), South Australia and Tasmania. Another two areas (ACT and Barkly NT) will be added in July 2014, with the full scheme rolling out from July 2016.

DisabilityCare emphasises choice and control. Once eligibility is confirmed, a plan is developed, supports are chosen and the plan is then implemented. To a large extent, people will be able to determine how much control they want over their funding. They can:

- manage the plan themselves or nominate another person to do this
- use a registered plan manager
- ask DisabilityCare to manage it for them
- a combination of the above.

**Challenges and opportunities**

The Productivity Commission noted in its report that although the community mental health system shares similar approaches and philosophies to the NDIS, it is placed within a broader mental health system, which, “with its clinical orientation, has been slow to recognise these approaches.”

The Commission felt that the extra resources provided through NDIS would strengthen community mental health services. This is however complex reform intersecting with an already complex and fragmented mental health system and there will be many challenges, as well as opportunities ahead.

Although the new system will no doubt strengthen some services, the sector is heading into a new less predictable, market driven world where organisations will need to work to attract and retain customers and at the same time compete effectively within the demands of the pricing schedules laid down by DisabilityCare. Some organisations will struggle to provide services within these parameters. New entrants will join the market. Many organisations will inevitably need to rethink and restructure to meet these demands. Some will not survive.

The ‘lifelong’ approach of the NDIS is very positive, as is the approach of putting people in control of the care and support they receive, based on their needs. This will create a ‘bottom-up’ demand for services, a big change from the current, largely ‘top down’, budget driven approach to service provision. Client and Carer demand and expectations are likely to increase. Services that listen and adapt to their customers’ needs will fare better than those that take a more ‘one size fits all’ approach. There is much opportunity here for innovation, for transformational service design, peer led and co-created services. There is however some cause for caution and concern. The pre-determined pricing of DisabilityCare Australia may drive many service providers out of the market. There is also a danger that the quality of staffing will suffer with price pressures, increasing casualisation, compromising workforce supply, development and capacity into the future.

Some clients will struggle as the services and supports they are used to change shape and evolve. There will be clients who are functionally more able or better supported than others to navigate these changes.
It is hoped that the staged rollout and the benefits of the learnings provided by overseas experience, will see DisabilityCare adapted and strengthened as it grows. In reality, there may well be very few people who fully manage their own packages. The new system already has its critics,

“The thinking is old fashioned – the architecture of the design is archaic and bureaucratic. Australia is building the equivalent of a 1970s IBM super mainframe computer in an era of mobile devices and the Cloud. Modern systems push control and responsibility out towards citizens, allow for networking, assume capacity and enable open source innovation at every level.”

Simon Duffy, Director, Centre for Welfare Reform UK12.

It will be interesting to see how the episodic nature of mental illness will sit within a structure largely built around functional impairments with far less variability. It will also be interesting to see how DisabilityCare interfaces with the mental health legal system, with clinical services and with existing intensive support programs such as the new Partners in Recovery program.

**Partners in Recovery**

The Partners in Recovery (PIR) program is a key plank of the current Federal Labour Government’s National Mental Health Reform Plan. With a $550 million dollar investment, it is second only in scale to the Better Access program introduced by the Howard Government in 2006 and about double the investment in the Personal Helpers and Mentors program.

PIR aims to improve the systemic response to the needs of individuals with severe and persistent mental illness with complex needs. It will do this by creating long-term partnerships, driving collaboration and system reform. It will provide Support Facilitators to offer care-coordination across a full range of supports and services necessary to meet the tailored needs of these individuals.

Almost all of the investment is in service coordination and ‘system’ development – very little will go to fund actual services like therapy sessions or respite care or day to day living support. It aims to reach 24,000 individuals over the three years – that’s 24,000 in total and not 24,000 each year. It is envisaged that most clients will ‘exit’ the program and therefore will not be a PIR client on an ongoing basis. The cost of PIR care or service coordination will be approximately $23,000 for each client.

This program was described recently as a ‘Disruptive Technology’13. It will invoke a “you can do it, we can help you” approach, engaging people by seeking to meet whatever needs they present with at the time – which may not necessarily be for mental health services. In this way, on the face of it, it seems consistent with the NDIS ethos of ‘choice and control’. PIR is funded for a three-year period. By the end of this time it is anticipated it will converge with the NDIS. Whilst both PIR and NDIS could be considered client-focused initiatives, they are actually working from quite different directions.

PIR is focused on system reform, bringing providers together and creating a more integrated, collaborative approach to service provision, to the benefit of the client. NDIS could also be considered a ‘Disruptive Technology’, which will be system reforming. Whilst we can expect a type of care coordination function to continue under DisabilityCare Australia, with significant market forces at play, the possibility is that competition may well drive providers further apart rather than together. System reform within PIR is top-down; system reform under the NDIS will be more bottom-up in nature. Time will tell how successfully this transition will occur.

**Activity-based funding**

Under the National Health and Hospital Reforms agreed to by COAG in 2010 and then reaffirmed under Julia Gillard’s leadership in 2011, health care services will move to activity based funding from the 2013–14 financial year.

Prima facie, there is probably no other sector with more to gain from the implementation of activity based funding (ABF) than mental health. Stories of funding originally earmarked for mental health being moved...

13 At the first PIR Annual Workshop held in Melbourne June 27–28, 2013.
to prop up other areas of the health budget are commonplace. ABF offers new classification and costing technologies to make transparent what resources are being used and where, severely curtailing the capacity of hospital administrators to covertly suck funding out of mental health and put it to use elsewhere.

This same technology offers the prospect of creating a new lingua franca in mental health, national naming conventions which permit practitioners to establish new benchmarks, to compare like with like and improve the quality of the care they provide. There are currently no such benchmarking tools available in mental health in Australia.

While these advantages accruing from ABF are considerable, there are also some immediate problems to overcome. In the absence of more suitable casemix classifications, governments are likely to use stop-gap measures such as diagnostic-related groups (DRGs) by which to classify and fund mental health care. Not only are DRGs not very accurate descriptions for mental health care types, but they are also not very accurate predictors of patient-by-patient resource use. Until new casemix technology is devised, the system will be quite inaccurate.

Perhaps more concerning than this however, is the fact interim ABF arrangements will likely perpetuate the hospital-centric nature of mental health care in Australia, providing new levels of Commonwealth-funded growth to precisely the wrong areas for the purposes of mental health reform. While the hospital-based acute inpatient and outpatient services may grow under these circumstances, the genuine community or home-based mental health services will be excluded from new funding arrangements and opportunities, left to further wither or go undeveloped.

The urgent task facing Australia in relation to the application of ABF to mental health is to build an approach which not only accurately describes the services we want to see flourish in a contemporary system of care, but one that also has the right financial incentives. Such incentives must properly prioritise the community over the hospital as the locus of care, including the use of appropriate incentives and sanctions to help guide decisions about what services to provide and where. Such an approach would then drive ABF to work consistently with the preceding 20 years of national mental health policies and plans including, most recently, the Contributing Life Framework issued by the National Mental Health Commission.

**What these policy developments all mean for mental health reform**

The short answer to this is we don’t yet know. However it is important to take note again of history and be aware that the momentum of mental health reform may yet again fall victim to broader health and human service reforms.

What may be beneficial in terms of cost, quality and consistency of care in cancer or orthopaedics or general surgery, may not necessarily be in the best interests of mental health service users or indeed providers. Efficiencies in many aspects of ‘procedural medicine’ can be achieved through ABF models of financing. However, the authors are unable to find any evidence where such models work well for mental health care.

Indeed here in Australia, ABF models have operated in Victoria for many years and as was shown in the *Not For Service* report in 2005, the access to care and the quality of mental health care (e.g. as it adequate length of time for recovery to commence prior to discharge from acute care) is not necessarily advanced through such funding models.

Equally, the introduction of DisabilityCare will on the present indications only provide care for those 50,000–60,000 people most severely disabled by mental illnesses. It offers little if anything for the hundreds of thousands of others with severe mental illness, or the hundreds of thousands of people on welfare and unemployment payments with moderate levels of mental illness or the 20,000–30,000 cases each year of first onset psychosis. Indeed as is becoming evident in the NDIS trial sites, it may reduce access to services for those not deemed eligible for DisabilityCare.
Scaling Innovation and evidence-based practice

Innovation and the ability to apply evidence routinely is often cited as a key factor in any organisations success. McDonalds, the global fast food giant, has a stunningly simply but seemingly effective business strategy: think big … start small … scale fast. It means to continue to be successful, the organisation must foster and support innovation and creativity, prove it works (Test it, stress it, try to break it) and then move quickly to market ahead of competitors – think big, be brave, be quick. One other dimension to McDonald’s strategy is to start small and don’t over invest in case it does not work out. If its trialling well then go flat out to scale it fast and stay ahead of competitors.

When sales began to fall in the early-2000s, McDonalds moved to trial and then rapidly scale a whole new line of products —the McCafe model plus new lines like wraps, salads and so on with lower saturated fats and levels of sugars. They got back on a growth path as a result within a couple of years despite the Global Financial Crisis.

Delivering effective MH care is obviously more complex than selling food, but McDonald’s strategies and principals could be applied to overcoming some of the problems evident in mental health care in Australia.

Results from the CareTrack report suggest that ‘appropriate care’ for mental health disorders was not routinely provided by healthcare professionals for the three mental health disorders included in the study. Evidence presented in this Report also raises many questions regarding the quality of mental health care. Table 11.1 lists a preliminary list of mental health care practices and models where there is robust evidence to support the widespread application and availability in Australia. The Table is included not as a definitive list, but simply to illustrate, there is a lot of evidence to support prevention, early intervention and recovery — we simply need to have the commitment to scale these.

### Table 11.1 Mental health services: Evidence-based components in the continuum of care


**Please note:** while it is important to identify and provide accurate costings for evidence based interventions which should be provided by all comprehensive mental health services, (column 1), it is equally important to identify and cost the essential infrastructure and evidence based vehicles or sub-systems which allow them to be appropriately accessed and delivered to the appropriate people in a timely manner at the most effective site (column 2).

<table>
<thead>
<tr>
<th>Evidence-based (or promising) Interventions i.e. contexts of care</th>
<th>Delivery systems for the Interventions supported by evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Primary care</strong></td>
<td>1. Primary care mental health liaison team or coordinator and supported transfer of care coordination systems (e.g. CLIPP)</td>
</tr>
<tr>
<td>GP liaison and shared care</td>
<td>2 a) Mental Health First Aid Course</td>
</tr>
<tr>
<td></td>
<td>2 b) Telephone help lines, web-based mental health information and brief intervention services</td>
</tr>
<tr>
<td></td>
<td>2 c) “headspace” centre for youth and young adult self and family referral, professional referral, assessment and engagement.</td>
</tr>
<tr>
<td></td>
<td>2 c) Prodromal assessment, monitoring and support service</td>
</tr>
<tr>
<td><strong>2. Promotion, prevention and early intervention</strong></td>
<td>2 d) Early intervention team in youth centre context (the Early Psychosis Prevention and Intervention Centre – EPPIC Model)</td>
</tr>
<tr>
<td>Public health proactive approach to prevention, early detection and intervention seeking</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence-based (or promising) Interventions i.e. contexts of care</th>
<th>Delivery systems for the Interventions supported by evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3. Acute and crisis care</strong></td>
<td>3.a) and b) 24 hours or extended hours mobile community-based crisis intervention services</td>
</tr>
<tr>
<td>3.a) Crisis and family intervention</td>
<td>3.c) 24 hour supervised community-based residential respite facility, as alternative to hospital admission, plus step up and down care</td>
</tr>
<tr>
<td>3.b) Home visit assessments interventions and reviews</td>
<td>3.d) Examples include: 24 hour roster of psychiatric triage nurse consultants in busy emergency departments – emerging evidence of effectiveness, though should not replace crisis services; 2) brief intervention clinic or role of crisis team in delivering repertoire of behavioural interventions following ED presentation—emerging evidence.</td>
</tr>
<tr>
<td>3.c) Acute respite care</td>
<td><strong>NOTE</strong> – PECCs or psychiatric emergency centres approximated to or in emergency departments – very costly, yet no evidence to support any advantage over less restrictive alternatives, such as 3.c above</td>
</tr>
<tr>
<td>3.d) Emergency psychiatric services in general hospital emergency departments, including effective triage and brief, targeted, behavioural interventions as required</td>
<td></td>
</tr>
<tr>
<td><strong>4. Assertive community treatment</strong></td>
<td>4.a) Local community-based mental health centre near shopping and transport hubs</td>
</tr>
<tr>
<td>4.a) Active-response intake and mobile care coordination (case management sub system)</td>
<td>4.b) Assertive community treatment team, meeting international fidelity criteria</td>
</tr>
<tr>
<td>4.b) Assertive/Intensive community care management for individuals with persistently severe disabilities</td>
<td></td>
</tr>
<tr>
<td><strong>5. Biological interventions</strong></td>
<td>5.a) Monitoring and adverse effects/interactions/polypharmacy minimising risk management system, community pharmacist consultation and liaison service</td>
</tr>
<tr>
<td>5.a) Medications and other technologies</td>
<td>5.b) Protocols, monitoring and intervention systems to minimise physical illness and risk factors in individuals with mental illness&gt; Examples include: CVS and diabetes regular risk factor monitoring system; aerobic exercise and weight monitoring programs, individual and group</td>
</tr>
<tr>
<td>5.b) Attending properly to physical care of individuals with mental illness</td>
<td></td>
</tr>
<tr>
<td><strong>6. Psychological and neuropsychological Interventions</strong></td>
<td>Delivery and supervision network, plus monitoring for fidelity.</td>
</tr>
<tr>
<td>– CBT</td>
<td></td>
</tr>
<tr>
<td>– DBT</td>
<td></td>
</tr>
<tr>
<td>– IPT</td>
<td></td>
</tr>
<tr>
<td>– ISSRT</td>
<td></td>
</tr>
<tr>
<td>– Neurocognitive remediation</td>
<td></td>
</tr>
<tr>
<td>– Supportive psychotherapy</td>
<td></td>
</tr>
<tr>
<td>– Primary care counselling</td>
<td></td>
</tr>
<tr>
<td>– Medication adherence</td>
<td></td>
</tr>
<tr>
<td><strong>7. Social interventions</strong></td>
<td>7a) Type of facilities or personnel. Examples include: clubhouse or equivalent; leisure/recreation/aerobic physical activity program; expert vocational rehabilitation counsellors operating individual placement and support (IPS) programme; financial counselling service.</td>
</tr>
<tr>
<td>7.a) Types of intervention:</td>
<td></td>
</tr>
<tr>
<td>– social</td>
<td></td>
</tr>
<tr>
<td>– leisure</td>
<td></td>
</tr>
<tr>
<td>– education</td>
<td></td>
</tr>
<tr>
<td>– work</td>
<td></td>
</tr>
<tr>
<td>– financial</td>
<td></td>
</tr>
<tr>
<td>7.b) Residential</td>
<td>7.b) Residential</td>
</tr>
<tr>
<td>Living in your own home wherever possible</td>
<td>A range of supervised residential facility options. Examples include: support in your own home; 24 hour supervised community residential care plus medium to long term residential cluster home scheme; Medium to long term community residentials with partial supervision; 24 hour supervised care residential units on general hospital sites</td>
</tr>
<tr>
<td>A range of different levels of supervision in residential settings</td>
<td></td>
</tr>
<tr>
<td>Evidence-based (or promising) Interventions i.e. contexts of care</td>
<td>Delivery systems for the Interventions supported by evidence</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7.c) Residential: Inpatient Interventions</td>
<td>7.c) Residential: Inpatient Team and facilities</td>
</tr>
<tr>
<td>Rigorous evidence – sparse for optimal characteristics and effectiveness. Supportive Interventions</td>
<td>Rigorous evidence – sparse for optimal characteristics and effectiveness. Setting:</td>
</tr>
<tr>
<td>– Psycho-education and adaptive communication and problem solving skills on an individual, group and family</td>
<td>– On general hospital site (in UK and USA sometimes in suburban setting away from general hospital)</td>
</tr>
<tr>
<td>– Supportive psychotherapies on an individual group and family basis</td>
<td>– Small scale, semi-domestic atmosphere.</td>
</tr>
<tr>
<td>– As there is little evidence to support inpatient admissions generally, seek less restrictive alternatives ASAP, whether for acute short term or supervised extended stay residential care</td>
<td>– Attractive, welcoming spaces, softly furnished, calming colours.</td>
</tr>
<tr>
<td>Clinical technologies and associated interventions: Medication, ECT, TMR etc. require up to date:</td>
<td>– Modularised unit, allowing separate</td>
</tr>
<tr>
<td>– Equipment, regular staff training and refreshers, daily pharmacist input</td>
<td>– safe spaces for vulnerable or dangerous inpatients</td>
</tr>
<tr>
<td>– Minimise / eliminate restraint and seclusion</td>
<td>– Separate acute observational locked sub-unit and unlocked sub-acute sub-unit</td>
</tr>
<tr>
<td>– Minimise involuntary care</td>
<td>– Maximise staff: inpatient ratio and interaction</td>
</tr>
<tr>
<td>– Minimise locking of doors</td>
<td>– Minimise lockable doors, restraints, seclusion and restriction of leave.</td>
</tr>
<tr>
<td>– Minimise holding down</td>
<td>– Maximise indoor and outdoor spaces</td>
</tr>
<tr>
<td>– Encourage exercise of human rights</td>
<td>– Separate bedrooms with good sightlines for staff with acute observation inpatients</td>
</tr>
<tr>
<td>– Encourage exercise of human rights</td>
<td>– Minimise hanging points and other dangerous environmental features</td>
</tr>
<tr>
<td>– Encourage exercise of human rights</td>
<td>– Unobtrusive but effective duress alarm system for service providers, inpatients and visitors</td>
</tr>
<tr>
<td>8. Cultural Interventions</td>
<td>8.a) Micro-cultural:</td>
</tr>
<tr>
<td>8.a) Micro-cultural:</td>
<td>– Individual family intervention at home</td>
</tr>
<tr>
<td>– family education support and communication and problem solving skills intervention, including surrogates, confidantes and support persons.</td>
<td>– Multiple family group intervention conducted by team which can systematically provide staff to work with families out of office hours</td>
</tr>
<tr>
<td>8.b) Macro-cultural:</td>
<td>8.b) Macro-cultural:</td>
</tr>
<tr>
<td>– community awareness</td>
<td>- Community awareness local meetings/local action committees</td>
</tr>
<tr>
<td>– community education</td>
<td>- Mental Health First Aid courses</td>
</tr>
<tr>
<td>– challenging stigma and discrimination</td>
<td>- Community awareness public/media campaigns</td>
</tr>
<tr>
<td>9. Comorbidities</td>
<td>9.a) to h).</td>
</tr>
<tr>
<td>Dual interventions for:</td>
<td>Service delivery system with professional expertise and facilities which will address both problems simultaneously, not making the treatment of one problem conditional and secondary to treatment of the other.</td>
</tr>
<tr>
<td>a) Substance abuse and mental illness</td>
<td>h) Consultation-Liaison psychiatric team for each general hospital facility – evidence that these significantly lengths of hospital stay</td>
</tr>
<tr>
<td>b) Intellectual disability and mental illness</td>
<td></td>
</tr>
<tr>
<td>c) Specific learning disability and mental illness</td>
<td></td>
</tr>
<tr>
<td>d) Brain injury and mental illness</td>
<td></td>
</tr>
<tr>
<td>e) Severe physical disability and mental illness</td>
<td></td>
</tr>
<tr>
<td>f) Eating/dieting disorders, physical and psychiatric components</td>
<td></td>
</tr>
<tr>
<td>g) Forensic problems and mental illness</td>
<td></td>
</tr>
<tr>
<td>h) Consultation-liaison psychiatric services to medical and surgical wards</td>
<td></td>
</tr>
<tr>
<td>10. Integrated and comprehensive service systems</td>
<td>10.a) Integrated at several levels:</td>
</tr>
<tr>
<td>10.a) Integrative holistic comprehensive interventions</td>
<td>i. care coordinator/house manager working closely together with service-users and family, to develop and review care plan</td>
</tr>
<tr>
<td>i – continuity over time</td>
<td>ii. interdisciplinary mental health team with coordinated delegation of tasks around service-user needs, encapsulated in an individual care plan, which is regularly reviewed</td>
</tr>
<tr>
<td>ii – integrated coordinated efforts at any one time</td>
<td>iii. collaborative planning between: primary care, acute mental healthcare and longer term rehabilitation recovery work and</td>
</tr>
</tbody>
</table>

250
<table>
<thead>
<tr>
<th>Evidence-based (or promising) Interventions i.e. contexts of care</th>
<th>Delivery systems for the Interventions supported by evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>specialist health services</td>
<td>iv. coordinated planning and service delivery between public private and NGO mental health services</td>
</tr>
<tr>
<td>v. coordinated planning and service delivery between mental health and all other relevant agencies e.g. housing, work, education, welfare, financial/ benefits, recreation and leisure – i.e. integrating efforts of state and federally funded agencies.</td>
<td></td>
</tr>
<tr>
<td>10.b) Recovery oriented interventions towards:</td>
<td>10.b) Recovery-oriented staff and facilities:</td>
</tr>
<tr>
<td>i – growth throughout life</td>
<td>i. Consumer peer support specialists certified training and placement in clinical teams</td>
</tr>
<tr>
<td>ii – empowering service users</td>
<td>ii. Recovery oriented experiential workshop training for service users, providers and families</td>
</tr>
<tr>
<td>iii – setting your own goals and priorities</td>
<td>iii. Working with communal organisations and workplaces towards social inclusion and full citizenship</td>
</tr>
<tr>
<td>iv – control over your own life</td>
<td>iv. Skills training for service users, providers and families – e.g. coping, resilience, buoyancy, work/life balance, etc.</td>
</tr>
<tr>
<td>v – social inclusion and citizenship</td>
<td>v. Consumer and carer participation in service management</td>
</tr>
<tr>
<td>vi – resilience</td>
<td>vi. Consumer choices take precedence, where possible, in drawing up own individual plan</td>
</tr>
<tr>
<td>10.c) Age-appropriate interventions</td>
<td>10.c) Age appropriate delivery systems provided specifically for each age-group wherever possible.</td>
</tr>
</tbody>
</table>
Obsessive Hope Disorder
Chapter 12

A better way for multicultural mental health issues in Australia

Rajiv Ramanathan
Obsessive Hope Disorder
1. Introduction

This chapter focuses on key multicultural mental health issues in Australia. It identifies a context for multicultural mental health reform and then discusses four key areas for reform:

1. Data and research
2. Interpreter access and quality
3. Stigma and mental health literacy

It should be noted that this essay was not intended to cover the range of sub-issues and sub-population issues that need to be considered when planning mental health services for Australia’s diverse populations. Rather, the chapter is intended as a starting point for reform.

2. A context for multicultural mental health reform

2.1 Australia is an increasingly diverse nation

Australia has always been a diverse land. Even prior to its colonial history, an estimated 500 indigenous dialects, making up around 250 indigenous languages, were spoken between 600 clans across Australia. In its more recent post-colonial history, Australia’s diversity continues to grow as a result of changing migration patterns. As the Australian Bureau of Statistics stated:

“For the first time since federation, migration consistently contributed more to population growth than the contribution from natural increase.”

Despite the economic impacts of the global financial crisis and the ongoing repercussions within global financial markets, Australia continued to experience strong population growth between 2007 and 2011, of which migration was a significant contributor.

Today, just over a quarter (26%) of Australia’s population was born overseas and a further one fifth (20%) had at least one parent born overseas with these proportions expected to increase into the future.

Australia’s growing diversity is also reflected in changing patterns of migration source countries. Australia’s most recent census (2011) revealed that there is an increasing shift towards those born in Asian countries. For example, 47% of the Indian-born population and 35% of the Chinese-born population arrived between 2007 and 2011, in contrast to the traditional source country, the United Kingdom, of which only 11% arrived in the same period.

Australia’s changing diversity is also reflected in changing patterns of religious affiliation towards increases in those reporting an affiliation to non-Christian religions, and those reporting ‘No Religion’. For example, there has been a long-term decrease in affiliation to Christianity from 96% in 1911 to 61% in 2011.

Additionally, while most people spoke English at home (81%), almost half (49%) of longer-standing migrants and 67% of recent arrivals spoke a language other than English at home.

---

7 Ibid.
8 Those who arrived before 2007.
Furthermore, as Australia’s resident population continues to age, it is expected that the proportion of older people from culturally and linguistically diverse (CALD) backgrounds will increase at a faster rate than the general population. And as labour demands continue to increase, migration continues to offer potential solutions to avert some of the risks associated with an ageing population.

Australia’s growing diversity, including the growing diversity of its ageing population, has a number of implications for the planning, delivery and reform of mental health services, now and into the future.

2.2 Policy and legislative drivers for reform

Commonwealth Government legislative requirements, such as the Racial Discrimination Act 1975 and the Human Rights and Equal Opportunity Act 1986, and national mental health policy imperatives, such as the National Mental Health Policy 2008 and the Fourth National Mental Health Plan 2009–2014, require that mental health services respond to the differing needs of all mental health consumers and carers and that they be culturally safe, regardless of one’s cultural or linguistic backgrounds.

Standard 4 (Diversity Responsiveness) of the National Standards for Mental Health Services (2010) requires that mental health services are cognisant of the cultural and social diversity of its consumers in the planning and delivery of its services.

Furthermore, the National Cultural Competency Tool for Mental Health Services recognises that there is consensus amongst all state and territory Mental Health Directorates that mental health services must ensure CALD consumers receive equitable services.

Australia’s recent multicultural policy also makes a clear commitment towards culturally responsive services:

“The Australian Government is committed to a just, inclusive and socially cohesive society where everyone can participate in the opportunities that Australia offers and where government services are responsive to the needs of Australians from culturally and linguistically diverse backgrounds.”

The Council of Australian Government’s Roadmap for National Mental Health Reform 2012 to 2022 outlines commitments made by local, state and territory, and Commonwealth governments towards mental health reform, with a key priority being the transformation of mental health policy, planning and delivery towards more person-centred approaches, including the acknowledgement of people’s cultural background as a driver for the need for mental health services to be culturally aware and culturally competent.

2.3 Poor access to timely and culturally appropriate services

Despite Australia’s long history as a diverse nation, and despite the range of policy and legislative drivers, the Commonwealth’s Framework for the Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia acknowledges that access to timely and culturally appropriate mental health services has been a problem for people from culturally and linguistically diverse backgrounds.

---

10 CALD, as defined by the Commonwealth’s Mental Health in Multicultural Australia project, refers to first and second generations of Australian immigrants born in a country where English is not the first language, including people from a range of diverse cultural backgrounds represented in the population, and those from asylum seeker and refugee backgrounds.


12 Cully and Pejoski, op. cit.


17 Department of Immigration and Citizenship 2011. The People of Australia: Australia’s Multicultural Policy, Commonwealth Department of Immigration and Citizenship, Canberra, p. 5.


Australian literature indicates that people from CALD backgrounds experiencing mental health problems tend to:

- have lower rates of access to community and inpatient mental health services, compared with Australian-born people
- have higher rates of involuntary and lower rates of voluntary admission to mental health services;
- be hospitalised for longer
- be more likely to present for treatment at the acute, crisis end of an episode.

A key issue is that the previously cited studies were conducted between 12 to 17 years ago. The lack of investment in multicultural mental health research since then has resulted in a dearth of CALD mental health research, thereby making it difficult to make contemporary assessments of the impact of mental health reforms on Australia’s CALD populations.

The last comprehensive study of access rates in mental health services was conducted almost seven years ago in Victoria. The 2006 Victorian study examining changes in access rates over the decade between 1995–96 and 2004–05 for selected Victorian mental health clinical services. The study suggested that, whilst utilisation of mental health services had increased overall for CALD communities over the decade, the rate of increase had been at a markedly slower rate than for those who were Australian born, indicating that the comparative gap between access rates for CALD groups had actually worsened.

One argument put forward for the lower levels of mental health service utilisation amongst CALD communities has been that there is a lower prevalence of mental health problems within Australia’s CALD communities. However, a key problem with epidemiological surveys on the prevalence of mental health problems is that they have generally excluded people with low English proficiency, and there is limited research conducted specifically on the prevalence of mental health problems within CALD communities. Furthermore, social, cultural and religious taboos within CALD communities are likely to inhibit self-reporting and contribute to lower participation in formal research.

Whilst there have been no controlled Australian clinical studies that have compared diagnoses between CALD populations and the general Australian population, some studies suggest widely varying treated prevalence according to ethnicity, if not at least, prevalence rates at the same frequency as the general population which has led researchers to suggest that under-representation in mental health services has been due to service barriers rather than a lower prevalence of mental illness.

In addition, there are a number of risk factors associated with migration, such as separation from family and friends and settling into a new country, and the migration journey (especially for refugees and asylum seekers) that may increase the risks of mental health problems for people from CALD backgrounds.

Two broad categories of barriers influence access to timely and culturally appropriate mental health services:

- those that impact on whether a person from a CALD background gets to the front door of a mental health service
- the experience they have once they get to and through the front door.

---

20 Minas IH et al. 1996. Mental Health Services for NESB Immigrants, Bureau of Immigration, Multicultural and Population Research, Department of Immigration and Ethnic Affairs, Commonwealth of Australia, Canberra; Klimidis S et al. (1999), Mental Health Service Use by Ethnic Communities in Victoria. Part 1: Descriptive Report, Victorian Transcultural Psychiatry Unit, University of Melbourne, Melbourne.
25 Stolk et al, op. cit.
3. Key multicultural mental health reform issues

3.1 We need to improve our understanding of the extent of the problem

One of the key barriers to improving access to mental health services for Australia's CALD populations is the lack of research that supports planning for Australia's diverse mental health needs.

A 2001 Commonwealth Department of Health and Ageing review of mental health research priorities identified that only 2.2% of research articles and only 1.5% of research funding targeted those from CALD backgrounds. A later review of suicide prevention research found that, for the period between 1999 and 2006, none of the 209 published journals, or any of the 26 research grants, targeted people from CALD backgrounds.

This is symptomatic of a broader lack of research into the health needs and experiences of Australia’s CALD populations. For example, of 4,146 articles published in three of Australia’s major health journals (The Medical Journal of Australia, The Australian Health Review and The Australian and New Zealand Journal of Public Health) between the period 1996 and 2008, only 2.2% of articles targeted multicultural health issues.

Furthermore, efforts to improve our understanding of the mental health need of Australia’s CALD populations have also been hindered by the lack of collection, reporting and analysis of high quality data that identifies the cultural and linguistic diversity of mental health service users, as well as their mental health outcomes. For example, a review of the Australian Institute of Health and Welfare’s collection of national minimum data sets revealed that Country of Birth was the only CALD data variable listed within mental health data sets.

A key problem is that the data variable Country of Birth alone does not accurately identify the cultural identity of someone who was born in Australia yet have other cultural dimensions to their identity.

For example, the limited collection of only two data variables, ‘Country of Birth’ and ‘Period of Residence in Australia’, by Australia’s National Coroners Information System impacts on our capacity to understand the extent of suicide in Australia’s CALD communities as those from second and subsequent generations of Australians from migrant backgrounds, including those from non-English speaking countries, would be included as Australian born. This can skew analyse of suicide rates leading to potentially erroneous conclusions that CALD communities are less at risk of suicide. This is in contrast to Swedish research that found that second generation migrants had a higher relative risk of death due to suicide when compared to first generation migrants.


The Australian Bureau of Statistics recognises the importance of a range of variables in understanding diversity. Whilst it suggests the use of twelve CALD data variables, it recommends the following four as a minimum core set:

1. Country of birth
2. Main language other than English spoken at home
3. Proficiency in spoken English

Others also suggest the importance of collecting data on the use of interpreters as a means to monitor the quality and safety of mental health services.

Yet, right across Australia’s mental health system, there are considerable variations in the quality and extent of CALD data variables collected, reported and analysed. And again, this symptom is persistent across broader health research as well.

Furthermore, the extent to which outcomes for CALD populations in mental health settings are measured has also varied across jurisdictions with a lack of aggregation of such work at the national level.

As the Commonwealth’s Mental Health in Multicultural Australia project states:

“Data collection in mental health services is inadequate to capture cultural and linguistic diversity and culturally and linguistically diverse populations are systematically excluded from national mental health research.”

The bottom line is that, if Australia’s mental health system can’t measure how it fares with regards to Australia’s CALD populations, then it effectively hinders planning for the needs of Australia’s diverse populations and thereby risks the continued exclusion of a significant part of Australia’s population.

A vision for the future

Planning for a future where all Australians have equitable access to mental health services, regardless of one’s cultural or linguistic background, requires more than policy frameworks. It requires making commitments.

It requires making commitments, at all levels of government, starting at the fundamental level of measuring the extent of the problem when it comes to CALD access to mental health services. This requires prioritising improved data collection, analysis and reporting on CALD mental health data dimensions through collaborative commitments across government departments and across governments (such as through the Council of Australian Governments’ Australian Health Ministers’ Advisory Council and its subsequent committees).

It also requires making a commitment towards ensuring that Australia’s CALD communities are systematically included in national mental health research. Policy and legislative reform is required to ensure that all future mental health research is mandated to demonstrate how it will include CALD populations, and if not, provide rationales for why not.

3.2 We need to improve the safety and quality of communications between CALD consumers and mental health practitioners

Another crucial aspect that impacts on the access to, and quality of, mental health services for Australia’s CALD populations, is the experience that CALD consumers and carers have once they get to the front door of a mental health service.

---

38 Miletic T et al 2006. Improving the Quality of Mental Health Interpreting in Victoria, Victorian Transcultural Psychiatry Unit, Melb.
41 Mental Health in Multicultural Australia, 2013. Fact Sheet 1: What is a Culturally responsive Mental Health Service.
Communication between the consumer, carer and the mental health practitioner is the key tool to understanding each other’s needs, issues and intentions. More specifically, verbal communication with a consumer is the key medium through which a mental health practitioner is able to make assessments, diagnose and negotiate treatment and recovery plans. And the quality of that communication directly impacts on the quality of the resulting assessment, diagnosis, treatment and recovery plans, and the relationship between each other.

In clinical settings, limits to the quality of communication, such as language and cultural barriers, can directly impact on the quality of the assessment of the nature and severity of a mental health problem and the assessment of risk, resulting in potentially harmful consequences.42

Yet barriers still exist towards the use of interpreters in mental health settings. National CALD community and sector consultations, conducted between 2007 and 2010 by the Commonwealth’s previous Multicultural Mental Health Australia project, found that there were significant gaps and discrepancies in the uptake and use of interpreters in mental health settings across Australia.43

These gaps exist despite resounding evidence that the use of professional interpreters can help mitigate the previously outlined problems44.

A 2012 review of evidence regarding the use of qualified interpreters in health settings, conducted by the Victorian Foundation for Survivors of Torture (Foundation House), revealed that a range of standards, policies and professional codes of conduct existed at the national level that aimed to provide guidance on the use of interpreters.45 Furthermore, despite the availability of the Australian government’s national Translating and Interpreting Service (TIS), there were gaps in its uptake and accessibility.

The TIS is freely available, with no limit, for services funded under the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs’ (FaHCSIA) Targeted Community Care (Mental Health) Program (that is, personal helpers and mentors; mental health respite; and mental health community based services).46

The TIS Doctor’s Priority Line has also been freely available since 2000 for medical practitioners for items claimable under Medicare (this includes pharmacists prescribing PBS medications and their relevant staff) with unlimited access for telephone interpreters and quotas for on-site interpreters.

Yet, despite the TIS Doctor’s Priority Line being available at no cost to the practitioner, Australian research shows that there is low uptake of interpreters by General Practitioners (GPs), with GPs tending to defer to the unsafe and inappropriate practice of using family members as interpreters.47

The Foundation House review identified a number of barriers to the uptake and access to interpreters.48 These include:

- The absence of organisational processes and systems to assess and identify the need for interpreters.
- The insufficient state funding for use of interpreters in state-funded services.
- The lack of Commonwealth funding for a range of health care practitioners who are not able to access interpreters through the TIS Doctor’s Priority Line or the FaHCSIA TCC Mental Health Program (this includes allied health practitioners, such as psychologists, social workers and occupational therapists working in private practice).

---

45 The Victorian Foundation for Survivors of Torture (2012), op. cit.
48 The Victorian Foundation for Survivors of Torture (2012), op. cit.
• The varying levels of knowledge and awareness of practitioners in best practice in using interpreters as well as people from CALD backgrounds’ lack of awareness of their rights to interpreter access.

• The varying levels of quality of interpreters and the range of languages available.

Whilst the Foundation House review focussed on constraints within Victorian healthcare settings, community members, practitioners and policy makers in mental health settings right across Australia have echoed similar barriers\(^{49}\).

The words we use to express our ideas, our thoughts, our concerns, our pains, our distresses, our hopes and our desires help us articulate the journey we take in life. They also help us articulate the experiences we have along that journey. Those words are therefore an important aspect of any therapeutic relationship. Yet, for many, those words go unheard, or misinterpreted, with the potential for harmful outcomes.

**A vision for the future**

A key problem to addressing this potentially harmful issue is that there is a knowledge gap about the use of and access to interpreters in mental health settings with little mapping and coordination of the range interpreter options available between state, territory and commonwealth jurisdictions. The Foundation House study, which focussed on interpreter issues between the Commonwealth and Victoria, is a start in the right direction.

There is need for the duplication and extension of the Foundation House study across other jurisdictions in order to map availability and limitations of interpreter services, and identify gaps, as well as opportunities, with regards to access and availability of interpreters in mental health settings.

Furthermore there is evidence for the need to improve the quality of interpreting services within mental health settings through training mental health staff in the use of interpreters; improving the capacity of interpreters to work in mental health settings and increasing the size of the interpreter workforce to meet the need for a range of languages.

### 3.3 Improving access to services requires working with CALD communities to reduce shame and stigma and improve mental health literacy

As previously outlined, one of the key issues for CALD communities is getting to the front door of a mental health service. Knowing where to go to get help and how to navigate a complex mental health system is key knowledge in order to get access to timely and relevant mental health services. However for CALD communities, research and sector consultations show that overcoming the shame and stigma associated with mental illness can also be a significant barrier to seeking help\(^{50}\).

A comprehensive review of literature was conducted by the Queensland Transcultural Mental Health Centre on behalf of the Commonwealth’s previous Multicultural Mental Health Australia project as part of the development of Australia’s first national initiative to address stigma associated with mental health in CALD communities\(^{51}\). Key findings from the review include:

- stigma in CALD communities is an obstacle to increasing mental health literacy and early detection and intervention, and reduces help seeking

- individuals from CALD backgrounds affected by mental health stigma experience a “double disadvantage” of being affected by a mental health problem as well as being exposed to the consequences of shame and stigmas within their communities which can lead to further isolation, marginalisation and discrimination

---

\(^{49}\) See Multicultural Mental Health Australia consultations, op. cit.

\(^{50}\) MMHA 2010. Stepping Out of the Shadows: National Report, Multicultural Mental Health Australia, Sydney.

• attempts to reduce stigma in CALD communities must be culturally relevant and must be congruent with the range of explanatory models about mental wellbeing and ill health that CALD communities may already have.

Following the initial literature review, the Multicultural Mental Health Australia project commissioned the development of the Stepping Out of the Shadows CALD Stigma Reduction Training Package resulting in two complementary train-the-trainer manuals; a range of translated materials and a multilingual DVD. National implementation commenced in 2009 with each of the state and territory mental health directorates partnering to support implementation at the state level52.

Whilst there was significant support for the initiative with 38 agencies initially partnering to roll out the initiative within their jurisdictions, a national evaluation of the initiative found that a major barrier to the success of the initiative was the inconsistent level of investment to support implementation at the state level.

Whilst some jurisdictions made financial investments towards the implementation of the initiative, some contributed policy and promotional support without any commensurate funds for implementation. This resulted in varying levels of implementation success with the participation of implementing agencies determined by their capacity to make in-kind and/or financial contributions53.

Furthermore, in 2010, following the initial investment by the Commonwealth in the development of the resources and the range of in-kind and financial contributions made by state and territory mental health directorates and partnering implementation agencies, official national implementation of the initiative ceased to a halt with only one jurisdiction (Western Australia) to date continuing the initiative on a funded basis.

Today, the Commonwealth’s Mental Health in Multicultural Australia project, the successor to the previous Multicultural Mental Health Australia project, has strategic carriage to reduce stigma as part of its mental health promotion, prevention and early intervention, stigma reduction and suicide prevention project activities54.

However the key implementation barrier continues with no identified additional funds for implementing any CALD mental health stigma reduction initiatives across Australia.

A vision for the future

Whilst there is a need for investment in the development of culturally responsive mental health services in order to improve the safety and quality of mental health services (discussed next), investment in reducing the barriers to get to the front door of a mental health service on a timely basis is also crucial.

This involves working directly with CALD communities to reduce the stigma associated with mental illness and increase mental health literacy. It also involves supporting communities to identify pathways to mental health prevention and early intervention initiatives. Furthermore, there is a need for any CALD-specific initiatives to be aligned with wider initiatives targeting the general population.

3.4 Improving the access, quality and safety of services for CALD populations requires a whole-of-organisation and whole-of-system approach

Current thinking55 indicates that successfully building the cultural responsiveness of a mental health service requires addressing three key domains focusing at the individual level, the organisational level and the community level. Furthermore, the Australian Government’s National Health and Medical
Research Council’s guide, *Cultural Competency in Health*, also articulates similar domains and includes the wider domain of health (and related) systems.\(^{56}\)

Therefore improving the cultural responsiveness of a mental health service is a shared responsibility between the service, the service system and the government departments that fund those services.

Where this shared responsibility fails, gaps in accessibility show up.

Community and sector consultations have revealed that mental health services and the systems within which they operate struggle to be culturally responsive with a lack of leadership and a lack of systemic responses to drive cultural responsiveness across mental health systems.\(^ {57}\)

A 2011 evaluation of FaHCSIA’s Targeted Community Care Mental Health Initiatives noted the impact of systemic and cultural barriers:

> “Access by clients of Indigenous and Culturally and Linguistically Diverse (CALD) target groups are much lower than hoped. Many systemic and cultural barriers remain, which are largely outside the control of services.”\(^ {58}\)

A key systemic barrier is the lack of investment in multicultural mental health services to support a culturally responsive mental health system. A review of FAHCSIA’s funding distribution found that:

> “…multicultural and ethno-specific services have increasingly been marginalised in recent commonwealth mental health funding rounds. For example, in July 2006, the Council of Australian Governments agreed to dedicate $1.9 billion to improve services for people with a mental illness, their families and carers. Under this national action plan, the Federal Department of Families, Housing, Community Services and Indigenous Affairs implemented three community-based mental health programs: Personal Helpers and Mentors; Mental Health Respite program; and Mental Health Community Based Program. As at April 2010, only two out of 277 mental health services funded under PHAMs were ethno-specific or multicultural organisations. This represents just 0.72% of the PHAMs funded services at that time. This is vastly disproportionate to the number of people from CALD backgrounds around Australia who may need multicultural or ethno-specific mental health services.”\(^ {59}\)

Devastatingly, this also includes the withdrawal of investments in the multicultural sector.

In 2011, the Commonwealth Government announced $2.7 million in funding for the Mental Health in Multicultural Australia (MHIMA) Project, to be delivered over a three year period\(^ {60}\) with Queensland Health to make a co-contribution of an additional $1.34 million to expand capacity of the project. Yet, in 2012, despite planning undertaken and commitments made by the MHIMA project based on this budget, Campbell Newman’s newly elected Queensland government withdrew the co-contribution of $1.34 million following a review of jointly funded state and commonwealth projects.\(^ {61}\)

**A vision for the future**

Changing funding systems may encourage mental health services, particularly those within the Community Managed Organisations (CMO) sector, to become more responsive to their diverse client base in order to attract and retain clients from diverse backgrounds. The National Disability Insurance Scheme (NDIS), currently being in tested in sites across Australia, is a looming reality for Australia’s CMO mental health sector. As a review of similar overseas initiatives by the NSW Mental Health Coordinating Council found:

---

57 See MMHA consultations, op. cit.
59 Multicultural Mental Health Australia (2010), op. cit.
60 The Hon Mark Butler MP 2011. Media Release: Mental Health in Multicultural Australia Project to get $2.7 Million, 17 June 2011.
61 Correspondence with Greg Turner, Director, World Wellness Group, Brisbane.
“In countries where self-directed care has been introduced, funding bodies have phased out block funding to community organisations which must then rely on the individual funding that clients bring with them…The transformation to this approach also means that in order to attract and retain clients, CMOs must provide the type of services that clients want, in the way and at the times that they want to receive them.”

As Australia’s diversity grows, it is inevitable that mental health services within the CMO sector will need to ensure that their organisations are inclusive and “CALD-ready” or risk losing potential future clients from CALD backgrounds to those that are.

Mental health services provided in hospitals will also be facing changes to the way they are funded with the introduction of Activity Based Funding (ABF). With the shift to episodic based funding, there will be increasing pressures to reduce hospital stays and potentially the time spent with patients.

Whilst the shift to ABF aims to create more efficiency in service delivery in hospitals, there are potential risks that services to patients with more complex needs, such as those with language or cultural barriers, may be under pressure under the new system.

Whilst it is still early days with the Independent Hospital Pricing Authority only recently undertaking a consultation process around the definition and cost drivers for mental health services, it is inevitable that Australia’s public clinical mental health system will have to prepare for this new funding model.

If mental health services already face difficulty in providing, or accessing, culturally appropriate and language specific services for presenting CALD clients, then the shift to ABF, with its associated time pressures, stands to exacerbate this difficulty.

Australia’s mental health system needs to prepare for these future changes so that it is ready to engage the reality that is Australia’s diversity. Current initiatives, such as the Framework for Mental Health in Multicultural Australia (being developed by the Commonwealth’s Mental Health in Multicultural Australia project) and the systemic approaches by various state-based transcultural mental health services and networks, are a key step towards supporting Australia’s mental health system.

A key action here would be to reinstate the pre-agreed $1.34 million for the MHiMA project in order to support the enhancement of its systemic and capacity building work.

Furthermore, existing funding criteria within FaHCSIA’s Targeted Community Care Mental Health Initiatives expects that services should cater for special needs groups, including those from CALD backgrounds. This criteria should be strengthened with a requirement of evidence from applicants of the extent to which they have engaged, and are capable of engaging, with Australia’s diversity. Where this is not demonstrated, FaHCSIA should target funding towards multicultural and ethno-specific agencies to meet such gaps.

4. Closing

Drivers for reform include the fact that Australia has always been a diverse nation and we are continuing to grow in our diversity. Furthermore, serious gaps already exist in terms of the accessibility of mental health services for Australia’s culturally and linguistically diverse populations. Policy, planning and implementation of mental health services cannot ignore this reality.

Addressing these gaps and planning for Australia’s future requires investment and action in its mental health system. Specifically, we need investment and action to:

- improve our understanding of the extent of the problem with regards to prevalence and access in relation to CALD communities

---

64 Mental Health in Multicultural Australia (MHiMA) 2013. Submission to Independent Hospital Pricing Authority Consultation.
65 University of Queensland 2012. Consultation Paper: Definition and Cost Drivers for Mental Health Services, Consultation paper prepared by the University of Queensland for the Independent Hospital Pricing Authority.
- improve the safety and quality of communications between CALD consumers and mental health practitioners
- reduce the shame and stigma around mental illness and improve mental health literacy in CALD communities
- improve the cultural responsiveness of Australia’s mental health system through whole-of-organisation and whole-of-system approaches.

So where do you start? A good start would be to re-instate the $1.34 million funding that was previously agreed to as part of the formation of the Mental Health in Multicultural Australia project. Further action and collaboration is needed through COAG and its subordinate structures to ensure that action is coordinated across governments and across systems. And when is action required? No surprises there. There’s no time like now to make the swytch towards a mental health system that is inclusive of all Australians, regardless of who they are or where they come from.
Obsessive Hope Disorder
Chapter 13

The past, present and future of mental health research

Helen Christensen, Katherine Petrie and Philip Batterham
Obsessive Hope Disorder
Introduction

Research in mental health is a critical activity. Without research, the causes of disorders will never be understood. Without research, the effectiveness of new treatments, better health service methods, and new methods to aid recovery will not be forthcoming. Importantly, research forms the basis on which we can reject service models, treatments and programs that are not effective, non-evidence-based, or even harmful. In other words, research tells us on the basis of “effectiveness” which approaches to jettison and which ones to embrace.

Given its importance, it is fitting and timely that an overview is provided of the nature of mental health research in Australia. What has happened in the research sector over the last 10 years? In order to best shape our future direction in the field, it is critical we take stock of the past and evaluate what worked and areas to improve moving forward.

This chapter focuses on three aspects of the research landscape:

- The extent to which mental health is prioritised relative to other research domains, and whether this has changed in the last decade. Is its share of the cake equitable?
- The research content of mental health publications relative to key stakeholder priorities and disease burden, and whether this has changed in the last 10 years.
- New initiatives in research practice and how this may impact mental health research into the future.

1. Mental health research: Its share of the cake is not equitable

In 2002 the National Health and Medical Research Council (NHMRC) established eight National Priority Areas for Research (NHPAs), namely: arthritis, asthma, cancer, cardiovascular disease, diabetes, injury, mental health, and obesity. There was no explicit statement as to how funding would be prioritised across these eight fields. In terms of burden of disease, mental health is a major contributor to both the global and national burden of disease. In the recent Institute of Health Metrics and Evaluation’s 2010 Global Burden of Disease Study1 (IHME, 2013), depression ranked eleventh among disorders responsible for global disease burden. In Australia, major depressive and anxiety disorders represented the seventh and eleventh leading causes of disease burden respectively (in terms of Disability-Adjusted Life Years [DALYs])2.

Two relevant questions with respect to NHPAs might be asked a decade after their introduction. Has the establishment of NHPAs (a) led to increased NHMRC research funding in priority areas compared to non-priority areas and (b) resulted in funding being more evenly spread across the NHPAs?

The answer to both these questions appears to be ‘no’. Data from NHMRC databases indicates that while there has been an increase in funding by NHMRC overall, there is no greater increase in funding to NHPAs. Secondly, there has been no differential spread of funding to mental health priority fields. To quote Christensen et al., “Mental health research receives lower levels of funding than cardiovascular disease and cancer research (about 9.5% compared to 21.7% and 14.9%, respectively, in 2009). However, when adjustments are made for burden of disease, the areas of diabetes, asthma, cancer, arthritis and cardiovascular disease all receive proportionately more research dollars per attributable disability-adjusted life-year (DALY) than does mental health. Relative to other conditions, diabetes had the largest increase in research funding from 2001 to 2009”3. This is illustrated in Figure 13.1 below.

---

We can conclude two things from Figure 1. (1) Taking into account the overall increase in NHMRC research expenditure over the past ten years, it appears that the introduction of a priority area does not seem to lead to increased funding (not shown in graph); and (2) mental health does not seem to be receiving its fair share of research funding, if prioritised in terms of the costs and significance of all diseases. Although the size of the cake has increased from NHMRC, there is no evidence that mental health is getting a larger slice of the cake compared to other National Health Priority Areas, nor a slice commensurate with its disease burden.

2. Priorities within mental health do not align with stakeholder priorities or disease burden

The above discussion relates to the extent of mental health funding in the context of other health fields. The issue of which or what research should be funded within mental health itself also needs to be examined. Mental health research can play an important role in providing evidence for identifying potentially useful strategies to address the burden of mental health problems and for evaluating the effectiveness of these strategies.

In 2001, Jorm and colleagues established a methodology for examining research priorities within mental health research, which aimed to establish a “comprehensive explicit set of priorities for establishing priorities within the mental health research field”. The methodology developed a typology of existing research applied to a year of research publications and grants, and then compared this to key benchmarks, including the prevalence and burden of various mental health disorders, costs to the health system, research priorities of stakeholders, and national policy goals. The initial analysis was reported in

---


2002 by Jorm et al and replicated in 2011\textsuperscript{6,7}. This most recent analysis canvassed the views of 672 stakeholders in mental health as to their priorities for the goals and targets of mental health research, through an online survey. The survey was fully completed by 570 of these respondents, representing medical and mental health practitioners, consumers and carers. A random sample of 1008 Australian-authored research publications and 126 competitive research grants from key national funding bodies was coded and compared to data collected in 1998. These findings document trends over the last 10 years in mental health research, funding and disease burden.

Three questions were asked using the data:

- Have the topics of research changed over the last decade?
- To what extent are fields of research within mental health commensurate with the stakeholders’ priorities for research?
- To what extent are the fields of research reflective of burden of disease?

Relevant data are presented below to answer each of these questions in turn.

**Nature of the research**

Data from the following two graphs indicate that substance abuse disorders continue to the most highly studied, followed by affective disorders and anxiety disorders. The goal of research is still strongly epidemiologically and biologically focused. In general, epidemiological research focused on risk factors and associations, whilst treatment research predominantly examined psychosocial treatments. The content of biological research varied, with the largest concentrations concerning cognitive processes and animal models. Services and prevention and promotion goals constituted only a small proportion of publication output over the last decade. Prevention and promotion efficacy studies were rarely reported.

In summary, the data shows that the topics of research have not changed over the last decade.


Figure 13.2 Category of mental disorder in publication output in 1998 and 2008 (weighted to account for multiple disorders)

Figure 13.3 Research goal identified in publication output in 1998 and 2008 (weighted to account for multiple goals)
Distribution of research relative to stakeholder priorities

The ratings of stakeholder priorities for research were plotted against publications and funding percentages to determine whether the existing research landscape is in line with the desires of stakeholders.

Figure 13.4 Stakeholder priorities for research on disorder categories (in rank order) compared to 2008 publication output and grant funding

Figure 13.4 reveals a considerable discrepancy between stakeholder priorities and the research that is currently being undertaken and funded. While there was significant publication and funding related to affective disorders in line with priorities, there were clear gaps in research on schizophrenia/psychosis, childhood conditions and suicide. In particular, childhood conditions and suicide received little funding, despite their high priority in the stakeholder rankings. A disproportionate amount of funding and publications in substance use disorders can be seen compared to their relatively lower ranking in stakeholder priorities. Although “other mental disorders” not specified elsewhere also appeared to represent a larger degree of funding and output relative to stakeholder ratings, this category does include non-specific mental health problems, and as such, may add to knowledge about specific types of mental disorder.

Figure 13.5 compares stakeholder ratings, publications and funding regarding subpopulations targeted by mental health research. Despite there being less funding for research on young people compared to older individuals and those with illness or injury, considerable publication output targeting young people is still achieved. A large gap between funding and published papers relative to stakeholder priorities is clearly evident for a number of subpopulations including; veterans, carers, refugees and asylum seekers, rural and remote populations, women in the perinatal period, the socially and economically disadvantaged and individuals of Indigenous descent. There remains substantial discrepancies between the target groups represented within present Australian publication output, and those subpopulations deemed worthy of such research by stakeholders.
Figure 13.5 Stakeholder priorities for research on specific population groups (in rank order) compared to 2008 publication output and grant funding

In short, stakeholders’ views are inconsistent with the distribution of research effort in mental health. Most stakeholders desire research focused on youth, those of Indigenous and Torres Strait Islander background, and socially and economically disadvantaged people.

Stakeholders also want greater emphasis on research considering prevention and promotion and service evaluation, which is at odds with the current distribution of research endeavour.
Distribution of research according to disease burden

Although affective disorders now receive a level of funding that is in line with disease burden, current publication output does not yet reflect this. Other disorders that appear to be adequately funded and researched in harmony with degree of disease burden include eating disorders, substance use disorders and schizophrenia and psychosis. However, it appears that there are marked discrepancies between the limited degree of funding and publication output in anxiety disorders, dementia and in particular, personality disorders and suicide, when considering their considerable contribution to burden of disease associated with mental disorders. Additionally, childhood disorders are no longer receiving adequate funding in 2008, representing a significant fall from their funding status in 2000, despite similar publication output for this subpopulation.

In summary, the data reveals that research output is inconsistent with the “burden of disease”. Dementia, anxiety and affective disorders and suicide are all underrepresented in Australian-authored publications, relative to their significant disease burden and costs to society.
3. The future of mental health research

Changing the research landscape seems to be a difficult task. Little has changed within funding or research endeavours over the past decade. The analyses above demonstrate that it will be hard to shift research priorities despite the views of stakeholders or the priorities of consumers and carers. Priority areas continue to attract funding but there is no shifting across disorder types. Mental health topics continue to be funded in the same proportion as a decade earlier.

On one level this is hardly surprising, given that researchers themselves rarely “change topics”, and funding and publications represents the proportion of researchers within research groups continuing to seek grants and submit publications. If this is the case, then pressure to shift will need to come from external sources. Below are some suggestions of external drivers for change:

Priority driven research may become commonplace and provide dedicated research funding to solve the types of crisis in health. For example, organisations such as the NHMRC may begin to make decisions to dedicate more research dollars to specific research directions. Organisations like beyondblue will shift funding towards projects that aim to solve the problem of anxiety rather than depression under its new strategic plan. Researchers may be attracted to these funds.

New initiatives to align research with national priorities and to embed research within health services may increase health service research (see McKeon Strategic Review8). The development of health research

---

and service hubs, as recommended by the 2012 Wills Review\(^9\), has the potential to accelerate the growth of a more vibrant clinical research agenda. If successful, embedding research into service reform will be likely to increase health services research and accelerate health reform, and increase accountability.

A focus on translational research may increase the types of groups who are served by the research targets. In other words, the implementation of new treatments and procedures will become a focus of research. Implementation methods will be different for different cultural groups.

The growth and development of philanthropy in Australia might be a consideration. More philanthropic grants to mental health research will grow the base. The type of research will be changed if philanthropists focus on specific health topics within psychiatry and mental health.

The power of the consumer voice may grow and directly and indirectly influence what topics and settings are covered. Advocacy for research might lead to increases in some research areas.

It is unlikely that Government will continue to increase funding via the NHMRC over the next decade. Hopefully, priority-driven research, translational research and research conducted within and around health systems will lead to increased creativity and research that is more responsive to priorities.

**Helen Christensen\(^1\)*, Katherine Petrie\(^1\) and Philip Batterham\(^2\)**

\(^1\) Black Dog Institute, University of New South Wales, Randwick, NSW, 2031
\(^2\) Centre for Mental Health Research, Australian National University, Canberra, ACT, 0200

---

Chapter 14

A better way for the mental health workforce: Time to get serious

Peter Long and John Mendoza
Obsessive Hope Disorder
Introduction

“Everybody talks about the weather but no one does anything about it.”
Mark Twain

After reading the evaluations of three National Mental Health Plans, the National and state Auditor Generals’ reports on aspects of the mental health system and the wide ranging review of mental health for this report, a reader could be forgiven for having a sense of déjà vu and ‘here we go again’.

In spite of the best intentions of government and significant investment there appears to have been only limited and patchy improvement in workforce capacity, capability, deployment and sustainability.

Recurring patterns of problems in organisations and even industries may signal embedded processes, which are often unconscious to the parties involved and difficult to change. This appears to be the case in mental health – so this Chapter will focus less on the workforce operational details and look more strategically at breaking the cycle of recurring patterns observed in the mental health workforce for the past 30 years.

We will resist repeating the mantra of hire more and specialist staff, deploy more staff to regional and remote centres, break down the multitude of demarcations, remunerate staff differently, recruit ATSI peoples for as long as possible, in favour of looking at some other aspects which may impact on the system and create some tipping point(s) for change. To do this we will employ systems thinking.

Systems thinking

Systems thinking, as defined by Michael Jackson¹ is:

"... holistic rather than reductionist and at least in the form of critical systems thinking, does everything possible to encourage creativity.”

The health system (and mental health as a nested sub-system) is identified as a complex system². A “complex system” is different to a “simple”, “complicated” or “chaotic” system³. Complexity is characterised by the following:

- Large number of interacting elements
- Interactions are non-linear – minor change creates disproportionately major consequences
- The system is dynamic – whole greater than the parts. Solutions not imposed but arise (are emergent)
- The system has a history – past integrated with present – elements evolve (irreversible)
- Hindsight does not lead to foresight – external conditions and systems constantly change
- In a complex system the agents and system constrain one another – especially over time, making it difficult to forecast.

As a consequence, reductionist, linear analysis (as per the traditional medical model’s cause and effect approach) may not be as fruitful as ‘complexity theory’ analysis. Complexity theory attempts to translate the system-of-systems perspectives into a more holistic picture, one that is often more than the sum of the parts. The earlier discussions on the history and journey of the workforce, sought to identify the issues of the present and systems thinking may pay dividends in a search for ways to provide an appropriate, adaptive mental health workforce for Australia.

---

Organisations are people constructs

It is useful to be reminded that organisations take entities unto themselves, yet are comprised of human agents. As Steinbeck reminded us in the “Grapes of Wrath”, when one of the tenant farmers, attempting to understand why they were thrown off their land, insisted that the bank is only ‘made of men’, the owner men replied:

“No you are quite wrong there. The bank is something else than men. It happens that every man in a bank hates what the bank does, and yet the bank does it. The bank is something more than men, I tell you. It’s the monster. Men made it but they can’t control it.”

As a consequence, first, the system is comprised of human beings who share a reality of their world and if required, this reality needs to be influenced; second, all organisms (even amoeba) are goal driven and in the modern world, values, goals and policies are contestable; and, third, in many ways and from numerous perspectives, the workforce is a large part of the mental health system and as semi-independent agents in the system can defend and transform it.

System’s features

Boundaries

The boundary of the present system discussion is the workforce, yet we know other systems (e.g. health, federalism and international systems) impact upon it, and that boundaries are not impervious. Even within the encapsulation of the workforce the latest Health Workforce Australia (HWA) Framework for Action\(^5\) has a more realistic view of the workforce than previous plans with the inclusion of ‘Domains’. The mental health system could benefit by a similar recognition.

In the COAG arena a boundary gap might be identified which has led to the ‘tragedy of the commons’ effect (where no one owns the field, it is not managed, is ravaged and rendered worthless as a consequence). By including planners, leaders, change agents, researchers, data modellers in the domains (those who work on the system – or tool box) there is a better possibility that they will be managed and, as consequence: a) accountabilities will be established; b) their performance will be managed to ensure outcomes; and c) their skills enhanced to improve services for all.

Processes

A simple view of systems is that inputs enter at one point, get ‘processed’ or mixed, and converted to an output. Peter Senge\(^6\) reminds us that various feedback loops can occur within the process.

The first loop, Lag, is where the input is injected and it takes a period of time until the effect, or output, is known. Lag can be noticed in the mental health reform agenda when one inquiry gets a change agreed, or one National Plan is agreed and some change happens and some not. With lag the requirement for an intervention may have moved on before the change is introduced. The result may be inappropriate.

A critical area where lag often occurs is in workplace culture. Management believes everyone is enrolled in the vision but the train leaves, and many of the workers, or fragments of the system, are still left at the station. It would appear that significant lag is evident in relation to the mental health workforce, making intervention awkward and too often ineffective. Lag is also evident between opening training places (e.g. to train a psychiatrist from medical graduate), and its impact on the system. In a similar fashion interventions such as re-engineering the workforce may break the bond of trust in the workforce and create a migration effect in the survivors for years following. The initial impact may appear positive but lag hides the negative.

The second loop, Balance is when forces in the system work to re-create equilibrium (the rubber band effect). When minimal difference is achieved (outcome) after considerable input, there is a chance that a self-balancing mechanism is in place. In the mental health system there are a number of such features as

---

a consequence of an input focus – e.g. Medicare funding based on the treatment of the ill (inputs) not upon the achievement of healthy outcomes – can lead to those who already ‘have’ getting more. Similarly, why would a private correctional facility, which gets paid on numbers of people in custody, be interested in rehabilitation?

Policy intervention to ensure a more equitable distribution of resources and capability will require critical analysis, not acceptance of norms.

The third, Waste is where forces in the system act in such a way (processes) as to use resources at less than optimum capacity. In human services waste might include: loss of time, talent, motivation, knowledge, goal achievement as well as funds, tools, and materials. Given the considerable investment in mental health there should be concern with the wastage as a consequence of poor processes. The processes in question here include: detailed planning across the network; best practice governance processes; and appropriate data (see various ANAO Reports) to steer the reform – rather than report post ipso facto.

In addition, these fundamentals, acting robustly, ensure the health of the cybernetic processes, which assists the system to respond appropriately to its environment. Given that its history has emerged from a tightly ‘closed’ system (e.g. asylums and public sector), there is every chance that this system is damaged, rudimentary or dysfunctional (or all three) and will require considerable attention.

**Future paradigms – A vision**

As discussed earlier, there have been a range of paradigms operating in the mental health field and to contribute to the future is to create discourse about the framed realities brought to the table.

The focus on ‘paradigms’ is important for the future of the mental health workforce because a paradigm has connected elements, values and logics which lead to certain problem solving and change styles. Triple-loop and double-loop learning leads to a contextual and paradigmatic change.

The Figure below illustrates that the mental health system in Australia is presently subject to numerous converging paradigms, which have added to the complexity yet, simultaneously, are assisting the system to meet the demands made upon it.

---

Back to Twain momentarily, an analysis of paradigms could be analogous to a weather pattern in that the weather is not predictable in the sense it can be turned on or predicted at will but, over time, and at a distance, it has features and patterns, which can be observed in a macro, which help to make sense of the micro. Those steeped in the mental health field will be able to do a more refined version of the ‘isometric paradigm chart’ but regardless of timing or badge, the changes in mindset (learning) required of all workers in the system from politicians to users, has been considerable.

The question for the future is to what extent are they aligned and how much lag needs to be concretely addressed?

The recent Vision as espoused in the Roadmap for National Mental Reform is for:

“A society that values and promotes the importance of good mental health and wellbeing, maximises opportunities to prevent and reduce the impact of mental health issues and mental illness and supports people with mental health issues and mental illness, their families and carers to live full and rewarding lives.”

It would appear that the paradigms align around:

Focus on Individual as a person and holistic interventions, early intervention, interventions with a view to recovery, CBT approach, community-based, broad view of client base: not merely acute care, GP frontline, psychiatrist as consultant, broadened roles for MH nurses and other Allied health people, and increasing the role and support of carers and the individual user of MHS, continued de-institutionalisation, team-based support, transparent care and creative ways of sharing case history, outcomes-based performance indicators.

It may well be that we know what to do, but we don’t know how to do it. As Braithwaite, Professor at the School of Health UNSW said of Garling’s review of NSW Health:

\[9\] Cluster of recurring themes in post-Burdekin reports, inquiries, reviews as distilled by the authors.
“… there had been many healthcare enquiries in NSW other Australian states and internationally, and our research showed that the real problem was not in formulating what should be done. Most of this is well known, although there can be innovative solutions at the margins. The much harder task is how the reforms envisaged should occur, which is these days called, variously, ‘systems change’ and ‘implementation science’. This is particularly challenging, and perhaps the main game. No health system has figured out how to implement reforms effectively and certainly not quickly, no matter how well crafted the recommendations made meant to give this effect. Yet Garling’s recommendations imply a timescale of months and a few years, rather than envisaging reform as generational change.”

If we know what to do, as is suggested, the whole system – policy makers, planners, leaders, workers, carers, and other stakeholders – need to roll their sleeves up and focus upon how to make it happen. Without diverting attention away from the mantra of recent years, attention needs also to be directed to what, at the risk of using a mechanical metaphor in an organic era, is the ‘system toolbox’ required to make the change happen – in this case a more modest ‘starter kit’.

**A starter kit for effective system change**

The ‘starter kit’ includes the following: Management Information Systems, coordinating processes, cultural sub-systems, planning, standards, shared competency, leadership, and change management.

**Figure 14.3 The starter kit or toolbox for change**
Management information systems

Based on the publicly available information, the UK appears to have been able to create a data model sophisticated enough to capture simple, but valuable outcome data. This includes:

- How many people have been treated?
- What has been their experience?
- Is the system improving or getting a return from its effort (investment)?
- Are we meeting our obligations?

After 20 years of national priority afforded to mental health it is comforting to see that the National Mental Health ‘Roadmap’ has a range of proposed indicators. Should this be developed and deployed, the data gathered would be far more likely to provide government with the information to make informed decisions about future investments. Having said that, there are significant gaps in the Roadmap’s proposed indicators – e.g. Indigenous needs are highlighted, yet there are no targets or measures.

The same clarity needs to be applied to mental health workforce planning. Why it is important to have this conversation is that in a complex system the right type of goals can act as an ‘attractor’ and add coherence. If, however, the workforce doesn’t have confidence in the integrity of the data they will not invest in it, nor will the community invest in the political capital to fund it.

Coordination

Federalism is an ongoing feature of the Australian policy landscape and it has had a chequered political history and can be viewed either as a major conservative force, or as a major opportunity to enable accommodation of diversity and inclusion, with state and territory systems providing experimentation platforms for improvement.

Federalism is an approach to coordinate national services: horizontally through the Grants Commission and, vertically, through COAG and Ministerial committees and meetings of experts. Federalism also makes integration more difficult as the parties to the agreement cling to preferred modes, priorities, standards and electoral timetables and this has certainly been the experience in relation to mental health generally and the mental health workforce particularly.

Since the First Evaluation report of the National Mental Health Strategy in 1997 through to the present, there have been repeated calls to address coordination and integration of mental health services. Specifically, these reports have called for:

- Better integration between private and public providers in the mental health system. Through the Medicare system, the Commonwealth has attempted to make it more attractive for psychiatrists to move between the private and public systems and for GPs to pick up more of the frontline assessment, treatment and referral to the hospital system, however serious problems remain.
- Better coordination between public funded services and the NGO providers. The problems are evident in the quality of care and inequities in access to care but also with workforce discontent over wage disparities and stress due to lack of competence and capacity.
- Greater standardisation of the treatment provided in different settings. There are simply no agreed service models and few agreed clinical or treatment guidelines in mental health care and little or no investment in rolling these out to the workforce. For example, consumers attending private services of a psychiatrist might receive therapies over an extended period of time, yet in the public system might

11 Appleby L 2010. Mental Health Ten Years on: progress on national mental health care reform. NHS.
14 WA Peak Bodies 2008. Workforce in Crisis: Value our Community Services – Value our workforce WA.
receive brief therapies and with a variety of different psychiatrists or other professionals; or a consumer might be discharged from a hospital to an NGO provider but privacy, or other, issues may preclude NGO access to the client treatment files thus causing discontinuity. The need for shared protocols and competencies are obvious.

The implications for performance management from systems level, to service provider and individual workers are obvious. Common training, record keeping, models and standards of care, competency sets and values would assist the mental health workforce to cope with demand and to provide significantly better services.

A study for mental health articulation for curriculum and skill development reports that, the mental health sector “is a fragmented sector – (and will have a) difficult task in unifying attitudes, identifying long term needs and overcoming funding difficulties” and reported “problems of fragmentation of supply chain approach to workforce development” 15. This demonstrates that lack of coordination in the processes set in place to ‘fix’ the system end up limiting its efficacy and contributing to rework.

One way to address these issues is the establishment of a national institute of mental health education/training, as in the UK and New Zealand, to provide the necessary leadership.

**Cultural sub-systems**

**Voices in another room**

There is very limited direct information available about the culture of the mental health workforce across Australia. Even inquiries into specific elements of the workforce provide only limited information of workforce culture in specific settings. Earlier in this Report, Kordes has provided an historical explanation of life for mental health nurses in a psychiatric institution and Burdekin 16 provided glimpses of culture through first-hand accounts of staff members who had provided submissions to the HREOC Inquiry. The 2006 Senate Committee Report, From Crisis to Community, identifies ‘stressful work’ and a significant level of violence as deterrence to the recruitment and retention of mental health nurses 17. Garling, in reviewing general health services in NSW, speaks of an ‘unhealthy culture’ and suggests a ‘just’ culture be established as a cure 18. The Blueprint for Health Reform in Queensland also recognises ‘low morale’ 19 across the public health services. One report on workforce culture conducted in Queensland on the NGO workforce provides a more positive account of the culture and morale within that sector 20.

It is as if culture is regarded as voices in another room and should not be spoken of directly. It may be that those in the system are so aware of it that they do not need to share, but in an ‘open’ system it will pay to have a better picture of the culture across all services as an element of reform.

**Images**

From a cultural perspective Morgan first drew attention to the power of metaphor to drive the culture of the system 21. The ‘Medical model’ has been a strong and persistent paradigm or image and has been the basis of the management of mental illness. While there are valid criticisms of the medical model generally and its dominance of service particularly, its focus on evidence-based treatment, its concern for care and nursing, its reliance on improved drug therapies and tightly controlled treatment regimes, and its ability to respond to crisis has been invaluable to the field.

However, like all cultures, its strengths can be its weakness and critics 22 point to the model’s propensity to deal with ‘symptoms’ rather than address and deal with ‘causes’, to focus on diagnosis and not the whole person and their needs, to be scientific at the expense of alternative paradigms, to be overtly unemotional and provide ‘cold’ or detached service, to be controlling rather than empowering (and more) as downsides

18 Garling op cit p. 22.
22 Burdekin 1993 op cit p. 257–258; CSHISC op cit p47.
of the model. In the workplace this played out in hierarchical organisational models, inorganic structures and processes rather than organic structures (networks) and processes (contingency appropriate). It allows individuals to be ‘sick’ and for ‘treatment’ to arise from outside their control, for s/he with the most knowledge to prevail in leadership, and for lay persons to be disempowered in the process, and a general desire for control.

The new paradigm for public sector generally is ‘public value’: those activities which create public value are to be supported, non-value activities should be avoided. With the rise in correctional institutions it might be argued, for example, that the community sees value in incarceration of those who can’t abide by its norms or values and is prepared to accept that 20–25% of prisoners who had been diagnosed as having a serious mental illness would be more appropriately placed in mental health care. This ‘shadow system’ is a substitute for a ‘failed system’ and perhaps a mark of failed leadership in the mental health field.

Morgan notes that in the twenty seven years since the publication of his book “Images”, information technology supporting instant networking and continuous learning, are making the systems theories relating to the image of ‘organisations as brains’ more of a reality. It may be that it is a case of ‘Physician (therapist) go heal thyself’ . The ‘learning’ paradigm appears to be increasingly appropriate as a cultural toolbox of the times with mental health literacy assisting in self-care and earlier help seeking and intervention; shared competency as a lubricant in boundary spanning behaviour; neuroscience assisting in early diagnosis and correct intake assessment; and, the building of learning organisations based on knowledge networks.

If the latter image (the healthy brain) drove the public sector workforce leadership, there would be a likelihood that: reports of ‘unhealthy’ cultures would be less prevalent due to a focus upon learning, competency, and flexibility; research institutes would take on a leadership role; and more creative pilot approaches to progress change would be sponsored for adaptive leadership.

Finally, culture can play a coordinating function and by addressing the mental health culture and subcultures better coordination may be derived as a consequence.

**Workforce planning**

A need for and the lack of diligent workforce planning has been consistently identified as a critical risk to Australia’s mental health reforms since the commencement of the strategy in 1992.

Simply put, better workforce planning means *detail needs to be put into the devil*. As in many aspects of mental health reform there has been a lot written and too little work on the deployment but in relation to workforce, there also has been too little written, or planned.

Medicare acts as a ‘pull model’ of service and a ‘pull model’ of funding, but because of its input focus, provides funding to where those providing the service choose to operate rather than where services are needed. There is no other area of public policy (and funding on a massive scale) where this occurs. ‘Root and branch’ reform of Medicare, including a focus on purchasing outcomes, could bring relief to the beleaguered mental health workforce.

Beyond Medicare reform the States can use locational funding to hire the workforce to meet the demand. Until this relationship is established there will be little semblance of planning, let alone building, a capable workforce able to service the rights of citizens wherever they live in Australia. The NDIS has an element where the funds are put in the purchaser’s hands and the purchaser can choose the service, which provides value for them. Market forces (especially if there is a differential for remote and special services) then may assist in rewarding professionals for working in less comfortable environs and hence, distributing the workforce and assisting their retention.

---

23 Note that estimates of prisoners with a mental health condition are substantially higher and range between 30-85%. The number referenced here is that which Professor Bryant Stokes argues require care in a mental health care facility.


26 Sammut J 2013. Saving Medicare: but not as we know it. Centre for Independent Studies, Melbourne.
The mid-term review of the Second National Mental Health Plan called for defining ‘the gap between the existing workforce and what is required’, and to define the number of each professional category required to meet particular area needs, rather than focusing only upon global ratios, which have only a very blunt relationship to ‘access’ needs. This is precisely the approach taken in the UK with considerable success.27 However no such effort has been mounted in Australia and the workforce situation becomes more critical annually. Such data is critical for effective planning purposes – all service providers still need to create, develop and retain a high performance workforce.

Planning to meet an estimated need appears to be a better strategy than a reactive approach, yet reactive responses, bandaid solutions and hope appear to frequently as proxy for strategy.

Complexity theory would alert us again not to assume increased workforce will result in increased or improved outcomes. For example, during the ten years 1997–07 each jurisdiction’s mental health clinical workforces increased by about one third yet treatment rates did not increase.28 Similarly, other reports tend to suggest that the same people are getting more and broader care.29,30

The HWA’s Strategic Framework31 for action agrees with a rethink about workforce planning.

“What is required is a paradigm shift in ways of thinking about workforce design and planning, one that works backward from outcome for communities, consumer and population need, versus the current thinking that is generally focussed on working forward from the base of existing professionals.”

Standards

It is difficult to ensure quality control if there are no agreed standards by which to operate or, worse still, there are standards that are poorly defined and difficult to apply.32 A set of national standards were prepared and agreed, but the roll-out strategy and resources to implement were absent. All international, and even institutional, quality systems rely on a three-legged stool to support them: one leg is the standard, another the education program to reinforce it, and the third is the independent compliance check and consequence. In relation to mental health standards legs two and three have never been fitted to the stool.

Mental health in Australia lacks a standard model(s) of treatment (clinical practice or community practice) in a fashion similar to other disciplines in the health field (e.g. oncology). The lack of this in mental health adds to the question about the credibility of the field. The research Institutes should pick up the leadership here based on evidence, and then Commonwealth funding aligned to the practice(s). This would assist equity and quality of care across the nation. Benchmarks both local (Victoria) and international (e.g. UK, NZ) could be used to drive improvement.

Shared competency

Developing the workforce to meet the complex and demanding needs of the mental health community requires the development of a model or framework of shared competencies and training in those for aspects of all professional development and curriculum. This has been done in Australia on a regional basis, and the UK and New Zealand nationally. The shared competencies are predicated by a belief that team-based approaches are best, allowing a range of expertise to impact on client treatment.

A standard set of competencies would enable an improved quality control and coordination function. It is proposed here that five areas be shared in that each staff member should have first, the professional skills of their particular discipline (support carer, social worker, psychologist); second a competence in a

33 Barwon Health Competency framework.
special client or treatment area (e.g. Forensic, adolescent, ATSI,) included in this competency is guidance around emotional intelligence and the ability to engage with the client group; third, a shared competency to work within a cross functional team; and fourth, institutional skills (e.g. institutional, General Hospital, acute, community, NGO). This is shown in Figure 14.2.

**Figure 14.2: Shared competency model for MH workers**

Central to the success of this approach is the inculcation of the appropriate shared values associated with modern, evidence-based approaches to the treatment of mental health.

A note of caution, as raised by the ANAO in an audit of DVA support for younger veterans, is that ‘there is little to no evidence that utilising peak health bodies to transfer learning has been cost-effective or successful’. The UK model has ten shared competencies and a creating capable teams (CCT) competency, which on the evidence has transform service quality and access.

**Leadership – Values-based**

Leadership in a complex system is a critical feature not only of coordination but also of change. Mostly, good leadership can influence a positive culture. Australian mental health appears to lack the necessary leadership – political, bureaucratic and service level – and will need to entice it through agreement and adherence to core values of the shared agenda of the various parties.

Uhl Bien, a leadership researcher, suggests that there are three types of leadership roles required of a leader in complex environments – administrative (keeping operations rolling); adaptive (setting the new) and enabling (enable conditions to catalyse adaptive leadership and manage the tensions between adaptive and administrative structures). Having studied the healthcare industry, which she agrees is “in” complexity, she found that leaders who respond effectively in these environments enable “complex” responses by creating climates and conditions conducive to adaptive leadership and enhanced performance.

---

36 DOH 2007. Creating Capable Teams Approach (CCTA) Best Practice Guidance to support the implementation of new ways of working and new roles. Executive summary.
Mental health leaders can use the opportunities of federalism to promote enticing models and attractive practices and successful activities to ‘pull’ the change envisaged by its values. Leadership needs to be driven by the toolbox (starter kit) (Namely: Policy leaders; Thought leaders [Mental Health Research Institute; Higher Education Mental Health curriculum and teachers]; Practitioner leaders using best practice from various States and international approaches; Advocating bodies; Change consultants; and, recruitment agencies); System entrepreneurs and intra-preneurs; and, by informed consumer groups and families, in order to be adaptive enough to respond to the complex environment. The traditional leaders (politicians, CEOs of government departments) and their leadership approaches have been unable to gain traction, so the toolbox which works on the system needs to be strengthened and managed to perform.

It could well be that considerable effort needs to be invested in leadership development of key personnel across the system to simultaneously bring it under control to ensure quality while enabling it to implement those changes, which appear self-evident to many across the system.

**Change management**

Finally, and not least in importance, is the need to invest heavily in the change management element of the reform. The UK approach appears to have recognised this and stated in detail what was required to implement their New Ways of Working agenda at national, regional and local level and introduced other guides, handbooks, toolkits to assist workers to adapt. They also utilised local and/or peer leaders to offer case studies and support to teams wishing to implement the policy, simultaneously reducing hierarchy while building leadership from any chair, and they brought people together across the nation to workshop and learn about the new way.

**Conclusions**

Considering mental health as a complex system has offered some insights that command and control simple approaches may not provide. It recognised that perhaps the key players agree on the reigning paradigms and have a vision, but do not have yet the adaptive leadership skills to implement the changes. A number of suggestions for change – mainly relating to coordination as a result of refining the ‘starter kit’ function – culture, planning, information for pro-activity, standards, shared competence, leadership and change management, were offered as a means to break the embedded patterns which seem to cause major change inertia.

---

Chapter 15

A manifesto for change: making a better way reality

Sebastian Rosenberg and John Mendoza
Obsessive Hope Disorder
Obsessive Hope Disorder: Reflections on 30 Years of Australian mental health reform and visions for the future

A Manifesto for Change

The history of Australian mental health reform over the past three decades is one of world class policies and strategies let down by inadequate planning, poor implementation and our complex system of government. The results have been disappointing, wasteful of scarce resources and all too often, devastating for the millions of Australians affected by mental illness.

Despite this, many consumers, carers and people working in mental health remain positive. They are afflicted with a condition known as Obsessive Hope Disorder, a condition which permits them to understand mistakes of the past and plan a better future for mental health. Obsessive Hope Disorder (OHD) is characterised by a willingness to keep hoping, keep dreaming.

We strongly believe that OHD can be cured, that mental health reform is both practically possible and enjoys overwhelming community support. From the evidence and the analysis presented in this Report, the key to curing OHD is immediate attention to five urgent elements of reform: governance; quality of care; our workforce; research and evaluation; and funding.

Area 1 – Governance

The recent involvement of the Council of Australian Governments in mental health since 2006 has been most welcome. However, a legacy of recent reforms has been to exacerbate role confusion between the states and territories and the Federal Government. It is in particular the area of community mental health services where this confusion is most problematic. This is ironic given that the development of these services has long been the focus of national mental health strategies and plans.

The key to a better future for mental health in Australia must be to end this confusion and put in place new, clarified governance arrangements for mental health. We need to get better organised to end waste and duplication and maximise the investment return. This should be done in several interrelated steps:

1. A study to establish cost of mental illness. Successive reports have called for greater investment in mental health and provided varying estimates of the cost of mental illness in Australia. One recent assessment estimated the cost of mental illness to Australia’s collective wellbeing had reached $190b a year or about 12% of GDP$^{1}$. So as to definitively understand both the scale of the problem and the investment required, the Productivity Commission should conduct an inquiry to develop a complete picture of the cost of mental illness and suicide to the Australian community. It is time for a formal inquiry to understand this matter, looking beyond the health costs to also consider issues of personal wellbeing, employment, education, housing, policing, justice, prisons and so on.

2. A national review of roles. The second task for the Productivity Commission is a formal review of the current roles and responsibilities for mental health across Australia. As stated, particularly in the area of community mental health, there are myriad players including federal, state and local governments, non-government organisations, Medicare Locals and private providers. This means significant costs in program management for all stakeholders and redundant reporting requirements focussed on inputs and outputs rather than impacts and outcomes. Current role confusion is both wasteful and unsustainable.

Building a more contiguous approach to real community-based mental health care starts with a better understanding about who does what. It must also answer questions regarding the service mix and scale to be available for a given population as well as issues of national quality standards. At the moment there is poor data and conjecture about these matters and significantly varying approaches

---

$^{1}$ Gruen N 2013. The Herald-Lateral Economics Index of Australia’s Wellbeing.
between (and within) jurisdictions. The Productivity Commission would be charged with providing clear recommendations about how to drive improvements.

3. **National Mental Health Commission as a statutory authority.** The next step would be to enhance the role of the National Mental Health Commission. Currently this body exists as an executive agency within the Department of Prime Minister and Cabinet. The Commissioners have no powers and their role is merely advisory. For the Commission to be effective it must become a more genuinely independent and bipartisan body, with its own statutory powers of inquiry and reporting functions to the Australian Parliament.

History shows that mental health reform is one of the most challenging areas of public policy. Past governance mechanisms for reform have been inadequate. A statutory authority with the appropriate legal provisions has an opportunity to overcome systemic barriers to reform and change.

The National Mental Health Commission should have some formal relationship with all the states and territories in relation to data sharing and policy-making, including those jurisdictions with their own nascent mental health commissions (currently WA, NSW and Queensland). A revamped National Mental Health Commission must have both the statutory powers and resources necessary to develop, monitor and independently report on national mental health policy, programs and outcomes in Australia.

4. **A national audit of mental health programs.** An important first task for a revamped National Commission is a nationwide audit of mental health services. The laissez-faire approach to mental health service development over past decades means that the nature and quality of care varies wildly depending on where you live. Each state and territory is doing things differently and these variations are evident also regionally.

A national audit would for the first time map the type and quantity of mental health services available across Australia, as well as document any evidence regarding the effectiveness of these services.

5. **The National Mental Health Report Card.** A further key role for the National Commission must be the regular public reporting of our progress towards reform. The National Mental Health Report Card must become the focus of our efforts to provide consumers, carers, service providers, policy-makers, researchers and funders with clear advice about whether what we are doing is really improving the lives of people with a mental illness.

The Report Card must include data on life expectancy given the gap between those with severe mental illness and the rest of the Australian population.

This Report Card cannot be the product of governments or dependent on data provided by government alone. Its timing cannot continue to be held hostage to the whims of individual departments. It must be a truly independent assessment, properly funded to enable it to draw on the validated experience of care of mental health consumers and carers and the views of the general community.

6. **Independent program evaluations.** Program evaluations, particularly those conducted by the Commonwealth Department of Health and Ageing on projects under the National Mental Health Strategy and the National Suicide Prevention Strategy have been too often compromised in scope and timing. This in turn has impacted in the quality of policy advice to successive governments and the ability of government to make informed decisions about future investment decisions.

Departments and agencies responsible for the development of policy and the administration of programs should not be controlling the timing, scope, management and public release of program evaluations. This responsibility, and the funding, should be moved to an appropriate independent body to manage. The task could be undertaken by the National Mental Health Commission, the Australian National Audit or possibly the National health Performance Authority.
7. **Model legislation and legal processes.** Harmonisation of legislation in mental health care was a goal under the first National Mental Health Plan. Regrettably, twenty years after that agreement was signed by all governments, we still have significant variations in mental health legislation in Australia. Variations in the justice system more broadly are also evident with some jurisdictions having a mental health court or tribunal for people changed under criminal laws. The lack of consistency across borders means rules, procedures and care vary considerably, as do the rights of consumers, carers and families.

In line with the recommendations of the Australian Law Reform Commission report in 2006\(^2\), the National Mental Health Commission, in partnership with states and territories should develop a model legislative framework for not only mental health care and forensic mental health but also examine the development of mental capacity legislation. The model legislation should ensure that Australian laws, as a minimum, comply with international obligations and clearly demonstrate their capacity to reflect best practice internationally in the legal protections for people with mental illness.

The National Mental Health Commission should work with states and territories to establish an agreed best practice approach to responding to people with mental illness in the justice system. The approach should include interactions with Police and extend to court and tribunal processes for people with mental illnesses. The high percentage of Police shootings of people with mental illness through to the rates of incarceration within the Corrections system, are clear markers of our collective failure to apply good practice in these areas.

8. **Discrimination law.** Regrettably twenty years on from Brian Burdekin’s report, there are still too many instances and independent reports of discrimination against people with mental illness. Housing, employment and social participation opportunities are being frequently denied to people with mental illness. The current Parliament made an unsuccessful attempt to strengthen discrimination laws at a Federal level.

On the basis of the evidence in this report, the Australian Law Reform Commission should be asked to examine the provisions of Australian law and international experience and bring recommendations before the next Parliament for consideration.

9. **Inquiry recommendations.** Recommendations formulated by government statutory authorities and government commissioned reviews frequently are not addressed or implemented by the respective government departments or agencies. What is also plainly evident is that the same recommendations are made repeatedly. Typically, in responding to inquiries or reviews, government agencies and departments offer some response to the recommendations made but generally never offer any genuine tracking mechanism by which to monitor corrective actions.

This is a broader whole-of-government governance issue and not unique to mental health services. The extent of the systemic problems in mental health care simply means there are more inquiries and reviews than most other areas of government policy and services. To address this, recommendations arising from reviews and the resultant actions need to be included in annual reports of government agencies. In the case of central departments, Minister’s should be required to table responses within a defined period in the relevant parliament. The National Commission could also perform a ‘watchdog’ role monitoring these reports and the implementation of recommendations.

**Area 2 – Quality of care**

The quality of mental health care across Australia remains highly dependent on where you live, your capacity to pay for services and your determination and persistence (or that of your loved ones) to get you to care. Astonishingly, we still see hundreds of Australians held indefinitely in stand-alone psychiatric facilities twenty years after all Australian governments agreed to close these relics of the 19th Century.

---

This is indefensible and a continuing violation of human rights as was highlighted by the report from the NSW Ombudsman in December 2012\(^3\).

The lack of a national service framework, agreed models of quality care, particularly community based mental health care, the lack of care guidelines\(^4\) and defined pathways to and from care, means people needing mental health care enter a bizarre lottery. This is possibly a key factor in the reluctance of so many Australians, whilst increasingly aware of mental illness, to seek help.

Access to affordable, timely and effective care for mental illness experienced by millions of Australians is long overdue and achievable through diligent planning and deployment of our existing knowledge. Real improvements in quality of care rely on the following elements:

10. **A National Service Framework.** National Service Frameworks have been demonstrated in both the UK and New Zealand to be central to achieving significant structural reform within a ten-year time frame.

There is no clear and shared understanding as to what community mental health care looks like. The architecture has never been drawn up. This must change. The spectrum of services, the standards of care, the pathways to and from care can be articulated through a National Service Framework agreed to by all governments and the sector. The Framework must ensure that the diversity of the Australian community and the geographical distribution of the population are primary considerations.

Furthermore, the National Service Framework must clearly articulate and define the mix of services: prevention, early intervention, primary care, specialist care, community based care, acute and sub-acute hospital based services. The Service Framework must be the end of the lip service to prevention, early intervention and community based care evident over the past thirty years.

Leadership for the development of the Framework should be vested in the revamped National Mental Health Commission and co-chaired with one of the new state mental health Commissions.

11. **National models of care.** A clear, progressive National Model of Community Mental Health Care informed by international experience and evidence is the basis for higher levels of consistency in the provision of services.

The deployment of a national model of care and the development of pathways to/from care for specific mental health problems supported by national training will improve the quality of care. It will mean that by 2020, a young person living in Bunbury WA who has the early onset of psychosis will get the same access to quality evidence based care, as someone in living in inner Melbourne. Or someone living with comorbid mental health and substance abuse will have integrated evidence based care for both conditions whether they live in the Broome or Burleigh Heads. If we can do this for asthma, heart disease and the majority of cancers, we must do this for the majority of mental health conditions.

12. **Investment in e-therapy and online services.** In the past few years, governments have begun to invest in universally accessible telephone helplines and online service platforms available 24/7. Yet our telephone and online help services like Kids Helpline and Lifeline are swamped with demand and remain dependent on volunteers. Very little investment has been made in the development and rollout of evidence based online treatments and services. This is changing with the Young and Well Cooperative Research Centre funded through the Commonwealth Department of Innovation and Science. Services such as Mindspot need to become a routine part of clinical services.

---

\(^3\) NSW Ombudsman 2012.

\(^4\) In Australia there are just four Clinical Guidelines relating to mental health conditions issued by the NHMRC. They are all medical in emphasis. In the UK, there are over 30 current and approved care guidelines issued by the equivalent body.
The deficiencies in current services, the workforce constraints, the poor distribution of Medicare funded services in many areas and Australia's dispersed population make investment in 24/7 telephone and online services a no-brainer. These services can be a pathway into care for some and improve care continuity but also, according to a growing body of international evidence, these services can in some instances take the lead role in care.

13. Employment policy. Another consistent theme in the evidence gathered for this report is the failure of employment policy to address the needs of those with mental illness. Employment is a proven component of recovery from a mental illness for the vast majority of people. There is close to twenty years of international evidence as to what works best for people with mental illness gaining and retaining employment. However, those providing the services for jobless Australians continue to report the difficulties in applying that knowledge within the policy and regulatory framework imposed by the Commonwealth Department of Employment and Workplace Relations and associated agencies such as Centrelink.

As in health care, employment policy must be framed on the basis of evidence. This is a very simple proposal. If the evidence on employment policy for people with multiple non-vocational barriers to employment is applied, then we will see a turnaround in the hundreds of thousands of Australians presently 'parked' indefinitely on the Disability Support Pension and Newstart Allowance.

The savings to the Budget bottomline of all governments, the improvement in productivity for our nation, the improved quality of life and prospects for recovery for these Australians will be the payoff. It's that simple and the need is urgent.

Area 3 – Our workforce

Mental health needs to be a place people want to work. Thirty years ago David Richmond made numerous recommendations relating to the mental health workforce and its needs to successfully transition to community based care. In the years since, the evidence in this report shows many of his recommendations have been repeated and further developed by other reviewers. Over and over again, one reads of the urgent need to act on workforce reform and development.

Despite the unequivocal message to act urgently and assertively on workforce, the best we have seen is an investment of $287 million over five years (or just $57 million per annum) under the COAG National Action Plan on Mental Health 2006–11. This is too little and it is getting close to being too late. The following key steps must be undertaken:

14. A national mental health workforce institute. Australia needs a National Mental Health Workforce Institute specifically established to nurture the workforce of the future and ensure that mental health is a sector where talented people want to work. The systems approach and ‘starter kit’ presented in this report provide a basis and focus for the Institute. This Institute need not necessarily be a new place or building but rather dedicated resources to bring together and augment some of the important workforce initiatives of organisations such as the Black Dog Institute.

15. A national workforce plan. There are already unsustainable pressures on our mental health workforce. It is ageing, and for too long, poorly resourced and poorly supported. There is no national plan to arrest this situation. The Institute would be charged with developing this plan, working in close cooperation with the professional organisations and service providers. The Plan would address not only the size, make up and competencies needed for a contemporary mental health workforce, but also ways of working, the desired culture and leadership.

16. New roles. A core focus for the Institute would be designing new roles for peer workers and strengthening the definition of community mental health workers. Australia is well behind some other countries in choosing to invest in a new cadre of suitably qualified peer workers. There is good evidence to show the positive impact these workers can have on patient outcomes. Greater involvement of peer workers in the delivery of community and hospital-based mental health care is probably key to making our future workforce sustainable. The same is true of community mental
health workers currently found employed as Personal Helpers and Mentors, Case Workers and Support Workers. New e-health services require e-health workers to be trained. We also need to ensure enough staff to make the most of new investments in youth mental health, such as the early psychosis (EPPIC) services.

**Area 4 – Research and evaluation**

The adage ‘there is nothing more iniquitous than the equal treatment of unequals’ seems apt when referring to the nation’s investment of public funds in mental health research over the past twenty years. Despite the prevalence of mental illness and the burdens of disease (13%) and disability\(^5\) (24%) mental health research remains stuck at less than 8% of total national research funding. This is further puzzling at a time when we are looking as a nation for ways to lift our declining productivity when that we know with more effective treatments more widely available we can change the outcomes. Maybe it’s time for a mental health research led recovery, using the following approach:

17. **A national institute for translational research in mental health.** In the 1980s and 1990s Australian governments recognised the merit of investing in a range of new national alcohol and drug research centres, such as the National Drug and Alcohol Research Centre and the National Drug Research Institute. As result, few treatments or services are implemented across Australia without thorough evaluation or sound evidence. These centres now boast hundreds of researchers, most focusing on these translational or service aspects of research – to continually pose and answer the question ‘what works?’

Funding for mental health research, as with mental health services, has unfairly failed to reflect the burden of disease. Where funds have been provided (largely by the NHMRC) they have focused on the laboratory rather than translational or service-focused research.

A new National Institute is a priority initiative, to enable greater focus around mental health research, promote collaboration between existing researchers and ensure proper attention on translational research. This means giving proper attention for the first time in Australia to consumer and carers in transformational service design, research and evaluation – making sure we build services people want to come to.

As with the Workforce Institute, rather than a new building or stand-alone organisation, this initiative might be best directed towards dedicated resources so as to link existing research bodies into new networks and enable new capacity.

18. **Prioritised funding for research.** What is clear is that in Australia, medical research is funded on the basis of demand and not epidemiology or national priority. Putting it bluntly, those with the greatest capacity, get the greatest allocation of public research funds. They also get disproportionate levels of private (community) funding as a result of their latent capacity. When one considers the cost of mental illness, prevalence and the limitations of treatments for a number of conditions, it is not in the national interest to allow this to continue with scarce public funds. The McKeon Review\(^6\) also highlighted the lack of investment in translational research.

The new **National Mental Health Research Institute** would require funds of $100m to be drawn from the existing NHMRC budget (approximately 12% of current funding). This step-up from around 8% should be phased in over four years to enable capacity to be developed.

---


Area 5 – Funding

Many of the ideas put forward in this manifesto cost little. However, and as recommended by successive inquiries and reports, real reform of mental health will require more resources as well as more intelligent use of resources. The following steps are necessary.

19. A fair allocation of funds. While the financial constraints facing Australia are acknowledged, what is also abundantly clear is that mental health has not had a ‘fair go’ in terms of the allocation of public funds. The discrimination and prejudices of the past are still evident in resource allocation across government.

Even with recent increases in spending on mental health, the rate of overall increase to the annual health budget means mental health’s share is actually declining not increasing. Australia spent $130bn on health in 2010–11, of which $6.9bn was directed towards mental health. So just over 5% of the health budget is directed to mental health despite the fact that mental illness represents 13% of the burden of disease and 24% of the disability burden. This is simply indefensible.

A better future for mental health in Australia rests on a fair allocation of funds. Mental health’s share of the total health budget should be 12% by 2020, better reflecting the burden of disease and enabling new investment in new services to cover the spectrum of care. Only the current ACT Labor–Greens Government has made a commitment to achieve this proportion of funding for mental health services.

20. Examine funding models. At the moment a key driver in mental health is not what works but who pays, an unhelpful legacy of the confused governance arrangements between the states and the Federal government. Another key task to be undertaken by the Productivity Commission therefore must be to examine funding models and options for mental health in Australia, including consideration of alternatives internationally.

This examination of funding models should also consider the impact of existing funding agreements, the aim being to ensure there is consistency between new approaches to mental health service delivery and, for example, the application of activity-based funding to mental health. A second example is the introduction of Disability Care for an estimated 10% of those people with severe levels of disability due to mental illness. Funding models need to consider how Disability Care for this small group within the overall population of people with mental illness will impact on services for the majority of consumers and carers. A further example is in relation to responsibility for housing for people with a mental illness. If this does not fit within state health responsibilities, nor is it to be covered by the NDIS or by activity based funding, how will this sector grow to meet existing needs let alone future challenges?

In the same way responsibility for services is currently confused, there is a need to ensure funding arrangements clearly support the goals of our mental health policy; namely, to ensure community based care is the focus of mental health service provision and enable people with a mental illness to live well in the community.

21. Funding directed to evidence-based services. New funding must be directed to the ‘best buys’ in terms of evidence. Australia still spends more than half a billion dollars a year on stand-alone psychiatric facilities, money that could otherwise be directed to prevention and early intervention. This is poor use of scarce funds. Some states are still spending over 50% of their entire mental health

---

10 The Productivity Commission recommendations on the NDIS identified some 60,000 adult Australians with severe and persistent mental illness and with complex needs that may qualify for the NDIS scheme. This represents just one in ten of the prevalence rate for those with a severe level of disability for mental illnesses such as major depression, major anxiety, psychoses and bi-polar disorder.
budget on hospital based acute services – again, this is an inefficient policy choice, directing funds to the most expensive element of the care system only once a person is already seriously unwell.

The results of the audits and reviews set out earlier and the National Service Framework must drive investment in mental health over the next decade.

**Conclusion**

Obsessive Hope Disorder (OHD) is a serious matter. Given what we know, probably the entire Australian population is afflicted, knowing that mental health care in Australia is not good enough and really wanting things to improve. Some people have been affected by OHD for thirty years, most more recently as their understanding of mental health has developed.

It is long past the time to deliver on the intentions of David Richmond’s 1983 report and the promise of community based care for people with mental illness. It is long past the time to end stigma against people with mental illness. It is time to respond with what is required to cure ‘Obsessive Hope Disorder’.

This Chapter has described key elements of the remedy, the essential steps to be taken in the effective treatment of OHD; to end the cycle of neglect in mental health care.

There is an urgent requirement for a ‘root and branch’ review of the governance of mental health in Australia, bolstered by new attention to accountability, research and workforce development. Together with a commitment to a fair share of funding allocation, these are the building blocks of real and sustainable mental health reform.

The Manifesto outlined here will help turn Australia’s inextinguishable hopes and dreams for a better future for mental health into a reality. It’s about time!
Appendix 1

A summary of the Australian Government’s mental health policy and programs since 2006

John Mendoza, Yve Gilbert and Sebastian Rosenberg

Australia was one of the first nations to have a national strategy in mental health. It has been argued that the strategy was born of political necessity:

- in 1990, the Human Rights Commissioner, Brian Burdekin commenced a formal inquiry into the human rights of people with mental illness – with 15 months of hearings in a wide range of cities and regional centres involving some 450 witnesses and over 820 written submissions.
- a second external driver for the development of a national mental health policy was the adoption by the United Nations General Assembly in December 1991 of the *Principles for the Protection of Persons with a Mental Illness and for Improvement of Mental Health Care*.

Broadly, the First National Mental Health Strategy aimed to:

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

The National Mental Health Strategy is articulated in four major documents:

1. The National Mental Health Policy – outlines the approach to mental health reform, promoting a shift from ‘institutional care’ to ‘community care’.
2. The Mental Health Statement of Rights and Responsibilities – articulates the principles of United Nations Resolution 98B (Resolution on the Protection of Rights of People with Mental Illness). This document was agreed to by all Health Ministers in 1991 and outlined the philosophical foundations of the Strategy in regard to civil and human rights.

The implementation of the National Mental Health Strategy is undertaken in collaboration with all Australian jurisdictions, consumers and carers and mental health sector representatives through the AHMAC National Mental Health Working Group.

Making No Sense

Since 1992 Australian Governments have collectively endorsed:

- Two National Mental Health Policy documents (1992 and 2008)
- Four National Mental Health Plans

In addition, there have been hundreds of other subordinate planning documents including separate implementation plans issued for most of the National Mental Health Plans, National Mental Health Service Standards (1996 and 2010), separate workforce plans and separate plans in every state and territory. In the case of state/territory plans, they generally do not align with the planning periods for the national plans.

---

3 Most of these publications are listed at www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs.
Regrettably the same degree of energy has not been applied to either the implementation or the evaluation of these planning documents.

Following the February 2006 COAG meeting, where formal discussions on mental health commenced, Prime Minister John Howard indicated at the press conference that Australia’s mental health system was broken. The then NSW Premier Morris Iemma went further and apologised to the individuals and their families for the failure to provide for them following de-institutionalisation.

While the formal treatment rates for people with a mental illness did not improve between 1997 and 2007, the second National Action Plan Progress Report suggests substantial service growth over the same period. However, the Report also shows that the great majority of this growth was focused on Commonwealth-funded mental health care services which rose from 3.1% to 4.8% from 2006–07 to 2007–08. The majority of this increase would be explained by the increase in services provided under the Better Access Program.

By contrast the percentage of the population accessing state-run mental health services actually dropped slightly from 1.6% to 1.5%. No jurisdiction recorded an increase.

Curiously, the Report also states that between 1997–2007, each jurisdiction’s mental health clinical workforces increased by about one third. If the spending effort in Action Area 2 is not leading to a discernible increase in treatment rates, it is reasonable to ask what substantive impact this increased investment on traditional services is actually having on mental health care in Australia?

There is significant debate regarding the effectiveness and reach of the Better Access Program. Recent data does not indicate that groups who were missing out on care before Better Access are now receiving care and that there is an urgent need to evaluate the Program in terms of equity and cost-effectiveness. Further evidence that those already accessing some care are getting more care and possibly a broader spectrum of service is provided in the report on People Living with Psychotic Illness.

On 7 December 2012, COAG endorsed the Roadmap for national mental health reform 2012–2022. The roadmap outlines the reform directions governments will take over the next 10 years and re-commits the Australian Government and states and territories to working together towards real improvements in the lives of people with mental illness, their families, carers and communities.

Expenditure

In early April 2006, John Howard unilaterally acted by announcing a $1.8 billion Commonwealth package for mental health reform. Howard had become frustrated with the pace of the negotiations with the states and territories and with the progress and quality of policy advice from DOHA. Only the week before in Federal Cabinet, a package of measures developed by DOHA and tabled by Health Minister Abbott, was rejected.

Howard’s strategy placed maximum pressure on the states/territories to match the (over five years) commitment.
The Federal Government commitment was later revisited in the May Budget to $1.9 billion over five years with at least $500 million in spending in the final year. When COAG met in early July the states and territories pledged an additional $2.2 billion over the same timeframe. The total COAG National Action Plan funding was over $5.5 billion over five years, allocated across four agreed action areas. The NAP has a fifth action area: Coordinating Care – Governments Working Together. However, no additional or separately identifiable funds are allocated specifically to this task.

<table>
<thead>
<tr>
<th>Action areas agreed in the COAG Plan</th>
<th>Agreed outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Promotion, prevention and early intervention</td>
<td>• Reducing the prevalence and severity of mental illness in Australia</td>
</tr>
<tr>
<td>2. Integrating and improving the care system</td>
<td>• Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent long term recovery</td>
</tr>
<tr>
<td>3. Participation in the community and employment including accommodation</td>
<td>• 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</td>
</tr>
<tr>
<td>4. Increasing workforce capacity</td>
<td>• 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</td>
</tr>
<tr>
<td>5. Coordinating care – Governments working together</td>
<td></td>
</tr>
</tbody>
</table>

While COAG agreed on the four action areas, there was no further agreement on the allocations to each action area nor to an agreed set of definitions to ensure some greater consistency and transparency. Action Area 2 accounts for fully two-thirds of all expenditure under the NAP, while Action Area 4 attracts merely 5% of new spending. Supported housing options, community participation and employment remain peripheral elements of the NAP, accounting for only 17% of total reported spending.

The NAP gives complete autonomy to each jurisdiction as to both the extent of their respective investments and as to how to report them under the NAP. Consequently, there are very significant variations in the spending effort of the respective jurisdictions.
The above table highlights the extent to which we have a patchwork of jurisdictional investments rather than any concerted national effort to address agreed priorities. Rather than moving to have a more consistent national service model and infrastructure in mental health care, the COAG NAP has merely added more to the complexity and discontinuity evident in the critiques of the system during 2005–06.

Table A1.1 – NAP spending effort by action area and jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Action Area 1</th>
<th>Action Area 2</th>
<th>Action Area 3</th>
<th>Action Area 4</th>
<th>Total NAP Spend by Jurisdiction ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spend ($m)</td>
<td>% of Total CoAG Effort</td>
<td>Spend ($m)</td>
<td>% of Total CoAG Effort</td>
<td>Spend ($m)</td>
</tr>
<tr>
<td>C'wealth</td>
<td>164.2</td>
<td>8.24</td>
<td>1329.8</td>
<td>66.71</td>
<td>369.5</td>
</tr>
<tr>
<td>NSW</td>
<td>121.7</td>
<td>12.41</td>
<td>721.6</td>
<td>73.61</td>
<td>113.8</td>
</tr>
<tr>
<td>Vic</td>
<td>97.7</td>
<td>15.15</td>
<td>432.1</td>
<td>67.01</td>
<td>110.6</td>
</tr>
<tr>
<td>Qld</td>
<td>16.3</td>
<td>1.66</td>
<td>717.5</td>
<td>72.97</td>
<td>168.4</td>
</tr>
<tr>
<td>WA</td>
<td>106.8</td>
<td>22.07</td>
<td>216</td>
<td>44.64</td>
<td>139.6</td>
</tr>
<tr>
<td>SA</td>
<td>47.1</td>
<td>16.33</td>
<td>215.1</td>
<td>74.56</td>
<td>22.1</td>
</tr>
<tr>
<td>Tas</td>
<td>2.2</td>
<td>3.75</td>
<td>36.6</td>
<td>62.35</td>
<td>11.3</td>
</tr>
<tr>
<td>ACT</td>
<td>5.1</td>
<td>12.26</td>
<td>20.1</td>
<td>48.32</td>
<td>8.1</td>
</tr>
<tr>
<td>NT</td>
<td>1.3</td>
<td>8.61</td>
<td>13</td>
<td>86.09</td>
<td>0.8</td>
</tr>
<tr>
<td>Total</td>
<td>562.3</td>
<td>10.24</td>
<td>3701.8</td>
<td>67.43</td>
<td>944.2</td>
</tr>
</tbody>
</table>
Summarising Table A1.2 above, the NAP Report demonstrates some huge variations across the four action areas, with the high and low spenders shown in Table A1.3 below.

Curiously, the Report also states that between 1997–2007, each jurisdiction’s mental health clinical workforces increased by about one third. If the spending effort in Action Area 2 is not leading to a discernible increase in treatment rates, it is reasonable to ask what substantive impact this increased investment on traditional services is actually having on mental health care in Australia?

One explanation might be that COAG’s NAP is primarily directing new funds into existing service systems and that these systems are simply failing to attract new clients. The current debate regarding the effectiveness and reach of the Better Access Program is significant in this regard. Recent data does not indicate that groups who were missing out on care before Better Access are now receiving care and that there is an urgent need to evaluate the Program in terms of equity and cost-effectiveness.

Further evidence that those already accessing some care are getting more care and possibly a broader spectrum of service is provided in the report on People Living with Psychotic Illness.

Table A1.2 – NAP spending variations summary

<table>
<thead>
<tr>
<th>Action Area 1: Promotion, Prevention and Early Intervention</th>
<th>Jurisdiction with highest % CoAG Effort</th>
<th>Jurisdiction with lowest % CoAG Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WA – 22.07% ($106m)</td>
<td>Qld – 1.66% ($16m)</td>
</tr>
<tr>
<td>Action Area 2: Integrating and Improving the Care System</td>
<td>SA – 74.56% ($215m)</td>
<td>WA – 44.46% ($216m)</td>
</tr>
<tr>
<td>Action Area 3: Participation in the Community and Employment, including Accommodation</td>
<td>WA – 28.85% ($140m)</td>
<td>SA – 7.66% ($22m)</td>
</tr>
<tr>
<td>Action Area 4: Increasing Workforce Capacity</td>
<td>ACT – 19.95% ($8.3m)</td>
<td>Vic – 0.68% ($4.4m)</td>
</tr>
</tbody>
</table>

The first two Budgets of the Rudd Government provided few wins for mental health. The most significant decision, not involving cuts, was the formation of the National Advisory Council on Mental Health (NACMH).

The Government’s focus in 2008–09 was national health reform. In March 2010 Prime Minister Rudd announced almost $7.4 billion in additional funding, just $181.3 million was specifically directed to mental health and of that only $115 million identified by the Government as new funding – representing less than 1.6% of all new healthcare funding. However this small increase was sufficient to commit to an additional 30 youth mental health or headspace services at a cost of $78.8 million funding for flexible care packages of $58.5 million and what might be best described as a ‘deposit’ of $25.6 million for early psychosis programs.

The Government unveiled a $2.2 billion package over five years for mental health in the May 2011 Budget. Of this the Government claimed $1.5 billion was “new money”, however an analysis of the package undertaken by Deloitte Access Economics showed the actual new funding was just $620m over the five years with the rest either re-directed, re-labelled and re-announced funding.

The Delivering National Mental Health Reform package in the 2011–12 Budget nonetheless contained several important structural initiatives and more targeted investments. The key aspects were:

- Expansion of the youth primary mental health services, headspace, with a further 30 sites bringing the total to 90 sites by 2016
- Expansion of the youth specialist mental health services, the early psychosis prevention and intervention centres (EPPIC) with an additional funding allocation of $222.4 million over 5 years

---

12 Rosenberg S Hickie I 2010 Op Cit.
15 COAG 2010. COAG Communique.
16 The Government had been advised that a national early psychosis program would cost over $500million over 4 years.
17 Budget Papers 2011-12 and Ministerial Press Releases.
A commitment of $549.8 million over five years to develop coordinated care and flexible funding for people with severe and persistent mental illness (the net cost of this measure $343.8 million)
- Savings of $580 million from the Better Access program through changes to GP and allied health treatment services
- A doubling of the ATAPS program with an additional $206 million over five years
- Expansion of the Day to Day Living program with an additional $4 million (on top of $10 million of existing funding)
- Health and wellbeing checks for 3–4 year old children relating to developmental disorders
- Development of a single mental health online portal at a cost of $14.5m
- Ear-marked research funding through the NHMRC of $26 million
- National Partnership funding of $201 million over five years for co-funding with states and territories to address ‘gaps in services’
- The establishment of the National Mental Health Commission.

The 2013–14 budget papers reconfirmed the Australian Government will continue to implement the 2011–12 Delivering National Mental Health Reform Budget package and included reference to new governance and accountability arrangements that will directly engage governments and stakeholders on furthering mental health reform. An investment of $23.8 million in 2013–14 was highlighted, to maintain existing service levels for the Mental Health Nurse Incentive program that provides coordinated clinical support for people with severe and persistent mental illness.

Key initiatives

Initiatives in the Employment and Workplace Relations Portfolio

The National Mental Health and Disability Employment Strategy was released in September 2009. This included a review of the Disability Employment Network and Vocational Rehabilitation Services and the implementation of Disability Employment Services on 1 March 2010.

The Department also developed and distributed a Mental Health Works CD-ROM to Disability Employment Services providers. The resource provides practical and evidence-based workplace strategies to recruit and retain employees with mental health conditions.

The Disability Support Pension (DSP) Employment Incentive Pilot commenced on 1 March 2010, encouraging employers to offer employment opportunities to people receiving the DSP.

Evaluations of the JS Pilots and the Family Centred Employment Programs will be available in 2013 to inform government policy settings for the next round of employment service contracts due in June 2014.

Initiatives in the Department of Veterans Affairs and Defence Portfolios

In 2007–08 Australian governments collectively spent $5.1 billion on mental health services, of which $142 million was for DVA programs and initiatives addressing mental health issues. By 2009–10, DVA’s expenditure on mental health was estimated to have risen to $160 million.

Since December 2006, DVA has contracted the Australian General Practice Network to implement, deliver and evaluate GP education and training around veteran mental health issues.

The Australian Centre for Post-Traumatic Mental Health began a review of the DVA and ADF mental health programs in 2007, concluding in 2009. The independence of this review is somewhat open to question given the Centre’s prime sources of funding are the two departments and the ACPMH has been an adviser since 2001. The Government committed $83 million over four years to implement the recommendations and commence a major program of reform that will address identified gaps.

---

18 The most common mental health conditions are anxiety, affective disorders (depression) and alcohol disorders: see Hodson, SE, McFarlane AC Van Hooff M & Davies C 2010. Mental Health in the Australian Defence Force—ADF Mental Health Prevalence and Wellbeing Study: Executive Report, Department of Defence: Canberra, p. 5. Some veterans have more than one accepted disorder.
In 2009, the Dunt Review of Mental Health Care in the ADF and Transition through Discharge and the Independent Study into Suicide in the Ex-Service Community were undertaken. There is evidence that the recommendations of the review are being implemented.

The ANAO also concluded a review of DVA’s program in mental health in 2012. It was concluded that the suite of small, disparate mental health programs and initiatives delivered by DVA have been of limited effectiveness, with a number of evaluations and reviews highlighting the need for DVA to more effectively target them and related communications activities, as a means of engaging its various client sub-groups, particularly younger veterans.

**Table A1.3. Initiatives in the Families and Communities Portfolio**

<table>
<thead>
<tr>
<th>Name and Description</th>
<th>Annual Budget</th>
<th>Intro Year and Funding period</th>
<th>Target Group</th>
<th>Est. Unmet Need^</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Helpers and Mentors Program (PHaMs)</td>
<td>$83.6m (2009-10)</td>
<td>2006-2007</td>
<td>People with severe and persistent mental illness</td>
<td>Stated unmet need 47,000 persons</td>
</tr>
<tr>
<td>Mental Health Respite Initiative</td>
<td>$52.1m (2009-10)</td>
<td>2006-2007</td>
<td>People with severe and persistent mental illness and their families</td>
<td>Unknown</td>
</tr>
<tr>
<td>Family Mental Health Support Services</td>
<td>$29.6m (2012-13)</td>
<td>2006-2007</td>
<td>Families, children or people with severe and persistent mental illness</td>
<td>Unknown</td>
</tr>
<tr>
<td>Helping Young People stay in Education</td>
<td>Unclear</td>
<td>2007</td>
<td>People with severe and persistent mental illness</td>
<td>Unknown</td>
</tr>
<tr>
<td>Helping People with a Mental Illness enter and remain in Employment</td>
<td>Unclear</td>
<td>2006-2007</td>
<td>People with severe and persistent mental illness</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Table A1.4. Initiatives in the Department of Health and Ageing**

<table>
<thead>
<tr>
<th>Name and Description</th>
<th>Annual Budget</th>
<th>Intro Year and Funding period</th>
<th>Target Group</th>
<th>Est. Unmet Need^</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beyondblue</td>
<td>$33.3m (2012)</td>
<td>2000</td>
<td>General community and at risk populations</td>
<td>Unknown</td>
</tr>
<tr>
<td>Expanding suicide prevention programs</td>
<td>$24.2m (2011-12)</td>
<td>2006-07</td>
<td>General community and at risk populations</td>
<td>Unknown</td>
</tr>
<tr>
<td>Mental Health Services in Rural and Remote Areas (MHSRRA) program</td>
<td>$13.9m (2010-11)</td>
<td>2006-07 $15.5m cut 2012-13 $82.6m for 2011-12 to 2015-16</td>
<td>Primary MH Care in rural and remote areas</td>
<td>Unknown</td>
</tr>
<tr>
<td>Funding for telephone counselling, self-help and web-based support programs</td>
<td>$12.9m (2010-11)</td>
<td>2006-07 $56.9m/5 years</td>
<td>General community and at risk populations</td>
<td>At least 40% of all calls to Lifeline are unanswered</td>
</tr>
<tr>
<td>Support for day-to-day living in the community</td>
<td>$10.6m (2010-11)</td>
<td>2006-07 $46m/5 years plus additional $19.3m/5 years</td>
<td>People with severe and persistent mental illness</td>
<td>Funds 3,650 people</td>
</tr>
</tbody>
</table>

20 ANAO Audit Report No.48 2011–12 Administration of Mental Health Initiatives to Support Younger Veterans
<table>
<thead>
<tr>
<th>Name and Description</th>
<th>Annual Budget</th>
<th>Intro Year* and Funding period</th>
<th>Target Group</th>
<th>Est. Unmet Need^</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of the National Advisory Council on Mental Health which is now replaced by the National Mental Health Commission</td>
<td>Unclear</td>
<td>2008 $2.4m/3 years to 2011 and $32m/5 years</td>
<td>Accountability</td>
<td>Unknown</td>
</tr>
<tr>
<td>The National Perinatal Depression Plan</td>
<td>$13.8m (2012-13)</td>
<td>2008-09 $55m/5 years</td>
<td>Mothers</td>
<td>Unknown</td>
</tr>
<tr>
<td>NGO capacity building grants</td>
<td>$6m (2008-09)</td>
<td>2008-09</td>
<td>NGOs</td>
<td>Unknown</td>
</tr>
<tr>
<td>Headspace</td>
<td>$22.5m (2012-13)</td>
<td>2010-11 Additional $197.3m/5 years</td>
<td>About 1 million young people 12-25 years</td>
<td>About 700,000 at present</td>
</tr>
<tr>
<td>Early psychosis prevention and intervention centres (EPPIC)</td>
<td>$23m (2012-13)</td>
<td>2011-12 $222.4m/5 years</td>
<td>About 20,000 young people 12-25 each year</td>
<td>At present 19,000 get limited or poor care</td>
</tr>
<tr>
<td>Coordinated care and flexible funding for people with severe and persistent mental illness (Partners in Recovery)</td>
<td>$35.5m (2012-13)</td>
<td>2011-12 $549.8m/5 years</td>
<td>People with severe and persistent mental illness</td>
<td>Gap stated by Government is 36,000</td>
</tr>
<tr>
<td>Expansion of Access to Allied Psychological Services (ATAPS)</td>
<td>$16.1m (2012-13)</td>
<td>2011-12 $205.9m/5 years</td>
<td>Primary MH Care – but lower income groups</td>
<td>Unknown</td>
</tr>
<tr>
<td>Continuation of ‘Leadership in mental health reform’ initiative</td>
<td>Unclear</td>
<td>2011-12 $56.8m/5 years</td>
<td>Accountability</td>
<td>Unknown</td>
</tr>
</tbody>
</table>
Results/achievements

The 2007 National Survey of Mental Health and Wellbeing found that, of the people who had both symptoms of a mental disorder and a need for the service, the need was fully met by mental health services in only:

- 31% of cases for social intervention
- 44% for skills training
- 57% for information
- 68% for counseling and
- 87% for medication

Mental health services in Australia are neither planned on the basis of need (that is to respond to the population’s mental health needs) or based on evidence of what works best. Instead there is sort of public lottery depending on where you live, your personal resources and resourcefulness to locate and purchase services and your determination to “get well” or persistence. There is, in short,, serious structural imbalances in the system of care compounded by poor and outdated practices.

The 2011 Australian Government Budget Papers on national mental health reform stated people with severe mental illness have to “deal with fragmented and uncoordinated systems” and “despite previous attempts at reform and investments by governments, too many people with severe and debilitating mental illness are still not getting the support they need, don’t know where to find it, and are falling through the cracks in the system. The families, and people who care for them, struggle with a system which often causes them frustration and even despair.”

According to a report released in May 2014,

- relative to other health outcomes, there is limited longitudinal data related to mental health outcomes that can be aggregated at a national level
- Australia’s mental health system lacks a clear end-to-end system design, indicating the system is characterised by fragmentation and insufficient coordination
- the fragmentation that arises from diverse funding and expenditure arrangements is exacerbated by the lack of coordination within the healthcare system
- the absence of coordinated, collaborative and consistently reliable recovery-based services for people with a mental illness has meant that the mental health system has become heavily reliant on the goodwill and ongoing care provided by carers to fund and resource recovery-based care

---

• fragmentation of the mental health service system also leads to frustration, confusion and distress for service users

• there is a strong case that the poor mental health system design exacerbates Australia's mental health challenges, identifying three key challenges being:
  • new initiatives can add complexity to an already fragmented system and fail to address the critical issue of system design
  • it is impossible to tell if Australia is spending the right amount of money to support people with mental illness and if money is being spent in the right area
  • mental health outcomes are likely to be sub-optimal, leading to additional health and non-health costs.

Most disturbing is a new study finding that mental illness sufferers in Australia are dying up to 16 years earlier than the general population, with most deaths due to disease such as cardiovascular disease and cancer, rather than accidents or suicide. The study found the differential in the gap increased by about two years between 1985 and 2005\(^{25}\).

There is still, 20 years after Brian Burdekin’s landmark report, no clear plan, no measurable targets or goals, no clear accountability framework or model of care.

Assessing the performance

Reports produced by government departments, agencies and inter-government committees typically paint a generally positive picture of reform in Australia’s mental health systems. Typically such reports speak to the progress being made and frequently conclude with statements pointing to “more work to do”. The reports listed below are only those with a national focus released in since 2008.

**Towards recovery: Mental health services in Australia\(^{26}\)**

This review built on the work undertaken by the Senate Select Committee on Mental Health from 2005-6. It followed two years after the COAG National Action Plan on Mental Health and the commitment of significant new resources and a new action agenda. The Community Affairs References Committee report stated that while many improvements were evident, a number of important aims had not been actioned. The report acknowledged that while the COAG NAPMH was a “further step in a long-process of reform in Australia”, there was a lack of clarity in the relationships between the COAG NAPMH and the National Mental Health Strategy (Policy and Plans) and continuing disparities in services across the states and territories.

**The hidden toll: Suicide in Australia\(^{27}\)**

Following considerable pressure on Senators from community advocates, it was agreed in late 2009 to establish an inquiry into suicide and suicide prevention in Australia. The Committee report accepted widespread criticism of Australia’s recording of suicide and made 42 recommendations to address this issue, including the need to address population groups with elevated risk of suicide. In the Federal Government’s response, little mention was made of tackling this fundamental issue.

**Administration of the access to allied psychological services program\(^{28}\)**

In 2010-11, the Australian National Audit Office conducted a review of the administration of the ATAPS program. While the ANAO review acknowledge the administrative challenges with this program, it was strongly critical of DOHA for failing to determine the allocation of funds on the basis of need, despite the policy basis for the program. DOHA had been aware for several years that the program was grossly over-subscribed and yet did not assess the demand or make recommendations to the Government regarding.

\(^{25}\)Lawrence D Hancock S Kisely S 2013. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers, BMJ;346:f2539.


\(^{27}\)Community Affairs References Committee 2010. The Hidden Toll: Suicide in Australia. The Senate, Parliament House Canberra.

an expansion of the program. The ANAO went on to criticise the Department’s failure to “actively manage initiatives and take timely corrective action to address identified delivery issues”.

Inquiry into the Commonwealth funding and administration of mental health services

This Inquiry continued the Senate’s vigilance in relation to mental health and suicide prevention that commenced in 2006. However, unlike previous inquiries, this one did not result in an all-party agreement nor a strong consensus. The more popularise nature of the inquiry reflected the political pressure on the Government to deliver on mental health reform and the position taken by the Opposition. It was also characterised by a vicious fractional battle between the various professional groups within psychology.

The focus of the inquiry was the Commonwealth’s proposed changes to the MBS Better Access program and administration of the ATAPS program. Some review of the proposed expansion of headspace, the early psychosis program and the support for people with persistent and severe mental illness.

Obsessive Hope Disorder
Appendix 2

A summary of state and territory mental health policy and programs

Yve Gilbert, Amy Elson, Amanda Bresnan, Sebastian Rosenberg, John Mendoza, Keith Wilson and Janet Hopkins
Obsessive Hope Disorder
Introduction

This Appendix endeavours to capture the recent policy and programs of each jurisdiction as a point of reference for the reader.

The primary focus of this Appendix is on activities and initiatives instigated post February 2006 when CoAG agreed to initiate a rapid process of policy development in response to the Not for Service Report¹ and the then on-going Senate Select Committee Inquiry on Mental Health.

Methodology

A review of publicly available information on state and territory government websites was undertaken between March and May 2013. The websites included departments of health, communities, employment, human services, and Premier’s and Chief Minister’s. The search included Ministerial websites and press statements. The local knowledge of project team member, project partner organisations and ConNetica associates was also obtained and utilised.

In a number of jurisdictions changes of government and changes in leadership resulted in changes in policy, programs and funding since 2006. While every reasonable effort was made to identify these changes, in a number of jurisdictions, very little information was available publicly. In one case, the Northern Territory, there was no publicly available updated policy in relation to mental health since the change of government in early 2012.

Every jurisdiction, through the state Directorate of Mental Health (or equivalent) was sent a copy of their relevant draft research report with a request for comment within two weeks. This timeframe was established based on what government departments consistently say is a fair and reasonable turnaround period and the fact that the reports were not complex. Jurisdictions were advised that if comments were not received by the due date, it would be assumed that the jurisdiction was satisfied with the content of the draft report. Where requested, the original timeframe was extended by a further two weeks.

Responses from the Australian Capital Territory and Victoria were received and the comments provided have been addressed in this final publication.

A senior official from New South Wales Department of Health did not endorse the research results and indicated the Department would not be providing any comments.

Several efforts were made to obtain a response from the Western Australia Mental Health Commission, with no result.

The communication received from Northern Territory indicated the research results did not reflect their status of events. Upon seeking assistance, we were referred back to sites that redirected to Commonwealth information already sourced.

No responses were received from South Australia, Tasmania or Queensland.

Australian Capital Territory

In November 2012, the Labor Party headed by the Chief Minister Katy Gallagher, was supported by the Greens to form government for a further 4 years. The Parliamentary Agreement between Labor and the Greens included an item to: Provide $35m in new funding to mental health related services over the term of the Assembly, including for: a) The construction of a secure adult mental health unit; b) A community-based, after hours crisis assessment team².

At the 2008 Australian Capital Territory (ACT) election, the Greens had supported Labor to form government, then under the leadership of Jon Stanhope as Chief Minister, and the Parliamentary Agreement included the following item: Commit to continuing to increase the proportion of the health

² Parliamentary Agreement for the 8th Legislative Assembly for the Australian Capital Territory (2012)
budget spent on mental health, with a goal of reaching 12% of overall health funding. By 2012, 30% of mental health funding should be allocated to the community sector for the delivery of service.

Arguably mental health services in the ACT are going through a period of more substantial change than in other states and territories, and with a greater emphasis on mental health promotion, prevention and early intervention and recovery orientation.

**Policy development**

The ACT Mental Health Services Plan 2009-2014 (MHSP) sets out the agenda for change across the mental health sector in the ACT. Its vision for the mental health system in the ACT in 2020 is:

_in the ACT in 2020 the mental health system will be consumer oriented and driven and focus on recovery and rehabilitation. Consumers and carers will have seamless access to a coordinated and interconnected network of services provided by the consumer, community, public and private sectors and designed to meet the mental health and psychosocial needs for individual health and wellbeing._

The MHSP is developed on three foundation pillars: 1) Recovery Focus; 2) Consumer and Carer Participation and 3) Partnership and Collaboration.

The strategic directions are as follows:

- **Reinforcing capacity in the mental health service system** through a Four Life Stages Development model;
- **Extending the mental health service system**, including an Access and Information Service and extending services in the community sector;
- **Innovation in the mental health service system**, supporting services that are current and evidence based, including consumer and carer led and directed services; and
- **Planned implementation of change**, including establishing a Strategic Oversight Group to oversee the MHSP.

**Building a Strong Foundations** is an integrated framework for promoting mental health and wellbeing in the ACT from 2009 to 2014. It acknowledges mental health is affected by many factors outside of the traditional health portfolio, and includes services in housing, education and employment. **Building a Strong Foundation** provides a collaborative, whole of community framework to guide investment in activities over the next five years to 2014.

---

3 Parliamentary Agreement for the 7th Legislative Assembly for the ACT (2008)  
The goals of the framework are:
- build awareness and capacity across the community
- reduce the incidence and prevalence of mental health problems through prevention strategies
- enhance effective early intervention and
- enhance the social equities and reduce social inequities that influence mental health and wellbeing.

It emphasises that:
- promoting mental health and wellbeing is everybody’s business
- preventing mental illness is a shared responsibility and
- early intervention requires strong inter-sectoral cooperation.

A sub-plan to the MHSP and a companion document to the Building a Strong Foundation, is the ACT suicide prevention strategy Managing the Risk of Suicide: A Suicide Prevention Strategy 2009-2014. This strategy takes a whole of government approach to suicide prevention and outlines the strategies and activities to be implemented to deliver a collaborative and cooperative approach to suicide prevention as directed by the objectives of the MHSP. The ACT "Let's Talk" Suicide Prevention Campaign aims to raise awareness about suicide and suicide prevention, reduce stigma and provides help seeking information.

**Expenditure**

The ACT Government aimed to increase mental health funding to 12% of the health budget by 2012. It made a stated commitment of $14.5 million for growth in the community mental health services over the four years from 2009, half of this for services within the community or NGO sector. In 2009-10 the sector received $10.9 million or 13.2% of the mental health budget. By 2012-13 community sector funding had increased to $14.8 million, or 14.3% of the mental health budget which exceeded the target set in the 2009 plan.

**Table A2.1 Mental health expenditure, ACT and national ($) per capita**

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>2010–11</th>
<th>Average annual change 2006-07 to 2010-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ACT</td>
<td>Nat Avg</td>
</tr>
<tr>
<td>Public psychiatric hospitals</td>
<td>0</td>
<td>23.69</td>
</tr>
<tr>
<td>Specialised psychiatric units/wards in public acute hospitals</td>
<td>50.97</td>
<td>57.71</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>88.82</td>
<td>74.17</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>27.50</td>
<td>10.74</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>23.70</td>
<td>13.76</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>8.13</td>
<td>10.38</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>199.11</td>
<td>190.45</td>
</tr>
</tbody>
</table>

The overall ACT expenditure on mental health per capita has been higher than the national average since 2002-03. Spending in categories such as community mental health care services and residential mental health is also higher than the national average, however ACT does not have a psychiatric hospital.

---

8 ACT Health 2009. ACT Mental Health Services Plan 2009-2014
9 Australian Institute of Health and Welfare 2012. Mental Health Services in Australia
The 2010 National Mental Health Report placed ACT spending per capita on mental health in 2007–2008 at $167.98, placing it third highest across Australia. This had risen to $199.11 in 2010-11.

In addition, the ACT spends a greater proportion of its mental health spending within the non-government sector at 14.3% this is the highest rate in Australia. It has the highest rate of contacts per 1000 population of public community mental health and hospital based services, and the highest level of involuntary service contacts. The rate of mental health related subsidised prescriptions in the ACT is relatively low per 1,000 population.

In 2010-11, ACT ranked fourth highest in terms of per capita spending on mental health.

![Per Capita Spending on Mental Health by Jurisdiction 2010-11](image)

**Community mental health services**

Community mental health services are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community mental health services still provided by the public mental health system. It does not include community mental health services provided by NGOs. ACT spends the third highest amount per capita on community mental health services, though its rate of growth over the past five years has decreased by 1.5%.

**Community mental health care services spending by jurisdiction, per capita 2010-11**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>ACT</td>
<td>88.82</td>
<td>-1.5</td>
</tr>
</tbody>
</table>

The 2012–2013 ACT Budget predicts the ACT will offer 185,000 mental health services to adults and 52,000 to children and young people. It aims to have less than 10% of clients return to hospital within 28 days of discharge.

The budget allocates:

- $20.5 million in funding for hospital based acute services;
- $42.6 million in funding for community based services;
- $16.5 million for community sector mental health services;
- $4.2 million over four years to develop post-traumatic stress prevention programs and expand mental health services for migrants and refugees; and
- $2 million in capital funding for a new adult secure mental health unit.

---

12 AIHW 2013. Mental Health Services in Australia, Expenditure Data.
The mental health service system in the ACT will also benefit from the $1 billion plus general redevelopment of the ACT Health infrastructure. The "Your health – our priority" program involves the overhaul and expansion of all aspects of the ACT Health system and includes a suite of new mental health facilities including the Mental Health Assessment Unit located with the Emergency Department of the Canberra Hospital (completed), the Adult Mental Health Unit at Canberra Hospital (completed), the adult secure inpatient unit and specialist mental health beds for young people. Each of the regions of the ACT will receive a new or refurbished community health centre as part of the ACT Health Infrastructure Project. These buildings will include improved facilities for community mental health services, and will allow for improved integration with other programs of ACT Health.

Key initiatives

The ACT now has three step-up, step-down services. The Adult Step-up, Step-down Program is a residential mental health program that is able to accommodate up to 5 people at any one time, and operates as a partnership between the Mental Illness Fellowship Victoria and the Mental Health, Justice Health, Alcohol and Drug Program. The Child and Adolescent Mental Health Service (CAMHS) STEPS Program is a sub-acute residential facility for young people aged 14-18 years who can stay up to 12 weeks. The sub-acute Mental Health Step-up, Step-down service for young people aged 18–25 years provides a supported accommodation service and was launched in March 2013.

Along with the Adult Mental Health Unit (30 designated beds) and the Mental Health Assessment Unit (6 rooms) at The Canberra Hospital, inpatient services are provided at Calvary Public Hospital with a 20-bed unit that provides sub-acute and limited acute care services, and the 15-bed Older Persons Mental Health Unit that provides inpatient unit and a community mental health team (weekdays only). The Brian Hennessy Rehabilitation Centre provides a residential rehabilitation service for up to 20 people.

The ACT Government has been undertaking a review of Mental Health (Treatment and Care) Act 1994. The first exposure draft was released for community consultation in late 2012 and the second exposure draft was open for public comment and submissions until 28 May 2013, which would be considered by a Review Advisory Committee for the final Amendment Bill. This major piece of legislation has a significant impact on the lives of people with mental illness or dysfunction, their families and carers.

The Mental Health Community Policing Initiative was developed after a review of ACT Policing mental health practices and procedures in 2010. Following a pilot of the initiative in 2011, the ACT Government has allocated recurrent funding to ensure its ongoing success.

The three main components of the initiative are:

- mental health clinicians are embedded with the Police Operations Centre seven days per week. They have access to Mental Health’s electronic clinical record, and are able to provide information relevant to situations/individuals.
- a four-day training program delivered monthly to ACT Police.
- a third mental health worker works with ACT Police on a full-time basis, working with Health and Police to address increasing pressures on the system, and promote greater mental health awareness and acceptance in the community.

The consumer scholarships program provides for mental health consumers to obtain qualifications in human services. The ACT Government has allocated funding to the Canberra Institute of Technology.

---

15 Ibid
17 Op Cit, viewed 7 May 2013
18 Ibid
19 Ibid
Obsessive Hope Disorder

(CIT) to provide training and support for mental health consumers to complete a Certificate IV of Mental Health, Alcohol and Other Drugs, Community Development, Youth Work or Community Services Work.\textsuperscript{21}

The Housing and Accommodation Support Initiative (HASI) and Housing and Recovery Initiative (HARI) are a partnership between Housing ACT, community-based mental health agencies and ACT Health. These initiatives support sustainable tenancies in public housing for 45 people with moderate to severe mental health issues through the provision of integrated packages for housing, mental health and personal support..

Under the National Health and Hospital Network Reform funding, ACT Health secured funding to expand the HASI program. The new program known as Mental Health Housing and Recovery Initiative (HARI) provided 20 places during the 2011-12 financial year. A further 10 places will be funded in both 2012-13 and 2013-14. The HARI program operates under the same partnership and guidelines arrangements between Housing ACT, ACT Health and community based mental health agencies as the HASI program.\textsuperscript{22}

The Mental Health Community Coalition ACT (MHCC) is the peak body for the non-government sector. The MHCC ACT has set its vision for Recovery in the Community and Home for 2020.\textsuperscript{23} The aims include the community sector to receive 30% of the mental health budget; a whole-of-life approach to mental health; better care coordination; greater resources for alternative therapies; and resources for specific needs of different groups. In its 2012–13 budget submission, the MHCC states that the key themes which should guide government investment in the ACT include: participation, capacity expansion, integration and health promotion.

The MHCC ACT Workforce Development Strategy was launched in 2012 and incorporates peer workers into the new career structure.

Results/Achievements

Against some of the key performance indicators established under the Council of Australian Governments (COAG) Action Plan for Mental Health 2006-2011, the ACT had the best figure of all jurisdictions for community follow-up for people within the first 7 days of discharge, and the lowest readmissions to hospital within 28 days of discharge of all the jurisdictions. The COAG Progress Report notes that states and territories had agreed to a target of 75% or above as an indicator for follow-up after discharge and the ACT was the only jurisdiction that achieved this over the life of the COAG Action Plan.\textsuperscript{26}

Assessing the performance

Independent reviews

The 2009 Review of Services for People with an Eating Disorder Across the ACT\textsuperscript{27} concluded that eating disorder services are inadequate for the level of demand, in the public and private sectors. It identified a number of key challenges including:

- the declining numbers of general practitioners and a lack of interest and skills to manage eating disorders amongst psychiatrists.
- the need for increased staffing levels in all treatment venues, and the need to improve or relocate the only dedicated service.
- need for more education and support in every treatment service, non-government organisations and education settings.

\begin{footnotes}
\footnote{Ibid}
\footnote{Community Services 2011. ACT Government Community Services Directorate Annual Report 2011-12, Vol One, ACT Government, Canberra}
\footnote{Mental Health Community Coalition ACT 2008. Mental Health Recovery in our Community 2020 Vision & Action Requirements. Canberra.}
\footnote{Mental Health Community Coalition ACT in consultation with member organisations and ACT Consumer Carer Caucus 2012. ACT Government Budget Submission 2012-2013.}
\footnote{Mental Health Community Coalition ACT 2012. A Real Career A Workforce Development Strategy. Canberra City.}
\footnote{Russell J 2009. Review of services for people with an eating disorder across the ACT. Executive Summary.}
\end{footnotes}
Improved and expand ambulant and step-down services, establish a dedicated hospital program for people older than 16 years, and improve the paediatric/adolescent impatient service.\textsuperscript{28}

A Review of the ACT Community Sector of Mental Health Services was conducted in 2011\textsuperscript{29}. Key themes from this review were:

- limitations on economies of scale have restricted organisational capacity in sector development and leadership, establishing and conducting quality process, and training and collaboration
- there needed to be links across the sector and beyond for people to navigate the system
- services have developed in an uncoordinated and inequitable manner, and there needed to be coordinated investment, growth management and a focus on capacity and support services.
- sector accountability was required to deliver quality, access and integration.

A major recommendation was a new approach to gathering consumer and carer experiences to shape reform. Fourteen other recommendations were provided\textsuperscript{30}.

<table>
<thead>
<tr>
<th>Editor's Comment and Illustrations used with Permission of ACT Health: A Facility on Par with Other Specialist Care: The New Psychiatric Services Unit (PSU), Canberra Hospital, 2012</th>
<th>Interior of New Step-up/Step Down Facility, Canberra, ACT.</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.jpg" alt="Image" /></td>
<td><img src="image2.jpg" alt="Image" /></td>
</tr>
</tbody>
</table>

\textsuperscript{28} Ibid.

\textsuperscript{29} Note: ConNetica was engaged to undertake aspects of this review.

\textsuperscript{30} Health 2011. Review of the ACT Community Sector of Mental Health Services, ACT Government, Canberra.
New South Wales

The 2011 NSW state election delivered a landslide victory to the Liberal National Party (LNP), led by the Hon Barry O’Farrell. One of the election promises made by the LNP was to establish a Mental Health Commission. This undertaking was made because of a widespread acknowledgement that mental health services in NSW were under unsustainable pressure and that both the access to and quality of mental health care was critically compromised. Numerous national and state inquiries had highlighted serious shortcomings in relation to the management of mental illness in NSW. The Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (the Richmond Report) was of course published in 1983. This was by no means the only such report highlighting systemic problems facing mental health care in NSW, for example:

- Select Committee on Mental Health, Mental Health Services in New South Wales, Legislative Council, Parliamentary Paper Number 368, December 2002
- Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals (Garling Report), November 2008
- Evaluation of Efficacy and Cost of the Mental Health Inquiry System, report prepared for the Mental Health and Drug and Alcohol Office (MHDAO) of NSW Health, January 2012

The new Mental Health Commissioner, John Feneley, began work in August 2012 and is charged with delivering a new draft strategic plan for mental health to the Government by March 2014.

As a result, it is reasonable to suggest that mental health in NSW stands at something of a crossroads. The Commissioner has made several statements indicating that continuation of past funding and service practices is unacceptable. New approaches must be funded and supported. The question is whether this new and novel model of a Commission, unlike other Australian jurisdictions, can drive its desired mental health reforms.

National difficulties in lifting the rate of access to state-provided mental health care have also been experienced in NSW. The number of people seen by state mental health services has not increased as a proportion of the population over recent years (it was 110,391 in 2006-07 and 113,875 in 2009-101), as shown below.

Right across Australia, the proportion of the population seen by state and territory mental health services right across Australia was 1.6% in 2006-07 dropping to 1.5% in the subsequent three years. This is in contrast to the strong growth in federal-funded Medicare services, principally the Better Access Program.

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW Mental Health Services</th>
<th>Private Hospital Services</th>
<th>Medicare Funded Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Priv Psychiatrists</td>
</tr>
<tr>
<td>2006-07</td>
<td>110,391</td>
<td>6,560</td>
<td>90,295</td>
</tr>
<tr>
<td>2007-08</td>
<td>106,540</td>
<td>7,286</td>
<td>89,754</td>
</tr>
<tr>
<td>2008-09</td>
<td>110,626</td>
<td>7,575</td>
<td>91,399</td>
</tr>
<tr>
<td>2009-10</td>
<td>113,875</td>
<td>7,822</td>
<td>94,773</td>
</tr>
</tbody>
</table>

In 2010-11 $261m was spent under the Pharmaceutical Benefits Scheme on just over 6.7m prescriptions for mental health medications.

The frequent requirement to seclude and restrain people with an acute mental illness highlights the ongoing failure of the mental health system to provide high quality care. Seclusion and restraint still occurs too often in modern Australian mental health care, including in NSW though again, and as pointed out by the National Mental Health Consumer and Carer Forum2, data is hard to come by. The Australian Council of Healthcare Standards (ACHS) Clinical Indicator Report for Australia and New Zealand 1998-

---

1 Council of Australian Government’s 4th Progress Report into the National Action Plan on Mental Health, Table 12
2005 indicated that the proportion of patients having seclusion is 10%. According to the AIHW, in 2009-10 there were 42,292 mental health admissions to public and private hospital in NSW. On this basis, it is reasonable to suggest there are just under 4300 incidences of this practice each year or, put another way, that a person is subject to seclusion and restraint every two hours across NSW.

Aboriginal mental health remains an important challenge in NSW. The Chief Health Officer of NSW prepares a special report into Aboriginal mental health. Some of the key findings include:

- The greatest differences in hospitalisation rates between Aboriginal people and non-Aboriginal people in NSW are for mental and behavioural disorders, and respiratory disease.
- In 2010, Aboriginal people were estimated to be 2.2 times more likely to report high or very high levels of psychological distress than non-Aboriginal people.
- In 2010–11, Aboriginal people were 2.9 times more likely to be hospitalised for intentional self-harm than non-Aboriginal people.
- In 2010 in NSW, using smoothed estimates from the NSW Population Health Survey, 26% of Aboriginal adults were calculated to have high or very high psychological distress compared with 12% of non-Aboriginal adults. Aboriginal adults were 2.2 times more likely to report high or very high psychological distress than non-Aboriginal adults. In the past 10 years the proportion of Aboriginal adults reporting high or very high psychological distress has remained constant and the gap between Aboriginal and non-Aboriginal adults has not changed over this time.

Policy development

Until recently, responsibility for mental health policy lay with the Mental Health and Drug and Alcohol Office within NSW Health. With the advent of the new Commission and its nascent strategic planning project, responsibility for whole of government mental health planning has changed. Clearly the success of the Commission will rest heavily on building and maintaining constructive relationships with all government agencies, especially Health, as it now builds its new Strategy.

Expenditure

According to the 2012 NSW Budget papers, mental health now accounts for just over $1.4bn out of a total health budget of $17.3bn or about 8% of total spending. This does not include costs across government agencies, such as the justice system, corrective services, education, police, disabilities and homecare, community services and Aboriginal affairs.

<table>
<thead>
<tr>
<th>Mental health expenditure, NSW and national ($) per capita</th>
<th>2010–11</th>
<th>Average annual change 2006-07 to 2010-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending Category</td>
<td>NSW</td>
<td>Nat Avg</td>
</tr>
<tr>
<td>Public psychiatric hospitals</td>
<td>34.00</td>
<td>23.69</td>
</tr>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>62.90</td>
<td>57.71</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>64.87</td>
<td>74.17</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>1.64</td>
<td>10.74</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>10.12</td>
<td>13.76</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>9.64</td>
<td>10.38</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>183.16</td>
<td>190.45</td>
</tr>
</tbody>
</table>

3 The health of Aboriginal people of NSW: Report of the Chief Health Officer 2012
4 Australian Institute of Health and Welfare 2012. Mental Health Services in Australia 2010
The overall NSW expenditure on mental health per capita is lower than the national average in each year but not in each category of spending and the overall rate of per capita spending has increased slightly faster than the national average over the period.

However, there are other noteworthy differences between the NSW system of mental health care and other jurisdictions. NSW directs 53% of its total mental health budget towards services to be provided in psychiatric hospitals or psychiatric wards of public hospitals, the highest proportion of any state. The national average expenditure on these services is 43% and while overall per capita spending on mental health is comparable in Victoria, this figure is only 32%.

In 2010, NSW ranked second lowest in terms of per capita spending on mental health (albeit narrowly), as shown below.

### Community mental health services

Community mental health services are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community mental health services still provided by the public mental health system. It does not include community mental health services provided by NGOs. NSW spends the lowest amount per capita on community mental health services, though its rate of growth over the past five years has matched the national average6.

NSW is a huge jurisdiction: multiple solutions and approaches reflect geographic, demographic and professional diversity. However, the data indicate a state-wide focus on the hospital as the locus of mental health care with the emphasis here being to build acute mental health facilities.

### Community mental health care services spending per capita 2010–11

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>NSW</td>
<td>64.87</td>
<td>4.1</td>
</tr>
</tbody>
</table>

### NGO sector spending

Another key characteristic of the NSW mental health system is the ongoing heavy reliance on government-run mental health services. Per capita, NSW directs the smallest proportion of its total mental health spending to support non-government mental health service provision of any jurisdiction6, $10.12 against the national average of $13.76. Coming from this low base, NSW has recently increased

---

5 Australian Institute of Health and Welfare 2013. Mental Health Services in Australia, Expenditure Data
6 AIHW Op Cit, 2012
its spending focus on NGOs, with growth in this area higher (10.8%) than the national average (6.8%) since 2006.

As shown in the graph below, NSW has generally not invested in alternatives to hospitalisation and hospital avoidance. While spending on psychiatric specialist hospitals has declined with the closure of some facilities, spending on mental health services provided in general hospitals, both acute and ambulatory has grown since 1992.

The graph below confirms that while there has been a considerable recent increase in spending directed towards the NGO sector, it still represents a tiny proportion of NSW activity.

### Change in Spending Mix in NSW Over Time $ per capita

![Graph showing change in spending mix in NSW over time.](image)

Source: Mental Health Services in Australia, AIHW (Table 14.4)

### Key initiatives

The key strategic document, the NSW Community Mental Health Strategy 2007–12, has now lapsed and NSW awaits development of the Commission’s new Strategy as a guiding document for all agencies.

NSW developed a Charter for Mental Health Care in NSW in 2000 to enunciate a set of consumer and carer rights. It is assumed this Charter will inform the Commission’s new Strategy.

NSW has also led development of the Mental Health Clinical Care and Prevention Model, a population mental health model designed to assist in better planning and resourcing of services across the State. This Model is now informing national development of a Services Planning Framework, again led by NSW.

A comprehensive piece of work was undertaken in 2010 to map the NSW community managed mental health sector. The resulting report includes a comprehensive international literature review on capacity building in the sector; details a capacity building framework and the mapping project results and makes eleven clear and actionable recommendations for the future. According to the report there are 247 Community Managed Organisations delivering 350 programs in NSW.

NSW has also embraced the opportunity afforded by two health National Partnership Agreements to establish a suite of new ‘sub-acute’ mental health beds, such as the 47 beds opened across three hospitals in the South East Sydney Local Health District since 2010–11.

---

7 Mental Health Coordinating Council 2010. The NSW Community Managed Mental Health Sector Mapping Report. NSW Australia.
Results/achievements

A key initiative in NSW has been the emergence of the Housing and Accommodation Support Initiative (HASI). Commenced in 2003 as a pilot program involving 100 clients, HASI now has 1200 clients and is able to point to remarkable, positive results for its clients, including stable housing, huge reductions in the need for acute hospital admission and improved quality of life for clients\(^8\).

NSW has also established the Mental Health Consumer Perception and Experiences of Services (MH-COPES) system of consumer feedback\(^9\). While only relatively new, this system offers potential to engage users of mental health services in a validated process of feedback to service providers.

More generally, while NSW collects an enormous quantity of statistics about mental health, this data often pertains to different aspects of the administration of the health system and does not reflect the experience of care. Little of this administrative data is useful to service providers to inform processes of quality improvement. There a paucity of regular data collected in NSW with which to assess whether things are getting better or worse for people with mental illness. Accountability is high on the agenda of the new NSW Mental Health Commission which is charged with developing more meaningful systems of regular and public reporting.

---

Northern Territory

In August last year Terry Mills, of the Country Liberal Party, became the Chief Minister of the Northern Territory. This signified the end of the ALP’s 11-year reign as the head of government in the Northern Territory. In March this year the Transport Minister, Adam Giles, replaced Terry Mills as Chief Minister. The current Minister for Health is Robyn Lambey. There is no Minister for Mental Health.

The Country Liberal Party’s available policy documents, the five-point plan and the Country Liberals Manifesto, do not make specific reference to mental health.

Policy development

The development of mental health services in the NT is the responsibility of the Mental Health Program’s Policy and Program Management team. It has the primary responsibility for implementing, monitoring and reporting progress against all National Mental Health Strategy initiatives.

Specialist integrated mental health services are delivered by the Top End and Central Australian Mental Health Services and include community based adult, child, youth and forensic services as well as inpatient services. Inpatient and community based services are provided in Darwin and Alice Springs. Rural and remote community mental health services are located in Darwin Rural, Katherine, East Arnhem, Alice Springs Remote and the Barkly Regions.

The former Labor Government’s policy emphasis was on wellness and prevention. The most recent strategic framework related specifically to mental health in the Northern Territory was the Northern Territory Suicide Prevention Action Plan released in 2009. It is suggested that the rate of suicide on the Northern Territory for the period of 2006-2010 was 20.2 deaths per 100,000, which is more than double the national average. Northern Territory also has the highest rate of youth suicide in Australia – over 3.5 times the national rate.

The 2009 Northern Territory Suicide Prevention Action Plan follows the key directions of the Northern Territory Strategic Framework for Suicide Prevention (2003). The Action Plan recognises the Australian Government as a key partner, with each action area of the plan linked to the corresponding key strategic direction of the revised Australian Government Living is for Everyone (LIFE) Framework.

Expenditure

On a per capita basis, in 2008 the Northern Territory was ranked fifth of all Australian States and Territories in terms of per capita spending on mental health at $151.27, close to the Australian average. It’s spending on mental health through the NGO sector amounted to 13.2 % of its mental health budget, which is significantly higher than the Australian average of 8.3%.

The 2012–13 Northern Territory Budget included $1.25 billion for the health budget, with a budget of $379 million for Health and Wellbeing Services which includes $53.8 million on mental health services. This included:

- $12.73 million for Individual Support Packages;
- $3 million to provide clinical service systems, enhance children and adolescent mental health services and implement suicide prevention programs in the Northern Territory;
- $7.78 million for hospitals to meet the health and wellbeing needs of those in the community who require acute or specialist care;

---

1 Mental Health Program 2009, NT Suicide Prevention Action Plan 2009-2011, Department of Health And Families, Darwin, NT.
3 Legislative Assembly NT 2012. Gone too Soon: A report on Youth Suicide in the NT. Select Committee on Youth Suicides in NT.
$1.6 million for secure care accommodation services for young people and adults with complex care needs; and

$0.33 million ongoing funding to implement the Youth Suicide Report recommendations.\(^8\)

**Mental health expenditure, NSW and national ($) per capita\(^9\)**

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>2010–11</th>
<th>Average annual change 2006-07 to 2010-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public psychiatric hospitals</td>
<td>NT</td>
<td>Nat Avg</td>
</tr>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>62.03</td>
<td>57.71</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>90.79</td>
<td>74.17</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>6.32</td>
<td>10.74</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>14.67</td>
<td>13.76</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>14.17</td>
<td>10.38</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>187.99</td>
<td>190.45</td>
</tr>
</tbody>
</table>

The overall Northern Territory expenditure on mental health per capita has been lower than the national average for the last two years, however residential service spending has increased significantly in the last three years. The average annual change from 2006-07 to 2010-11 of 35.2% is the largest increase in any category of spending in any jurisdiction.

In 2010, Northern Territory ranked fourth lowest in terms of per capita spending on mental health and close to the lowest per capita expenditure as shown below.

Across Australia, the proportion of the population seen by state and territory mental health services was 1.6% in 2006-07 dropping to 1.5% in the subsequent three years. This is in contrast to the strong growth in federal-funded Medicare services, principally the Better Access Program. In 2010-11 $261m was spent under the Pharmaceutical Benefits Scheme on just over 6.7 million prescriptions for mental health medications.

---

9 Australian Institute of Health and Welfare, Mental Health Services in Australia 2012
Community mental health services

Community mental health services are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community mental health services still provided by the public mental health system. It does not include community mental health services provided by NGOs. Northern Territory spends the second highest amount per capita on community mental health services, though its rate of growth over the past five years has been below the national average.  

Community mental health care services spending by jurisdiction, per capita 2010-11

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>NT</td>
<td>90.79</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Key initiatives

In March 2009 the Department of Health and Families released the Northern Territory’s Suicide Prevention Action Plan 2009-2011. The plan focuses on the need for a whole of government and community approach, and is based on the Australian Government’s LIFE framework. The main aims of the plan are to:

- Strengthen wellbeing, optimism, connectedness, resilience, health and capacity across the NT community, with a particular focus on young people and their families;
- Support initiatives that reduce risk factors and promote positive protective factors for suicide and self-harm;
- Improve the ability of a wide range of services, systems and support networks to meet the needs of groups at increased risk of suicide and self-harm through prevention, recognition and response;
- Strengthen effective responses to individuals at particular risk to reduce and respond to suicidal and self-harming behaviour;
- Provide culturally appropriate programs that support community response to high rates of suicide and self-harm in Indigenous communities; and
- Build the evidence base, share good practice and provide education and training.

Results/achievements

In 2010–2011, the Northern Territory had the lowest rate of MBS-subsidised mental health-related services provided by psychologists. It had the lowest rate of use of non-residential psychiatric disability support services, the lowest number of 24-hour mental health care beds per 100,000 population (20.6 against the average of 37.2 in 2009–2010) and the highest rate of supported accommodation services per 100,000 population.  

10 AIHW 2012 Op Cit
Assessing the performance – Government and independent reviews

The Legislative Assembly of the Northern Territory established a Select Committee in 2011 on Youth Suicides in the Northern Territory. Its report – *Gone too Soon: A report on Youth Suicide in the Northern Territory* – was tabled in March 2012. Prior to this report, the *Review of the Northern Territory Youth Justice System Report* was released in September 2011. The *Gone Too Soon* report recommended prioritising youth-specific infrastructure funding for accommodation, mental health facilities, drop-in centres and recreation services for young people across the Northern Territory. The Youth Justice Review also recommended increased resources for youth diversion, rehabilitation camps and provisions for young people at risk of entering the youth justice system.  

Queensland

The 2012 Queensland state election resulted in a landslide victory to the Liberal National Party (LNP). The resultant machinery of government changes included relocating responsibility for the community managed mental health services from Department of Communities to Qld Health. The Department of the Premier and Cabinet has released three action plans since coming to office. The only commitment to mental health in any of the plans (from some 255 actions) has been the modelling and then finalisation of Queensland’s first Mental Health Commission.

The public health system in Queensland is currently in the process of a significant period of change. There is a clear focus on the patient and the clinician with a resulting move to shift resources to the frontlines, decentralising decision-making and empowering communities to have a greater role in how care is designed and delivered in the future. As a result of this drive to decentralise, public health services are now provided through 17 Hospital and Health Services (HHS). These are governed by a Hospital and Health Board accountable to both the local community and the Queensland Parliament. Performance monitoring and protocols are contained the Hospital and Health Services Framework.

In Queensland it is estimated that 16.6% of the population is affected by mental disorders in any one year, 2.5% will experience severe mental disorders. In 2008 there were more than 1,400 beds in the inpatient system. This represented approximately 33 beds per 100,000. The 2012-13 budget supports more beds for mental health. The 2011–12 budget anticipated that there would be 190,000–200,000 mental health acute admitted psychiatric care days. The actual was 207,904. The estimate for 2012–13 is 200,000–210,000 days. Queensland has the highest level of ‘admitted’ patient separations across Australia. The 2011–12 budget anticipated there would be 70,000–75,000 mental health patients accessing community mental health care. The actual was 81,178. This measure has been discontinued for 2012–13. In 2011-12 the target for the proportion of re-admission to acute psychiatric care within 28 days of discharge was 15–20%. The actual was 11.3%. In 2012–13 the target is 10–14%.

Across Australia, the proportion of the population seen by state and territory mental health services was 1.6% in 2006–07 dropping to 1.5% in the subsequent three years. This is in contrast to the strong growth in Federal-funded Medicare services, principally the Better Access Program.

In 2010–11 $261m was spent under the PBS on 6.7 million prescriptions for MH medications.

<table>
<thead>
<tr>
<th>Year</th>
<th>QLD Mental Health Services</th>
<th>Private Hospital Services</th>
<th>Medicare Funded Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Priv Psychiatrists</td>
<td>GPs</td>
</tr>
<tr>
<td>2006-07</td>
<td>72,856</td>
<td>4,963</td>
<td>50,006</td>
</tr>
<tr>
<td>2007-08</td>
<td>75,541</td>
<td>4,791</td>
<td>49,579</td>
</tr>
<tr>
<td>2008-09</td>
<td>72,989</td>
<td>5,270</td>
<td>50,236</td>
</tr>
<tr>
<td>2009-10</td>
<td>72,304</td>
<td>5,380</td>
<td>51,536</td>
</tr>
</tbody>
</table>

2 Queensland Health 2012. Hospital and Health Services Performance Framework 2012-2013, Queensland Government, Brisbane
4 Ibid
5 Queensland Government State Budget 2012-13 Service Delivery Statements, Queensland Health

ConNetica
Policy development

Under the Bligh Labor Government, mental health reform was guided by the Fourth National Mental Health Plan\(^6\) and the Queensland Plan for Mental Health 2007–2017\(^7\) and the Supporting Recovery Mental Health Community Services Plan\(^8\). The vision of the Queensland Plan is to facilitate access to a recovery-orientated mental health system, with a stronger role planned for NGOs.

“Mission: To provide a comprehensive, resilience and recovery-based mental health system across Queensland, with emphasis upon promotion, prevention and early intervention.”

It identified the following key priorities:

- promotion, prevention and early intervention
- improving and integrating the care system
- participation in the community
- coordinating care
- workforce, information, quality and safety

The Queensland Plan was complemented by the 2011, Supporting Recovery: Mental Health Community Services Plan 2011–2017, which gives priority to providing a coordinated and integrated response to community and individual mental health needs arising from the disasters and reflected the commitment to strengthening the community mental health sector.

Mental health promotion in Queensland is guided by the Strategic Directions for Mental Health Promotion 2009–2012, released by the Division of the Chief Health Officer\(^9\). It identified the priorities and measures for mental health promotion, including finalising the Queensland Framework for Mental Health Promotion and developing and implementing a response to the issues identified in the report, “Key directions for a social, emotional, cultural and spiritual wellbeing population health framework for Aboriginal and Torres Strait Islander Australians in Queensland.”\(^10\) In April 2012 the Brisbane Lion’s football club partnered with Queensland Health in support of the Change Our Minds mental illness stigma reduction campaign\(^11\).

Expenditure

The Queensland health budget for 2011–12 was $11.046 billion of which $950.7 million or 8.6% is allocated to Integrated Mental Health Services.

Further investments include:

As part of Natural Disaster Recovery, the Qld and Australian Governments provided $12.6 million additional funding for community mental health staff to work in Mental Health Trauma Recovery Services (MHTRS) over the next two years.

The Australian Government is providing $7 million additional funding in 2011–12 ($97.7 million over five years) under the Health and Hospitals Fund Regional Priority Round to construct mental health community care units in Nambour, Bundaberg, Rockhampton and Toowoomba and to develop regional inpatient mental health services in Bundaberg, Hervey Bay, Toowoomba and Maryborough.

As part of the National Partnership Agreement, the Australian Government is providing $4.3 million additional funding in 2011–12 ($31.6 million over four years) to enhance mental health services including accommodation, EDs and community based crisis support.

---

\(^7\) Op Cit. Queensland Government 2008
\(^9\) Division of Chief Health Officer 2009. Strategic Directions for Mental Health Promotion 2009-2012, Queensland Health, 2009.
\(^10\) Centre for Rural and Remote Mental Health 2009. Key directions for a social, emotional, cultural and spiritual wellbeing population health framework for Aboriginal and Torres Strait Islander Australians in Queensland, CRRMH.
\(^11\) Queensland Health media statement April 28, 2012, Lions pledge to help Queenslanders change their mind about mental illness.
The 2012–13 health budget is $11.862 billion of which $1.072 million or 9% is allocated to Integrated Mental Health Services. The overall Queensland expenditure on mental health per capita is lower than the national average in each year but not in each category of spending and the overall rate of per capita spending is 59% higher than the national average over the period.

Mental health expenditure, Qld and national ($) per capita\(^\text{12}\)

In 2010–11, Queensland ranked third lowest in terms of total per capital spending on mental health (albeit narrowly), as shown below.

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>2010–11 Qld</th>
<th>Nat Avg</th>
<th>Average annual change 2006-07 to 2010-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public psychiatric hospitals</td>
<td>20.33</td>
<td>23.69</td>
<td>0.9</td>
</tr>
<tr>
<td>Specialised psychiatric units/wards in public hospitals</td>
<td>57.13</td>
<td>57.71</td>
<td>1.9</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>81.95</td>
<td>74.17</td>
<td>7.9</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>0</td>
<td>10.74</td>
<td>-</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>14.75</td>
<td>13.76</td>
<td>11.8</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>13.64</td>
<td>10.38</td>
<td>13.8</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>187.80</td>
<td>190.45</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Natural disasters have hit both the people of Queensland and its economy hard in recent years. Disaster recovery costs and the impact on income sources from mining, agriculture and tourism have been enormous. Hence over the next few years the Qld Government will continue to incur deficits.

Community mental health services

Community mental health services are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community mental health services still provided by the public mental health system. It does not include community mental health services provided by NGOs. Although Queensland has the fifth lowest rate of spending per capita it has highest average annual change on community mental health services\(^\text{13}\).

\(^{12}\) Op Cit AIHW 2012
\(^{13}\) Ibid
Community mental health care services spending by jurisdiction, per capita 2010–11

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006–11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>Qld</td>
<td>81.95</td>
<td>7.9</td>
</tr>
</tbody>
</table>

The community mental health care services expenditure in Queensland increased in 2006–07 by 21% on the previous year, with increases of approximately 10% per annum in the subsequent three years.

**NGO sector spending**

In 2011, the Qld Government provided approximately $98 million funding to more than 100 NGOs to provide support to over 14,500 people. Of this funding, nearly $36 million represents personal support services and $62 million additional supported social housing places under the HASP program (see below). Whilst funding to this sector has increased from 6.7% of the mental health budget in 2008 to approximately 10% in 2010–11, the percentage of funding to the community managed mental health sector has been consistently below the Australian average of 8.3%.

**Key initiatives**

Severe cuts to Government spending in late 2012 and early 2013 have cast doubt over the progress of several key initiatives concerning mental health.

**Mental Health Commission**

The previous ALP government set out a commitment to establish an independent Queensland Mental Health Commission in July 2012 to drive improved performance, coordination and transparency in the delivery of mental health services in Queensland.

A Transition Team was established and it released the First Report of the Queensland Mental Health Commission in January 2012.

The *Blueprint for Better Healthcare in Queensland, February 2013*, purports that the independent Mental Health Commission will address the “lack of coordinated approach to delivery of mental support and treatment. It is reported the Commission will work towards a more integrated, evidence-based recovery-oriented mental health systems of support and treatment, enabling Queenslanders to have their say about the way mental health services are delivered.

There is strong stakeholder and community support for the advancement of reforms aimed at greater accountability, promoting greater continuity of care and better integration and coordination across the full continuum of mental health services.

The legislation to establish the Queensland Mental Health Commission was approved in Parliament on 7 March 2013 including the appointment of a Mental Health Commission.

---

17 Queensland Government Blueprint for better healthcare in Queensland, February 2013, Queensland Government, Brisbane
Results/achievements

There have been significant increases in clinical staff across the health system since 2009. More than 193 positions were established up to 2008 and 569 new positions in community mental health (public sector managed) to 2011.18

- Forensic mental health services and specialist liaison services were expanded.
- $4.7 million was invested in care co-ordination with 20 service
- $80 million was invested in workforce, information quality, safety and development in both non-government and government sectors.
- $10.6 million was invested to deliver promotion, prevention and early intervention initiatives, including funding for a stigma reduction social marketing campaign.
- The establishment of Queensland Centre for Mental Health Promotion and Prevention
- The Ed-LinQ initiative19 was established. This aims to improve mental health outcomes for children and young people by strengthening integration between the schools, primary care providers and child and youth mental health services.
- The establishment of nine social enterprises was supported through the Queensland Inclusive Social Enterprise Project (QISEP)
- A Time Out early intervention initiative for youth was trialled and evaluated.
- Training was provided for 10,000 front line police, health and ambulance workers for effectively dealing with people experiencing a mental illness crisis.
- The Housing and Support Program (HASP) was established to provide coordinated social housing, clinical treatment and non-clinical support to people with moderate to severe mental illness. COAG also supported the development of service delivery 'hubs' in areas of high need.
- The Partners in Mind framework was implemented by the Divisions of General Practice in 2006 to improve integration in the primary mental health care sector.
- A Consumer Carer and Family Participation Framework20 was implemented.

Assessing the performance

Project 300

Project 300 was established in 1995 with the aim of relocating 300 clients from the three psychiatric hospitals in Queensland to supported living arrangements in the community of their choice. During 2010–11 a final assessment of the overall Project 300 model was instigated21. Of the 204 discharged clients, 66 agreed to participate in the 14-year evaluation.

While most clients indicated their quality of life was reasonably high, they had ongoing difficulties with relationships, socialisation and integration into the general community. 35% of clients reported spending most days being quite inactive for the majority of the day, a further 18% were inactive 3-4 days a week, leaving 47% of clients who reported leading relatively active lives. Lack of finances was cited as a barrier to activity participation. The data (n=32) indicated that 53% of the clients in the study group improved on measures of their clinical functioning while 31% remained stable and 16% deteriorated. Similarly, the data (n=44) showed improvement in their life skills performance for 41% of clients, while 25% remained stable and 34% deteriorated.

In terms of resettling people with long histories of hospitalisation in the community, Project 300 has been very effective. However, outcomes related to community integration and ‘normalisation’ are not so straightforward. After 14 years of community living, few clients were working, engaged in structured activities or married/in a relationship. Although living in the community, many still remain in a “mental health world”.

20 Consumer, Carer and Family Participation Framework, Queensland Government, Brisbane.
21 Department of Psychiatry (UQ) and Service Evaluation and Research Unit 2011. The Park, Centre for Mental Health ‘Project 300’ Follow-up Evaluation Over 14 Years Final Report.
Housing and Support Program

The Housing and Support Program (HASP) was established in 2006 to support individuals with psychiatric disability leaving acute and extended treatment mental health facilities. During 2010 researchers were engaged to evaluate HASP22. 204 clients have been offered HASP packages. 80 of the 153 clients who were living in the community at the time of the evaluation, enrolled in the evaluation.

Whilst HASP was reported to have helped clients to move from a life filled with despair to one of hope and promise for the future over 40% experienced loneliness, over 30% experienced depression and over 50% felt bored. The data indicated that 43% of the clients in the study group improved on measures of their clinical functioning while 33% remained stable and 24% deteriorated. Similarly, the data showed improvement in their life skills performance for 43% of clients, while 33% remained stable and 24% deteriorated.

In terms of helping clients to achieve their goals HASP has been very effective. Improvements in functioning were, however, not statistically significant. Overall, it is clear that whilst some clients have made considerable advances in securing a future in the community, others have been less successful in taking advantage of the opportunities available to them.

Despite the P300 and HASP programs hundreds of people are still held indefinitely in stand-alone psychiatric hospitals in Queensland.

Recovery-Oriented Mentoring Program

The Queensland Plan for Mental Health has a 10-year goal of providing a comprehensive, recovery-oriented mental health system. Recovery-oriented mentoring programs (ROMP) have been delivered in Queensland as training programs in 2008–09 and 2011. The objective of ROMP was to facilitate organisation and sector-wide adoption of recovery-oriented service delivery. Program evaluations were undertaken in 2009 and 2012.

The acceptance of the recovery-oriented approach depends on the acceptance of a radical change in the focus of service provision. The analysis of enablers and barriers to adopting a recovery approach showed that organisational and managerial support for change is the most important factor. The 2012 evaluation23 acknowledged the complexity of the issue of identifying the extent to which training affects behaviour, but concluded that ROMP was successful in increasing the adoption of the recovery-oriented approach.

22 Department of Psychiatry (UQ) and Service Evaluation and Research Unit 2010. The Park, Centre for Mental Health Housing and Support Program (HASP) Final Evaluation Report
The 19th Century built Baillie Henderson Hospital Toowoomba: 206 mental health ‘patients as at 6 March 2013’. 

Reception Area for patients inside Baillie Henderson Hospital Toowoomba. Photo was taken on a Tuesday at approx. 10am. Note the Reception Area is fully meshed with security screening, windows and doors are closed and locked. There is no buzzer or bell and access to the ‘counter’ is further restricted with furniture placed directly in front.

24 Reported in Toowoomba Chronicle, 7 March 2013. Statement by Darling Downs Health & Hospital Service chief executive officer Dr Peter Bristow. There are still 2 stand alone psychiatric hospitals in Queensland – the other is located in Charters Towers. While exact numbers of clients are not reported, it is estimated that at least 300 people are held indefinitely. Some have been in care for decades.
South Australia

The Labor Governments of Mike Rann and Jay Weatherall have held power since 2006. South Australia was the first and only state or territory to establish a Social Inclusion Board in 2002. In 2010 the Office of the Chief Psychiatrist was established, following the commencement of the Mental Health Act 2009. This office is also overseeing the introduction of the new Community Visitor Scheme.

Policy development

Like other states, South Australia is currently undertaking an extensive program of mental health sector reform focusing on facilities and service delivery, collaborative partnerships, and the involvement of consumers and their families and to create 251 more beds and places by late 2014.


- promote positive mental health and wellbeing and prevent mental ill-health as far as possible
- protect the human rights of people with a mental illness and support people who experience mental ill-health to live fulfilling lives in the community, without stigma or discrimination
- prioritise early intervention and facilitate timely access to a range of high quality, integrated mental health services that are culturally respectful and meet needs regardless of age, disability, cultural background, geographical location or circumstances of life
- promote and implement principles and strategies that support recovery across the mental health care system and the general community.

A Framework for recovery-oriented rehabilitation in mental health care, released in 2012, provides a guide to recovery-oriented rehabilitation policy and service development, planning and implementation in mental health services. The framework assumes a commitment at policy and service levels to the implementation of recovery-oriented rehabilitation services throughout South Australia.

Expenditure

In total, the South Australian Government 2012–2013 Health Budget is $4.895 billion. The overall SA expenditure on mental health per capita has been higher that the national average since 1993. However, not every category has received higher than average spending, residential mental health for example had consistently less expenditure per capita than the national average with the highest level of spending on public psychiatric hospitals.

---

Mental health expenditure, SA and national ($) per capita $^5$

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>2010–11</th>
<th>Average annual change 2006-07 to 2010-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SA</td>
<td>Nat Avg</td>
</tr>
<tr>
<td>Public psychiatric hospitals</td>
<td>40.91</td>
<td>23.69</td>
</tr>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>45.90</td>
<td>57.71</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>83.07</td>
<td>74.17</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>7.20</td>
<td>10.74</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>22.35</td>
<td>13.76</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>3.83</td>
<td>10.38</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>203.24</td>
<td>190.45</td>
</tr>
</tbody>
</table>

In 2010–11 SA per capita spending had increased to $203.24 ranking third highest in per capita spending, with approximately 43% of expenditure on public psychiatric hospital services and psychiatric wards in General Hospitals.

The breakdown of expenditure on new projects in 2012–13 was as follows $^6$:

- $12 million to redevelop James Nash House, a 40 med mental health facility.
- $11.1 million towards the development of six community mental health centres.
- $5.8 million towards country community rehabilitation centres.
- $3.3 million towards construction of three intermediate care MH facilities in the metropolitan area.
- $2.5 million towards youth inpatient services to provide early intervention services for young people experiencing early psychosis.
- $2 million for early intervention services across three metropolitan locations.
- $2 million towards step down facilities for integrated forensic MHS.

**Community mental health services**

Community mental health services are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community mental health services still provided by the public mental health system. It does not include community mental health services provided by NGOs. SA

---

$^5$ OP Cit AIHW, 2012

spends the fourth highest amount per capita on community mental health services, though its rate of growth over the past five years has been higher than the national average by 1.8\%\textsuperscript{7}.

**Community mental health care services spending per capita 2010-11**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>SA</td>
<td>83.07</td>
<td>5.8</td>
</tr>
</tbody>
</table>

**Key initiatives**

**Children and adolescents and adults**

Within South Australia, services to young people are currently in a process of expansion. The government has allocated $1.6m over four years for service delivery to adolescents and young adults experiencing early symptoms or a first episode of psychosis.

The number of beds for adult treatment has been increased as follows:

- redevelopment of Glenside Campus to provide a new 129 bed mental health and substance abuse facility, scheduled to open in late 2012;
- ten limited treatment centre beds at Hub hospitals;
- two new 15 bed intermediate treatment facilities opened in 2010–11; and
- six new community mental health services to be established.

**Older people**

- New 20 bed aged acute mental health unit underway at The Queen Elizabeth Hospital;
- A 20-bed aged acute unit built as part of the Lyell McEwen Hospital redevelopment and a 30-bed aged acute unit at the Repatriation General Hospital.
- Expansion and further development of community team sites to be completed by June 2012; and
- A “whole of country” Older Person MHS model for country South Australia is in development.

**Specialist services/other**

- Eating disorders: There has been a review of the Weight Disorder Unit and funding has been allocated to implement the recommendations.
- Forensic Mental Health Service – Redevelopment of James Nash House was due to be completed in 2012. Final approval was announced in late November 2012. Facilities are being extended by 10 sub-acute care beds to increase total bed capacity to 40.
- A Nurse Practitioner Candidate (NPC) Framework has been developed and five Mental Health Nurse Practitioners recruited, with a further 3 to come\textsuperscript{8}.
- COAG funding will support the implementation of mental health sub-acute initiatives, which will deliver 159 beds or bed equivalents across six projects.

**Housing**

Supported accommodation expanding from 128 beds with a further 339 to be added through Housing and Support Program (HASP) and Supported Social Housing (SSH) programs. Available to Adelaide metropolitan areas only, the HASP Program provides mainstream community living for people who are experiencing severe and enduring mental illness.

\textsuperscript{7} OP Cit AIHW, 2012
\textsuperscript{8} Op Cit, SA Health Budget 2012-2013, viewed August 7, 2012,
Results/achievements

There are approximately 16,000 occasions of service for mental health in the Public Hospital inpatient services and approximately 558,000 contacts with Community MHS. Based on 2007–2008 figures, they have a relatively higher rate of mental health related subsidised prescriptions and a higher than average number of mental health nurses (82 against a national average of 69). They also have a higher number of inpatient beds per 100,000 people relative to other states.

In progress against the COAG Action Plan for Mental Health 2006–2011, for rates of community follow-up for people within seven days of discharge from hospital, South Australia was one of two jurisdictions with low rates of follow-up that experienced noticeable improvement.

South Australia continues to operate stand-alone psychiatric hospitals. It spends more of these services than any other jurisdiction on a per capita basis. Efforts to close these facilities have been subject to strong campaigns headed by mental health professionals and some community action groups over the past three decades.

**New Glenside mental health facilities** (Source: ABC TV News Adelaide, 27 Nov 2012)

---

Tasmania

Since 2006, the ALP has held power in Tasmania in an absolute majority or more recently in coalition with the Tasmanian Greens. Since 2005, there have been four Premiers – Jim Bacon, Paul Lennon, David Bartlett and since 2011, Lara Giddings. After the 2010 state election Michelle O’Byrne was appointed Minister for Health in Tasmania. Tasmania is one of the few jurisdictions to not have a Minister for Mental Health.

Policy development

Statewide and Mental Health Services sits within the Department of Health and Human Services. The MHS Strategic Plan (2006–2011)\(^1\) provides the policy and program direction with a stated aim of delivering care that is recovery and consumer and carer focused. There are four service streams:

1. Child and adolescent;
2. Adult community;
3. Older persons; and

Tasmanian Health Organisations (THO’s) deliver these service streams regionally. The THO’s were formed as part of the National Health Reform agenda and commenced on 1 July 2012. There are three THO’s responsible for the provision of public hospital services and other health services, including mental health services.

As a result of a series of reviews released in 2004, including *Bridging the Gap*\(^2\), the Tasmanian Government committed $47 million over four years for mental health services. The Mental Health Strategic Plan 2006–2011 focused on expanding services through partnerships across Government sectors and with non-government organisations. It identified the following six strategic priority areas:

1. Model of care;
2. Participation and partnerships;
3. Governance and leadership;
4. Workforce development;
5. Quality and safety; and
6. Sustainable resources.

In addition, there is the *Tasmania Together* long-term plan developed ‘by Tasmanians for Tasmanians’ which was revised in 2011\(^3\). It has two specific mental health targets:

1. Goal 4.3.2 of this plan was to reduce the proportion of Tasmanians 18 years and over who report their level of psychological distress as high/very high by 10% on 2005 figures. An actual figure of 11% was reported in 2006–2007.

2. Goal 4.4.5 of the plan sets a target of 60% for the proportion of people with a serious mental illness whose needs are met by the Tasmanian Mental Health Service. This represents a significant increase on the actual result for 2009, which was 34.5%.

The implementation of the Promotion, Prevention and Early Intervention (PPEI) Building the Foundations for Mental Health and Wellbeing Framework\(^4\) is continuing.

Expenditure

In 2007–2008 Tasmania spent an average $180.40 per capita on mental health, which placed it second highest of the Australian States and Territories. It allocates 11.2% of its funding to Non-Government organisations, higher than the national average of 8.3%\(^5\).

---

1 Dept of Health and Human Services 2006. Mental Health Services Strategic Plan 2006-2011 partners towards recovery. Tas Govt.
4 Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) (2009), Building the Foundations for Mental Health and Wellbeing, Department of Health and Human Services, Tas.

346
The Tasmanian Health Budget for 2012–2013 was $1.84 billion of which $149.4 million or 8.1% is directed to mental health services, which includes alcohol and drug services. Whilst the number of people receiving care from the Tasmanian Mental Health Services is increasing year on year, budget papers indicate that in 2010–2011, only 32% of persons with a mental illness in Tasmania have their needs met. The 28-day readmission rate was 15% in the 9 months to March 2012 and the average inpatient stay 12.2 days.

It is noted that funding from the Federal Government under National Mental Health Reform for up to 70 individual packages of support for people with severe and persistent mental illness, will assist the Tasmanian Government to reconfigure its mental health services.

**Mental health expenditure, Tasmania and national ($) per capita**

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>2010–11</th>
<th>Average annual change 2006-07 to 2010–11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tas</td>
<td>Nat Avg</td>
</tr>
<tr>
<td>Public psychiatric hospitals</td>
<td>0</td>
<td>23.69</td>
</tr>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>87.28</td>
<td>57.71</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>71.07</td>
<td>74.17</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>41.28</td>
<td>10.74</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>15.06</td>
<td>13.76</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>13.67</td>
<td>10.38</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>228.36</td>
<td>190.45</td>
</tr>
</tbody>
</table>

The overall Tasmanian expenditure on mental health per capita has been higher than the national average for the last six years.

In 2010–11, Tasmania ranked highest in terms of total per capital spending on mental health, as shown below:

![Per Capita Spending on Mental Health by Jurisdiction 2010-11](chart.png)

Source: AIHW, Mental Health Services in Australia, 2012

5 Op Cit AIHW 2011
6 Department of Health and Human Services (2012), Your Health and Human Services Progress Chart June 2012, System Purchasing and Performance Group, Department of Health and Human Services, Hobart TAS.
8 Op Cit AIHW 2012
Across Australia, the proportion of the population seen by state and territory mental health services was 1.6% in 2006–07 dropping to 1.5% in the subsequent three years. This is in contrast to the strong growth in federal-funded Medicare services, principally the Better Access Program.

<table>
<thead>
<tr>
<th>Year</th>
<th>Tas Mental Health Services</th>
<th>Private Hospital Services</th>
<th>Medicare Funded Mental Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Priv Psychiatrists</td>
<td>GPs</td>
<td>Clin Psychologists</td>
</tr>
<tr>
<td>2006-07</td>
<td>8,492</td>
<td>4,827</td>
<td>8,480</td>
</tr>
<tr>
<td>2007-08</td>
<td>9,499</td>
<td>4,631</td>
<td>15,273</td>
</tr>
<tr>
<td>2008-09</td>
<td>9,362</td>
<td>4,917</td>
<td>18,525</td>
</tr>
<tr>
<td>2009-10</td>
<td>9,435</td>
<td>5,288</td>
<td>20,914</td>
</tr>
</tbody>
</table>

In 2010–11 $261m was spent under the Pharmaceutical Benefits Scheme on just over 6.7 million prescriptions for mental health medications.

**Community mental health services**

Community MHS are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community mental health services still provided by the public mental health system. It does not include community mental health services provided by NGOs. Tasmania has a below national average rate of spending per capita annual change on community MHS.

**Community mental health care services spending, per capita 2010-11**

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>Tas</td>
<td>71.07</td>
<td>2.4</td>
</tr>
</tbody>
</table>

**Key initiatives**

- *Our Children Our Young People Our Future* – the Agenda for Children and Young People is a whole of Government, multi-sector, multi-agency 10-year action plan to focus on 13 priority areas. Action Area 3 focuses on improving the mental health and wellbeing of young people with a focus on early intervention and prevention and health promotion.

- The Mental Health Bill 2012 was tabled in June 2012 and aims to reflect a human rights approach to treatment for people with a mental illness.

- In December 2010 the Tasmanian Suicide Prevention Strategy 2010–2014 was launched focusing on early intervention and prevention and the promotion of mental health.

- New Integrated Care Centres house community nursing and respiratory clinics alongside adult mental health, alcohol and drug, chronic and complex disease and youth health services. Clarence ICC opened in July 2012 and the Northern Integrated Care Service, positioned beside Launceston Hospital, opened late 2012.

- The *Male Matters* program, which started in 2012, is being offered to grade 10 boys to provide learning opportunities on resilience, mental health, and leadership and general male issues.

- A 24 hour Mental Health Services HELPLINE
Results/achievements

Tasmania has the highest number of 24-hour mental health care beds per 100,000 population (44.4 compared to the average of 37.5 in 2008–2009)\textsuperscript{12}. The suicide rate in Tasmania is 15.6 per 100,000, the second highest in any State or Territory in Australia\textsuperscript{13}. In 2010–2011 the number of people treated in acute mental health settings increased by 11.7% on the previous year\textsuperscript{14}. In progress against the Council of Australian Governments (COAG) Action Plan for Mental Health 2006–2011, for rates of community follow-up for people within seven days of discharge from hospital, Tasmania was one of two jurisdictions with low rates of follow-up that experienced noticeable improvement\textsuperscript{15}.

Equality of care – Equality of facilities would be good. (Editor’s comment and inclusion of photos.)

Psychiatric Intensive Care Unit: Below is a photo of the entrance to the Psychiatric Intensive Care Unit, located at Royal Hobart Hospital. The unit is located on the bottom ground in this hospital block. The Department of Psychological Medicine appears to be located next to or with Psychiatric Intensive Care Unit.

![Psychiatric Intensive Care Unit](image1.jpg)

Same Hospital, different care: The entry to the Psychiatric Intensive Care Unit contrasts greatly with the main public entrance to the Royal Hobart Hospital, and proud signage for the new Integrated Cancer Centre which a number of organisations have put branding to (both below).

![Same Hospital, different care](image2.jpg)

\textsuperscript{12} Op Cit DOHA 2010. National Mental Health Report 2010
\textsuperscript{13} Op cit. 2010. Tasmania’s Suicide Prevention Strategy 2010-2014
\textsuperscript{14} Department of Health and Human Services (2011), Annual Report 2010-2011 Department of Health and Human Services
Obsessive Hope Disorder

Victoria

Labor was in Government in Victoria from 1999 until 2010. John Brumby was Premier and Labor leader until 2010 succeeded by Ted Baillieu of the Liberal party at the 2010 election. In the 2013 election, Liberal member Denis Napthine became Victoria’s 47th Premier. When the Coalition won the election in 2010, Mary Wooldridge became the Minister for Mental Health, a role she still holds.

Policy development

Victoria has traditionally been seen as the leader in the provision of mental health services across Australia due to a more assertive response to the National Mental Health Strategy in the 1990s.

The public mental health sector is supported by a well-established community managed mental health sector (CMMH), with over 100 agencies providing support to more than 14,000 individuals in the CMMH sector.

There has been a significant amount of change within the Victorian Government’s Mental Health Program in recent years. Key developments have included the creation of mental health ministerial responsibility, development of the Because Mental Health Matters reform strategy¹, review and reform of legislation, and the creation of the new Psychiatric Disability Rehabilitation and Support Services (PDRSS) Reform Framework², which is in the final consultation stage.

The PDRSS Reform Framework focused on how the PDRSS sector will be reconfigured and rationalised. It emphasises the move to more consumer directed, client focused care that is tailored and flexible and offers family focused support. Ultimately there will be a move to ‘client-directed’ or ‘client-managed’ funding.

In recent years as part of the Because Mental Health Matters reform strategy, there has been significant change and additional funding into the sector. A state-wide Mental Health Reform Council has been established to progress the reform³. There were eight major reform areas:

1. promoting mental health and wellbeing
2. early in life – helping children, adolescents and young people (0–25 years) and their families
3. pathways to care – strengthening service access and emergency responses
4. specialist care – meeting the needs of adults and older people with moderate to severe mental illness
5. support in the community – building foundations for recovery and participation in community life
6. reducing inequalities – responding better to vulnerable people
7. workforce and innovation – improving capacity, skills, leadership and knowledge, and
8. partnerships and accountability – strengthening planning, governance and shared responsibility for outcomes.

Broadly, these various reform agendas for mental health and alcohol and drug (AOD) treatment services include the following:

- redesign of mental health services and increased service integration.
- integrated care for those with eating disorders.
- better responses to AOD in emergency departments.
- review of boundaries and governance across the sector.
- improvements to family-centred practice.

There will also be new strategies around eating disorders and suicide prevention.

The PDRSS reform framework acknowledges that in Victoria, people under the age of 24 years are under-serviced, the sector is not well integrated with other sectors, and links to clinical services could be improved. There is a push for evidence based service models and for agencies to share information and work together in a more collaborative way.


**Expenditure**

As part of the *Because Mental Health Matters Reform*, the Brumby Government committed over $300 million for the three-year period from 2008-2009 to implement reforms.

The total Victorian health budget for 2013-2014 amounts to $14.34 billion, with mental health accounting for 11.9%. In Victoria in 2010–2011, the total number of people treated by public mental health services was 61,645 of which 21% had a hospital admission (n=13,175).

**Mental health expenditure, Victoria and national ($) per capita**

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>2010–11</th>
<th>Aver annual change 2006-07 to 2010-11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Victoria</td>
<td>Nat Avg</td>
</tr>
<tr>
<td>Public psychiatric hospitals</td>
<td>7.68</td>
<td>23.69</td>
</tr>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>49.34</td>
<td>57.71</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>67.06</td>
<td>74.17</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>29.89</td>
<td>10.74</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>14.99</td>
<td>13.76</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>10.24</td>
<td>10.38</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>179.19</td>
<td>190.45</td>
</tr>
</tbody>
</table>

The overall expenditure on mental health per capita in Victoria is lower than the national average. Spending categories such as public psychiatric hospitals and specialised psychiatric units have lower than average expenditure, whereas residential mental health services and grants to non-government organisations spending are higher than the national average. Victoria spends the third highest amount per capita on community mental health services, though its rate of growth over the past five years has decreased by 1.5%. In 2010, Victoria ranked lowest of all jurisdictions in terms of per capita spending on mental health as shown below.

---

5 Dept of Health 2012. Victorian health policy and funding guidelines 2012-2013 Part one: Key changes and new initiatives, Melb.
7 Op Cit AIHA 2012
8 Op Cit AIHW 2013
Community mental health services

Community mental health services are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community mental health services still provided by the public mental health system. It does not include community mental health services provided by NGOs. Victoria has the second lowest rate of spending per capita and has a less than average annual change of community mental health services.9

Community mental health care services spending national and Victoria, per capita 2010–11

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006–11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>Vic</td>
<td>67.06</td>
<td>1.5</td>
</tr>
</tbody>
</table>

The 2013–14 Budget shows mental health and drug and alcohol services in Victoria receiving a $42 million increase. This includes $25.2 million over four years for mental health services in Bairnsdale; funding to build three five-bed mother and baby units for mothers experiencing a mental illness; and allocating 16 more mental health beds across Western Health, Eastern Health, Austin Health and the Latrobe Regional Hospital.10 It is not clear from the Budget Papers where the remaining funds have been allocated.

In 2011–12 the Victorian Government funding for mental health was as follows:

- $976.1 million funding for clinical services
- $95.1 million to Community Managed Mental Health (CMMH) services. Approximately 40% of this is directed to face-to-face outreach support and 20% to fund Day Programs.11 This represented approximately 8.88% of the total mental health budget and less than 1% (0.7%) of the total health budget
- $61 million for 95 new mental health inpatient beds12
- $7.8 million to build three four bed Psychiatric Assessment and Planning Units
- $6 million to build two, new five-bed regional mother-baby units
- An additional $16.3 ($67.8 million over four years) was for initiatives that include:
  - $13.7 million to hospitals to improve capacity
  - $1 million for capital improvements to PDRSS services

---

9 Ibid
• $1 million for a new intensive eating disorder day program at the Royal Children’s hospital
• Smaller amounts for advocacy ($0.1 million) and short stay assessment beds at Sunshine Hospital ($0.5 million)\(^{13}\).

With the advent of growth funds from the Federal Government, by 2015–16 it will be contributing around $127 million to fund CMMH services in Victoria and the State Government $104 million\(^{14}\).

**Key initiatives**

The Multiple and Complex Needs Initiative (MACNI) is a voluntary specialist service for people over 16 who are experiencing mental ill health or have multiple and complex needs. The MACNI involves an assessment of the individual, creation of a personalised care plan and intentional follow up. Although the initiative took effect in August 2004, the new legislation that employed a Central Eligibility and Review Group rather than the Department of Human Services MACN Panel took effect in 2009. This change was the result of many consultations and forums conducted in 2008 to review the progress and make changes that could enhance the work being conducted\(^{15}\).

The Victorian mental health workforce strategy\(^{16}\), which includes funding of $2.4 million over four years to establish a Mental Health Workforce Development and Innovation Institute.

In November 2012, the $10 million Mental Illness Research Fund (MIRF) was dispersed across five research projects. The aims of the research projects are to find improvements for individuals that experience mental ill health. Projects are focussed on use of online technology to promote self-management and recovery in people with psychosis ($1,966,610); the HORYZONS project: Moderated Online Social Therapy for Maintenance of Treatment Effects from Specialised First Episode Psychosis Services ($1,792,727); Getting to the CORE: testing a co-design technique to optimise psychosocial recovery outcomes for people affected by mental illness ($1,777,332); working together with shared values towards recovery-oriented practice – Principles Unite Local Services Assisting Recovery – the PULSAR project ($2,331,460); and developing an Australian-first recovery model for parents in Victorian mental health and family services ($1,855,891).

The Adult Prevention and Recovery Care (PARC) services came into effect in 2010, after trials in Melbourne and regional Victoria in 2003. The aims of adult PARC are to improve mental health outcomes and avoid preventable admissions to acute mental health units. By providing a mix of clinical and psychosocial service options the PARC initiative plans to supplements crisis intervention and improve access to inpatient services. Victoria currently has 14 adult PARCs\(^{17}\) and 2 youth PARCs (Y-PARC)\(^{18}\) in operation with an additional six adult PARCs in planning.

A new Therapeutic 4Cs drug and alcohol and drug support and counselling service has been proposed for Cranbourne\(^{19}\) with two others to be established in the Barwon-South West region and Melbourne’s outer east\(^{20}\). The Therapeutic 4Cs team provides services of counselling, consultancy and continuing care to individuals facing alcohol and drug issues.

The Victorian Department of Education and Early Childhood Development promote mental health within the framework ‘Promoting Healthy Minds for Living and Learning’\(^{21}\). The promotion is a component of the ‘Victorian Mental Health Reform Strategy 2009-2019’ and provides strategies to sustain each of the five areas:

---

\(^{13}\) Ibid
\(^{14}\) Psychiatric Disability Services of Victoria 2012. Community Managed Mental Health, An Agenda for the future consultation paper.
\(^{17}\) Press Release The Hon Mary Wooldridge MP, New youth mental health service opens in Dandenong, April 9, 2013.
\(^{19}\) Press Release The Hon Mary Wooldridge MP, Coalition delivers new counseling team for Casey, August 2, 2012.
safe inclusive and empowering environments
social and emotional learning
family, community and service partnerships
integrated mental health promotion
building capacity to promote mental health.\textsuperscript{22}

Results/achievements and independent reviews

In 2010–2011 among the states and territories, Victoria had the highest usage rates for both MBS-subsidised mental health-related patients and services (psychiatrist and allied mental health-related)\textsuperscript{23}. However, in 2010 it ranked last across Australia in terms of per capita State/Territory spending on mental health\textsuperscript{24}. It had the highest rate for non-residential psychiatric disability support services in 2010–2011\textsuperscript{25} and the highest rates of GP consultations for mental health issues (with NSW). It had the highest level of ‘separations’ per 1000 people (inpatient care occurrences) and the lowest rate of supported accommodation services per 100,000 people.

Responding to mental health crises in the community\textsuperscript{26}

This audit in 2009 assessed the coordination, preparation, and effectiveness of police, ambulance and mental health triage and Crisis Assessment and Treatment (CAT) service responses to mental health crises. The audit did not examine the broader mental health service system. The key areas assessed were whether:

- agency responses to mental health crises are coordinated
- agencies are adequately prepared to respond to mental health crises, and respond appropriately, and
- agencies can show the effectiveness of their responses to mental health crises.

The conclusion of the audit was that responses to mental health crises were not consistently meeting standards in the Mental Health Act 1986 or in interagency protocols. The needs of the person in crisis often came second to other considerations. It noted there was a demonstrated commitment from all agencies to improve responses to mental health crises, however greater coordination was needed along with efforts to ensure staff complied with protocols received appropriate training\textsuperscript{27}.

27 Ibid
Western Australia

In 2006, the ALP lead by Alan Carpenter, occupied the Treasury benches in WA. Carpenter had succeeded Geoff Gallop as Premier in 2006. Gallop stepped down as Premier and resigned from Parliament due to depression – an act seen by many as significant for the open acknowledgement of his mental illness.

The Barnett Coalition Government came to power in early 2009 and was recently re-elected with an increased majority in 2013. The Government appointed the first Mental Health Minister in its first term.

Policy development

Prior to the current mental health plan ‘Mental Health 2020: Making it personal and everybody’s business’ implemented by the Mental Health Commission in 2010, the Government of Western Australia employed a psychiatric rehabilitation policy and framework strategy ‘A Recovery Vision for Rehabilitation’. That policy was released in 2004 and focused on the need for a comprehensive recovery focused rehabilitation, targeted assertive and intensive case management as well as a range of supported housing options.1

Currently WA conforms to the 1996 Mental Health Act legislation. A new Bill on Mental Health was tabled in Parliament in November 2012 and submissions closed in February 2013. The WA Mental Health Commission is presently considering submissions and will provide advice to the Minister.2

Expenditure

The 2012–13 WA Budget shows an increase of close to $39.4 million for MHS (including drug and alcohol services) over four years. Overall the budget has estimated $483 million towards the delivery of mental health services over the 2012–2013 period. For 2013–14 an estimated amount of $515 million has been allocated with a further $549 million for the 2014–15 period. The total health budget estimated for 2012–13 was $6.76 billion. The mental health share of the budget was 7.1%.3

Mental health expenditure, WA and national ($) per capita4

<table>
<thead>
<tr>
<th>Spending Category</th>
<th>2010–11</th>
<th>Average annual change 2006-07 to 2010–11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WA Nat Avg</td>
<td>WA Nat Avg</td>
</tr>
<tr>
<td>Public psychiatric hospitals</td>
<td>35.41 23.69</td>
<td>-0.6 0.1</td>
</tr>
<tr>
<td>Specialised psychiatric units or wards in public acute hospitals</td>
<td>65.14 57.71</td>
<td>5.1 4.2</td>
</tr>
<tr>
<td>Community mental health care services</td>
<td>95.46 74.17</td>
<td>2.1 4.0</td>
</tr>
<tr>
<td>Residential mental health services</td>
<td>7.65 10.74</td>
<td>20.0 0.9</td>
</tr>
<tr>
<td>Grants to non-government-organisations</td>
<td>12.27 13.76</td>
<td>4.6 6.8</td>
</tr>
<tr>
<td>Other indirect expenditure</td>
<td>10.60 10.38</td>
<td>16.3 5.1</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>226.52 190.45</td>
<td>3.5 3.6</td>
</tr>
</tbody>
</table>

The overall WA expenditure on mental health per capita is higher than the national average in each year but not in each spending category. Although residential mental health services have increased 20% they are still lower than the average overall. In 2010, WA ranked second highest in terms of per capita spending on mental health as shown below.

4 Op Cit AIHW 2012.
Community mental health services

Community MHS are classified in national data collections to include mostly outpatient or ambulatory hospital activity, plus those community MHS still provided by the public system. It does not include community MHS provided by NGOs. WA spends the highest amount per capita on community MHS services, though its rate of growth over the past five years has been half the national average.

Community mental health care services spending national and WA, per capita 2010–11

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>$ Spending</th>
<th>Average Annual Change 2006–11 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat Avg</td>
<td>74.17</td>
<td>4.0</td>
</tr>
<tr>
<td>WA</td>
<td>95.46</td>
<td>2.1</td>
</tr>
</tbody>
</table>

WA is moving towards placing support closer to communities through a more decentralised spread of inpatient beds and the provision of individualised packages of support, some of which include the provision of housing. In relocating existing mental health resources and the building of new ones, in total WA is developing 257 extra inpatient beds including 50 sub-acute beds. WA has a lower than average number of mental health nurses per 100,000 people (59 against the national average of 69) and the highest length of stay in public acute hospitals for separations providing specialised care (18.5 days).

Funding breakdown:

Mental health diversion assistance and the justice system: $6.7 million

- $5 million to be provided over a two year period to trial a new MH court diversion and support program.
- $1.7 million to be provided over two years to place specialised MH expertise within the Perth Children’s Court

---

5 Op cit. AIHW 2013
Housing and community support services: $18.57 million

- $2.5 million will be allocated to a new six-bed mental health step up/step down service to operate in the Goldfields-Esperance region of WA. The service is planned to become available in 2014–15.
- $8.7 million over three years will fund 16 new homes that will assist people with mental health problems and complex needs.
- $4.6 million over four years to deliver 18 individualised support packages.
- $2.77 million over four years on drug and alcohol services for people exiting alcohol and other drug residential treatment programs.

Mental health legislation and reforms: $16.5 million

$20.1 million ($3.6 million transferred from the Department of the Attorney General) will go towards implementing key changes to the legislation proposed in the Mental Health Bill.

Key initiatives

The WA Government allocated funding of $15.3 million to a community based youth mental health service: The Early Psychosis Youth Centre (EPYC) aims to provide early psychosis intervention and treatment in a youth friendly environment and is expected to assist around 600 young people aged 15-24 a year. The centre is based on the model of care implemented by Orygen Health in Victoria. It will be phased in over four years and commences construction in 20149.

Construction has started on the new MH Unit at the Queen Elizabeth II Medical Centre (QEII), which will be a 30-bed unit with 12 secure beds. It will replace the current 36-bed unit at Charles Gardiner Hospital, and the remaining six beds will be relocated to the new Midland Health Campus.

The Joondalup sub-acute facility opened in April 2013 and can provide accommodation for 22 clients for up to 90 days. The facility will give people with an acute mental health disorder supportive care and prepare them to live successfully and independently in the community10. The facility will also allow people who are becoming unwell to receive support without having to go to hospital. In 2009 the Joondalup Health Campus’ 47-bed Mental Health Unit underwent a $12 million renovation.

The Individualised Community Living initiative provides 100 people with a mental illness with personalised support packages, funding and home based in the community. It involves collaboration between the Mental Health Commission, the Department of Housing, Department of Health and community service providers. The initiative was expanded in the 2012–13 Budget11.

In addition WA also has over a dozen help lines, including the Mental Health Emergency Response Line and Rurallink that are state funded and available 24 hours for advice and counselling.

Establishment of the WA Mental Health Commission

The Barnett Government was the first in Australia to establish a Mental Health Commission (2010). However the form of the Commission differed considerably from those in NZ, Canada and Ireland in that the functions of the Department of Health in all aspects of mental health were effectively transferred to the new Commission. The WAMHC became a service purchaser from the Department of Health (DOH) and also the ‘watchdog’ with responsibility for accountability and reporting.

The initial establishment period focused on the changes to the machinery of government and contractual arrangements with the DOH.

---

11 Govt of WA, 2012-13 Budget, Budget Statements, Budget Paper No. 2, Volume 2
Results/achievements

WA was the first jurisdiction in Australia to establish a Mental Health Commission and the third to appoint a Mental Health Minister. WA has also recently developed a Bill to replace the current mental health legislation the ‘Mental Health Act 1996’.

Figure 1: Joondalup sub-acute facility
Assessing performance

Government and independent reviews

In 2011, the government commissioned Gregor Henderson Limited to provide advice on the development of a Quality Assurance Framework for Mental Health in Western Australia. The report provided several recommendations including:

- create a mental health tribunal to protect the rights of users of services under involuntary status.
- develop an outcomes-based set of standards to help drive quality assurance.
- commission an independent evaluation and monitoring service\(^{12}\).

Professor Bryant Stokes conducted an independent review of the ‘admission or referral to and the discharge and transfer practices of public mental health facilities services in Western Australia’. Amongst the findings, the report noted that there appeared to be an absence of a single point of authority with responsibility for accountability of consumer care and consistent process and practices, and that these tensions were exacerbated by demand not being met by service provisions\(^{13}\).

The Government developed a WA Health Clinical Services Framework, which was finalised in December 2012. The framework expands on the existing 2005–2015 Clinical Services Framework, and provides an outline for health services in WA. Including the transformation of three hospitals: Osborne Park Hospital, Bentley Hospital, and Fremantle Hospital, into specialist hospitals that will focus on mental health, aged care, rehabilitation services and elective surgery\(^{14}\).

---


\(^{13}\) Stokes, B (2012), Review of the admission or referral to and discharge and transfer practices of public mental health facilities/services and Western Australia, July 2012. Government of Western Australia, 2012.

\(^{14}\) Health System Improvement Unit 2009. WA Health Clinical Services Framework 2010-2020. Department of Health Western Australia.
Appendix 3

Results from survey of community priorities for reforms
Survey 1: Community review of mental health services In Australia

1. Are you completing this survey as an individual or on behalf of an organisation?
   Individual 392 (86.0%)  Organisation 64 (14.0%)

2. Name of organisation (in alphabetical order)

| Access Community Services Ltd | Incapacitated (Veterans) Association |
| Access2HomeCare | Jacaranda Clubhouse Association Inc |
| ACT Women and Prisons Group | Job Centre Australia Keppel Community Care |
| Aftercare Redcliffe Barrier Breakers Inc | Macedonian Community Education and Support Services |
| Bravo Consulting Group Pty Ltd | Maroondah City Council Mission Australia |
| Carer Assist | Network of Alcohol and other Drugs Agencies (NADA) |
| Central Adelaide Local Health Network | NSW Health |
| Connections Inc | Open Minds |
| FSG Australia | Our Place Wellness Centre Inc. (Innisfail) |
| Helping Hand Aged Care | Paul Hopkins Medical Center |
| Hervey Bay GEMS Peer operated MH Respite and Support Accommodation | Prevention Australia |
| IAIM Australia | Sally’s Place Learning Centre/Templar Training |
| | SFNSW |
| | SHIPS (Satellite Housing Integrated Support) |
| | SNSW LHD |
| | South Western Sydney |
| | S Vincent de Paul compeer |
| | St Vincent’s Private Stepping Up Consortium |
| | Tarampa Lodge Ted Noffs Foundation |
| | Totally and Permanently |
| | Victorian Mental Illness Awareness Council |
| | Western NSW Health |

3. Please select ONE of the following descriptions which BEST describes your position, interest or role in the mental health sector, or the position or role of your organisation:

<table>
<thead>
<tr>
<th>Description</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer of mental health services</td>
<td>139 (30.5)</td>
</tr>
<tr>
<td>Carer of a person with a mental illness</td>
<td>48 (10.5)</td>
</tr>
<tr>
<td>Consumer or carer advocacy group</td>
<td>10 (2.2)</td>
</tr>
<tr>
<td>Public provider of specialist treatment</td>
<td>52 (11.4)</td>
</tr>
<tr>
<td>Private provider of specialist treatment</td>
<td>11 (2.4)</td>
</tr>
<tr>
<td>Provider of early intervention services</td>
<td>4 (0.9)</td>
</tr>
</tbody>
</table>
### Obsessive Hope Disorder

<table>
<thead>
<tr>
<th>Category</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Medicare Local</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>Divisions of General Practice</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Non-government community service provider</td>
<td>85</td>
<td>18.7</td>
</tr>
<tr>
<td>Mental health promotion or education</td>
<td>23</td>
<td>5.1</td>
</tr>
<tr>
<td>Mental health research or evaluation</td>
<td>12</td>
<td>2.6</td>
</tr>
<tr>
<td>Health policy maker or advisor</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>Human services agency other than health</td>
<td>9</td>
<td>2.0</td>
</tr>
<tr>
<td>Other</td>
<td>53</td>
<td>11.6</td>
</tr>
</tbody>
</table>

#### 4. Jurisdiction

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales and Australian Capital Territory</td>
<td>151</td>
<td>33.3</td>
</tr>
<tr>
<td>Victoria</td>
<td>75</td>
<td>16.6</td>
</tr>
<tr>
<td>Queensland</td>
<td>158</td>
<td>34.9</td>
</tr>
<tr>
<td>South Australia and Northern Territory</td>
<td>33</td>
<td>7.3</td>
</tr>
<tr>
<td>Western Australia</td>
<td>17</td>
<td>3.8</td>
</tr>
<tr>
<td>Tasmania</td>
<td>19</td>
<td>4.2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>453</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table A 3.1: ALL RESPONDENTS: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.

<table>
<thead>
<tr>
<th>Priority</th>
<th>N</th>
<th>Don’t know or can’t say</th>
<th>No action OR no support</th>
<th>Discussion OR low level support</th>
<th>Implementation OR moderate support</th>
<th>Nearly complete OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Provision of early intervention services</td>
<td>338</td>
<td>74 (21.9)</td>
<td>61 (18.0)</td>
<td>97 (28.7)</td>
<td>81 (24.0)</td>
<td>17 (5.0)</td>
</tr>
<tr>
<td>7. Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>337</td>
<td>66 (19.6)</td>
<td>82 (24.3)</td>
<td>90 (26.7)</td>
<td>70 (20.8)</td>
<td>20 (5.9)</td>
</tr>
<tr>
<td>8. Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>336</td>
<td>59 (17.6)</td>
<td>87 (25.9)</td>
<td>89 (26.5)</td>
<td>74 (22.0)</td>
<td>19 (5.7)</td>
</tr>
<tr>
<td>9. Implementation of the national standards for mental health services</td>
<td>334</td>
<td>110 (32.9)</td>
<td>39 (11.7)</td>
<td>76 (22.8)</td>
<td>72 (21.6)</td>
<td>30 (9.0)</td>
</tr>
<tr>
<td>10. Programs that promote attitudinal change among mental health workers</td>
<td>334</td>
<td>109 (32.6)</td>
<td>81 (24.3)</td>
<td>69 (20.7)</td>
<td>45 (13.5)</td>
<td>21 (6.3)</td>
</tr>
<tr>
<td>11. Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns and initiatives)</td>
<td>332</td>
<td>49 (14.8)</td>
<td>84 (25.3)</td>
<td>93 (28.0)</td>
<td>73 (22.2)</td>
<td>22 (6.6)</td>
</tr>
<tr>
<td>12. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>332</td>
<td>94 (28.3)</td>
<td>68 (20.5)</td>
<td>81 (24.4)</td>
<td>60 (18.1)</td>
<td>19 (5.7)</td>
</tr>
<tr>
<td>13. Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>332</td>
<td>93 (28.0)</td>
<td>61 (18.4)</td>
<td>85 (25.6)</td>
<td>69 (20.8)</td>
<td>15 (4.5)</td>
</tr>
<tr>
<td>14. Genuine consumer participation</td>
<td>331</td>
<td>57 (17.2)</td>
<td>62 (18.7)</td>
<td>113 (34.1)</td>
<td>74 (22.4)</td>
<td>15 (4.5)</td>
</tr>
<tr>
<td>15. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>331</td>
<td>83 (25.1)</td>
<td>93 (28.1)</td>
<td>84 (25.4)</td>
<td>50 (15.1)</td>
<td>13 (3.9)</td>
</tr>
<tr>
<td>Priority</td>
<td>N</td>
<td>Don’t know or can’t say</td>
<td>No action taken OR no support</td>
<td>Discussion and planning OR low level support</td>
<td>Implementation begun OR moderate support</td>
<td>Nearly complete OR high level support</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----</td>
<td>------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>16. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>331</td>
<td>82 (24.8)</td>
<td>77 (23.3)</td>
<td>97 (29.3)</td>
<td>54 (16.3)</td>
<td>17 (5.1)</td>
</tr>
<tr>
<td>17. Genuine carer participation</td>
<td>331</td>
<td>83 (25.1)</td>
<td>72 (21.8)</td>
<td>111 (33.5)</td>
<td>39 (11.8)</td>
<td>17 (5.1)</td>
</tr>
<tr>
<td>18. Support for enhanced role of non-governmental organisations in all aspects of care</td>
<td>331</td>
<td>67 (20.2)</td>
<td>70 (21.1)</td>
<td>85 (25.7)</td>
<td>77 (23.3)</td>
<td>25 (7.6)</td>
</tr>
<tr>
<td>19. Clear accountability for expenditure of mental health strategy funds</td>
<td>331</td>
<td>178 (53.8)</td>
<td>76 (23.0)</td>
<td>39 (11.8)</td>
<td>20 (6.0)</td>
<td>9 (2.7)</td>
</tr>
<tr>
<td>20. Clearly defined roles for the primary care, community care and specialist workforces</td>
<td>331</td>
<td>111 (33.5)</td>
<td>82 (24.8)</td>
<td>74 (22.4)</td>
<td>38 (11.5)</td>
<td>20 (6.0)</td>
</tr>
<tr>
<td>21. Devolution of service planning to local level</td>
<td>331</td>
<td>162 (48.9)</td>
<td>55 (16.6)</td>
<td>62 (18.7)</td>
<td>41 (12.4)</td>
<td>6 (1.8)</td>
</tr>
</tbody>
</table>

Table A 3.2 ALL RESPONDENTS: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.
<table>
<thead>
<tr>
<th></th>
<th>Clear accountability for expenditure of mental health strategy funds</th>
<th>282</th>
<th>137 (48.6)</th>
<th>59 (20.9)</th>
<th>50 (17.7)</th>
<th>22 (7.8)</th>
<th>6 (2.1)</th>
<th>8 (2.8)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ongoing support for suicide prevention campaigns</td>
<td>282</td>
<td>64 (22.7)</td>
<td>40 (14.2)</td>
<td>91 (32.3)</td>
<td>61 (21.6)</td>
<td>22 (7.8)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td></td>
<td>Development of datasets for monitoring the quality of local services</td>
<td>282</td>
<td>127 (45.0)</td>
<td>49 (10.3)</td>
<td>51 (10.7)</td>
<td>32 (11.3)</td>
<td>19 (6.7)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td></td>
<td>Service development for those in forensic (i.e. prison-based) services</td>
<td>282</td>
<td>159 (56.4)</td>
<td>39 (13.8)</td>
<td>41 (14.5)</td>
<td>28 (9.9)</td>
<td>11 (3.9)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td></td>
<td>Specification of clear primary care, community care and specialist workforces</td>
<td>282</td>
<td>109 (38.7)</td>
<td>57 (20.2)</td>
<td>66 (23.4)</td>
<td>36 (12.8)</td>
<td>7 (2.5)</td>
<td>7 (2.5)</td>
</tr>
<tr>
<td></td>
<td>Service enhancement for persons from culturally-and linguistically-diverse backgrounds</td>
<td>281</td>
<td>100 (35.6)</td>
<td>29 (10.3)</td>
<td>83 (29.5)</td>
<td>54 (19.2)</td>
<td>12 (4.3)</td>
<td>3 (1.1)</td>
</tr>
<tr>
<td></td>
<td>Support for community leadership in mental health</td>
<td>281</td>
<td>76 (27.0)</td>
<td>85 (30.2)</td>
<td>77 (27.4)</td>
<td>33 (11.7)</td>
<td>6 (2.1)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td></td>
<td>Support for professional leadership in mental health</td>
<td>281</td>
<td>94 (33.5)</td>
<td>59 (21.0)</td>
<td>62 (22.1)</td>
<td>46 (16.4)</td>
<td>16 (5.7)</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td></td>
<td>Development of specific procedures for reporting Human Rights abuses or neglect</td>
<td>281</td>
<td>108 (38.4)</td>
<td>62 (22.1)</td>
<td>51 (18.1)</td>
<td>37 (13.2)</td>
<td>15 (5.3)</td>
<td>8 (2.8)</td>
</tr>
<tr>
<td></td>
<td>Increased support for stigma reduction campaigns</td>
<td>281</td>
<td>53 (18.9)</td>
<td>87 (31.0)</td>
<td>85 (30.2)</td>
<td>38 (13.5)</td>
<td>14 (5.0)</td>
<td>4 (1.4)</td>
</tr>
</tbody>
</table>

If you are in a regional or rural area of Australia, please answer the following question.

38. IN YOUR STATE, what is the level of support for service development in rural and regional areas? 163 40 (24.5) 49 (30.1) 48 (29.4) 24 (14.7) 1 (0.6) 1 (0.6)

If you are in a poorly resourced area of Australia, please answer the following question.

39. IN YOUR STATE, what is the level of support for service development in poorly resourced areas? 151 50 (33.1) 55 (36.4) 37 (24.5) 7 (4.6) 2 (1.3) 0
Table A 3.3: NEW SOUTH WALES AND THE AUSTRALIAN CAPITAL TERRITORY: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.

<table>
<thead>
<tr>
<th>Priority</th>
<th>N</th>
<th>Don’t know or can’t say</th>
<th>No action</th>
<th>No support</th>
<th>Discussion planning OR low level support</th>
<th>Implementation begun OR moderate support</th>
<th>Nearly complete OR high level support</th>
<th>Fully implemented OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Provision of early intervention services</td>
<td>110</td>
<td>29 (26.4)</td>
<td>16 (14.5)</td>
<td>28 (25.5)</td>
<td>30 (27.3)</td>
<td>4 (3.6)</td>
<td>3 (2.7)</td>
<td></td>
</tr>
<tr>
<td>7. Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>110</td>
<td>28 (25.5)</td>
<td>24 (21.8)</td>
<td>27 (24.5)</td>
<td>23 (20.9)</td>
<td>7 (6.4)</td>
<td>1 (0.9)</td>
<td></td>
</tr>
<tr>
<td>8. Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>110</td>
<td>28 (25.5)</td>
<td>28 (25.5)</td>
<td>22 (20.0)</td>
<td>25 (22.7)</td>
<td>5 (4.5)</td>
<td>2 (1.8)</td>
<td></td>
</tr>
<tr>
<td>9. Implementation of the national standards for mental health services</td>
<td>109</td>
<td>41 (37.6)</td>
<td>10 (9.2)</td>
<td>27 (24.8)</td>
<td>22 (20.2)</td>
<td>6 (5.5)</td>
<td>3 (2.8)</td>
<td></td>
</tr>
<tr>
<td>10. Programs that promote attitudinal change among mental health workers</td>
<td>109</td>
<td>42 (38.5)</td>
<td>29 (26.6)</td>
<td>20 (18.3)</td>
<td>11 (10.1)</td>
<td>5 (4.6)</td>
<td>2 (1.8)</td>
<td></td>
</tr>
<tr>
<td>11. Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns and initiatives)</td>
<td>108</td>
<td>23 (21.3)</td>
<td>25 (23.1)</td>
<td>23 (21.3)</td>
<td>26 (24.1)</td>
<td>9 (8.3)</td>
<td>2 (1.9)</td>
<td></td>
</tr>
<tr>
<td>12. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>108</td>
<td>40 (37.0)</td>
<td>21 (19.4)</td>
<td>21 (19.4)</td>
<td>19 (17.6)</td>
<td>4 (3.7)</td>
<td>3 (2.8)</td>
<td></td>
</tr>
<tr>
<td>13. Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>108</td>
<td>42 (38.9)</td>
<td>15 (13.9)</td>
<td>25 (23.1)</td>
<td>19 (17.6)</td>
<td>6 (5.6)</td>
<td>1 (0.9)</td>
<td></td>
</tr>
<tr>
<td>14. Genuine consumer participation</td>
<td>108</td>
<td>25 (23.1)</td>
<td>19 (17.6)</td>
<td>32 (29.6)</td>
<td>25 (23.1)</td>
<td>3 (2.8)</td>
<td>4 (3.7)</td>
<td></td>
</tr>
<tr>
<td>15. Direct support for 'innovation', 'research' and 'service evaluation' in mental health</td>
<td>108</td>
<td>35 (32.4)</td>
<td>25 (23.1)</td>
<td>23 (21.3)</td>
<td>16 (14.8)</td>
<td>7 (6.5)</td>
<td>2 (1.9)</td>
<td></td>
</tr>
</tbody>
</table>
16. Introduction of specific schemes to enhance access to mental health specialists 108 37 (34.3) 24 (22.2) 29 (26.9) 12 (11.1) 5 (4.6) 1 (0.9)

17. Genuine carer participation 108 34 (31.5) 23 (21.3) 32 (29.6) 12 (11.1) 4 (3.7) 3 (2.8)

18. Support for enhanced role of non-government organisations in all aspects of care 108 31 (28.7) 15 (13.9) 25 (23.1) 26 (24.1) 11 (10.2) 0

19. Clear accountability for expenditure of mental health strategy funds 108 70 (64.8) 16 (14.8) 11 (10.2) 6 (5.6) 2 (1.9) 3 (2.8)

20. Clearly defined roles for the primary care, community care and specialist workforces 108 52 (48.1) 25 (23.1) 16 (14.8) 8 (7.4) 5 (4.6) 2 (1.9)

21. Devolution of service planning to local level 108 62 (57.4) 16 (14.8) 18 (16.7) 10 (9.3) 0 2 (1.9)

Table A 3.4 NEW SOUTH WALES AND THE AUSTRALIAN CAPITAL TERRITORY: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.

<table>
<thead>
<tr>
<th>Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.</th>
<th>N</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Don’t know or can’t say</td>
</tr>
<tr>
<td>22. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>92</td>
<td>41 (44.6)</td>
</tr>
<tr>
<td>23. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>92</td>
<td>38 (41.3)</td>
</tr>
<tr>
<td>24. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>92</td>
<td>36 (39.1)</td>
</tr>
<tr>
<td>25. Support for specific disease prevention initiatives (e.g. in anxiety, depression, alcohol or other substance misuse)</td>
<td>92</td>
<td>16 (17.4)</td>
</tr>
<tr>
<td>26. Support for general mental health promotion</td>
<td>92</td>
<td>14 (15.2)</td>
</tr>
<tr>
<td>27. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>92</td>
<td>37 (40.2)</td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>92</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>28</td>
<td>Clear accountability for expenditure of mental health strategy funds</td>
<td>92</td>
</tr>
<tr>
<td>29</td>
<td>Ongoing support for suicide prevention campaigns</td>
<td>92</td>
</tr>
<tr>
<td>30</td>
<td>Development of datasets for monitoring the quality of local services</td>
<td>92</td>
</tr>
<tr>
<td>31</td>
<td>Service development for those in forensic (i.e. prison-based) services</td>
<td>92</td>
</tr>
<tr>
<td>32</td>
<td>Specification of clear primary care, community care and specialist workforces</td>
<td>92</td>
</tr>
<tr>
<td>33</td>
<td>Service enhancement for persons from culturally-and linguistically-diverse backgrounds</td>
<td>92</td>
</tr>
<tr>
<td>34</td>
<td>Support for community leadership in mental health</td>
<td>92</td>
</tr>
<tr>
<td>35</td>
<td>Support for professional leadership in mental health</td>
<td>92</td>
</tr>
<tr>
<td>36</td>
<td>Development of specific procedures for reporting Human Rights abuses or neglect</td>
<td>92</td>
</tr>
<tr>
<td>37</td>
<td>Increased support for stigma reduction campaigns</td>
<td>92</td>
</tr>
</tbody>
</table>

If you are in a regional or rural area of Australia, please answer the following question.

38. IN YOUR STATE, what is the level of support for service development in rural and regional areas?

|   | Question                                                                 | 63 | 19 (30.2) | 16 (25.4) | 16 (25.4) | 11 (17.5) | 1 (1.6) | 0 |

If you are in a poorly resourced area of Australia, please answer the following question.

39. IN YOUR STATE, what is the level of support for service development in poorly resourced areas?

|   | Question                                                                 | 56 | 26 (46.4) | 13 (23.2) | 14 (25.0) | 1 (1.8) | 2 (3.6) | 0 |
Table A 3.5 VICTORIA: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.

<table>
<thead>
<tr>
<th>Priority</th>
<th>N</th>
<th>Don’t know or can’t say</th>
<th>No action or no support</th>
<th>Discussion planning or low level support</th>
<th>Implementation begun or moderate support</th>
<th>Nearly complete or high level support</th>
<th>Fully implemented or full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of early intervention services</td>
<td>58</td>
<td>17 (29.3)</td>
<td>9 (15.5)</td>
<td>12 (20.7)</td>
<td>16 (27.6)</td>
<td>3 (5.2)</td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>57</td>
<td>15 (26.3)</td>
<td>11 (19.3)</td>
<td>12 (21.1)</td>
<td>14 (24.6)</td>
<td>2 (3.5)</td>
<td>3 (5.3)</td>
</tr>
<tr>
<td>Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>57</td>
<td>10 (17.5)</td>
<td>14 (24.6)</td>
<td>12 (21.1)</td>
<td>15 (26.3)</td>
<td>4 (7.0)</td>
<td>2 (3.5)</td>
</tr>
<tr>
<td>Implementation of the national standards for mental health services</td>
<td>57</td>
<td>20 (35.1)</td>
<td>7 (12.3)</td>
<td>11 (19.3)</td>
<td>12 (21.1)</td>
<td>7 (12.3)</td>
<td>0</td>
</tr>
<tr>
<td>Programs that promote attitudinal change among mental health workers</td>
<td>57</td>
<td>23 (40.4)</td>
<td>9 (15.8)</td>
<td>12 (21.1)</td>
<td>11 (19.3)</td>
<td>1 (1.8)</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns and initiatives)</td>
<td>57</td>
<td>10 (17.5)</td>
<td>14 (24.6)</td>
<td>14 (24.6)</td>
<td>13 (22.8)</td>
<td>3 (5.3)</td>
<td>3 (5.3)</td>
</tr>
<tr>
<td>Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>57</td>
<td>16 (28.1)</td>
<td>11 (19.3)</td>
<td>12 (21.1)</td>
<td>10 (17.5)</td>
<td>5 (8.8)</td>
<td>3 (5.3)</td>
</tr>
<tr>
<td>Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>57</td>
<td>15 (26.3)</td>
<td>10 (17.5)</td>
<td>11 (19.3)</td>
<td>15 (26.3)</td>
<td>2 (3.5)</td>
<td>4 (7.0)</td>
</tr>
<tr>
<td>Genuine consumer participation</td>
<td>56</td>
<td>13 (23.2)</td>
<td>13 (23.2)</td>
<td>12 (21.4)</td>
<td>13 (23.2)</td>
<td>3 (5.4)</td>
<td>2 (3.6)</td>
</tr>
<tr>
<td>Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>56</td>
<td>15 (26.8)</td>
<td>12 (21.4)</td>
<td>15 (26.8)</td>
<td>8 (14.3)</td>
<td>2 (3.6)</td>
<td>4 (7.1)</td>
</tr>
<tr>
<td>Introduction of specific schemes to enhance access to mental health specialists</td>
<td>56</td>
<td>14 (25.0)</td>
<td>16 (28.6)</td>
<td>10 (17.9)</td>
<td>9 (16.1)</td>
<td>6 (10.7)</td>
<td>1 (1.8)</td>
</tr>
<tr>
<td>Priority</td>
<td>N</td>
<td>Don’t know or can’t say</td>
<td>No action OR no support</td>
<td>Discussion OR low level support</td>
<td>Implementation OR moderate support</td>
<td>Nearly OR high level support</td>
<td>Fully implemented OR full support</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----</td>
<td>-------------------------</td>
<td>-------------------------</td>
<td>---------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>22. Development of specific intergovernmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>44</td>
<td>16 (36.4)</td>
<td>5 (11.4)</td>
<td>15 (34.1)</td>
<td>5 (11.4)</td>
<td>3 (6.8)</td>
<td>0</td>
</tr>
<tr>
<td>23. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>44</td>
<td>17 (38.6)</td>
<td>7 (15.9)</td>
<td>12 (27.3)</td>
<td>4 (9.1)</td>
<td>3 (6.8)</td>
<td>1 (2.3)</td>
</tr>
<tr>
<td>24. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>44</td>
<td>11 (25.0)</td>
<td>9 (20.5)</td>
<td>11 (25.0)</td>
<td>10 (22.7)</td>
<td>2 (4.5)</td>
<td>1 (2.3)</td>
</tr>
<tr>
<td>25. Support for specific disease prevention initiatives (e.g. in anxiety, depression, alcohol or other substance misuse)</td>
<td>44</td>
<td>9 (20.5)</td>
<td>9 (20.5)</td>
<td>12 (27.3)</td>
<td>11 (25.0)</td>
<td>3 (6.8)</td>
<td>0</td>
</tr>
<tr>
<td>26. Support for general mental health promotion</td>
<td>44</td>
<td>8 (18.2)</td>
<td>5 (11.4)</td>
<td>18 (40.9)</td>
<td>8 (18.2)</td>
<td>5 (11.4)</td>
<td>0</td>
</tr>
<tr>
<td>27. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>44</td>
<td>12 (27.3)</td>
<td>6 (13.6)</td>
<td>12 (27.3)</td>
<td>11 (25.0)</td>
<td>2 (4.5)</td>
<td>1 (2.3)</td>
</tr>
</tbody>
</table>

Table A 3.6 VICTORIA: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.
<table>
<thead>
<tr>
<th>28. Clear accountability for expenditure of mental health strategy funds</th>
<th>44</th>
<th>24 (54.5)</th>
<th>5 (11.4)</th>
<th>11 (25.0)</th>
<th>1 (2.3)</th>
<th>3 (6.8)</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Ongoing support for suicide prevention campaigns</td>
<td>44</td>
<td>15 (34.1)</td>
<td>5 (11.4)</td>
<td>12 (27.3)</td>
<td>8 (18.2)</td>
<td>4 (9.1)</td>
<td>0</td>
</tr>
<tr>
<td>30. Development of datasets for monitoring the quality of local services</td>
<td>44</td>
<td>22 (50.0)</td>
<td>7 (15.9)</td>
<td>7 (15.9)</td>
<td>6 (13.6)</td>
<td>1 (2.3)</td>
<td>1 (2.3)</td>
</tr>
<tr>
<td>31. Service development for those in forensic (i.e. prison-based) services</td>
<td>44</td>
<td>25 (56.8)</td>
<td>9 (20.5)</td>
<td>6 (13.6)</td>
<td>1 (2.3)</td>
<td>1 (2.3)</td>
<td>0</td>
</tr>
<tr>
<td>32. Specification of clear primary care, community care and specialist workforces</td>
<td>44</td>
<td>23 (52.3)</td>
<td>5 (11.4)</td>
<td>9 (20.5)</td>
<td>5 (11.4)</td>
<td>1 (2.3)</td>
<td>1 (2.3)</td>
</tr>
<tr>
<td>33. Service enhancement for persons from culturally- and linguistically-diverse backgrounds</td>
<td>44</td>
<td>21 (47.7)</td>
<td>3 (6.8)</td>
<td>12 (27.3)</td>
<td>6 (13.6)</td>
<td>2 (4.5)</td>
<td>0</td>
</tr>
<tr>
<td>34. Support for community leadership in mental health</td>
<td>44</td>
<td>13 (29.5)</td>
<td>16 (36.4)</td>
<td>11 (25.0)</td>
<td>3 (6.8)</td>
<td>1 (2.3)</td>
<td>0</td>
</tr>
<tr>
<td>35. Support for professional leadership in mental health</td>
<td>44</td>
<td>19 (43.2)</td>
<td>6 (13.6)</td>
<td>9 (20.5)</td>
<td>8 (18.2)</td>
<td>2 (4.5)</td>
<td>0</td>
</tr>
<tr>
<td>36. Development of specific procedures for reporting Human Rights abuses or neglect</td>
<td>44</td>
<td>22 (50.0)</td>
<td>8 (18.2)</td>
<td>6 (13.6)</td>
<td>6 (13.6)</td>
<td>2 (4.5)</td>
<td>0</td>
</tr>
<tr>
<td>37. Increased support for stigma reduction campaigns</td>
<td>44</td>
<td>10 (22.7)</td>
<td>10 (22.7)</td>
<td>13 (29.5)</td>
<td>10 (22.7)</td>
<td>1 (2.3)</td>
<td>0</td>
</tr>
<tr>
<td>If you are in a regional or rural area of Australia, please answer the following question.</td>
<td>38. IN YOUR STATE, what is the level of support for service development in rural and regional areas?</td>
<td>16</td>
<td>4 (25.0)</td>
<td>4 (25.0)</td>
<td>6 (37.5)</td>
<td>2 (12.5)</td>
<td>0</td>
</tr>
<tr>
<td>If you are in a poorly resourced area of Australia, please answer the following question.</td>
<td>39. IN YOUR STATE, what is the level of support for service development in poorly resourced areas?</td>
<td>14</td>
<td>4 (28.6)</td>
<td>7 (50.0)</td>
<td>2 (14.3)</td>
<td>1 (7.1)</td>
<td>0</td>
</tr>
</tbody>
</table>
Table A 3.7 QUEENSLAND: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.

<table>
<thead>
<tr>
<th>Priority</th>
<th>N</th>
<th>Don’t know or can’t say</th>
<th>No action taken OR no support</th>
<th>Discussion planning OR low level support</th>
<th>Implementation begun OR moderate support</th>
<th>Nearly complete OR high level support</th>
<th>Fully implemented OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Provision of early intervention services</td>
<td>116</td>
<td>18 (15.5)</td>
<td>25 (21.6)</td>
<td>33 (28.4)</td>
<td>26 (22.4)</td>
<td>10 (8.6)</td>
<td>4 (3.4)</td>
</tr>
<tr>
<td>7. Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>116</td>
<td>13 (11.2)</td>
<td>29 (25.0)</td>
<td>37 (31.9)</td>
<td>23 (19.8)</td>
<td>10 (8.6)</td>
<td>4 (3.4)</td>
</tr>
<tr>
<td>8. Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>115</td>
<td>10 (8.7)</td>
<td>26 (22.6)</td>
<td>39 (33.9)</td>
<td>26 (22.6)</td>
<td>10 (8.7)</td>
<td>4 (3.5)</td>
</tr>
<tr>
<td>9. Implementation of the national standards for mental health services</td>
<td>115</td>
<td>24 (20.9)</td>
<td>15 (13.0)</td>
<td>29 (25.2)</td>
<td>27 (23.5)</td>
<td>16 (13.9)</td>
<td>4 (3.5)</td>
</tr>
<tr>
<td>10. Programs that promote attitudinal change among mental health workers</td>
<td>115</td>
<td>24 (20.9)</td>
<td>31 (27.0)</td>
<td>27 (23.5)</td>
<td>15 (13.0)</td>
<td>13 (11.3)</td>
<td>5 (4.3)</td>
</tr>
<tr>
<td>11. Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns and initiatives)</td>
<td>115</td>
<td>8 (7.0)</td>
<td>37 (32.2)</td>
<td>38 (33.0)</td>
<td>18 (15.7)</td>
<td>9 (7.8)</td>
<td>5 (4.3)</td>
</tr>
<tr>
<td>12. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>115</td>
<td>21 (18.3)</td>
<td>21 (18.3)</td>
<td>35 (30.4)</td>
<td>25 (21.7)</td>
<td>9 (7.8)</td>
<td>4 (3.5)</td>
</tr>
<tr>
<td>13. Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>115</td>
<td>18 (15.7)</td>
<td>21 (18.3)</td>
<td>36 (31.3)</td>
<td>30 (26.1)</td>
<td>6 (5.2)</td>
<td>4 (3.5)</td>
</tr>
<tr>
<td>14. Genuine consumer participation</td>
<td>115</td>
<td>12 (10.4)</td>
<td>15 (13.0)</td>
<td>49 (42.6)</td>
<td>26 (22.6)</td>
<td>9 (7.8)</td>
<td>4 (3.5)</td>
</tr>
<tr>
<td>15. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>115</td>
<td>19 (16.5)</td>
<td>38 (33.0)</td>
<td>36 (31.3)</td>
<td>16 (13.9)</td>
<td>4 (3.5)</td>
<td>2 (1.7)</td>
</tr>
<tr>
<td>16. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>115</td>
<td>20 (17.4)</td>
<td>26 (22.6)</td>
<td>40 (34.8)</td>
<td>21 (18.3)</td>
<td>6 (5.2)</td>
<td>2 (1.7)</td>
</tr>
</tbody>
</table>
### Table A 3.8 QUEENSLAND: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.

<table>
<thead>
<tr>
<th>Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.</th>
<th>N</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Don’t know or can’t say</td>
</tr>
<tr>
<td>17. Genuine carer participation</td>
<td>115</td>
<td>22 (19.1)</td>
</tr>
<tr>
<td>18. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>115</td>
<td>10 (8.7)</td>
</tr>
<tr>
<td>19. Clear accountability for expenditure of mental health strategy funds</td>
<td>115</td>
<td>54 (47.0)</td>
</tr>
<tr>
<td>20. Clearly defined roles for the primary care, community care and specialist workforces</td>
<td>115</td>
<td>23 (20.0)</td>
</tr>
<tr>
<td>21. Devolution of service planning to local level</td>
<td>102</td>
<td>30 (29.4)</td>
</tr>
<tr>
<td>22. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>102</td>
<td>25 (24.5)</td>
</tr>
<tr>
<td>23. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>102</td>
<td>22 (21.6)</td>
</tr>
<tr>
<td>24. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>102</td>
<td>13 (12.7)</td>
</tr>
<tr>
<td>25. Support for specific disease prevention initiatives (e.g. in anxiety, depression, alcohol or other substance misuse)</td>
<td>102</td>
<td>13 (12.7)</td>
</tr>
<tr>
<td>26. Support for general mental health promotion</td>
<td>102</td>
<td>14 (13.9)</td>
</tr>
<tr>
<td>27. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>101</td>
<td>41 (40.2)</td>
</tr>
</tbody>
</table>
### Obsessive Hope Disorder

<table>
<thead>
<tr>
<th>29. Ongoing support for suicide prevention campaigns</th>
<th>102</th>
<th>18 (17.6)</th>
<th>19 (18.6)</th>
<th>33 (32.4)</th>
<th>19 (18.6)</th>
<th>10 (9.8)</th>
<th>3 (2.9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Development of datasets for monitoring the quality of local services</td>
<td>102</td>
<td>36 (35.3)</td>
<td>22 (21.6)</td>
<td>20 (19.6)</td>
<td>10 (9.8)</td>
<td>12 (11.8)</td>
<td>2 (2.0)</td>
</tr>
<tr>
<td>31. Service development for those in forensic (i.e. prison-based) services</td>
<td>102</td>
<td>51 (50.0)</td>
<td>16 (15.7)</td>
<td>20 (19.6)</td>
<td>9 (8.8)</td>
<td>6 (5.9)</td>
<td>0</td>
</tr>
<tr>
<td>32. Specification of clear primary care, community care and specialist workforces</td>
<td>102</td>
<td>30 (29.4)</td>
<td>29 (28.4)</td>
<td>23 (22.5)</td>
<td>12 (11.8)</td>
<td>3 (2.9)</td>
<td>5 (4.9)</td>
</tr>
<tr>
<td>33. Service enhancement for persons from culturally- and linguistically-diverse backgrounds</td>
<td>101</td>
<td>27 (26.7)</td>
<td>14 (13.9)</td>
<td>33 (32.7)</td>
<td>19 (18.8)</td>
<td>6 (5.9)</td>
<td>2 (2.0)</td>
</tr>
<tr>
<td>34. Support for community leadership in mental health</td>
<td>101</td>
<td>17 (16.8)</td>
<td>38 (37.6)</td>
<td>23 (22.8)</td>
<td>16 (15.8)</td>
<td>3 (3.0)</td>
<td>4 (4.0)</td>
</tr>
<tr>
<td>35. Support for professional leadership in mental health</td>
<td>101</td>
<td>20 (19.8)</td>
<td>32 (31.7)</td>
<td>23 (22.8)</td>
<td>16 (15.8)</td>
<td>6 (5.9)</td>
<td>4 (4.0)</td>
</tr>
<tr>
<td>36. Development of specific procedures for reporting Human Rights abuses or neglect</td>
<td>101</td>
<td>28 (27.7)</td>
<td>28 (27.7)</td>
<td>18 (17.8)</td>
<td>16 (15.8)</td>
<td>6 (5.9)</td>
<td>5 (5.0)</td>
</tr>
<tr>
<td>37. Increased support for stigma reduction campaigns</td>
<td>101</td>
<td>14 (13.9)</td>
<td>37 (36.6)</td>
<td>27 (26.7)</td>
<td>14 (13.9)</td>
<td>5 (5.0)</td>
<td>4 (4.0)</td>
</tr>
</tbody>
</table>

If you are in a regional or rural area of Australia, please answer the following question.

38. IN YOUR STATE, what is the level of support for service development in rural and regional areas?

| 62 | 14 (22.6) | 20 (32.3) | 18 (29.0) | 9 (14.5) | 0 | 1 (1.6) |

If you are in a poorly resourced area of Australia, please answer the following question.

39. IN YOUR STATE, what is the level of support for service development in poorly resourced areas?

<p>| 57 | 17 (29.8) | 22 (38.6) | 14 (24.6) | 4 (7.0) | 0 | 0 |</p>
<table>
<thead>
<tr>
<th>Priority</th>
<th>N</th>
<th>Don’t know or can’t say</th>
<th>No action OR no support</th>
<th>Discussion planning OR no level support</th>
<th>Implementation begun OR moderate support</th>
<th>Nearly complete OR high support</th>
<th>Fully implemented OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Provision of early intervention services</td>
<td>21</td>
<td>4 (19.0)</td>
<td>4 (19.0)</td>
<td>9 (42.9)</td>
<td>4 (19.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>21</td>
<td>2 (9.5)</td>
<td>10 (47.6)</td>
<td>5 (23.8)</td>
<td>3 (14.3)</td>
<td>1 (4.8)</td>
<td>0</td>
</tr>
<tr>
<td>8. Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>21</td>
<td>2 (9.5)</td>
<td>8 (38.1)</td>
<td>7 (33.3)</td>
<td>4 (19.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. Implementation of the national standards for mental health services</td>
<td>20</td>
<td>6 (30.0)</td>
<td>5 (25.0)</td>
<td>4 (20.0)</td>
<td>4 (20.0)</td>
<td>1 (5.0)</td>
<td>0</td>
</tr>
<tr>
<td>10. Programs that promote attitudinal change among mental health workers</td>
<td>20</td>
<td>7 (35.0)</td>
<td>4 (20.0)</td>
<td>4 (20.0)</td>
<td>3 (15.0)</td>
<td>1 (5.0)</td>
<td>1 (5.0)</td>
</tr>
<tr>
<td>11. Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns and initiatives)</td>
<td>20</td>
<td>5 (25.0)</td>
<td>0</td>
<td>6 (30.0)</td>
<td>7 (35.0)</td>
<td>1 (5.0)</td>
<td>1 (5.0)</td>
</tr>
<tr>
<td>12. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>20</td>
<td>7 (35.0)</td>
<td>7 (35.0)</td>
<td>5 (25.0)</td>
<td>1 (5.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13. Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>20</td>
<td>7 (35.0)</td>
<td>6 (18.2)</td>
<td>6 (18.2)</td>
<td>0</td>
<td>1 (5.0)</td>
<td>0</td>
</tr>
<tr>
<td>14. Genuine consumer participation</td>
<td>20</td>
<td>3 (15.0)</td>
<td>7 (35.0)</td>
<td>7 (35.0)</td>
<td>3 (15.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>20</td>
<td>5 (25.0)</td>
<td>6 (30.0)</td>
<td>7 (35.0)</td>
<td>2 (10.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>20</td>
<td>5 (25.0)</td>
<td>2 (10.0)</td>
<td>6 (30.0)</td>
<td>7 (35.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17. Genuine carer participation</td>
<td>20</td>
<td>5 (25.0)</td>
<td>9 (45.0)</td>
<td>4 (20.0)</td>
<td>1 (5.0)</td>
<td>1 (5.0)</td>
<td>0</td>
</tr>
<tr>
<td>18. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>20</td>
<td>3 (15.0)</td>
<td>7 (35.0)</td>
<td>3 (15.0)</td>
<td>6 (30.0)</td>
<td>1 (5.0)</td>
<td>0</td>
</tr>
<tr>
<td>19. Clear accountability for expenditure of mental health strategy funds</td>
<td>20</td>
<td>9 (45.0)</td>
<td>7 (35.0)</td>
<td>3 (15.0)</td>
<td>0</td>
<td>0</td>
<td>1 (5.0)</td>
</tr>
<tr>
<td>20. Clearly defined roles for the primary care, community care and specialist workforces</td>
<td>20</td>
<td>5 (25.0)</td>
<td>7 (35.0)</td>
<td>4 (20.0)</td>
<td>4 (20.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21. Devolution of service planning to local level</td>
<td>20</td>
<td>8 (40.0)</td>
<td>4 (20.0)</td>
<td>7 (35.0)</td>
<td>1 (5.0)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table A 3.10 SOUTH AUSTRALIA AND THE NORTHERN TERRITORY: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.

<table>
<thead>
<tr>
<th>Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.</th>
<th>N</th>
<th>n(%)</th>
<th>Don’t know or can’t say</th>
<th>No action OR no support</th>
<th>Discussion planning and low level support</th>
<th>Implementation begun OR moderate support</th>
<th>Nearly complete OR high level support</th>
<th>Fully implemented OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>19</td>
<td>4 (21.1)</td>
<td>8 (42.1)</td>
<td>4 (21.1)</td>
<td>2 (10.5)</td>
<td>1 (5.3)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>23. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>19</td>
<td>5 (26.3)</td>
<td>8 (42.1)</td>
<td>3 (15.8)</td>
<td>3 (15.8)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>24. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>19</td>
<td>5 (26.3)</td>
<td>5 (26.3)</td>
<td>3 (15.8)</td>
<td>6 (31.6)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>25. Support for specific disease prevention initiatives (e.g. in anxiety, depression, alcohol or other substance misuse)</td>
<td>19</td>
<td>4 (21.1)</td>
<td>5 (26.3)</td>
<td>7 (36.8)</td>
<td>2 (10.5)</td>
<td>0</td>
<td>1 (5.3)</td>
<td></td>
</tr>
<tr>
<td>26. Support for general mental health promotion</td>
<td>19</td>
<td>4 (21.1)</td>
<td>4 (21.1)</td>
<td>6 (31.6)</td>
<td>3 (15.8)</td>
<td>2 (10.5)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>27. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>19</td>
<td>6 (31.6)</td>
<td>5 (26.3)</td>
<td>7 (36.8)</td>
<td>1 (5.3)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Clear accountability for expenditure of mental health strategy funds</td>
<td>19</td>
<td>7 (36.8)</td>
<td>7 (36.8)</td>
<td>3 (15.8)</td>
<td>1 (5.3)</td>
<td>0</td>
<td>1 (5.3)</td>
<td></td>
</tr>
<tr>
<td>29. Ongoing support for suicide prevention campaigns</td>
<td>19</td>
<td>5 (26.3)</td>
<td>2 (10.5)</td>
<td>8 (42.1)</td>
<td>3 (15.8)</td>
<td>1 (5.3)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>30. Development of datasets for monitoring the quality of local services</td>
<td>19</td>
<td>6 (31.6)</td>
<td>3 (15.8)</td>
<td>6 (31.6)</td>
<td>3 (15.8)</td>
<td>1 (5.3)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>31. Service development for those in forensic (i.e. prison-based) services</td>
<td>19</td>
<td>10 (52.6)</td>
<td>3 (15.8)</td>
<td>2 (10.5)</td>
<td>4 (21.1)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>32. Specification of clear primary care, community care and specialist workforces</td>
<td>19</td>
<td>4 (21.1)</td>
<td>6 (31.6)</td>
<td>6 (31.6)</td>
<td>3 (15.8)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>33. Service enhancement for persons from culturally- and linguistically-diverse backgrounds</td>
<td>19</td>
<td>6 (31.6)</td>
<td>6 (31.6)</td>
<td>5 (26.3)</td>
<td>1 (5.3)</td>
<td>1 (5.3)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>34. Support for community leadership in mental health</td>
<td>19</td>
<td>5 (26.3)</td>
<td>6 (31.6)</td>
<td>5 (26.3)</td>
<td>2 (10.5)</td>
<td>1 (5.3)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>35. Support for professional leadership in mental health</td>
<td>19</td>
<td>8 (42.1)</td>
<td>3 (15.8)</td>
<td>5 (26.3)</td>
<td>1 (5.3)</td>
<td>2 (10.5)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>36. Development of specific procedures for reporting Human Rights abuses or neglect</td>
<td>19</td>
<td>3 (15.8)</td>
<td>3 (15.8)</td>
<td>8 (42.1)</td>
<td>2 (10.5)</td>
<td>3 (15.8)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>37. Increased support for stigma reduction campaigns</td>
<td>19</td>
<td>3 (15.8)</td>
<td>8 (42.1)</td>
<td>4 (21.1)</td>
<td>1 (5.3)</td>
<td>3 (15.8)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

If you are in a regional or rural area of Australia, please answer the following question.

38. IN YOUR STATE, what is the level of support for service development in rural and regional areas?

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>2 (25.0)</td>
<td>3 (37.5)</td>
<td>3 (37.5)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

If you are in a poorly resourced area of Australia, please answer the following question.

39. IN YOUR STATE, what is the level of support for service development in poorly resourced areas?

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>2 (25.0)</td>
<td>4 (50.0)</td>
<td>2 (25.0)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Table A 3.11 WESTERN AUSTRALIA: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.

<table>
<thead>
<tr>
<th>Priority</th>
<th>N</th>
<th>Don’t know or can’t say</th>
<th>No action OR no support</th>
<th>Discussion planning OR and low level support</th>
<th>Implementation begun OR moderate support</th>
<th>Nearly complete OR high level support</th>
<th>Fully implemented OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Provision of early intervention services</td>
<td>16</td>
<td>5 (31.3)</td>
<td>3 (18.8)</td>
<td>5 (31.3)</td>
<td>3 (18.8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>16</td>
<td>5 (31.3)</td>
<td>5 (31.3)</td>
<td>1 (6.3)</td>
<td>4 (25.0)</td>
<td>0</td>
<td>1 (6.3)</td>
</tr>
<tr>
<td>8. Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>16</td>
<td>5 (31.3)</td>
<td>6 (37.5)</td>
<td>5 (31.3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. Implementation of the national standards for mental health services</td>
<td>16</td>
<td>11 (68.8)</td>
<td>0</td>
<td>3 (18.8)</td>
<td>2 (12.5)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10. Programs that promote attitudinal change among mental health workers</td>
<td>16</td>
<td>5 (31.3)</td>
<td>3 (18.8)</td>
<td>4 (25.0)</td>
<td>3 (18.8)</td>
<td>1 (6.3)</td>
<td>0</td>
</tr>
<tr>
<td>11. Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns and initiatives)</td>
<td>16</td>
<td>2 (12.5)</td>
<td>5 (31.3)</td>
<td>6 (37.5)</td>
<td>3 (18.8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>16</td>
<td>6 (37.5)</td>
<td>3 (18.8)</td>
<td>4 (25.0)</td>
<td>3 (18.8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13. Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>16</td>
<td>6 (37.5)</td>
<td>4 (25.0)</td>
<td>2 (12.5)</td>
<td>4 (25.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14. Genuine consumer participation</td>
<td>16</td>
<td>1 (6.3)</td>
<td>5 (31.3)</td>
<td>5 (31.3)</td>
<td>5 (31.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>16</td>
<td>6 (37.5)</td>
<td>5 (31.3)</td>
<td>0</td>
<td>5 (31.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>16</td>
<td>4 (25.0)</td>
<td>5 (31.3)</td>
<td>6 (37.5)</td>
<td>1 (6.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Priority</td>
<td>N</td>
<td>Don’t know or can’t say</td>
<td>No action OR can’t say</td>
<td>Discussion and planning OR low level support</td>
<td>Implementation OR moderate support</td>
<td>Nearly complete OR high level support</td>
<td>Fully implemented OR full support</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----</td>
<td>------------------------</td>
<td>------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>17. Genuine carer participation</td>
<td>16</td>
<td>5 (31.3)</td>
<td>2 (12.5)</td>
<td>7 (43.8)</td>
<td>2 (12.5)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>16</td>
<td>4 (25.0)</td>
<td>5 (31.3)</td>
<td>3 (18.8)</td>
<td>4 (25.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>19. Clear accountability for expenditure of mental health strategy funds</td>
<td>16</td>
<td>9 (56.3)</td>
<td>5 (31.3)</td>
<td>1 (6.3)</td>
<td>1 (6.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20. Clearly defined roles for the primary care, community care and specialist workforces</td>
<td>16</td>
<td>5 (31.3)</td>
<td>5 (31.3)</td>
<td>3 (18.8)</td>
<td>3 (18.8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21. Devolution of service planning to local level</td>
<td>16</td>
<td>8 (50.0)</td>
<td>2 (12.5)</td>
<td>3 (18.8)</td>
<td>3 (18.8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>12</td>
<td>3 (25.0)</td>
<td>4 (33.3)</td>
<td>4 (33.3)</td>
<td>1 (8.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>23. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>12</td>
<td>3 (25.0)</td>
<td>4 (33.3)</td>
<td>2 (16.7)</td>
<td>3 (25.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>12</td>
<td>2 (16.7)</td>
<td>0</td>
<td>6 (50.0)</td>
<td>4 (33.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>25. Support for specific disease prevention initiatives (e.g. in anxiety, depression, alcohol or other substance misuse)</td>
<td>12</td>
<td>1 (8.3)</td>
<td>2 (16.7)</td>
<td>6 (50.0)</td>
<td>2 (16.7)</td>
<td>1 (8.3)</td>
<td>0</td>
</tr>
<tr>
<td>26. Support for general mental health promotion</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>6 (50.0)</td>
<td>6 (50.0)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>27. Support for enhanced role of non-government organisations in all aspects of care</td>
<td>12</td>
<td>2 (16.7)</td>
<td>2 (16.7)</td>
<td>4 (33.3)</td>
<td>4 (33.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>28. Clear accountability for expenditure of mental health strategy funds</td>
<td>12</td>
<td>3 (25.0)</td>
<td>5 (41.7)</td>
<td>2 (16.7)</td>
<td>2 (16.7)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Table A 3.12 WESTERN AUSTRALIA: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.
<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>29. Ongoing support for suicide prevention campaigns</td>
<td>12</td>
<td>1 (8.3)</td>
<td>1 (8.3)</td>
<td>4 (33.3)</td>
<td>6 (50.0)</td>
<td>0</td>
</tr>
<tr>
<td>30. Development of datasets for monitoring the quality of local services</td>
<td>12</td>
<td>9 (75.0)</td>
<td>1 (8.3)</td>
<td>1 (8.3)</td>
<td>1 (8.3)</td>
<td>0</td>
</tr>
<tr>
<td>31. Service development for those in forensic (i.e. prison-based) services</td>
<td>12</td>
<td>5 (41.7)</td>
<td>2 (16.7)</td>
<td>2 (16.7)</td>
<td>3 (25.0)</td>
<td>0</td>
</tr>
<tr>
<td>32. Specification of clear primary care, community care and specialist workforces</td>
<td>12</td>
<td>4 (33.3)</td>
<td>5 (41.7)</td>
<td>1 (8.3)</td>
<td>2 (16.7)</td>
<td>0</td>
</tr>
<tr>
<td>33. Service enhancement for persons from culturally- and linguistically-diverse backgrounds</td>
<td>12</td>
<td>2 (16.7)</td>
<td>0</td>
<td>5 (41.7)</td>
<td>5 (41.7)</td>
<td>0</td>
</tr>
<tr>
<td>34. Support for community leadership in mental health</td>
<td>12</td>
<td>1 (8.3)</td>
<td>5 (41.7)</td>
<td>5 (41.7)</td>
<td>1 (8.3)</td>
<td>0</td>
</tr>
<tr>
<td>35. Support for professional leadership in mental health</td>
<td>12</td>
<td>3 (25.0)</td>
<td>2 (16.7)</td>
<td>2 (11.8)</td>
<td>5 (41.7)</td>
<td>0</td>
</tr>
<tr>
<td>36. Development of specific procedures for reporting Human Rights abuses or neglect</td>
<td>12</td>
<td>4 (33.3)</td>
<td>3 (25.0)</td>
<td>2 (16.7)</td>
<td>3 (25.0)</td>
<td>0</td>
</tr>
<tr>
<td>37. Increased support for stigma reduction campaigns</td>
<td>12</td>
<td>1 (8.3)</td>
<td>2 (16.7)</td>
<td>5 (41.7)</td>
<td>4 (33.3)</td>
<td>0</td>
</tr>
</tbody>
</table>

If you are in a regional or rural area of Australia, please answer the following question.

38. IN YOUR STATE, what is the level of support for service development in rural and regional areas?

If you are in a poorly resourced area of Australia, please answer the following question.

39. IN YOUR STATE, what is the level of support for service development in poorly resourced areas?
Table A 3.13 TASMANIA: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.

<table>
<thead>
<tr>
<th>Priority</th>
<th>N</th>
<th>Don’t know or can’t say</th>
<th>No action OR no support</th>
<th>Discussion planning OR low level support</th>
<th>Implementation begun OR moderate support</th>
<th>Nearly OR high level support</th>
<th>Fully implemented OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Provision of early intervention services</td>
<td>15</td>
<td>0</td>
<td>4 (26.7)</td>
<td>9 (60.0)</td>
<td>2 (13.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Development of innovative services for people with mental health and alcohol or substance abuse disorders</td>
<td>15</td>
<td>3 (20.0)</td>
<td>3 (20.0)</td>
<td>6 (31.6)</td>
<td>3 (15.8)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8. Development of a wider spectrum of acute and community-based care services providing more options for care</td>
<td>15</td>
<td>4 (26.7)</td>
<td>5 (33.3)</td>
<td>2 (13.3)</td>
<td>4 (26.7)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9. Implementation of the national standards for mental health services</td>
<td>15</td>
<td>7 (46.7)</td>
<td>2 (13.3)</td>
<td>2 (13.3)</td>
<td>4 (26.7)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10. Programs that promote attitudinal change among mental health workers</td>
<td>15</td>
<td>7 (46.7)</td>
<td>5 (33.3)</td>
<td>2 (13.3)</td>
<td>1 (6.7)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11. Support for mental health promotion programs (e.g. Mindfulness programs, stigma reduction campaigns and initiatives)</td>
<td>14</td>
<td>1 (7.1)</td>
<td>3 (21.4)</td>
<td>5 (35.7)</td>
<td>5 (35.7)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12. Development of specific inter-governmental service agreements (e.g. between health, education, housing, employment, and social security)</td>
<td>14</td>
<td>3 (21.4)</td>
<td>5 (35.7)</td>
<td>4 (28.6)</td>
<td>1 (7.1)</td>
<td>1 (7.1)</td>
<td>0</td>
</tr>
<tr>
<td>13. Development of specific inter-agency service agreements (e.g. between primary care, community care, education, housing and employment)</td>
<td>14</td>
<td>4 (28.6)</td>
<td>5 (35.7)</td>
<td>4 (28.6)</td>
<td>1 (7.1)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14. Genuine consumer participation</td>
<td>14</td>
<td>2 (14.3)</td>
<td>3 (21.4)</td>
<td>8 (57.1)</td>
<td>1 (7.1)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>15. Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health</td>
<td>14</td>
<td>2 (14.3)</td>
<td>7 (50.0)</td>
<td>3 (21.4)</td>
<td>2 (14.3)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16. Introduction of specific schemes to enhance access to mental health specialists</td>
<td>14</td>
<td>2 (14.3)</td>
<td>4 (28.6)</td>
<td>4 (28.6)</td>
<td>4 (28.6)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>17. Genuine carer participation</td>
<td>14</td>
<td>2 (14.3)</td>
<td>3 (21.4)</td>
<td>6 (42.9)</td>
<td>2 (14.3)</td>
<td>1 (7.1)</td>
<td>0</td>
</tr>
</tbody>
</table>
### Table A 3.14 TASMANIA: Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.

<table>
<thead>
<tr>
<th>N</th>
<th>n (%)</th>
<th>Don't know or can't say</th>
<th>No action OR no support</th>
<th>Discussion planning OR low level support</th>
<th>Implementation begun OR moderate support</th>
<th>Nearly OR high support</th>
<th>Complete level of support</th>
<th>Fully implemented OR full support</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.</td>
<td>11</td>
<td>1 (9.1)</td>
<td>3 (27.3)</td>
<td>5 (45.5)</td>
<td>2 (18.2)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>23.</td>
<td>11</td>
<td>1 (9.1)</td>
<td>5 (45.5)</td>
<td>3 (27.3)</td>
<td>2 (18.2)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>24.</td>
<td>11</td>
<td>1 (9.1)</td>
<td>3 (27.3)</td>
<td>4 (36.4)</td>
<td>3 (27.3)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>25.</td>
<td>11</td>
<td>1 (9.1)</td>
<td>5 (45.5)</td>
<td>2 (18.2)</td>
<td>3 (27.3)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>26.</td>
<td>11</td>
<td>4 (36.4)</td>
<td>0</td>
<td>5 (45.5)</td>
<td>2 (18.2)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>27.</td>
<td>11</td>
<td>1 (9.1)</td>
<td>1 (9.1)</td>
<td>5 (45.5)</td>
<td>3 (27.3)</td>
<td>1 (9.1)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>28.</td>
<td>11</td>
<td>3 (27.3)</td>
<td>5 (45.5)</td>
<td>1 (9.1)</td>
<td>2 (18.2)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>29.</td>
<td>11</td>
<td>1 (9.1)</td>
<td>1 (9.1)</td>
<td>6 (54.5)</td>
<td>3 (27.3)</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>30. Development of datasets for monitoring the quality of local services</strong></td>
<td>11</td>
<td>4 (36.4)</td>
<td>4 (36.4)</td>
<td>1 (9.1)</td>
<td>2 (18.2)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>31. Service development for those in forensic (i.e. prison-based) services</strong></td>
<td>11</td>
<td>4 (36.4)</td>
<td>3 (27.3)</td>
<td>0</td>
<td>4 (36.4)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>32. Specification of clear primary care, community care and specialist workforces</strong></td>
<td>11</td>
<td>3 (27.3)</td>
<td>3 (27.3)</td>
<td>3 (27.3)</td>
<td>2 (18.2)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>33. Service enhancement for persons from culturally- and linguistically-diverse backgrounds</strong></td>
<td>11</td>
<td>4 (36.4)</td>
<td>1 (9.1)</td>
<td>2 (18.2)</td>
<td>4 (36.4)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>34. Support for community leadership in mental health</strong></td>
<td>11</td>
<td>1 (9.1)</td>
<td>3 (27.3)</td>
<td>6 (31.6)</td>
<td>1 (9.1)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>35. Support for professional leadership in mental health</strong></td>
<td>11</td>
<td>3 (27.3)</td>
<td>3 (27.3)</td>
<td>3 (27.3)</td>
<td>2 (18.2)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>36. Development of specific procedures for reporting Human Rights abuses or neglect</strong></td>
<td>11</td>
<td>6 (54.5)</td>
<td>3 (27.3)</td>
<td>0</td>
<td>1 (9.1)</td>
<td>1 (9.1)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>37. Increased support for stigma reduction campaigns</strong></td>
<td>11</td>
<td>2 (18.2)</td>
<td>5 (45.5)</td>
<td>2 (18.2)</td>
<td>2 (18.2)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

If you are in a regional or rural area of Australia, please answer the following question.

38. IN YOUR STATE, what is the level of support for service development in rural and regional areas?

If you are in a poorly resourced area of Australia, please answer the following question.

39. IN YOUR STATE, what is the level of support for service development in poorly resourced areas?
Obsessive Hope Disorder
Appendix 4

Community survey of experiences of care in mental health
Obsessive Hope Disorder
Survey 2: Consumers and carers direct experiences of mental health care in Australia

Section one: Background information

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you, or someone else very close to you, received treatment for a mental health problem in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>486</td>
<td>86.6</td>
</tr>
<tr>
<td>No</td>
<td>75</td>
<td>13.4</td>
</tr>
<tr>
<td>Total</td>
<td>561</td>
<td>100.0</td>
</tr>
<tr>
<td>2. Who provided this treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health services</td>
<td>144</td>
<td>29.6</td>
</tr>
<tr>
<td>Private health services</td>
<td>206</td>
<td>71.9</td>
</tr>
<tr>
<td>Public and private health services</td>
<td>137</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>487</td>
<td></td>
</tr>
<tr>
<td>3. Was the main provider a...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A general practitioner</td>
<td>71</td>
<td>14.6</td>
</tr>
<tr>
<td>A clinical psychologist/ counsellor</td>
<td>128</td>
<td>26.3</td>
</tr>
<tr>
<td>A specialist psychiatrist</td>
<td>150</td>
<td>30.9</td>
</tr>
<tr>
<td>Hospital/ emergency service</td>
<td>57</td>
<td>11.7</td>
</tr>
<tr>
<td>Community mental health service</td>
<td>62</td>
<td>12.8</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>3.7</td>
</tr>
<tr>
<td>Total</td>
<td>486</td>
<td>100.0</td>
</tr>
<tr>
<td>4. Have you, or someone else very close to you, been admitted to a hospital as a mental health inpatient in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, once</td>
<td>106</td>
<td>21.9</td>
</tr>
<tr>
<td>Yes, two or three times</td>
<td>62</td>
<td>12.8</td>
</tr>
<tr>
<td>Yes, more than three times</td>
<td>26</td>
<td>5.4</td>
</tr>
<tr>
<td>No</td>
<td>291</td>
<td>60.0</td>
</tr>
<tr>
<td>Total</td>
<td>485</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Section one: A. If you, or someone else very close to you, did receive treatment for a mental health problem in the last 12 months...

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. To what extent were you/ they treated with respect and dignity by health professionals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>163</td>
<td>37.0</td>
</tr>
<tr>
<td>Nearly always</td>
<td>141</td>
<td>32.0</td>
</tr>
<tr>
<td>Sometimes</td>
<td>76</td>
<td>17.2</td>
</tr>
<tr>
<td>Not often</td>
<td>53</td>
<td>12.0</td>
</tr>
<tr>
<td>Never</td>
<td>8</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>441</td>
<td>100.0</td>
</tr>
<tr>
<td>6. How much information about your/ their condition or treatment was given to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too much</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>Right amount</td>
<td>193</td>
<td>43.8</td>
</tr>
<tr>
<td>Some</td>
<td>115</td>
<td>26.1</td>
</tr>
<tr>
<td>Not enough</td>
<td>92</td>
<td>20.9</td>
</tr>
<tr>
<td>None</td>
<td>40</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>441</td>
<td>100.0</td>
</tr>
<tr>
<td>7. To what extent were you able to access adequate services for your/ their mental health problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>75</td>
<td>17.2</td>
</tr>
<tr>
<td>Nearly always</td>
<td>111</td>
<td>25.4</td>
</tr>
<tr>
<td>Sometimes</td>
<td>127</td>
<td>29.1</td>
</tr>
<tr>
<td>Not often</td>
<td>98</td>
<td>22.4</td>
</tr>
<tr>
<td>Never</td>
<td>26</td>
<td>5.9</td>
</tr>
<tr>
<td>Total</td>
<td>437</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Obsessive Hope Disorder

8. Did you find a health professional to talk to about your concerns?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>169</td>
<td>38.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>114</td>
<td>26.0</td>
</tr>
<tr>
<td>Yes, a little</td>
<td>90</td>
<td>20.5</td>
</tr>
<tr>
<td>No</td>
<td>61</td>
<td>13.9</td>
</tr>
<tr>
<td>I had no concerns</td>
<td>4</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>438</td>
<td>100.0</td>
</tr>
</tbody>
</table>

9. If your family or someone else close to you wanted to talk to a health professional, did they have enough opportunity to do so?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>97</td>
<td>22.2</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>161</td>
<td>36.8</td>
</tr>
<tr>
<td>No</td>
<td>88</td>
<td>20.1</td>
</tr>
<tr>
<td>No family or friends were involved</td>
<td>37</td>
<td>8.5</td>
</tr>
<tr>
<td>My family didn’t want or need information</td>
<td>35</td>
<td>8.0</td>
</tr>
<tr>
<td>I didn’t want my family or friends to talk to a health profe</td>
<td>19</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>437</td>
<td>100.0</td>
</tr>
</tbody>
</table>

10. How much information about your condition or treatment was given to your family or someone else close to you?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough</td>
<td>152</td>
<td>34.9</td>
</tr>
<tr>
<td>Right amount</td>
<td>126</td>
<td>29.0</td>
</tr>
<tr>
<td>Too much</td>
<td>5</td>
<td>1.1</td>
</tr>
<tr>
<td>No family or friends were involved</td>
<td>71</td>
<td>16.3</td>
</tr>
<tr>
<td>My family didn’t want or need information</td>
<td>38</td>
<td>8.7</td>
</tr>
<tr>
<td>I didn’t want my family or friends to have any information</td>
<td>43</td>
<td>9.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>435</td>
<td>100.0</td>
</tr>
</tbody>
</table>

11. If you/ they were prescribed any medication for a mental health problem, was its purpose, benefits and/or side-effects fully explained?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>120</td>
<td>27.5</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>102</td>
<td>23.3</td>
</tr>
<tr>
<td>Yes, a little</td>
<td>68</td>
<td>15.6</td>
</tr>
<tr>
<td>No</td>
<td>115</td>
<td>26.3</td>
</tr>
<tr>
<td>I was not prescribed any medications</td>
<td>32</td>
<td>7.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>437</td>
<td>100.0</td>
</tr>
</tbody>
</table>

12. If you/ they were admitted as a hospital inpatient for treatment of a mental health problem, did staff attend to your/ their physical health needs in a timely manner?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>51</td>
<td>11.7</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>59</td>
<td>13.5</td>
</tr>
<tr>
<td>Yes, a little</td>
<td>33</td>
<td>7.6</td>
</tr>
<tr>
<td>No</td>
<td>58</td>
<td>13.3</td>
</tr>
<tr>
<td>I did not require assistance with any physical health needs</td>
<td>235</td>
<td>53.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>436</td>
<td>100.0</td>
</tr>
</tbody>
</table>

13. Sometimes, one health professional will say one thing and another health professional will say something quite different. Did this happen to you?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>63</td>
<td>14.5</td>
</tr>
<tr>
<td>Nearly always</td>
<td>68</td>
<td>15.6</td>
</tr>
<tr>
<td>Sometimes</td>
<td>162</td>
<td>37.2</td>
</tr>
<tr>
<td>Not often</td>
<td>82</td>
<td>18.9</td>
</tr>
<tr>
<td>Never</td>
<td>60</td>
<td>13.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>435</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Section One: B. Overall

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Did you have enough say in decisions about your/ their care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>151</td>
<td>35.1</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>150</td>
<td>34.9</td>
</tr>
<tr>
<td>No</td>
<td>129</td>
<td>30.0</td>
</tr>
<tr>
<td>Total</td>
<td>430</td>
<td>100.0</td>
</tr>
<tr>
<td>15. Has your/ their diagnosis been discussed with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>172</td>
<td>40.0</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>174</td>
<td>40.5</td>
</tr>
<tr>
<td>No</td>
<td>84</td>
<td>19.5</td>
</tr>
<tr>
<td>Total</td>
<td>430</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Section One: C. About You

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Your gender?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>396</td>
<td>81.5</td>
</tr>
<tr>
<td>Male</td>
<td>90</td>
<td>18.5</td>
</tr>
<tr>
<td>Total</td>
<td>486</td>
<td>100.0</td>
</tr>
<tr>
<td>17. Your age?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-24 years</td>
<td>71</td>
<td>14.6</td>
</tr>
<tr>
<td>25-34 years</td>
<td>92</td>
<td>18.9</td>
</tr>
<tr>
<td>35-44 years</td>
<td>117</td>
<td>24.1</td>
</tr>
<tr>
<td>45-54 years</td>
<td>134</td>
<td>27.6</td>
</tr>
<tr>
<td>55-64 years</td>
<td>59</td>
<td>12.1</td>
</tr>
<tr>
<td>65+ years</td>
<td>13</td>
<td>2.7</td>
</tr>
<tr>
<td>Total</td>
<td>486</td>
<td>100.0</td>
</tr>
<tr>
<td>18. Your postcode?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NSW</td>
<td>201</td>
<td>41.7</td>
</tr>
<tr>
<td>VIC</td>
<td>81</td>
<td>16.8</td>
</tr>
<tr>
<td>QLD</td>
<td>112</td>
<td>23.2</td>
</tr>
<tr>
<td>SA</td>
<td>40</td>
<td>8.3</td>
</tr>
<tr>
<td>WA</td>
<td>36</td>
<td>7.5</td>
</tr>
<tr>
<td>TAS</td>
<td>10</td>
<td>2.1</td>
</tr>
<tr>
<td>NT</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>ACT</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>Total</td>
<td>482</td>
<td>100.0</td>
</tr>
<tr>
<td>19. What is the geographical nature of the area you live in?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural/ district (less than 10,000 people)</td>
<td>48</td>
<td>9.9</td>
</tr>
<tr>
<td>Regional centre (greater than 10,000 people)</td>
<td>147</td>
<td>30.2</td>
</tr>
<tr>
<td>Major urban area (greater than 100,000 people)</td>
<td>291</td>
<td>59.9</td>
</tr>
<tr>
<td>Total</td>
<td>486</td>
<td>100.0</td>
</tr>
<tr>
<td>20. In which country were you born?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>417</td>
<td>85.8</td>
</tr>
<tr>
<td>Overseas</td>
<td>69</td>
<td>14.2</td>
</tr>
<tr>
<td>Total</td>
<td>486</td>
<td>100.0</td>
</tr>
<tr>
<td>21. Are you an Aboriginal or Torres Strait Islander?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, Aboriginal</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td>Yes, both Aboriginal and Torres Strait Islander</td>
<td>1</td>
<td>.2</td>
</tr>
<tr>
<td>No</td>
<td>477</td>
<td>98.1</td>
</tr>
<tr>
<td>Total</td>
<td>486</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### 22. What language do you most commonly speak?

<table>
<thead>
<tr>
<th>Language</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>485</td>
<td>99.8</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>486</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### 23. What language do you most commonly speak at home?

<table>
<thead>
<tr>
<th>Language</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>477</td>
<td>98.1</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>486</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### 24. Who else, if anybody, do you live with?

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No-one, I live alone</td>
<td>92</td>
<td>18.9</td>
</tr>
<tr>
<td>Partner</td>
<td>136</td>
<td>28.0</td>
</tr>
<tr>
<td>Child/ children under 18</td>
<td>54</td>
<td>11.1</td>
</tr>
<tr>
<td>Child/ children over 18</td>
<td>17</td>
<td>3.5</td>
</tr>
<tr>
<td>A parent or guardian</td>
<td>39</td>
<td>8.0</td>
</tr>
<tr>
<td>With other family members</td>
<td>108</td>
<td>22.2</td>
</tr>
<tr>
<td>With people other than family members</td>
<td>40</td>
<td>8.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>486</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### 25. Are you a:

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer (i.e. receive care yourself)</td>
<td>310</td>
<td>63.8</td>
</tr>
<tr>
<td>Carer</td>
<td>69</td>
<td>14.2</td>
</tr>
<tr>
<td>Family member or close friend</td>
<td>87</td>
<td>17.9</td>
</tr>
<tr>
<td>None of the above</td>
<td>20</td>
<td>4.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>486</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### 26. During the past four weeks how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable?)

<table>
<thead>
<tr>
<th>Level</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>44</td>
<td>9.1</td>
</tr>
<tr>
<td>Slightly</td>
<td>113</td>
<td>23.3</td>
</tr>
<tr>
<td>Moderately</td>
<td>119</td>
<td>24.5</td>
</tr>
<tr>
<td>Quite a lot</td>
<td>125</td>
<td>25.7</td>
</tr>
<tr>
<td>Extremely</td>
<td>85</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>486</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### 27. In general, how is your mental health right now?

<table>
<thead>
<tr>
<th>Health Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>34</td>
<td>7.0</td>
</tr>
<tr>
<td>Very good</td>
<td>73</td>
<td>15.0</td>
</tr>
<tr>
<td>Good</td>
<td>120</td>
<td>24.7</td>
</tr>
<tr>
<td>Fair</td>
<td>150</td>
<td>30.9</td>
</tr>
<tr>
<td>Poor</td>
<td>74</td>
<td>15.2</td>
</tr>
<tr>
<td>Very poor</td>
<td>35</td>
<td>7.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>486</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
### Section Two: D. Your care and treatment

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. How long have you been in contact with mental health services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One year or less</td>
<td>20</td>
<td>6.6</td>
</tr>
<tr>
<td>One to five years</td>
<td>80</td>
<td>26.3</td>
</tr>
<tr>
<td>More than five years</td>
<td>195</td>
<td>64.1</td>
</tr>
<tr>
<td>Don’t know/ Can’t remember</td>
<td>4</td>
<td>1.3</td>
</tr>
<tr>
<td>I have never been in contact with mental health services</td>
<td>5</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>304</td>
<td>100.0</td>
</tr>
</tbody>
</table>

29. Overall, how would you rate the health care you have received for your mental health problem in the last 12 months?

<table>
<thead>
<tr>
<th>Rating</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>61</td>
<td>20.4</td>
</tr>
<tr>
<td>Very good</td>
<td>70</td>
<td>23.4</td>
</tr>
<tr>
<td>Good</td>
<td>60</td>
<td>20.1</td>
</tr>
<tr>
<td>Fair</td>
<td>51</td>
<td>17.1</td>
</tr>
<tr>
<td>Poor</td>
<td>34</td>
<td>11.4</td>
</tr>
<tr>
<td>Very poor</td>
<td>23</td>
<td>7.7</td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Section Two: E. Health professionals

#### General practitioners

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>30. Have you seen a general practitioner in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>294</td>
<td>97.7</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>100.0</td>
</tr>
</tbody>
</table>

31. Did the general practitioner listen carefully to you?

<table>
<thead>
<tr>
<th>Listening</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>175</td>
<td>59.5</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>88</td>
<td>29.9</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>10.5</td>
</tr>
<tr>
<td>Total</td>
<td>294</td>
<td>100.0</td>
</tr>
</tbody>
</table>

32. Did you have trust and confidence in the general practitioner you saw?

<table>
<thead>
<tr>
<th>Trust</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>167</td>
<td>56.8</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>92</td>
<td>31.3</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>11.9</td>
</tr>
<tr>
<td>Total</td>
<td>294</td>
<td>100.0</td>
</tr>
</tbody>
</table>

33. Did the general practitioner treat you with respect and dignity?

<table>
<thead>
<tr>
<th>Treatment</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>219</td>
<td>74.5</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>60</td>
<td>20.4</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>5.1</td>
</tr>
<tr>
<td>Total</td>
<td>294</td>
<td>100.0</td>
</tr>
</tbody>
</table>

34. Were you given enough time to discuss your condition and treatment?

<table>
<thead>
<tr>
<th>Time</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>145</td>
<td>49.3</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>89</td>
<td>30.3</td>
</tr>
<tr>
<td>No</td>
<td>60</td>
<td>20.4</td>
</tr>
<tr>
<td>Total</td>
<td>294</td>
<td>100.0</td>
</tr>
</tbody>
</table>

35. The last two times you had an appointment with a general practitioner, was it...

<table>
<thead>
<tr>
<th>Appointment</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>With the SAME general practitioner both times</td>
<td>219</td>
<td>74.7</td>
</tr>
<tr>
<td>With two DIFFERENT general practitioners</td>
<td>74</td>
<td>25.3</td>
</tr>
<tr>
<td>Total</td>
<td>293</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Psychologists

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>36. Have you seen a psychologist in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>180</td>
<td>59.8</td>
</tr>
<tr>
<td>No</td>
<td>121</td>
<td>40.2</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>100.0</td>
</tr>
<tr>
<td>37. Did the psychologist listen carefully to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>139</td>
<td>77.2</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>26</td>
<td>14.4</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100.0</td>
</tr>
<tr>
<td>38. Did you have trust and confidence in the psychologist you saw?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>116</td>
<td>64.4</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>40</td>
<td>22.2</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>13.3</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100.0</td>
</tr>
<tr>
<td>39. Did the psychologist treat you with respect and dignity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>147</td>
<td>81.7</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>26</td>
<td>14.4</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>3.9</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100.0</td>
</tr>
<tr>
<td>40. Were you given enough time to discuss your condition and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>104</td>
<td>57.8</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>52</td>
<td>28.9</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>13.3</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>100.0</td>
</tr>
<tr>
<td>41. The last two times you had an appointment with a psychologist, was it...?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the SAME psychologist both times</td>
<td>167</td>
<td>93.3</td>
</tr>
<tr>
<td>With two DIFFERENT psychologists</td>
<td>12</td>
<td>6.7</td>
</tr>
<tr>
<td>Total</td>
<td>179</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Psychiatrists

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>42. Have you seen a psychiatrist in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>187</td>
<td>62.1</td>
</tr>
<tr>
<td>No</td>
<td>114</td>
<td>37.9</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>100.0</td>
</tr>
<tr>
<td>43. Did the psychiatrist listen carefully to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>117</td>
<td>62.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>46</td>
<td>24.6</td>
</tr>
<tr>
<td>No</td>
<td>24</td>
<td>12.8</td>
</tr>
<tr>
<td>Total</td>
<td>187</td>
<td>100.0</td>
</tr>
<tr>
<td>44. Did you have trust and confidence in the psychiatrist you saw?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>103</td>
<td>55.1</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>47</td>
<td>25.1</td>
</tr>
<tr>
<td>No</td>
<td>37</td>
<td>19.8</td>
</tr>
<tr>
<td>Total</td>
<td>187</td>
<td>100.0</td>
</tr>
<tr>
<td>45. Did the psychiatrist treat you with respect and dignity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>136</td>
<td>72.7</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>36</td>
<td>19.3</td>
</tr>
<tr>
<td>No</td>
<td>15</td>
<td>8.0</td>
</tr>
<tr>
<td>Total</td>
<td>187</td>
<td>100.0</td>
</tr>
<tr>
<td>Question</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>46. Were you given enough time to discuss your condition and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>104</td>
<td>55.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>41</td>
<td>21.9</td>
</tr>
<tr>
<td>No</td>
<td>42</td>
<td>22.5</td>
</tr>
<tr>
<td>Total</td>
<td>187</td>
<td>100.0</td>
</tr>
<tr>
<td>47. The last two times you had an appointment with a psychiatrist, was it...?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the SAME psychiatrist both times</td>
<td>163</td>
<td>87.6</td>
</tr>
<tr>
<td>With two DIFFERENT psychiatrists</td>
<td>23</td>
<td>12.4</td>
</tr>
<tr>
<td>Total</td>
<td>186</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Mental Health Nurses**

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>48. Have you seen a mental health nurse in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>74</td>
<td>24.6</td>
</tr>
<tr>
<td>No</td>
<td>227</td>
<td>75.4</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>100.0</td>
</tr>
<tr>
<td>49. Did the mental health nurse listen carefully to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>36</td>
<td>48.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>26</td>
<td>35.1</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>16.2</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
</tr>
<tr>
<td>50. Did you have trust and confidence in the mental health nurse you saw?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>35</td>
<td>47.3</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>19</td>
<td>25.7</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>27.0</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
</tr>
<tr>
<td>51. Did the mental health nurse treat you with respect and dignity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>44</td>
<td>59.5</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>20</td>
<td>27.0</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
<td>13.5</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
</tr>
<tr>
<td>52. Were you given enough time to discuss your condition and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>29</td>
<td>39.2</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>27</td>
<td>36.5</td>
</tr>
<tr>
<td>No</td>
<td>18</td>
<td>24.3</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Social Workers**

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>53. Have you seen a social worker in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>46</td>
<td>15.3</td>
</tr>
<tr>
<td>No</td>
<td>255</td>
<td>84.7</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>100.0</td>
</tr>
<tr>
<td>54. Did the social worker listen carefully to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>27</td>
<td>58.7</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>11</td>
<td>23.9</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>17.4</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>100.0</td>
</tr>
<tr>
<td>Question</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>------</td>
</tr>
<tr>
<td>55. Did you have trust and confidence in the social worker you saw?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>23</td>
<td>50.0</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>6</td>
<td>13.0</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
<td>37.0</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>100.0</td>
</tr>
<tr>
<td>56. Did the social worker treat you with respect and dignity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>29</td>
<td>63.0</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>12</td>
<td>26.1</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>10.9</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
<td>100.0</td>
</tr>
<tr>
<td>57. Were you given enough time to discuss your condition and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>24</td>
<td>53.3</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>10</td>
<td>22.2</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>24.4</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100.0</td>
</tr>
<tr>
<td>58. The last two times you had an appointment with a social worker, was it...?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With the SAME social worker both times</td>
<td>41</td>
<td>91.1</td>
</tr>
<tr>
<td>With two DIFFERENT social workers</td>
<td>4</td>
<td>8.9</td>
</tr>
<tr>
<td>Total</td>
<td>45</td>
<td>100.0</td>
</tr>
<tr>
<td>Other health professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59. Have you seen anyone else in mental health services in the last 12 months?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>67</td>
<td>22.3</td>
</tr>
<tr>
<td>No</td>
<td>234</td>
<td>77.7</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td>100.0</td>
</tr>
<tr>
<td>61. Did they listen carefully to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>44</td>
<td>65.7</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>14</td>
<td>20.9</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>13.4</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>100.0</td>
</tr>
<tr>
<td>62. Did you have trust and confidence in the person you saw?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>40</td>
<td>59.7</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>16</td>
<td>23.9</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>16.4</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>100.0</td>
</tr>
<tr>
<td>63. Did the person treat you with respect and dignity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>50</td>
<td>74.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>9</td>
<td>13.4</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>11.9</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Section Two: F. Medications

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>64. In the last 12 months have you taken any medications for your mental health problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>259</td>
<td>87.8</td>
</tr>
<tr>
<td>No</td>
<td>36</td>
<td>12.2</td>
</tr>
<tr>
<td>Total</td>
<td>295</td>
<td>100.0</td>
</tr>
<tr>
<td>65. Do you have a say in decisions about the medication you take?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>136</td>
<td>52.5</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>97</td>
<td>37.5</td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>259</td>
<td>100.0</td>
</tr>
<tr>
<td>66. In the last 12 months, have any new medications (e.g. tablets, injections, liquid medicines) been prescribed for you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>152</td>
<td>58.7</td>
</tr>
<tr>
<td>No</td>
<td>106</td>
<td>40.9</td>
</tr>
<tr>
<td>Can't remember</td>
<td>1</td>
<td>.4</td>
</tr>
<tr>
<td>Total</td>
<td>259</td>
<td>100.0</td>
</tr>
<tr>
<td>67. Who prescribed these medications?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td>48</td>
<td>31.6</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>95</td>
<td>62.5</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>5.3</td>
</tr>
<tr>
<td>Can't remember</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Total</td>
<td>152</td>
<td>100.0</td>
</tr>
<tr>
<td>68. Were the purposes of the medications explained to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>146</td>
<td>56.4</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>92</td>
<td>35.5</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>8.1</td>
</tr>
<tr>
<td>Total</td>
<td>259</td>
<td>100.0</td>
</tr>
<tr>
<td>69. Were you told about possible side-effects of the medications?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>80</td>
<td>30.9</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>96</td>
<td>37.1</td>
</tr>
<tr>
<td>No</td>
<td>83</td>
<td>32.0</td>
</tr>
<tr>
<td>Total</td>
<td>259</td>
<td>100.0</td>
</tr>
<tr>
<td>70. Did this medication help?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>100</td>
<td>38.6</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>119</td>
<td>45.9</td>
</tr>
<tr>
<td>No</td>
<td>40</td>
<td>15.4</td>
</tr>
<tr>
<td>Total</td>
<td>259</td>
<td>100.0</td>
</tr>
</tbody>
</table>

### Section Two: G. Talking therapies

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>71. In the last 12 months have you had any talking therapy (e.g. counselling) from mental health services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>209</td>
<td>71.1</td>
</tr>
<tr>
<td>No</td>
<td>85</td>
<td>28.9</td>
</tr>
<tr>
<td>Total</td>
<td>294</td>
<td>100.0</td>
</tr>
<tr>
<td>72. Did the talking therapy help?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>107</td>
<td>51.4</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>82</td>
<td>39.4</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>9.1</td>
</tr>
<tr>
<td>Total</td>
<td>208</td>
<td>100.0</td>
</tr>
<tr>
<td>73. Did you want talking therapy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>48</td>
<td>55.2</td>
</tr>
<tr>
<td>No</td>
<td>39</td>
<td>44.8</td>
</tr>
<tr>
<td>Total</td>
<td>87</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Section Two: H. Your care plan (CPA)

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>74. Have you been given (or offered) a written or printed copy of your care plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>98</td>
<td>33.8</td>
</tr>
<tr>
<td>No</td>
<td>163</td>
<td>56.2</td>
</tr>
<tr>
<td>Don't know/ Not sure</td>
<td>29</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>290</td>
<td>100.0</td>
</tr>
<tr>
<td>75. Do you understand what is in your care plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>67</td>
<td>68.4</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>27</td>
<td>27.6</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>I don't have a care plan</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>100.0</td>
</tr>
<tr>
<td>76. Do you agree with what is in your care plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>48</td>
<td>49.0</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>38</td>
<td>38.8</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>8.2</td>
</tr>
<tr>
<td>Don't know/ Can't remember</td>
<td>3</td>
<td>3.1</td>
</tr>
<tr>
<td>I don't have a care plan</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>100.0</td>
</tr>
<tr>
<td>77. In the last 12 months have you had a care review?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, I have had more than one</td>
<td>25</td>
<td>8.7</td>
</tr>
<tr>
<td>Yes, I have had one</td>
<td>44</td>
<td>15.2</td>
</tr>
<tr>
<td>No, I have not had a care review in the last 12 months</td>
<td>220</td>
<td>76.1</td>
</tr>
<tr>
<td>Total</td>
<td>289</td>
<td>100.0</td>
</tr>
<tr>
<td>78. Were you told that you could bring a friend or relative to your care review meetings?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>19</td>
<td>27.5</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>46.4</td>
</tr>
<tr>
<td>Don't know/ Can't remember</td>
<td>18</td>
<td>26.1</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>100.0</td>
</tr>
<tr>
<td>79. Were you given a chance to express your views at the meeting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>36</td>
<td>52.2</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>27</td>
<td>39.1</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>8.7</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>100.0</td>
</tr>
<tr>
<td>80. Did you find the care review helpful?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>24</td>
<td>34.8</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>29</td>
<td>42.0</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>23.2</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>100.0</td>
</tr>
<tr>
<td>81. Have you been told who your care co-ordinator is?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>47</td>
<td>16.3</td>
</tr>
<tr>
<td>No</td>
<td>200</td>
<td>69.2</td>
</tr>
<tr>
<td>Not sure/ Don’t know</td>
<td>42</td>
<td>14.5</td>
</tr>
<tr>
<td>Total</td>
<td>289</td>
<td>100.0</td>
</tr>
<tr>
<td>82. How long is it since you last saw your care co-ordinator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one month</td>
<td>25</td>
<td>53.2</td>
</tr>
<tr>
<td>One to three months</td>
<td>8</td>
<td>17.0</td>
</tr>
<tr>
<td>Three to six months</td>
<td>8</td>
<td>17.0</td>
</tr>
<tr>
<td>More than six months</td>
<td>6</td>
<td>12.8</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>100.0</td>
</tr>
</tbody>
</table>
### Section Two: I. Support in the community

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>83. Can you contact your care co-ordinator if you have a problem?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, always</td>
<td>26</td>
<td>55.3</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>18</td>
<td>38.3</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>6.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>47</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>84. In the last two months, how often have you visited a day centre?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most days</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>Once or twice a week</td>
<td>11</td>
<td>3.8</td>
</tr>
<tr>
<td>Once or twice a month</td>
<td>3</td>
<td>1.0</td>
</tr>
<tr>
<td>I have not visited a day centre in the last two months</td>
<td>270</td>
<td>94.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>85. Were the activities provided by the centre helpful?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>8</td>
<td>47.1</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>8</td>
<td>47.1</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>86. In the last 12 months, have you received any help with accommodation?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>17</td>
<td>5.9</td>
</tr>
<tr>
<td>No, but I would have liked help</td>
<td>47</td>
<td>16.4</td>
</tr>
<tr>
<td>I did not need any help</td>
<td>223</td>
<td>77.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>87. In the last 12 months have you received help with finding work or keeping a job?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31</td>
<td>10.8</td>
</tr>
<tr>
<td>No, but I would have liked help</td>
<td>62</td>
<td>21.6</td>
</tr>
<tr>
<td>I did not need any help</td>
<td>147</td>
<td>51.2</td>
</tr>
<tr>
<td>I am unable to work because of my mental health problems</td>
<td>47</td>
<td>16.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>88. Are you currently in paid work?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>146</td>
<td>50.9</td>
</tr>
<tr>
<td>No</td>
<td>89</td>
<td>31.0</td>
</tr>
<tr>
<td>No, but I work on a casual or voluntary basis</td>
<td>28</td>
<td>9.8</td>
</tr>
<tr>
<td>No, but I am a full-time student</td>
<td>24</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>89. In the last 12 months have you received help with getting benefits?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>40</td>
<td>14.0</td>
</tr>
<tr>
<td>No, but I would have liked help</td>
<td>82</td>
<td>28.7</td>
</tr>
<tr>
<td>I did not need any help</td>
<td>164</td>
<td>57.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>286</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>90. In the last 12 months have you received any information about local support groups for those with mental health problems?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>70</td>
<td>24.4</td>
</tr>
<tr>
<td>No, but I would have liked information</td>
<td>128</td>
<td>44.6</td>
</tr>
<tr>
<td>I did not need any information</td>
<td>89</td>
<td>31.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>91. When was the last time you saw someone about your mental health problem?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one month ago</td>
<td>188</td>
<td>65.5</td>
</tr>
<tr>
<td>One to three months ago</td>
<td>47</td>
<td>16.4</td>
</tr>
<tr>
<td>Three to six months ago</td>
<td>24</td>
<td>8.4</td>
</tr>
<tr>
<td>More than six months ago</td>
<td>28</td>
<td>9.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Section Two: J. Crisis care

92. In the last 12 months, have any appointments been cancelled or changed by mental health services?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, one appointment was cancelled or changed</td>
<td>49</td>
<td>17.1</td>
</tr>
<tr>
<td>Yes, two or three appointments have been cancelled or changed</td>
<td>41</td>
<td>14.3</td>
</tr>
<tr>
<td>Yes, four or more appointments have been cancelled or changed</td>
<td>9</td>
<td>3.1</td>
</tr>
<tr>
<td>No</td>
<td>188</td>
<td>65.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>287</td>
<td>100.0</td>
</tr>
</tbody>
</table>

93. Do you have the number of someone in mental health services that you can call out of office hours?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>135</td>
<td>47.2</td>
</tr>
<tr>
<td>No</td>
<td>133</td>
<td>46.5</td>
</tr>
<tr>
<td>Not sure/ Don’t know</td>
<td>18</td>
<td>6.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>286</td>
<td>100.0</td>
</tr>
</tbody>
</table>

94. In the last 12 months, have you called this number?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>54</td>
<td>40.0</td>
</tr>
<tr>
<td>No</td>
<td>81</td>
<td>60.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

95. The last time you called the number, how long did it take you to get through to someone?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I got through immediately</td>
<td>23</td>
<td>41.8</td>
</tr>
<tr>
<td>I got through in one hour or less</td>
<td>20</td>
<td>36.4</td>
</tr>
<tr>
<td>A few hours</td>
<td>9</td>
<td>16.4</td>
</tr>
<tr>
<td>A day or more</td>
<td>1</td>
<td>1.8</td>
</tr>
<tr>
<td>I could not get through to anyone</td>
<td>2</td>
<td>3.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>55</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Section Two: K. Standards

96. In the last 12 months, have you been detained (sectioned or scheduled) under the Mental Health Act?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>28</td>
<td>9.8</td>
</tr>
<tr>
<td>No</td>
<td>258</td>
<td>90.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>286</td>
<td>100.0</td>
</tr>
</tbody>
</table>

97. When you were detained, were your rights explained to you?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>21.4</td>
</tr>
<tr>
<td>No</td>
<td>22</td>
<td>78.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Appendix 5

List of contributors
Obsessive Hope Disorder
Project team/contributors

Amanda Bresnan
From October 2008 to 2012 Amanda was an elected Member of the ACT Legislative Assembly (MLA) for the ACT Greens. Amanda was the ACT Greens spokesperson for health, disability, housing, ageing, multicultural affairs, transport and corrections. During her term, Amanda was Chair of the Standing Committee on Education, Training and Youth Affairs, and Deputy Chair of the Standing Committee on Health, Community and Social Services. Amanda was also Chair of the 2012 ACT Budget Estimates Committee. A major focus of Amanda’s work as an MLA was on preventative and mental health. As a part of the Parliamentary Agreement with the Government, Amanda and her colleagues successfully negotiated the inclusion of an item for 12% of health funding to go to mental health and 30% of this funding to go to community-based and run services. During her term as an MLA, Amanda had legislation successfully passed on kilojoule labeling for food sold at major fast food outlets; establishing a fairer system of fine repayments for people who are vulnerable or disadvantaged; and establishing an Official Visitor for people with a disability in group homes; an Official Visitor for people using homelessness services; and an office for official visitors, under the Office of the Public Advocate. Prior to being elected as an MLA, Amanda was the Acting Director of Policy and Projects for the Mental Health Council of Australia (MHCAl.

Amy Elson
Amy is a research consultant at ConNetica and is currently undertaking a Bachelor of Occupational Therapy at the University of the Sunshine Coast. Amy has a keen interest in physical and mental health and improving policy design and implementation.

Yve Gilbert
Yve has worked with government and non-government agencies for over 20 years reviewing statewide policy, workforce strategies and funding methods, as well as developing continuing professional development programs, event managing an international refereed conference, managing procurement processes, monitoring service delivery contracts and developing market capacity for community service provision.

Janet Hopkins
Janet, is the former CEO of Lantern, an innovative Melbourne based community managed mental health service. A proven leader on innovation in community mental health, Janet managed a diverse portfolio of programs which included Psychosocial Rehabilitation and Recovery Services, Carer Support Services, a Disability Employment Service and a Registered Training Organisation. Janet is highly regarded as a strategic thinker and innovator and has led the sector in the use of social media tools and practice. Besides driving the rebranding and repositioning of Lantern in 2010, Janet created the award winning MentalHealth2.0 Unconference and has been instrumental in the development of the innovative Blossom project for young women.

Dr Peter Long
Dr Long is an organisational consultant with a focus upon alternative thinking strategies, participative work design, planning, change management, leadership and training. He is a Rotary Graduate Fellow (in recognition of community service) and recipient of Public Service Awards including the 2004 NSW Premier’s Public Sector Award in the Business, Management and Financial Performance category. Peter is a foundation presenter in the Public Sector Management Program for middle managers and is a corporate educator with the QUT Graduate Business School, teaching into the EMBA, MBA and EMCPM Programs in Systems Thinking, Organisational Behaviour and Leadership topics. In 2000 he was a visiting lecturer in the International MBA, Waikato University lecturing on change management. As a consultant, he has completed major assignments with State Government lead agencies, Commonwealth and Local Government bodies. In the private sector he has had significant involvement with household names in the food, metal, manufacturing and financial industries.
Obsessive Hope Disorder

John Mendoza

John is a Director of ConNetica. He has previously held several executive positions including the inaugural Chair of the Australian Government’s National Advisory Council on Mental Health, CEO of the Mental Health Council of Australia and CEO of a Commonwealth Statutory Authority, the Australian Sports Drug Agency. John’s current appointments are: Adj. Professor, Faculty of Health and Sport Science, University of the Sunshine Coast, Adj Asso. Professor, Faculty of Medicine, University of Sydney, Board member of Young&Well Cooperative Research Centre, Chairperson, headspace Sunshine Coast and Foundation member of the Queensland Mind and Neuroscience Institute. John has authored and co-authored dozens of reports and submissions to public inquiries on mental health and suicide in the past decade including the landmark Not for Service Report in 2005. John has had a long involvement in the alcohol and drug field. Previously in the 1980s he was Director of Education with the Drug and Alcohol Services Council of SA and a member of the National Steering Committee for the National Campaign Against Drug Abuse (NCADA) and later a lecturer in Public Health at Queensland University of Technology. In 2002, John was awarded the QUT Vice Chancellor’s Alumni Award for Innovation and Excellence and the Faculty of Health’s Outstanding Alumni recipient. He is also a recipient of a ‘Life Achievement Award’ for his contribution to suicide prevention in Australia.

Sebastian Rosenberg

Sebastian is Senior Lecturer in Mental Health Policy at the Brain and Mind Research Institute, University of Sydney. He is also an Associate at the Menzies School of Health Policy. Sebastian worked from 2005-09 as Deputy CEO of the Mental Health Council of Australia and before this had 16 years experience working in both state and federal governments. In 2011 Sebastian was appointed Expert Facilitator to the Taskforce to establish the NSW Mental Health Commission and was also a member of the NHMRC Committee on Prevention and Community Health from 2009-12. Sebastian is a current member of the ACT Clinical Senate and is a PhD candidate, his topic being to establish a National Mental Health Report Card for Australia.

The Hon Keith Wilson

Keith Wilson has been a prominent WA and national mental health advocate for the past two decades. Keith was WA Minister for Health at the time of the Burdekin Report in the early 1990s. He was the Chairperson of the Mental Health Council of Australia at the time of the preparation and release of the Not for Service Report in 2005 and has served as president of the WA Alliance for Mental Health

Alphabetic list of contributors

Dr Phillip Batterham

Philip Batterham, PhD, is a Fellow in Mental Health Research at the Centre for Mental Health Research, The Australian National University in Canberra. He was awarded an Early Career Fellowship from the National Health and Medical Research Council (NHMRC) in 2011 and is a Chief Investigator for the NHMRC Centre of Research Excellence in Suicide Prevention and for three NHMRC project grants. His research interests include developing tailored screening measures for mental disorders, developing online programs to prevent mental disorders, identifying suicide risk, and reducing the stigma of mental illness.

The Hon Emeritus Professor Peter Baume AC

MB BS (Syd), MD (Syd), Hon DUniv (ANU), Hon Litt D (USQ), FRACP, Hon FRACGP, FAFPHM

Chancellor, The Australian National University 1994-2006; Director of Sydney Water 1998-2005; Governor, Foundation for Development Cooperation 1996-2007; Management Committee, Wayside Chapel 1998-2006; Professor of Community Medicine and Head of School, University of New South Wales 1991-2000; Senator for New South Wales 1974-1991; successively Government Whip, Minister for Aboriginal Affairs, Minister Assisting the Minister for National Development and Energy, Minister for Health, Minister for Education, and a Minister in Cabinet. Was Foundation Chair of the Australian Sports Drug Agency, Director, Futures Foundation Ltd.; Commissioner of the Australian Law Reform Commission, Deputy-Chair of the Australian National Council on AIDS, President of the Public Health Association (NSW Branch), Patron of the Voluntary Euthanasia Society of NSW and other positions. A physician, was an Officer in the Order of Australia and is now a Companion in the same Order. He has published extensively, reviews for a number of journals, has supervised and examined doctoral candidates and has received a number of competitive grants.
**Dr Jennifer Bowers**

Dr Bowers is the Managing Director of the Australasian Centre for Rural and Remote Mental Health and has held Chief Executive positions in Queensland and South Australian Mental Health Services. She has over thirty years’ experience in health and mental health in Commonwealth and State Governments and the private sector. Having established the Centre seven years ago, Dr Bowers continues to lead in the development and implementation of innovative responses to the mental health challenges confronting Aboriginal and Torres Strait Islander, farming and agricultural communities and the mining and resource sectors in rural and remote Australia. Dr Bowers is an adjunct Associate Professor at Griffith University and a Professorial Research Fellow at James Cook University.

**Dr John Brayley**

Dr Brayley is the South Australian Public Advocate. He is a former State Director of Mental Health in South Australia and Chief Advisor in Psychiatry and also holds an unpaid academic appointment as Associate Professor in Health Services Management at Flinders University.

**Professor Brian Burdekin AO**

Brian Burdekin is currently Visiting Professor at the Raoul Wallenberg Institute in Sweden and Professorial Visiting Fellow at the University of New South Wales. In 1995 he was made an Officer of the Order of Australia for his services to human rights.

From 1995 to 2003 he was Special Adviser on National Institutions, Regional Arrangements and Preventive Strategies to the first three United Nations High Commissioners for Human Rights and conducted over 200 missions to countries in Africa, Asia, Europe and Latin America where governments or civil society had expressed interest in creating an independent Human Rights Commission or similar institution.

From 1986 to 1994 he was Federal Human Rights Commissioner of Australia and in this capacity conducted major national inquiries into the systemic abuse of homeless children and Australians affected by mental illness. For over 30 years he has also been involved in negotiating international treaties to protect the rights of particularly vulnerable groups. From 1978 to 1986 he served as Principal Advisor to a former Australian Prime Minister, Deputy Prime Minister, Trade Minister, Minister for Federal-State Relations and the Federal Attorney General. Prior to this he was a diplomat and lawyer.

**Michael Burge**

Michael Burge has been advocating for consumers and carers for approx 17 years on numerous local, state and national committees; Mental Health Workforce Advisory Council, National Register of Consumers and Carers, National Recovery Working Group, National Advisory Council on Mental Health, National Consumer Reference Group, Expert Reference Group for development of Certificate IV Mental Health Peer Support and full time Mental Health Advocate since 2002. Michael is a Master Mental Health First Aid Instructor having conducted more than 77 courses. Michael is the co-chair of the National Mental Health Consumer and Carer Forum (NMHCCF) a combined national voice for mental health consumers and carers. He is very passionate about his work and is committed to improving the quality of life for both consumers and carers.

**Associate Professor Jane Burns**

Jane Burns is the founder and CEO of the Young and Well Cooperative Research Centre, having established the $100m initiative in 2010. The organisation brings together the youth and mental health sector in a partnership with young people and many of Australia’s great researchers. Its establishment is a culmination of Jane’s work in suicide and depression prevention and builds on her national and international partnerships with the corporate, philanthropic and not-for-profit sectors. The Young and Well CRC’s research explores young people’s use of technology and its impact on mental health and wellbeing.

**Joe Calleja**

Joe Calleja has been the CEO of the Richmond Fellowship of WA since July 2005. He has thirty years experience working with the community. He was previously Director for Court Support Services with the Department of Justice in Western Australia, Principal Social Worker of the Department for Community Services and Executive Manager of Kin Way Family Relationship Services, Anglicare WA. He is a past President of the Western Australian Association of Mental Health (WAAMH). He has previously been a National Vice President of the Australian Association of Social Workers (AASW), President of the WA Branch of the AASW, Board member of WACOSS, Institute of Public Administration Australia WA (IPAA WA), and Chair of the Centrelink Consultative Committee on Mental Health in WA.
Obsessive Hope Disorder

Dr Michael Carr-Gregg

Dr Carr-Gregg works as a nationally registered child and adolescent psychologist working in private practice in Melbourne. Best known for establishing CanTeen – the support group for Teenagers with Cancer, he has been an academic, researcher and public policy activist. He is a Board member of the Young and Well CRC, the Alannah and Madeline Foundation and is an Ambassador for Mindmatters, Big Brother Big Sister and Playgroup Victoria and beyondblue. He has a high media profile working for Fairfax Radio, Channel 7 and Pacific Publications. He is the author of 9 books and is working on his 10th.

Brad Carron-Arthur

Brad Carron-Arthur is Professor Kathy Griffiths’ Research Assistant at the Centre for Mental Health Research, ANU. He graduated from the Australian National University with a Bachelor of Psychology (Hons) in 2011. Soon after he graduated, he hit the ground running on a mission for mental health advocacy quite literally as he completed a 5000km charity run up the East Coast of Australia in 2012. Brad continues to be a passionate advocate for mental health particularly in the area of suicide prevention. Seeking to ground this advocacy with a strong evidence-based understanding, he will soon begin a PhD in the area.

Professor Helen Christensen

Helen Christensen is the Director of the Black Dog Institute, University of New South Wales, and an NHMRC Senior Principal Research Fellow. She is the immediate past President of the Australasian Society for Psychiatric Research (ASPR), and immediate past president of the International Society for Research on Internet Interventions (ISRII), currently Treasurer of ISRII, which leads efforts to incorporate an international society of researchers and to establish an international exchange program for young researchers in e health. She has more than 350 research publications, and the author of e health websites, some of which are used throughout the world to deliver automated cognitive therapy for depression.

Graeme Cowan

Graeme Cowan is a mental health speaker, author, and consultant, who is passionate about helping people lead a more resilient and thriving life, by learning how to manage their mood. He is also the author of the bestselling BACK FROM THE BRINK book series and a Director of R U OK? Day. In 2000, whilst Joint Managing Director of a management consulting firm, he went through the worst depression his psychiatrist had ever treated. www.GraemeCowan.com.au

Tracey Davenport

Tracey Davenport is a Research Associate at the Brain & Mind Research Institute, The University of Sydney. She is also Co-Director of Academic Research and Statistical Consulting. Tracey has consulted on a wide range of academic research projects including design, implementation, management and statistical analysis and write-up. This work has been conducted in association with a number of different universities, hospital and private clinics as well as for not-for-profit community organisations such as beyondblue: the national depression initiative, headspace – Australia’s National Youth Mental Health Foundation, Mental Health Council of Australia and Young and Well Cooperative Research Centre. Tracey completed her undergraduate and Honours degrees in 1996 and her executive MBA in 2005. She is currently enrolled in a PhD focused on primary care psychiatry.

Sue Deacon

Sue Deacon has been the General Manager of Choice Support Service Inc since 2010. She has worked as a psychologist in community mental health and in private practice in Gympie. Last year she completed an Advanced Diploma of Community Sector Management and in 2011 participated in ROMP2 (Recovery Oriented Mentoring Program).

Dr Darrell Doessel

Dr Doessel’s work covers issues in welfare economics, public finance and health economics. His recent focus has been on the economics of mental health and suicide. He is the author/co-author of six books and editor/co-editor of seven books. He has almost a hundred refereed publications, and fourteen chapters in books

Professor Rob Donovan

Rob Donovan is Professor of Behavioural Research in the Faculty of Health Sciences, Adjunct Professor of Social Marketing in the School of Marketing and principal of Mentally Healthy WA’s Act-Belong-Commit campaign at Curtin University. After a career in commercial marketing he returned to academia in the early 1990s. He has a broad range of interests, including alcohol, tobacco and drugs, child abuse, domestic violence, racism, doping in sport, suicide prevention and mental health. He is currently Vice-president of the Board of Relationships Australia WA, a member of Mates in Construction board, and Chair of the World Anti-Doping Agency’s Ad Hoc Social Sciences Research Subcommittee.
Professor Pat Dudgeon
Professor Dudgeon is an Indigenous Australian psychologist from the Bardi people of the Kimberley, steering committee member of the Australian Indigenous Psychologists Association (AIPA), a member of the Indigenous Strategies Working Group, a Research Fellow and Professor at the University of Western Australia. She is a National Mental Health Commissioner

Learne Durrington
Learne is presently CEO of Perth Central East Metro Medicare Local in Western Australia. Previously she was the Executive Director of Adult Mental Health in Central North Adelaide Health Services South Australia with responsibility for forensic, acute and community services, and prior that Deputy Director of the Mental Health Unit in the Department of Health SA with responsibility for the legislation, policy, planning an funding of mental health reform.

Senator Concetta Fierravanti-Wells
Since 8 December 2009, Concetta was appointed Shadow Minister for Ageing by the new Leader of the opposition, the Hon Tony Abbott MHR. During the August 2010 Federal election Concetta was entrusted with the responsibility of leading the Liberal Senate ticket in New South Wales. She was subsequently re-elected for a new six year term. Since the election in 2010, Concetta was appointed Shadow Minister for Mental Health. She also retained her tole as Shadow Minister for Ageing.

For 25 years, Concetta was actively involved in a wide range of community activities including: fundraising, charities and work in her local community. She was an active member of the Australian–Italian community holding representative positions at a national and international level. She also spent four years on the Board of Father Chris Riley’s Youth off the Streets, including two years as its Chairman.

Ivan Frkovic
Ivan Frkovic, has a Masters of Social Welfare, Administration and Planning and is currently the Queensland State Manager for Aftercare. He has more than 20 years of experience in mental health in Queensland. Ivan has recently worked on the development of the Queensland Mental Health Commission, as well as in the multicultural non-governent sector and the Commonwealth income maintenance sector. For five years, Ivan was Director of the Community Mental Health Branch in the Department of Communities where he led the development of a strategic plan for the growth and development of the mental health community sector. In 2003 he participated in an international study tour comparing mental health systems in Australia to New Zealand, USA, England and Italy.

Professor Geoff Gallop AC
Geoff Gallop was Premier and Minister for Public Sector Management, Federal Affairs, Science, Citizenship and Multicultural Interests in Western Australia. As Premier, he oversaw a range of political and social reforms (electoral reform, gay and lesbian equality, and a State Administrative Tribunal), upgraded the State's industrial and labour laws, brought a spirit of reconciliation to the resolution of Native Title and developed partnership models for the State's indigenous communities, changed the law to require all 16 and 17 year olds to be on education or training, stopped the logging of all the State's Old Growth Forests creating record numbers of new national parks, restructured the State's electricity and racing industries, and started construction of the Perth to Mandurah Railway and City Tunnel.

In January 2006, Dr Gallop resigned as Premier of WA citing his treatment for depression and inability top continue as that state’s government leader. He was widely applauded from all sections of the community for his open acknowledgement of his depression.

Professor Kathleen Griffiths
Kathy Griffiths is Professor and Director of the Centre for Mental Health Research (CMHR) at the Australian National University. She is also the founding Director of the CMHR's Consumer Research Unit, the co-founding Director of Ehub, the Centre's mental health and research development Unit, an ANU Policy Fellow and an NHMRC Senior Research Fellow. Griffiths has been a member of a large number of national and State mental health and suicide prevention reference committees. Prior to returning to academia in 2001 she was a policy consultant in which capacity she was the Executive Editor of the first national action plan for the promotion of mental health and the prevention of mental illness. Griffiths is the author of approximately 200 publications and has been the recipient of 12 awards for research, health services, outreach or internet innovation over the past 10 years.
Amanda Gore
Amanda is the Founder and Director of The Joy Project – see www.thejoyproject.com. For more than 20 years, Amanda Gore has been one of America's and Australia's most admired professional speakers. Her expertise is in transforming the spirit of people and cultures by changing attitudes, improving relationships, connecting people, managing change, leadership, innovation, and team dynamics. She is an author of four books and several video and audio training programs, Amanda has a bachelor's degree in physical therapy, a major in psychology, and expertise in ergonomics, stress management, group dynamics, neurolinguistics, and occupational health.

Sarah Hardy
Sarah Hardy is currently the CEO of Smiling Mind. Sarah has a strong academic background and grassroots experience in the area of youth mental health and national program development. With a long history of working in the not for profit sector, Sarah is particularly interested in growing initiatives that promote mental wellness across whole populations.

Jack Heath
Jack, CEO of SANE Australia, is widely-known and respected for his work in suicide prevention, and the promotion of mental health in young people. In 1996, he founded the Inspire Foundation which runs the Reachout.com youth mental health service. More recently, he established the Inspire Foundation in Ireland and in the United States where he was CEO from 2010-11. Jack also has extensive government experience as a senior adviser and speechwriter to Federal Ministers. He has received a number of awards in recognition of his work, including the Centenary Medal for his contribution to Australian society.

Professor Ian Hickie AM
In 2003, Professor Hickie was appointed as the inaugural executive director of the flagship Brain and Mind Research Institute at the University of Sydney. Since then he has overseen its development as a major hub in translational neuroscience and clinical psychiatry.

Prior to this, in October 2000 he was appointed as the inaugural CEO of beyondblue: the Australian national depression initiative and from 2003-06 served as its Clinical Advisor. In 2006, Professor Hickie received the Australian Honours Award of Member (AM) in the General Division; for services to medicine in the development of key national mental health initiatives and general practice services in both the public and non-government sectors. From 2006 he was a founding member of Headspace; the National Youth Mental Health Foundation. In 2007, Professor Hickie was elected as Fellow of the Academy of the Social Sciences in Australia. From 2007-12 Professor Hickie was one of the first round of HYMRC Australian Research Fellows, recognising excellence in Australian Medical Research. From 2008-10, he was appointed to the Federal Health Minister’s National Advisory Council on Mental Health and then in 2010-11, the Federal Ministers Mental Health Expert Advisory Group. From 2012, Professor Hickie has been appointed as a Commissioner in the new National Mental Health Commission, to oversee enhanced accountability for mental health reform in Australia. Professor Hickie’s research, clinical and health services development work focus on neurobiological and clinical aspects of the major mood disorders.

Angus Houston AC
Air Chief Marshal Angus Houston AC, AFC (Ret’d) was the Chief of the Defence Force from 2005 until 2011. Angus is currently Chair of the Anzac Centenary Advisory Board, Airservices Australia, the Council for the Order of Australia and the Canberra Symphony Orchestra. Recently, he led the Expert Panel on Asylum Seekers.

Aram Hosie
Aram Hosie is the Director of Research and Public Affairs at the Inspire Foundation and a co-author of the 2012 report Counting the Cost: The Impact of Young Men's Mental Health on the Australian Economy. He has previously held senior policy roles within the West Australian public service, and commenced his professional life as an Occupational Therapist working in adult mental health and youth drug and alcohol settings.
**Professor Ernest Hunter**

Ernest Hunter is an Australian medical graduate who trained in adult, child and cross-cultural psychiatry in the United States before returning to work in remote northern Australia, which he has done for the last two decades. A leading figure in psychiatric research with indigenous people in Australia, Ernest became the inaugural Regional Psychiatrist with Queensland Health in 1992, providing clinical services to remote Indigenous communities of Cape York and the Torres Strait. He was the Foundation Professor of Public Health (Mental Health) with the North Queensland Clinical School of the University of Queensland based in Cairns, which subsequently became the North Queensland Health Equalities Promotion Unit. He returned to clinical practice with Queensland Health in 2001 but remains involved in a range of projects including suicide prevention and the use of technology and multimedia approaches for health promotion. In the 2010 Australia Day Honours list Ernest was awarded a Public Service Medal for outstanding public service to Queensland Health, particularly in the delivery of mental health initiatives in rural Queensland. He is an Adjunct Professor with James Cook University.

**Rachelle Irving**

Rachelle Irving is the Executive Coordinator of the East Kimberley Homelessness Project in Western Australia as well as being a volunteer ambulance officer with St John’s Ambulance in Kununurra. She previously worked as the Deputy CEO and Director of Projects and Research at the Mental Health Council of Australia and as a Research Analyst with both the Australian Institute of Suicide Research and Prevention and the Australian Institute of Criminology. She has a Master of Suicidology, Master of Health Promotion and a Bachelor of Psychology. Other previous professional roles have included managing and working in a number of youth and homelessness programs as well as being a Detective in the Queensland Police Service.

**Jan Kealton**

Jan Kealton is a long-term carer and passionate advocate for mental health. She has represented carers on various Queensland Health committees and is on the Board of the Queensland Voice for Mental Health. Jan has also addressed medical students and mental health clinicians of all levels as a guest lecturer; and has spoken at various conferences, including the Rotary Early Psychosis Forum 2012 and 2013 and the 2012 TheMHS Carer Day.

**Doris Kordes**

Doris Kordes works in a mental health carers policy and representation role with Carers ACT. Her research interests include the history and politics of mental health care, and the title of her PhD thesis is: *The arts of care in an asylum and community 1925-2004: Kenmore Hospital NSW and Canberra ACT.*

**Professor Jayashri Kulkarni**

Jayashri Kulkarni commenced her appointment as Professor of Psychiatry, The Alfred and Monash University in 2002. She directs a large psychiatric research group, the Monash Alfred Psychiatry Research Centre (MAPrc), with approximately 170 staff and students. The Centre is dedicated to discovering new treatments, new understanding and new services for people with a range of mental illnesses. She became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in 1989 and was awarded a PhD from Monash University in 1997 for her thesis “Women and Psychosis”. Jayashri has pioneered the novel use of estrogen as a treatment for schizophrenia and is internationally acknowledged as a leader in the field of reproductive hormones and their impact on mental health.

**Mary Lawson**

Mary Lawson was born and grew up in Brisbane, QLD. While schooling was interrupted by illness and multiple hospitalisations, she completed year 12 at St. Aidan’s Anglican Girls’ School in 1991. Following over 20 years of recurrent hospitalisations for anorexia, depression, and PTSD, Mary became increasingly frustrated with the ineffectiveness of, and gaps in services for women with eating disorders. This motivated her to return to university in 2006 to attain a degree in Public Health, with the intention of becoming instrumental in the improvement of service provision and quality for people with mental illness in Australia. Mary now has a degree in Public Health (with honours) and a degree in Media and Communications (with honours) and is currently working on setting up her own non-profit organisation that will provide a new treatment option for women with eating disorders (see story on RED HOUSE).

**Quentin McDermott**

Quentin McDermott works for the ABC's Four Corners program, where he has reported several stories around issues of suicide and mental health. His 2009 report Lethal Force investigated the deaths of four men who were mentally unwell and who died in incidents involving the police. His 2012 report Closing Ranks investigated the death of Adam Salter, and the police cover-up that followed it.
Obsessive Hope Disorder

Professor Pat McGorry AO

Patrick McGorry, MBBS, MD, PhD, FRCP, FRANZCP, is Professor of Youth Mental Health at the Centre for Youth Mental Health at the University of Melbourne, and Executive Director of Orygen Youth Health in Victoria, Australia. Professor McGorry’s professional interests are in the area of youth mental health, and more particularly, in early intervention for emerging serious mental illnesses in young people.

In 1992 Professor McGorry founded the pioneering Early Psychosis Prevention and Intervention Centre in Melbourne in 1992, a highly innovative model for mental health service delivery that has been hugely influential world-wide, and has been a driving force behind the growth of today’s movement towards preventive psychiatry. Professor McGorry has played, and continues to play, a major role in mental health reform nationally and internationally, most notably in the establishment of headspace, the National Youth Mental Health Foundation.

Professor McGorry has published over 300 papers and book chapters in the specialised literature, and his contribution to academic psychiatry and health service reform has been recognised with numerous awards and distinctions, the most recent being his nomination as the Australian of the Year for 2010. Apart from his work on youth mental health, Professor McGorry has an interest in mental health care for the homeless, refugees, and torture survivors, and continues to advocate on their behalf.

Dee McGrath

Dee McGrath has been the CEO of Carers ACT since 2005 and has worked in senior management roles in Australia, the Middle East and Ireland. Dee is a passionate advocate in influencing change so that the community recognise the contribution caring families make and that caring is accepted as a shared community responsibility.

David Meldrum

David is Executive Director of the Mental Illness Fellowship of Australia (MIFA). He is Vice-Chairman the Board of the Mental Illness Fellowship of South Australia, is has until recently been Deputy Chair of Foodbank South Australia, and a Director of the Northern Adelaide Medicare Local. Originally qualifying as a teacher, then as a social worker, he also holds a Master’s Degree in Public Administration. His professional experience includes government and nongovernment leadership roles in health, education and community services. These have included Chief Executive Officer of the South Australian Mental Health Services, the South Australian Dental Service and Metropolitan Domiciliary Care. From 2003-2006 he led the development and implementation of ‘Metro Home Link’, which has evolved as the basis for Australia’s largest range of hospital avoidance programs. David says ‘I hope my experience and profound admiration for the mental health sector and its people helps me to contribute useful advice on matters of policy, governance and the development of better overall responses to people affected by severe mental illness.’

Senator Claire Moore

Senator Claire Moore (ALP) became a senator for Queensland in July 1, 2002 after a career that has seen her work for the then Department of Social Security and later for the Community and Public Sector Union. Claire is Chair of the Community Affairs – Legislation Committee, and Depute Chair of the Community Affairs – References Committee. She played a lead role in the 2006 and 2008 Senate Inquiries into mental health services in Australia.

Christine Morgan

Christine is the CEO of The Butterfly Foundation, a national charity that supports and advocates for everyone affected by eating disorders, including sufferers, carers and their families. Christine is also the National Director of the National Eating Disorders Collaboration, a federally funded collaboration led by Butterfly that is continuing to develop a nationally consistent evidence based approach to the prevention, treatment and management of eating disorders in Australia. In the not for profit sector, Christine was General Manager in Wesley Mission, over the areas of Corporate Services; and Community and Family Development. Prior to joining Wesley Mission, Christine held senior executive positions in a number of listed companies. She has qualifications in Arts / Law and Management.

Outside business hours, Christine enjoys going to the theatre, seeing movies and trying out new tastes at great restaurants and to work off such excesses she tries to spend time at the gym.

Dr Stephen Mugford

Dr Mugford trained as a sociologist in the UK in the latter 1960s before teaching the subject in NZ (VUW, ’70-74) and Australia (ANU, ’75-97). In 1997 he started full time consultancy, setting up QQSR. Since then he has done a mix of research, change management and executive coaching for a wide range of clients, increasingly incorporating psychology and cognitive science into his approach.
**Sue Murray**

Sue’s background in education and health promotion has underpinned a career spanning more than 25 years in the community sector where she had responsibility for programs in education, media, communications and fundraising. After 10 years leading the National Breast Cancer Foundation positioning it as a highly recognised organisation and raising $100 million for breast cancer research, Sue built on her experience to establish the George Foundation for Global Health. Now leading Suicide Prevention Australia Sue is implementing the collective impact approach. Sue is Chair of Macquarie Community College, a director of Charities Aid Foundation, a graduate of the AICD and a member of both the Advisory Council for the Centre for Social Impact and Chief Executive Women.

**Lydia Najepszy**

Lydia has an education and management background, with extensive experience in training in the areas of mental health and wellbeing, leadership, careers, coaching, personality type, high performance teams and a range of topics that support individuals and organisations to maximise their potential. Lydia has worked in the government, corporate, professional sport and NGO sectors and is currently managing Queensland Youth Industry Links and Sunshine Coast Youth Partnership. Her post graduate studies are in Career Development and Human Resource Management and she has also worked as a support teacher in a Child and Youth Mental Health residential hospital program, and as a trainer for Mindmatters, working with teachers and the community to develop a whole school approach to mental health and wellbeing.

**Adj. Associate Professor Stephen Niemiec**

Stephen has been a registered psychiatric nurse for 37 years. He has worked in NZ, Australia and the UK in clinical, academic, and management positions. He completed undergraduate and postgraduate degrees in NZ and his early interest in psychotherapy and group work spread to service restructuring and redesign. He established the Newcastle-upon-Tyne crisis resolution and home treatment team in 1999 which was regarded as gold standard, winning many awards, and attracting strong interest in alternatives to Inpatient admission. He also served on the Mental Health Taskforce which was the main think-tank on mental health reform at that time for 5 years, and was a consultant to the Sainsbury Centre for mental health and an Associate for the National Mental Health Institute, before his return to Australia in 2005.

**Paul O’Halloran**

Paul O’Halloran is a Senior Clinical Psychologist, and has worked and studied for over 30 years in mental health services. He has worked in both the UK and Australia at all levels including direct clinical care, policy, service and practice. His positions have included Directorship of Practice Development and Training at the Sainsbury Centre for Mental Health, Kings College London; Regional Director of Workforce and Service Development with the National Institute for Mental Health, NIMHE; Head of Service Improvement and Practice Development within Hertfordshire Partnership Foundation NHS Trust. His work has also included consultancy with the World Health Organisation in Palestine (Gaza and the West Bank), Jordan, Bosnia and Herzegovina, Montenegro, Serbia, Sri Lanka and the Caribbean. He also works part time with WSLHD as a Senior Clinical Psychologist and Consultant in Assertive Community Treatment. Currently, as Director of MHINDS-INOZ Pty. Ltd, an Australian based consultancy organisation, he leads a programme of service improvement and practice development focussed primarily on improving the provision of evidence based mental health care.

**Dr Nick O’Connor**

Dr O’Connor is Clinical Director North Shore Ryde Mental Health Service, and Clinical Senior Lecturer, Northern Clinical School (Psychiatry) University of Sydney. His current clinical role is as psychiatrist in the Emergency Department and Psychiatric Emergency Care Centre (PECC) at Royal North Shore Hospital. He is a member of the Board of the NSW Institute of Psychiatry and the Board of the Mental Health Association of NSW and a Council appointed psychiatrist for the NSW Medical Council. Dr O’Connor’s areas of interest include: management and leadership of mental health services, clinical and corporate governance, quality improvement and patient safety, suicide prevention, treatment resistance and relapse prevention in schizophrenia, partnerships between general practitioners and mental health services, and the management of people with personality disorders.

**Dawn O’Neill AM**

Dawn was previously CEO of one of Australia’s largest charities – Lifeline Australia – and in 2009 was appointed a Member of the Order of Australia for services to the community and to Mental Health. In 2011 Dawn joined beyondblue as CEO. Dawn has a background in business management and marketing and is a member of the Australian Suicide Prevention Advisory Council (ASPAC) and the National Advisory Council for Mental Health (NACMH).
Ingrid Ozols

Ingrid Ozols, is an active workplace mental health and suicide prevention advocate and educator for more than a decade, and founding director of Mental Health at Work (mh@work®) a national consultancy aimed at improving the mental health, resilience and productivity of organisations and their people. An ambassador of Lifeline, Ingrid has and continues to participate on many national boards, committees, advisory groups and research committees. A former board member of Mental Health Council of Australia, and the inaugural Chair of beyondblue’s blueVoices, the national depression initiative’s lived experience arm for many year. Ingrid travels the country and internationally speaking to many groups, facilitating forums and seminars. She shares her journey of living, living and working with many people who have been touched directly and indirectly by mental illness and suicide, sharing vulnerability that has become a strength to bring humanness to the workplace alongside commercial realities, linking healthiness to the important role of work and productivity outcomes. A Victorian State Finalist at the 2007 Telstra Business Women’s Awards and finalist in the Social Contribution section of the Ernst and Young Entrepreneurship Awards in 2009. Ingrid holds a Bachelor of Science, Graduate Diploma’s in Business Management and Community Mental Health and has just completed a Masters in Mental Health Science.

Mick Palmer AO

Mick Palmer is a career police and law enforcement officer who enjoyed some 34 years police experience including 7 years as Commissioner NT Police Fire and Emergency Services and 7 years as Commissioner of the AFP. Since his retirement from the AFP in 2001 Mick has conducted a range of reviews and inquiries for the Federal and for State Governments including the Inquiry into the Immigration Detention of Cornelian Rau. He was a member of the Federal Governments Human Rights Consultation process chaired by Father Frank Brennan. During a break from policing between 1978 and 1983 Mick qualified with honours in the Queensland Barristers Board and practised as a barrister at law in 1982 and 1983. In 1988 he was awarded the Australian Police Medal and in 1998 he was made an Officer in the Order of Australia for introducing far reaching anti-corruption initiatives. Mick is a Director of the national think tank organisation AUSTRALIA 21.

Katherine Petrie

Ms Katherine Petrie completed her Bachelor of Science (Psych) and Honours in Psychology in 2011 at the University of Sydney. She is Professor Helen Christensen’s research assistant at the Black Dog Institute working on a variety of NHMRC grants and publications, predominantly in suicide prevention and E mental health. She also volunteers for the Black Dog Institute as a Youth Presenter and Educator in NSW high schools to educate youth about mental illness and reduce stigma. Her research interests include prevention of mental health problems and suicide, optimising treatment for depression and anxiety and boosting resilience.

Anita Phillips

Anita Phillips has been the ACT Public Advocate for nearly eight years. During her time at the Public Advocate of the ACT, Anita has successfully developed and implemented a model of advocacy for mental health that focuses on promoting and protecting the rights of people with mental health issues, particularly those who are confronted by the challenges of compulsory treatment. She has been an invaluable member of the group involved in the review of the Mental Health legislation in the ACT, advancing the inclusion of an assessment of capacity as a consideration, prior to involuntary orders being imposed. Anita is also a sessional lecturer at the ACU in “Social Work and Legal Studies” and a Director of the National Board of the Australian Association of Social Workers.

Toby Raeburn

Toby Raeburn is the founder and CEO of Australia’s first mental health nursing charity “ROAM communities.” A nurse practitioner in psychiatry he is an honorary clinical lecturer at the University of Sydney and has received various awards for his work including a Churchill Fellowship and an Australian Altruisim Award.

Rajiv Ramanathan

Rajiv Ramanathan leads Practical Visionaries, a specialist consultancy that supports agencies across Australia to connect with Australia’s diversity. Rajiv previously led key Commonwealth and Statewide multicultural initiatives including the Commonwealth’s Multicultural Mental Health Australia capacity building and policy initiatives; the Co-Exist NSW Diversity Health Comorbidity Service; and the Victorian statewide Transcultural Mental Health Access Program at ADEC. Most recently Rajiv led a review of multicultural mental health initiatives on behalf of the Mental Health Commission of Western Australia. With a history in designing social inclusiveness strategies, Rajiv is keen to support agencies across Australia with expanding possibilities in a diverse world.

Rob Ramjan

Rob Ramjan has worked in mental health for over 40 years in hospital, community and administration settings. The bulk of this time has been spent in the non-government sector. He has been CEO of the Schizophrenia Fellowship of NSW for 22 years. He is also a carer.
**Professor Alan Rosen**

Alan Rosen is the author or co-author of more than 110 published and submitted journal articles or chapters on studies of 24 hour community based alternatives to acute and long-term inpatient care, rehabilitation and recovery, assertive case management and integrated mental health service systems; early intervention in psychosis; psychiatric stigma; dual disorders, deinstitutionalisation, family intervention, Aboriginal and remote area mental health, cultural influences on mental health service systems, qualitative and quantitative outcome measures, impaired doctors, research and evaluation in mental health, service standards, the National Mental Health Strategy, International community psychiatry, Human Rights of individuals with Severe and persistent mental illnesses, international comparisons between Mental Health Commissions, and the history of Australian Psychiatry. He is an assessor for several national and international journals. He is currently co-editing a book on the Early Intervention of Nearly Everything in Mental Health Services for Blackwell-Wiley, and was guest editor for a special issue on International Mental Health Commissions for the Mental Health Review Journal (UK) published in December 2012.

**Dr Lesley Russell**

Dr Russell is a Senior Research Fellow at the Australian Primary Health Care Research Institute at the Australian National University. Her research interests include health care reform in Australia and the US, mental health, Indigenous health, addressing health disparities and health budget issues. Dr Russell returned to Australia in October 2012 after three years in Washington DC where she worked on a range of issues around the enactment and implementation of health care reform, initially as a Visiting Fellow at the Center for American Progress and later as a Senior Advisor to the U.S. Surgeon General in the Department of Health and Human Services.

Dr Russell has substantial experience working in health policy in the United States and Australia, both in and out of government. She was previously the inaugural Menzies Foundation Fellow at the Menzies Centre for Health Policy (MCHP) and a Research Associate at the US Studies Centre at the University of Sydney. Prior to that she was a health policy advisor to the Federal Australian Labor Party. She worked for seven years as health policy advisor on the Energy and Commerce Committee in the US House of Representatives. Dr Russell is also an Honorary Research Associate at the MCHP and a Senior Fellow at the Center for Australian, New Zealand and Pacific Studies at Georgetown University. She holds a PhD in biochemistry from the John Curtin School of Medical Research at the ANU.

**Sally Sinclair**

Sally Sinclair is the CEO of the National Employment Services Association, the peak body for the Australian employment and related services industry. Sally has been instrumental in informing key stakeholders on addressing Australia’s employment and inclusion challenges including strengthening the integration of employment, education and training, and increasing employment of disadvantaged jobseekers. Sally has extensive expertise in the design, development and delivery of employment and related services and her experience includes numerous government appointments. Sally is a Board member of the OECD LEED Programme’s Forum on Partnerships and Local Governance. Sally holds a BSc (Hons) from the University of Melbourne, majoring in neuropsychology.

**Anthony Smith**

Anthony Smith has achieved a national profile for his work in Suicide Prevention and Men’s Issues. Anthony has been a state delegate to the Board of Suicide Prevention Australia, has collaborated on Suicide Prevention Research as co-author of the ‘Pathways to Despair: The Social Determinants of male suicide (aged 25- 44), Central Coast, NSW’ (2010) and in 2011 was a Keynote Speaker at the Korea LifeLine Suicide Prevention Conference – Community Strategies for Suicide Prevention. Anthony is a strong advocate for reconsideration of our approach to ‘mental health’ issues where adverse life circumstances such as unemployment are contributing factors to personal distress.

**Maria Smith**

Maria Smith began Bounce in 2006. Initially, Bounce was formed to fill the need for emotional intelligence and non-vocational training for the long-term unemployed and severely disengaged. However, as the word—and success—spread about Bounce, Maria developed more programs and training tools that changed the lives of job seekers, at-risk youth, the homeless and executives alike. In recent years, Maria has implemented Bounce LifeSkills® Training Programs to long-term unemployed people throughout Australia; with high success rates leading to permanent employment for Bounce participants. Bounce won the prestigious Powercor New Business Award and most recently the MOMA Woman of the Year Award (May 2013). The Bounce message has reached state-side, resulting in more than three trips to the US to start conversations with key policy and decision makers ranging from Harvard professors to White House executives. Maria’s first book, *The Guide To Getting The Job You Want*, was published in November 2011 with rave reviews from the media and employment consulting community.
Melissa Sweet
Melissa Sweet is a freelance health journalist, moderator of the public health blog Croakey, and a PhD candidate at the University of Canberra. Professor Dudgeon is one of her supervisors.

Professor Colin Tatz AO
Professor Tatz is a founding director of the Australian Institute for Holocaust and Genocide Studies, visiting fellow in Politics and International Relations at the Australian National University, and honorary visiting fellow at the Australian Institute of Aboriginal and Torres Strait Islander Studies. He teaches and publishes in genocide studies, comparative race politics, youth suicide, migration studies, and sports history.

Simon Tatz
Simon Tatz was Director of Communications and Marketing for the Mental Health Council of Australia (MHCA) from 1996 to 2012, and before that was the Manager of the Communications and Marketing Unit, ACT Health, ACT Government. Simon Tatz has been a senior policy and media advisor to the Australian Labor Party for over a decade, including to a number of Shadow Ministers in the portfolios of Ageing, Disabilities and Carers, Consumer Affairs, Allied Health and Sport. He has also been a media and public relations consultant.

Professor Harvey Whiteford
Harvey Whiteford is Professor of Psychiatry and Population Health at the University of Queensland. He trained in medicine, psychiatry and health policy in Queensland and at Stanford University and has held senior clinical and administrative positions including those of Director of Mental Health in the Queensland and Federal governments in Australia and at the World Bank in Washington DC. He heads the Policy and Evaluation Group at the Queensland Centre for Mental Health Research, an NHMRC Centre for Research Excellence in mental health and the Mental Disorders Expert Group for the Global Burden of Disease Study 2010.

Dr Ruth Williams
Dr Williams’ fields of interest entail applying industrial economics, public finance and welfare economics to the mental health services industry and also suicide. Her co-authored book with Darrel Doessel is The Economics of Mental Health Care… She has nearly forty refereed publications and several books chapters.

Alan Woodward
Alan has held executive positions with Lifeline at the national level for over 8 years. He has responsibility for Lifeline’s Foundation for Suicide Prevention. Through the Foundation, Alan works with academic and professional experts to build the evidence base for Lifeline services, and to establish best practices for crisis support and community based suicide prevention. Recently, he has overseen evaluation projects for Lifeline’s crisis chat service, suicide hot spot interventions and education/training programs. Alan has had extensive experience in service development for the Lifeline 13 11 14 crisis line and in Lifeline’s social policy advocacy. Alan sits on several advisory committees on suicide prevention and is a Board Director for Suicide Prevention Australia, the national peak association for suicide prevention in this country. He is the immediate Past President of the Australasian Evaluation Society, a 1,000 member association for the promotion of sound evaluation practice in Australian and New Zealand. Alan has a Masters Degree in social science and policy, and a business degree in public administration, majoring in economics, politics and organisations, and a diploma in arts/communications (journalism).

Senator Penny Wright
Penny Wright is a Greens Senator for South Australia and the Australian Greens spokesperson for Mental Health, Legal Affairs, Schools and Education, Veterans’ Affairs and assisting with Industrial Relations in the Senate. Senator Wright is also the Chair of the Legal and Constitutional Affairs References Committee. Prior to entering parliament, Senator Wright has worked as a solicitor, university lecturer and deputy president of the Guardianship Board. Her legal career included such diverse areas as tenancy law, mental health, social security and violence against women. As a lawyer, she often worked in the ‘little end of town’ and assisted those living on the margins of society – people with low incomes, people affected by mental illness and generally those who had been dealt a tough hand by life.

As Greens spokesperson for Mental Health, Senator Wright has toured rural, regional and remote Australia to talk to real people, on the ground, about the state of mental health services in their region.
Appendix 6

List of 48 project partners
List of partners

ConNetica

ConNetica works to bring out the best in communities, organisations and their people. We have a strong commitment to initiatives that facilitate fair and just communities and workplaces. Our efforts assist individuals, organisations and communities to reap the rewards of fulfilling their potential and experiencing success. Our way of working is flexible, with openness to new ideas and a drive to continually improve.

OMC Connect

OMC Connect is a strategic creative agency specialising in the development and implementation of digital platforms, integrated marketing strategies and client conversion. Working with businesses to Create, Connect and Convert, OMC Connect is dedicated to delivering innovative solutions that connect both with the client and with their audience ensuring continued growth and success.

Queensland Youth Industry Links

Queensland Youth Industry Links Inc (QYIL) broker sustainable partnerships between schools, business, community groups and parents to improve education outcomes and career transitions. QYIL delivers a Partnership Brokers program as part of the Federal Governments National Partnerships Agreements initiative, working with stakeholder groups including Business, Industry, Educators and Families to foster a strategic, whole of community approach that supports young people to stay engaged in education and realise their full social and economic potential.

YOUNG and WELL CRC

The Young and Well Cooperative Research Centre unites young people with researchers, practitioners, innovators and policy-makers from over 70 partner organisations across the non-profit, academic, government and corporate sectors.

Neami National

Neami, a non-government mental health organisation, provides support services within a recovery framework to people with a serious mental illness. Our staff use the Collaborative Recovery Model and the Optimal Health Program to assist consumers build confidence and skills to develop a sense of meaning and purpose in their life, encouraging consumers to identify and enhance their strengths and values when working towards achieving goals.

Orygen Youth Health

Orygen Youth Health is a world leading youth mental health organisation based in Melbourne, with a specialised youth mental health clinical service, internationally renowned research centre and integrated training and communications program.

QLD Alliance for Mental Health

Queensland Alliance for Mental Health is the peak body for the mental health community sector. We’re working with you to create communities that value differences, promote wellbeing and create a sense of belonging for everyone. We aim to achieve this vision by influencing, connecting, strengthening, and collaborating with our communities, to improve mental health and wellbeing.
Mental Illness Fellowship

The Mental Illness Fellowship of Australia has member organisations across the whole of Australia. We have nearly 80 'front doors' in metropolitan and regional locations where people affected by mental illness and those who care about them are guaranteed support, information and links to the kind of ongoing assistance they may need.

Pathways

Pathways promotes and facilitates positive mental health lifestyles within the community and supports those with a mental illness, their carers and families, to attain improved mental health and wellbeing. We provide a range of programs, including supported housing, psychology services and assistance from social groups to outreach support and employment through our Clearwater Business Services and MadCap Cafe businesses.

After Care

Founded in 1907, Aftercare is a not-for-profit organisation providing programs and services to assist people who might be experiencing mental illness and intellectual disability, as well as their families and carers. Aftercare also works to promote a better understanding in the community of mental illness and intellectual disability through education.

Boystown

BoysTown is dedicated to enabling young people, especially those who are marginalised and without voice, to improve their quality of life. Our services include counselling, job services, training, education, family refuges and help with parenting.

Butterfly Foundation

The Butterfly Foundation is Australia's leading not for profit charity supporting those affected by eating disorders and negative body image. Butterfly was established in 2003 and over the last 10 years has expanded its advocacy and fundraising work to include support services, education services, research and collaboration across the sector. Butterfly runs the national Eating Disorders Teleweb Counselling Service, funded by the Federal Government.

Open Minds

Open Minds is a community managed organisation which provides support to people living with mental illness, disability and acquired brain injury. Our purpose is to work together to improve mental health and wellbeing. Our vision is for an inclusive community where each person has the opportunity to live a life of choice, fulfilment and participation and where diversity is embraced and valued.

Richmond Fellowship of WA

Richmond Fellowship WA is a leader and key influencer in bringing Recovery into mainstream mental health practices and provides a comprehensive range of mental health services with programs that address a full spectrum of mental health concerns. Underpinning RFWA-developed and managed programs is an unyielding belief that People Can and Do Recover from mental ill health.

SANE

SANE Australia is a national charity helping all Australians affected by mental illness lead a better life – through campaigning, education and research. SANE conducts innovative programs and campaigns to improve the lives of people living with mental illness, their family and friends. It also operates a busy Helpline and website, which have thousands of contacts each year from around Australia.
atWork Australia, part of the WorkFocus Group, helps job seekers with a range of physical disabilities, injuries, and mental health issues to find the ‘right’ job across a broad range of industries. We assess eligible job seekers using experienced health professionals; accurately identify barriers to employment; and link job seekers with our community partners for training and support services.

The OzHelp Foundation, a not for profit, community based mental health support organisation, focuses on suicide prevention in workplaces. Our development and resources have been forged in the building, construction and mining industries and more recently applied in the utilities industry, community services and the white collar private and public service sectors.

United Synergies is a not-for-profit organisation committed to making a difference to the lives of others. Our services support young people, families and communities around Australia, with particular emphasis on those experiencing some form of disadvantage. Working directly with those in need we are committed to the full development of human potential.

The Black Dog Institute is dedicated to improving the lives of people affected by mood disorders through high quality translational research, clinical expertise and national education programs. The Institute focuses on the development of new and more effective, diagnostic, intervention and treatment strategies for people living with depression and bipolar disorder.

Heal for Life, a not for profit organisation, provides safe, affordable healing places for survivors of childhood trauma and abuse. Our five day residential program, run by survivors for survivors, deals with the trauma and resultant low self-esteem that causes mental health problems and self-destructive behaviours. We carefully select and train survivors to ‘walk alongside’ our guests.

Our Vision – People with lived experience are the drivers of positive change in all mental health services and mental health reforms. Our Purpose – To build the capacity and ability of community organisations to support people on their recovery journeys.

The Ted Noffs Foundation continues the legacy of the great Australian humanitarian, Rev. Ted Noffs, by providing essential services for young people and their families who are experiencing drug and alcohol problems and related trauma. Our range of programs for young people are all based on leading research, continually evaluated and government endorsed.

ACON is a NSW community-based health promotion organisation which works to reduce HIV transmission, support people affected by HIV and improve the health and wellbeing of the gay, lesbian, bisexual and transgender community.
Act–Belong–Commit

The Act–Belong–Commit campaign is a world-first comprehensive community-based health promotion campaign designed to build population mental health. The ‘act’, ‘belong’ and ‘commit’ domains are a simple ‘a-b-c’ for good mental health. There is substantial evidence that being active, having a sense of belonging and having a purpose in life all contribute to good mental health and wellbeing.

Action on Disability within Ethnic Communities

ADECs vision is to empower people with disabilities from ethnic backgrounds, their carers and families to fully participate as Victorian community members. Our mission is to assist these people to access services, to achieve full citizenship, ensuring that service systems are inclusive and responsive to their needs.

Australasian Centre for Rural and Remote Mental Health

The ACRRMH champions proactive and preventative initiatives for rural and remote communities. The Centre is committed to practical outcomes, focusing on early intervention, the identification of problems and the prevention of them where possible. Where problems can’t be prevented, we focus on collaborative delivery of integrated solutions and recovery mechanisms.

Australian College of Mental Health Nurses

The ACMHN, the peak professional mental health nursing organisation, is the recognised credentialing body for mental health nurses in Australia. We seek to represent the profession at all levels of government and across all health service sectors. We set standards for practice, support mental health nursing research and provide a forum for professional development for our members.

Australian National University

The ANUs Centre for Mental Health Research (CMHR) aims to improve individual’s mental health through research and development, training, policy and information dissemination. We seek to reduce the prevalence of mental health concerns in the community and improve the lived experience of people with a mental illness, through translation of research into practice and policy.

Brain and Mind Research Institute

The BMRI has a fundamental commitment to the long-neglected areas of brain and mind disorders, pursuing genuine partnerships with the wider community as a vital part of our research and activities. The BMRI brings together patients, support groups and front-line carers with scientists and clinicians working in neurosciences and brain research.

Bounce Consulting

Bounce Consulting creates life changing courses and products designed to get you to the next level. From confidence building to breaking down mental roadblocks; amping up job skills to lowering inhibitions, Bounce Consulting has helped thousands of people Bounce forward, Bounce through, Bounce beyond what they thought was possible.

Carers ACT

Carers ACT campaigns with and for unpaid carers to advocate for the systemic support they need. We also provide services to support carer needs and the needs of the people for whom they care. The Mental Health Carers Voice program hosts a specialised website, runs workshops and networking opportunities and provides information or feedback on mental health policy and service issues.
mh@work

 mh@work® is an Australian based boutique consultancy whose purpose is to improve the wellbeing and productivity of people, workplaces and the community. To reduce the discrimination and stigma that is still associated with mental ill-health, by partnering with business, mh@work® mentors workplaces to create mentally healthy, resilient and supportive cultures. Using strategic sustainable educational programs incorporating innovative educational tools and services mh@work® specialises in designing and developing tailored programs for each client.

Chris Barrett Foundation

The Chris Barrett Foundation is a not for profit charity, formed by the family and friends of a 16 year old that died from mental illness. Our aim is to increase community awareness and acceptance of mental illness, with emphasis on youth. We hope decreasing mental illness stigma and increasing community awareness of the symptoms will result in early intervention and less young lives lost to suicide.

ComLink

ComLink supports older adults, younger people with disabilities and disadvantaged people stay in their own homes. We recruit, train and support volunteers to assist with our services and also act as a coordinating body to liaise with government and other groups in matters of funding, policy and community needs.

Federation of Ethnic Communities’ Councils of Australia

FECCA is the peak, national body representing Australians from culturally and linguistically diverse backgrounds. FECCA’s role is to advocate, lobby and promote issues on behalf of our constituency to government, business and the broader community. We strive to ensure the needs and aspirations of Australians from diverse cultural and linguistic backgrounds are properly recognised in public policy.

Inspire Foundation

The Inspire Foundation was established in 1996 in direct response to Australia’s then escalating youth suicide rates. We combine clinical research and evidence with the direct involvement of young people to deliver innovative and practical online programs that improve young people’s mental health and wellbeing. Our flagship ReachOut.com is the first online mental health service in the world.

Medicare Local Perth Central and East Metro

A leading not-for-profit charity in the primary health care sector focusing on the delivery of quality health outcomes to local communities by supporting primary health care providers and consumers. We seek to build better health and wellbeing for health professionals and consumers through leadership in the coordination and provision of effective primary care services.

NESA

The National Employment Services Association is a national not-for-profit peak body for the employment and related services industry in Australia. NESA provides an influential voice, industry leadership, development and representation to support our members to improve the lives of people through employment and inclusion.

Nicci Wall

Nicci Wall is a mental health advocate from Victoria. She has been putting together Glimpses, a manuscript of personal experiences with mental illness for free distribution to carers, consumers, educators and clinicians, with the aim of increasing awareness and reducing stigma.
Practical Visionaries

Practical Visionaries is a specialist consultancy that supports agencies across Australia to connect with Australia’s diversity. Drawing on our key expertise in co-designing diversity engagement strategies, we’ve been busy helping our clients expand possibilities in a diverse world.

Richmond Fellowship
Queensland

RFQ, a not for profit company, is a well-respected leader in the provision of psychosocial mental health services. RFQ is a member of the Richmond Fellowship Asia Pacific Forum and Richmond Fellowship Australia. RFQ builds on its traditional values and strong mission focus with our own progressive thinking, advanced research and best practice service delivery.

ROAM Communities

ROAM communities is Australia’s first mental health nursing charity. We are dedicated to helping people overcome mental illness in the community, avoiding hospitals, jails and homelessness. We conduct psychiatric assessment and diagnostic evaluation, prescribe medications, train patients and families in mental health and engage in social advocacy for housing, finance or criminal justice concerns.

Smiling Mind

Smiling Mind is modern meditation for young people. We are a not-for-profit providing unique web and App-based programs developed by a team of psychologists with expertise in youth and adolescent therapy and web-based wellness programs. Our simple-to-use FREE programs utilise Mindfulness Meditation to assist with stress, resilience, mental health and wellbeing.

Stand Tall for PTS

Post-traumatic stress is one of the single biggest health problems in Australia, affecting up to 1.5 million Australians in some form. Our vision is that one day, every Australian will have a clear understanding of and respect for those who are affected by PTS. We see an Australia where PTS has the full support of Governments for research and treatment.

Stronger Smarter

The Stronger Smarter Institute has been relentlessly focused on changing the tide of low expectations for Indigenous and disadvantaged children right across Australia. The Institute has committed to do this by arming school and community leaders with the belief and capacity to transform their own schools with the Stronger Smarter philosophy.

St Vincent de Paul Society
NSW Support Services

St Vincent de Paul Society NSW Support Services provides individualised people-centred support for those affected by or at risk of homelessness across NSW. Men, women, families, young and old, are supported with outreach, crisis and longer-term accommodation, provision of meals, casework and counselling, clothing, medical services, art therapy, tenancy advice, life skills, education and vocational training. We aim to prevent or break the cycle of homelessness by providing a holistic approach that empowers our clients to achieve sustainable outcomes.

Suicide Prevention
Australia

Suicide Prevention Australia is the national peak body for the suicide prevention sector in Australia. We support communities and organisations throughout Australia, promoting collaboration, coordination and partnerships in suicide and self-harm prevention, intervention and postvention. Our mission is to make suicide prevention everybody’s business.

Wise Employment

WISE Employment is a not-for-profit organisation. We empower jobseekers to find meaningful work and become self-sufficient. We help employers find the right staff by understanding their needs and providing workers from diverse backgrounds. Our passionate and skilled staff assist over 10,000 people into jobs annually. Our services are cost-free to eligible jobseekers and employers.