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.

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About the Cover Design

This Report has been prepared in conjunction with:

Australian National University

The University of Sydney

Black Dog Institute

Young and Well

Cooperative Research Centre
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

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We wish to thank the more than eighty authors of the 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 those with lived experiences, some who wished to remain anonymous, for sharing their perspective. We commend them for their courage, hope and strength, and their insight provides the basis for real, enduring reform.

We also wish to thank all of our Project Partners for their support of the Project. They too have provided many examples of innovative programs across a diverse range of settings.

The Perspectives Essay Authors


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, Sydney University 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.

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Preface

The eighty-one perspective 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 Ministers\(^1\), 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, Learne 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 lead 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 focused 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.

In a year that 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.

\(^{1}\) ‘First Ministers’ is the collective term given to Prime Minister, State Premiers and Territory Chief Ministers in Australia.
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’Neil 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, culturally and linguistically diverse people, 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.

John Mendoza
On behalf of the Project Team
An analysis of the perspectives essays

Introduction

There are several key themes evident in the perspectives 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, and indeed neglect of, our workforce.

Several authors highlight that this situation has arisen in an environment in which mental health could be characterised as 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 vs. 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 that 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. In a time of apparent resource scarcity, mental health initiatives may continue to struggle to gain funding.

Several contributors highlight themes or strategies that 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 high-falutin’ reform rhetoric is not matched with concrete implementation. Part of this is about disaggregated and ineffective governance structures, and weak stewardship of the process, 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” re-labelled 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.

Method

To facilitate diversity and depth of input, consumers across the lifespan, carers/natural supports, front-line 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 1).

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 1 below. 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 of the received submissions, choosing to represent the full breadth of the voluntary contributions given, rather than conduct any kind of selection or culling process.

2 Dr Lesley Russell coined this term in media interviews following the 2011 Federal Budget when discussing mental health funding.
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

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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 1: 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’s 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.

Analysis

All perspectives essays were loaded into a qualitative data analysis tool – hyperResearch. Investigator triangulation, described by Patton as the use of several different researchers to interpret a set of data, was used 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.

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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 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 Brotherton 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, The University of Queensland.

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 these people with severe mental illness.

Leanne 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, stigmatised, 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 perspectives 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. Labelled “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 perspectives 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 and 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. They 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 Brain Burdekin nearly twenty years earlier.

Many perspectives 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 wellbeing, 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 person’s health and longevity, as can lack of access to good general health care.

Dr John Brayley, Public Advocate South Australia

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.

**Consumer “Bill”, mid-40s male, speaking of his experience 2004–2012**

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, marginalisation 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 and 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 perspectives 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,
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 form.

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 perspectives 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) being 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

Yet, in fact, we don’t have a ‘mental health system’. We have a complex mix of services and programs, which are unevenly distributed, and sometimes missing when and where they are most needed. Overall, our efforts remain ineffective or too small to meet the vast need.

Dawn O’Neil AM

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 standardisation 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”.

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, publically-available analysis of how much the Australian Government spends on mental health treatment and prevention strategies. Funding models or streams and the reporting requirements are 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 & Minister for Health
Lack of support for the mental health workforce

While recent changes to Medicare have 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 specialty. … 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 these targets, leaving the sector with the perception that the targets are not realistic or achievable.*
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*

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 peer support programs.

*Joe Calleja, CEO Richmond Fellowship WA*

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 whether 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 that include references to successful programs in almost every setting and
context. It is 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’.

United Synergies, StandBy Response Service

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’. …results 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 & Qld University

The continuing rhetoric vs 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 is highlighted, especially in the way they work against engaging people with mental illness. 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 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 ongoing mental health and wellbeing 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 among Aboriginal and Torres Strait islander peoples**

Four perspectives 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 may be 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
1. What do we need: When do we need it?

Martha Ansara – Carer for 18 years, Mother

Dear Friends,

My 40-year-old daughter has lived with (suffered from) schizophrenia for about 18 years. I won’t talk about the past when it was horrendously difficult to get any help for her whatsoever, but list the present needs I see them in view of my experience of the past few years in supporting her.

1) Decent acute care (including locked ward) facilities that are pleasant, safe and offer more than just being locked up with medicine. My daughter was in Caritas for three months – what a terrible place – and thank God was one of the select few who got to Turon House at Bloomfield for the next three months. Even at Turon House most of the programs had been cut.

2) Real programs for follow-up on release. People can’t just be dumped out into the community, as even with CTOs there is insufficient care.

3) Attractive, supported mental care housing in the community at many locations – THIS IS A VERY URGENT NEED.

4) Community occupational/recreational programs at health centres and drop-in centres (not so off-putting to people who are resistant to mental health care) – there used to be some but most have been closed.

5) MAT teams in all mental health districts to help with compliance in taking medication. (I believe that there is only one in Sydney.)

6) The provision/integration of full medical and dental care at the mental health centres for all clients – as a matter of course. Just doling out medicine is not enough.

7) More counselling and other psychological support for clients at mental health centres, including long-term therapy. Also group therapy which helps people create networks and share survival skills. So many people like my daughter are terribly isolated.

8) Good carers’ groups with calm, skilled leadership – when my daughter first got ill, I went to ARAFMI (I think it was called) run by carers who were as insane with worry and resentment against the mental health system as I then was.

9) Assistance for carers in planning what is to happen to their loved one when they die or can no longer help. Some sort of comprehensive care plan is needed. How this is to be done is beyond me, but I would happily participate in a workshop exploring the possibilities.

10) Some sort of assistance with meals and nutrition for those with mental illness.

There may well be other possibilities, but these are the ones which are readily on my mind.

Thanks for your interest.

Martha Ansara
2. Stigma in the school yard and beyond

Anonymous struggling mum with a teen

Support for new mums and dads when the stork delivers the much anticipated precious new life gains a lot of excitement and attention. On the reverse side of having a baby and the life change this brings, the ability to recognise signs and symptoms of postnatal depression has been growing over the recent years with intense awareness campaigns and effort.

Once our cute babies grow older, however, the information is less obvious or easily accessible. More often than not, the change in our pubescent children and their journeys into and through adolescence and teenage years can be a massive shock for all concerned that no one prepares families for.

Some schools leave parents isolated in the dark on many important health issues because they themselves don’t know how to deal with complex and often confronting situations our youth are facing in our fast-paced technology-driven world.

My daughter was hospitalised in 2012 for a suicide attempt and self-harming. In her peer group, six of her friends had similar issues; clearly troubled, another friend was also hospitalised just before her for serious mental health issues including bulimia.

On return to school from hospitalisation, my daughter was in a chain of girls who were at risk of suicide. My daughter came to me and said “Mum, E’s boyfriend of 15 at the local private boys’ school was suicidal, she was terribly worried that this would cause her friend E to take her life” and then my daughter added that this would in turn cause a chain reaction and she couldn’t promise me that if this did occur that she would follow. There had been discussions around ‘pact’ or group self-harm and suicidality, which I immediately reported to the school. The actions were not shared.

This all girls’ school’s policy and response was at times in these very painful and complex health instances of vulnerability came across in a most confusing way. In some instances reactions/responses were punitive rather than supportive; in other ways the school was trying to help.

For instance on sharing the news of our daughter’s suicide attempt to the school, she was immediately “removed in the middle of her class and classmates and asked to take all her things as she wouldn’t be returning by a senior staff member who came into her class to escort her out.”

There was no waiting for the end of the class to remove her in a less conspicuous or distressing way. There was no thought, no respect to her dignity or privacy. I implored, begged the senior staff and principal of the school to wait until the end of the class to no avail. They did not tell her why she was being removed so abruptly, dramatically and unexpectedly. “I was advised that the school’s actions were to protect the whole community, not just my daughter.” That seems a paradox given that the population of that class of 19 who witnessed this humiliating exit may not be so willing to come forward for assistance if they required it after seeing first-hand what might happen! These 19 young people very quickly used social media that within a few minutes of my daughter and I leaving the school premise and walking to the car both our phones were pinging with texts/messages from parents/children from other schools in the area asking what was wrong, if my daughter was suspended, expelled, going to “juvenie”, was she pregnant?

Which other of our children in that classroom would put up their hands to say they were vulnerable and not coping? So much for helping the population.

Rather than encouraging connection, the school’s immediate “removal “ of the child was seen as a policy that cared for the “larger” population in case a troubled teen harmed themselves in class or worse potentially harmed another student. Research tells us this is very, very rare and in fact self-harmers are very savvy at hiding what they do and their consequential scars. They also generally do this in private.
There is also a difference between self-harm and suicidality, but the school did not wish to take risks, which is understandable if they don’t have the knowledge or skills to deal with these sadly increasingly actions of girls.

We were required to gain “a fitness for school” report from a psychiatrist (not any other medical professional) prior to granting the student a re-entry to school. The assumption being that one could gain access to such a specialist in a relatively quick timeframe or that we would be keeping my daughter disconnected and at home for an extended period of time. When my daughter did return to school, the senior school staff member and counsellor advised my daughter “not to discuss anything related to self-harm, suicide or her stay in hospital with any of the other students. Her extended stay away from school was explained as “having the flu”.

She was also advised that she “would have to wear long sleeves” to hide her scars and that this was expected during all of summer and included during physical education classes. If she was getting “hot” she would not be able to participate if she did remove the jumper/long sleeved top. She was told that this was a way to not to draw attention to herself!” How ironical! Let’s send a red flag to a bull... Girls in this situation were all told the same instruction, so there were many wearing such tops!

This is an endemic issue in this girls’ school, which is being hidden so as not to damage the school’s reputation. Anecdotally we know of many more who find themselves in this situation and the turnover of girls leaving is high. My daughter in fact reported to the school that another one of her peers was planning on taking her life in late 2011. The reality was that these girls did want to and needed to talk about these issues, so they chose social media, networking sites, blogging and using tblr, and sadly not in the most positive or supported environments or ways.

No adults or peers were present to help support these lost troubled teens online. But this is all they had and needed to vent and showed their vulnerability in an unmoderated space. Social networking policies and practices were loose and somewhat superficial. The school allowed access to all social networking sites during school and after school hours. Here again families were not included or educated and there were no synergies or cross-management of students health or wellbeing when dealing with technology use.

As a family this has been a most traumatic experience. We don’t wish to lay total blame for any of this onto one party; however the toxicity that fuelled some of our daughter’s distress was the very stigmatising and confusing messages and behaviours of the school pastoral care. In the academic side of this journey, the school was most helpful and supportive, having a health plan and strategy for our teen if she did find herself not coping and in this plan was also a funnelled academic management plan to make up for what was missed and to fill knowledge gaps to ensure her passing the year.

Our education system, particularly our private girls schools anecdotally seem to be toxic secrets that could potential have tragic outcomes if not better managed more sensitively. Parents are being left to fend for themselves with many challenges that they don’t know how to cope with, and left worrying 24/7 waiting to see if this is the day that something tragic happens to their loved teen.
3. Preventative programs for ATSI Communities

Australasian Centre for Rural and Remote Mental Health

**Deadly Thinking and Creative Livelihoods** are comprehensive mental health awareness, education and preventative programs for Indigenous communities that have been successfully implemented by the Australasian Centre for Rural and Remote Mental Health (ACRRMH).

The ACRRMH has in some communities combined these programs aimed at further enhancing their effectiveness and ensuring sustainability of the health, social and emotional wellbeing and economic outcomes.

In 2011 the ACRRMH developed, piloted and evaluated a series of one-day mental health focused workshops called “**Deadly Thinking**”, specifically designed for Aboriginal and Torres Strait Islanders. The pilot workshops were delivered in five communities across Qld, NT and WA.

Since then Deadly Thinking has been delivered in many remote communities across Australia. The workshops are designed to provide awareness, basic literacy and knowledge to equip individuals and families to work towards building and sustaining social, emotional and mental wellbeing in a “whole person, whole community” context. The workshops target community members and ‘natural helpers’, community members who don’t necessarily work in the health or mental health field but who play active, leadership roles in their communities.

The workshops provide a unique opportunity for participants to build local “safe” networks enabling them to continue to explore issues of concern in their community, particularly suicide prevention strategies. The yarning techniques used in the workshops were embraced by the community and became a valid and culturally appropriate mechanism for them to talk about sensitive personal problems as they arose after the initial workshop.

**Creative Livelihoods** evolved out of an innovative, community arts-based, wellbeing and mental health recovery project in 2008 aimed at improving social and emotional wellbeing in remote Indigenous communities in Far North Queensland. It utilised creativity as a tool to engage with people with mental health problems and produced a multitude of positive and unexpected outcomes for participants. The arts programs were each tailored to the needs of the local communities with activities including but not limited to:

- Training in painting, sculpture, weaving, and other artistic outlets,
- Revival of traditional cultural practices such as collecting clay and bark to make paints and dyes and collecting traditional fibres such as pandanas for weaving,
- Creating individual art works to reflect personal totems and cultural story places,
- Community art works such as large scale public art murals referencing the importance of connection to country and culture and community pride,
- Creating documentary films which encouraged community members to tell their stories of recovery, and
- Local artists became mentors to others in their community exploring new opportunities to create livelihoods.
A significant aspect of the project is to include opportunities for intergenerational exchange between community Elders and young people. The evaluation of the previous project supported the hypothesis that arts can improve social capital and inclusion, as well as social and emotional wellbeing in the target communities. It can be a catalyst to help communities document and preserve traditional cultural practices and stories for future generations as well as an agent for inspiring individual connection and recovery.

**The combined program**

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.

The ACRRMH believes strongly that the interventions of Deadly Thinking and Creative Livelihoods are extremely effective programs that will continue to deliver positive outcomes.

By delivering the Deadly Thinking and Creative Livelihoods initiative, at the invitation of Indigenous communities, the ACRRMH is improving social and emotional wellbeing and raising awareness about suicide prevention.


The “Four good stories. Four happy endings” brochure about Creative Livelihoods is available on the website or in hardcopy from ACRRMH.

4. Psychiatry services

Peter Baume AO

Dedicated and hard-working people staff psychiatric facilities. But they are over-stretched in the work they have to do. They often have to hurry from job to job, and statutory requirements are great – they have to keep enormous records and too much of their time is spent on clerical, as opposed to clinical, tasks. So they have little time to talk with people or sit with people – just getting to know people well; that is one part of their legitimate clinical task that they cannot do physically.

The facilities too are not good enough. They are often crowded and environmentally sub-standard. Some of them are very old and well past their “use by” date. Furniture is too often dull and tired. Hospital planners have a problem here – on a defined and often crowded campus they have what is like a domino problem – they can only replace a unit by tearing it down and rebuilding. And then they have to house the patients somewhere else temporarily while they rebuild. So, they need some spare space before they go tearing down old facilities. There is at least one facility in which a bulldozer, driven very fast, would be the best option. The problem for the Hospital is to allocate priority for this rebuilding in line with the many capital requests before it, together with what to do with the patients while the facility is rebuilt (as it needs to be).

Psychiatrists take calculated risks every time they make a decision about a patient – for example the decision to grant leave or the decision to move a person from a closed to an open ward or the decision to use a drug that increases appetite and weight. So we get tales of innocent third parties being bashed or abused by psychiatrically ill fellow patients. The only way to avoid risk completely is to lock people up alone for a long time. But, what we need to avoid too is discharge being made because a bed is needed rather than on proper clinical grounds – it happens now in spite of official protestations to the contrary.

The private and public systems operate in a kind of symbiosis. The private hospitals take many of the less sick patients, who still need hospitalisation, while the public hospitals take the very sickest patients. The two systems could not operate independent of each other. The private hospitals generally transfer to the nearest public facility anyone who needs a certificate written, while the standard for admission to public hospital beds is set very high. But the public hospitals rest more secure knowing that the private hospitals are taking many of the less sick patients, and the private hospitals rest more secure knowing that the public system is there as a back-up for it.

In the community, it is striking just how much professionalism and caring there is. Staff are competent and hard working. Sadly the professionals are also very busy and the clerical demands on them are great. Nevertheless, the “clerking” is often of good standard, and the knowledge of clients is great. Since much of the work takes place in the homes of clients, the physical state of community mental health facilities is less important – but many of the facilities are quite good.

One administrative problem is lack of parking in hospitals (which makes employment in certain facilities unattractive) and a lack of preferential and safe community parking. There is no good sense in someone being seen in their home and the nurse who sees them receiving a parking ticket for their trouble – it is not beyond the realms of possibility that this problem could be fixed. That it has not been fixed already probably reflects some decision not to bring it to the attention of top people. Staff are often engaged in a risky activity, and should not then be penalised.

Another problem is the acute mania that occurs for 36 hours with some psychoactive illicit substances. As use of these substances is increasing in our society, so is the number of people with acute mania who will be “better” in 36 hours. By the way, if you had no job, no education and no future prospects, might not the use of illicit drugs be an attractive alternative?
Obsessive Hope Disorder

The “conventionality” of many of our beliefs is a worry too. Did you know that in the old Soviet Union people were sometimes put in psychiatric hospitals because they rejected communism – because such a rejection of communism was not in line with community beliefs. We need to protect people with heterodox views from admission to psychiatric institutions solely on account of those views. Luckily, most psychiatrists are aware of this danger and do their best to avoid it.

Change is occurring very fast in all the healing areas. There must be a capacity for the psychiatric services to embrace change – they have done well over a generation and change will keep occurring rapidly over the next decades.

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.

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, he 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.
5. Eight months locked up!

“Bill” – a mid-40s male
(Note: name has been changed)

That’s how long I have been in the Public Mental Health Wards. That’s been over nine years, having been admitted or committed.

This has been over six occasions, my sentences have included.

- 2004 Manly – East Wing (Involuntary Treatment Order) Police Involved
- 2009 Nambour (ITO) Police Involved
- 2010 Nambour (ITO) Police Involved
- 2012 Brisbane Royal Women’s then to Nambour (ITO) Police Involved
- 2012 Nambour (Voluntary)
- 2012 St Vincent’s Sydney short spell in St Augustine’s (ITO) Police Involved

Triage

I find it hard to believe that on two occasions I have been taken to hospital in the back of a ‘paddy wagon’, then Police escort me to Emergency Unit. The Police normally hang around for a hour or so then they are back off to work. I sit there for a few more hours in my Manic episode, now I getting psychotic so it’s off to explore the city and run amuck.

We may come to Emergency looking healthy physically, but just cause we don’t look sick nothing could be further from the truth. Triage needs a makeover.

Memories – Maybe?

I do not have many memories of hospital during my first week or two as I am very heavily medicated. This makes it a particularly bad time to have visitors as I generally have a foul mouth and tell them all my plans which may not be very pleasing to loved ones.

All hospitals – I cannot say enough positive about the Nurses, Mental Health Workers and Support Staff.

St Vincent’s great doctors – listened about my medication and willing to try something new. But no TV on the ward as someone had broken it previously. Four weeks in a ward where you brain is very active from Mania, if you get bored you cause trouble. Yes I was the one that set off the Fire Sprinkler!

Manly was a long time ago, I remember lots of Doctors telling me I have a Mental Illness, you have Bi Polar Type One was the debate.

Nambour experience is mixed if on the Upper ward there is only a small verandah to get some respite. In amongst the cigarette smoke. You get so bored I even take up smoking inside. The Lower Ward has a Garden; now nature does heal. You can do some gardening and get some fresh air.

Nambour has a negative reputation, but I take the garden any day. It’s the little things that matter.
Obsessive Hope Disorder
6. Redefining interventions for outback Australians

Jennifer Bowers

Introduction

This paper focuses on the rationale and evidence base for mental health and wellbeing preventative interventions and services in rural and remote Australia. It draws on:

- the perspectives and expectations of rural and remote Australians; and
- on-ground experience of the Australasian Centre for Rural and Remote Mental Health (ACRRMH/Centre) over almost seven years of work building the mental health and social and emotional wellbeing through its culturally appropriate interventions for those who live and work in rural and remote Australia.

The Centre believes that Australians who live and work in rural and remote regions are not recognised, understood or valued as they should be, especially in the context of the disproportionate contribution made by them to Australia’s economic prosperity.

Over one tenth of the Australia’s Gross Domestic Product (GDP) comes from the mining and agriculture sectors predominately based in rural and remote Australia. In 2009–10, the agriculture and mining sectors contributed $23.6 billion (1.8%) and $121.1 billion (9.4%) respectively to Australia’s GDP.

The Centre understands that mental health and wellbeing underpin the very fabric of rural and remote Australia: that is, unless people have “clear heads”, their very real challenges appear insurmountable. This drives the Centre’s “whole person, whole community” approach to mental health and individual and community resilience.

Rural and remote Australians live and work in conditions characterised by incessant and destabilising change, economic and financial uncertainty and extreme weather events. Ravaged again and again by droughts, floods and bushfires, rural and remote communities often lack the sort of services that urban Australians take for granted.

All these things can – and do – result in mental health problems, substance misuse and, in extreme cases, suicide.

Instructive Australian statistics with regard to mental health give an indication of the audience and potential demand for services and prevention programs. One in five (4.3 million) Australians live outside major urban and regional centres. 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). Rural and remote areas in every state and territory have a higher rate of suicide and higher co-morbidity than in urban areas, with the exception of New South Wales and the ACT.

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Defining preventative interventions

The Centre’s core business is developing and delivering preventative, culturally-specific, awareness-raising, educative mental health programs focussed on breaking down stigma and delivering effective preventative interventions. A key objective is to translate vital mental health information in culturally-specific ways and maintain and expand its activities across Indigenous, agricultural and mining and resources communities. The Centre’s physical footprint is light. However, its reach is substantial and has a proven impact.

State and federal governments and large companies bear ultimate responsibility for those living and working in these 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. This is compounded by the fact that they pay two to ten times more to access essential services including health services.

Therefore, another goal of the Centre is to redress this imbalance to:

- contribute to closing the gap for Indigenous Australians;
- build the resilience of farming families facing environmental and financial hardship; and
- build recognition in ‘macho’ miners of the impact of mental health issues on safety and productivity.

The Centre develops and delivers preventative, stress management interventions, which are characterised as ‘primary’ and ‘secondary’.

A ‘primary intervention’ reduces risk factors, de-stigmatises mental health and makes it a safe topic within the community or organisation. We do this in a number of ways: public speaking and media interviews, arts-based activities, musical performances, community events and seminars.

The Centre’s ‘secondary interventions’ provide personal protective and coping strategies through more formal, educative workshops, training sessions and the dissemination of promotional and educational material such as the “Passports to Mental Health”, posters, wallet-sized ‘helpline and website’ cards, workshop manuals and training guides. Information is always provided about pathways to care and ‘tertiary interventions’.

‘Tertiary interventions’ are reactive and outside the realm of the Centre’s activity. They involve clinical consultations, medication and rehabilitation.

Community strategy

ACRRMH understands and respects that each community is unique. The ACRRMH’s community strategy is predicated on consultation and careful, considered planning to ensure that every program is designed specifically for each key audience.

The areas of focus are mental health, social and emotional wellbeing and suicide prevention. The consistent themes across all programs are:

- breaking down the stigma of mental illness in ways that engage with and attract each group e.g. using music, humour, art, empathy and understanding;
- raising awareness by providing relevant information about risk factors and symptoms and signs to look for in themselves, their families and friends; and
- encouraging everyone to speak to someone and seek help early by the promotion of help-lines, websites, local support agencies, health and mental health services (if they are available in a remote location).

Developing current and new interventions always:

- identifies needs and community values;
- engages all stakeholders to ensure community ownership and effective collaboration;

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8 National Rural Health Alliance 2010. Measuring the metropolitan-rural inequality. 31 January.
respects cultural diversity and appropriateness;
prevents duplication; and
improves sustainability.

The approach to working in communities comprises four essential phases:

1. **The Consultation Phase is marked by:**
   - communication and consultation plans;
   - meetings with key stakeholders, organisations and community leaders;
   - reviews and identification of factors regarding mental health issues in the community;
   - collecting all relevant information and data; and
   - analysis of baseline demographic and mental health data.

2. **The Commitment Phase is marked by consensus regarding:**
   - the program’s aim;
   - the program’s components;
   - the involvement of other groups, organisations and individuals; and
   - determination and allocation of resources.

3. **The Implementation Phase is marked by:**
   - confirmation and communication of the program initiatives;
   - engagement with stakeholders;
   - training and/or access to the information and resources;
   - production and dissemination of tailored, creative communication collateral;
   - awareness sessions; and
   - the implementation of all program initiatives.

4. **The Evaluation and Sustainability Phase:**
   - ensures that the communities’ views and needs are reflected in the program initiatives;
   - embeds in the community skills, knowledge, information, products, self-esteem, a sense of wellbeing, new relationships and/or networks;
   - is marked by advocacy for continuation and/or modification by identifying new resources and activities;
   - features reports, records and publishes evidence and outcomes; and
   - is marked by the sharing of evidence and outcomes with other communities nationally and internationally\(^{10}\) \(^{11}\).

**Outcomes achieved include:**
- increased information and knowledge and preventative strategies embedded into the client community which build:
  - community resilience and morale; and
  - protective strategies and help-seeking behaviour in relation to emotional wellbeing and mental health;

\(^{10}\) Centre for Rural and Remote Mental Health (NSW) and ACRRMH 2011. Evaluation Report, Pilot of Deadly Thinking Workshops, November.
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- reduced social isolation;
- economic opportunities from the products of program initiatives; and
- improved quality of life.

**Examples of current interventions/programs**

**Programs for farmers and the agricultural workforce include:**

- the respected suicide prevention program “Building Bridges”, in its seventh year, is designed to share information and experiences between neighbouring rural communities to tackle the psychological, physical and financial impact of droughts and floods and, more recently, the tensions arising from the changing use of land and resources; 12 & 13;
- the co-ordination and delivery of educative workshops for the rural workforce to equip them to recognise and refer clients; and
- the renewal of courage and optimism through uplifting, family events which:
  - provide respite from emotionally debilitating crises;
  - assist in rebuilding personal and community linkages; and
  - raise awareness of symptoms and signs of mental health issues and pathways to care through the distribution of the Centre’s educative booklet “Passport to Mental Health in Agriculture”.

**Programs for Aboriginal and Torres Strait Islanders include:**

- the acclaimed suicide prevention and social and emotional wellbeing one-day workshop “Deadly Thinking” for those who live in remote communities; 8 & 14; and
- “Creative Livelihoods” – an innovative, evidence-based intervention which encourages people to join in arts and music activities leading to marked improvements in social and emotional wellbeing.

**Programs for the mining, resource and remote construction sectors include the “Minds in Mines” which:**

- delivers a range of preventative interventions which are sustainable and integrated into occupational health and safety programs;
- raises awareness, grows understanding and reduces the stigma of mental health that is so often a feature of the male dominated, “macho” mining environment; and
- assists with the early identification and prevention of mental problems before they turn into expensive, unproductive mental illnesses.

The ACRRMH is developing innovative interventions for ‘Breaking Down the Distances’ using smart, new and effective communication devices made possible by the internet (and the NBN).

The tyranny of distance and sparse populations dictate that access to mental health care, from primary interventions through to tertiary clinical services, is limited and/or non-existent.

All ACRRMH’s programs and services are predicated on building community spirit, connectedness and inclusiveness in both a community and organisational context.

**Recent examples of successful outcomes from primary and secondary interventions**

In 2012, ACRRMH was approached by several Queensland communities to assist them in their pathways to recovery from droughts and the floods. The Centre’s longstanding relationships and existing linkages ideally positioned it to render this assistance. Partnering with John Schumann (ex Redgum writer of “I

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14 ACRRMH 2011. Evaluation Report, From Creative Recovery to Creative Livelihoods: “It’s not just art...it’s a healing thing”. The benefits of an arts based health initiative in remote Indigenous communities
Was Only 19”) and his seven piece band, the Vagabond Crew and local health providers, a “Roadshow – It’ll be alright in the long run” through flood-affected communities, was devised. The “Roadshow” comprised morale-building concerts, family BBQs and access to health providers and subtle but effective messages. They proved valuable in binding communities and delivering positive information and referrals. The demand is such that the Roadshow concept has been repeated twice and is now one of the Centre’s key programs. Service providers have subsequently reported they believe at least two suicides were prevented through their ability to engage and intervene early15.

“Creative Livelihoods” has been nominated for two awards:

- the 2013 Creative Partnerships Australia Award for excellence in Arts and Health; and
- Arts Queensland Regional Arts and Culture Award for Indigenous Programs with Community Cultural Benefits.

Two exhibitions of the artwork from “Creative Livelihoods” in Cairns and Perth generated sales for the emerging artists who were previously identified as “at risk” program participants. These events demonstrate the personal and financial benefits of interventions to improve the mental wellbeing of Indigenous Australians.

The results of the Wellbeing and Lifestyle Survey undertaken as an integral component of the Minds in Mines program are proving invaluable for companies involved while contributing to evidence about the FIFO lifestyle. A recent media release about women on a construction site in the Pilbara proving to be more mentally resilient than the men generated headlines in the industry around Australia which was regarded as a very positive outcome for recruiters.

**Economically sound best practice**

ACRRMH programs and services exemplify best practice because:

- the phased approach described above is a “best practice” model for building community capacity;
- the evidence from independent evaluations has shown that:
  - community resilience, inclusions and morale improves;
  - protective strategies and help-seeking behaviour improves;
- social isolation is reduced;
- provide economic opportunities from the products of program initiatives
- community members report improved quality of life; and
- mental illness and suicides are prevented.

As well as the obvious benefits to individuals, families and communities, the delivery of innovative and compelling services and programs which raise awareness, de-stigmatises mental illness, educate individuals and encourage the early seeking of help, lessens the demand for expensive tertiary interventions which are either non-existent or in short supply in rural and remote regions.

Systemic financial, health and social outcomes can, ultimately, reduce demand for services in the following portfolios in federal and state governments and have a positive impact on related industries:

- Health, Ageing and Mental Health
- Agriculture, Fisheries & Forestry
- Resources & Energy
- Community Services
- Indigenous Health and Employment

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15 ACRRMH 2012. Evaluation Report “It’ll be alright in the long run” Roadshow, September
The annual cost of mental ill health to Australia is over $20 billion, which includes lost productivity and workforce participation. Therefore, in rural and remote Australia the annual cost could equate to $1.2 billion.

In 2011, a report published in the UK provided a strong economic case for the application of evidence-based promotion, prevention and early intervention initiatives with regard to mental health. For every dollar invested in mental health prevention, this research provided evidence that $9 dollars could be saved in the first year and up to $48 saved in the next 2 to 5 years. The report found that even a small shift in expenditure from treatment to prevention and promotion generated very significant efficiency gains, a broad range of pay-offs and benefits that lasted for many years.

**Limitations and Lack of Understanding of this culturally specific, targeted approach to prevention**

The development and delivery of the Centre’s programs to date have been dependent on successful applications to federal and state governments. This grant-based approach has led to some highly acclaimed, practical programs for each of the key target groups. However, this ad hoc approach has limitations which include the inability to continue to deliver programs and meet expectations once they have proven to be successful. This diminishes reputations and wastes valuable human and financial resources.

**Rural and remote prevention in the context of national policies**

The National Mental Health Policy and Plan’s first strategy aims to “promote the mental health of the Australian community and, where possible, prevent the development of mental disorders”.

Despite this ambitious and very worthy sentiment, it is difficult to find any evidence in existing national or state funding that this is:

- happening with this high level of priority; and
- targeting rural and remote Australian proportional to their identified need and economic contribution to the country.

There are no dedicated organisations funded by Commonwealth or state governments whose charter is to “promote the mental health of the rural and remote Australian community and, where possible, prevent the development of mental disorders”.

The National Mental Health Commission must be able to report reliably on the first strategy of the National Mental Health Policy in relation to the rural and remote Australians. In order to achieve this there must be more accurate and timely data.

**Building the Evidence Base from a Rural and Remote Perspective**

There are major differences between metropolitan research and research undertaken in rural and remote areas. The challenges for research in rural and remote Australia include relatively small sample sizes, sparse populations, long distances and limited numbers of researchers with “lived” rural or remote experience.

Despite their qualifications, expertise and abundant goodwill, research undertaken by researchers living in metropolitan areas and (usually) based at city-based universities, often lacks credibility. In some instances, one can be forgiven for thinking that city-based university research projects into mental health in rural and remote Australia are less about on-ground knowledge and passion and more about securing funding.

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Organisations working in rural and remote Australia are frequently approached by researchers and service providers to share relationships and networks in order to advance their projects or requirements. These relationships/networks have taken time, resources and effort to build and are of considerable value:

- farmers are tough and not used to sharing confidences;
- resource and constructions workers are macho and will not disclose personal issues; and
- Indigenous people, for cultural reasons among others, are not inclined to share their mental health problems.

It is regrettable but these relationships/networks are often neither recognised nor valued by external researchers and indeed service providers. Real rural-based research brings credibility as it is usually practical, culturally sound, appropriate and based on a need for evidence to attract services, resources etc.

Negotiating and engagement with organisations and/or applying for funding and grants from all governments can be challenging for NFPs and NGOs operating in rural and remote areas. In addition, long-distance travel and the time and costs involved are expensive and generally not recognised or adequately recompensed. These challenges are made more complex due to the number of portfolios related to rural and remote mental health summarised above.

**Future priorities**

Drawing on significant on-ground experience, the following priority areas for improving mental health for rural and remote Australians have been identified:

- Greater emphasis and resources be given to primary and secondary preventative interventions, given the economic benefits of such programs.
- Greater attention be paid to coordination, consistency and direction of messages to ensure appropriate culturally-specific translation of information.
- More resources be allocated to the development of creative, compelling and culturally appropriate promotional material across rural and remote Australia.
- Greater equity of funding in the context of higher comorbidity and greater number of suicides in rural and remote Australians.
- Evaluations be accorded appropriate status to ensure a strong evidence-base for best practice projects.
- Greater involvement of those with a lived-experience in rural and remote areas in research and evaluations.
- Future funding be predicated on robust evidence rather than high public profile and/or political affiliation.
- Encourage greater collaboration between service providers where there are scarce resources to ensure a continuum of support and care, that is, from primary through to tertiary interventions.

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**Dr Jennifer Bowers is the Chief Executive Officer/Managing Director of the Australasian Centre for Rural & Remote Mental Health.** As a leader in mental health nationally, Dr Bowers has held Chief Executive positions in Queensland and South Australian Mental Health Services. She has over thirty years’ experience in health, mental health and aged care in Commonwealth and State Governments and the private sector.

Having established the Centre almost 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 the Cairns Institute at James Cook University.**

She was a finalist in the Telstra Business Women’s Awards for Innovation in 2010 and is a Fellow of the Australian Institute of Company Directors.
Obsessive Hope Disorder
7. Kids are not small adults: the reform priorities

BoysTown

BoysTown provides support to children, young people and their families through a wide and distinctive spectrum of services. Through this experience we have learnt that children and young people ‘are not small adults’. Young people have distinctive preferences in relation to their help seeking behaviour. Furthermore their pathways to assistance can be more restricted than that for adults. They are individuals needing specialised support to grow and prosper in the Australian community.

About BoysTown

It is BoysTown’s mission to enable young people, especially those who are marginalised and without voice, to improve their quality of life. For this reason the organisation typically locates its offices in the regions with high numbers of young people and families facing social exclusion.

Of BoysTown’s services, Kids Helpline is no doubt that most associated with younger children. As Australia’s only 24/7 information, referral, support and counselling service for children and youth aged 5-25 it is in great demand by children and young people. Counsellors delivered 285,556 phone, email and web interactions with young people in 2012.

Recognising that the key to child wellbeing are healthy families, families are also a focus for BoysTown. BoysTown provides crisis and short-term accommodation responses to families experiencing homelessness and to women and children escaping situations of domestic violence. Education programs for young parents are also offered to increase their capacity to provide safe and developmentally stimulating care for their children. Our Parentline telephone and web counselling service provides help and support to parents and carers in Queensland and the Northern Territory.

BoysTown is one of the few youth specialist providers in the national employment support network, Job Services Australia (JSA). On average each month, just over 4,000 young people are supported in their search for work. Vocational training and social enterprises are also provided to assist longer term unemployed youth to transition into the labour market. In South-East Queensland, BoysTown manages three Youth Connections services that aim to assist young people to either reengage with education or transition to vocational training and work.

It is in this context that BoysTown’s staff engages on a daily basis with young people with mental health concerns.

Focus on mental health

In 1993, not only was the Burdekin report into Human Rights and Mental Illness published but the Kids Helpline service was also implemented nationally. In that year, Kids Helpline provided 1,990 counselling sessions to children and young people who were contacting the service about mental health as their primary concern. In 2012, this figure had increased to 11,407 counselling sessions. Contacts about suicide totalled 1,002 sessions in 1993, increasing to 8,728 counselling contacts in 2012. In 2004, contacts about self injury totalled 8,564. In 2012, this figure had grown to 15,887. These and other trends are detailed in Figures 1 and 2 below.
Figures 1 and 2

*Mental health concerns
Client concerned about mental ill-health of self or that of another. Ranges from emerging symptoms to moderate or significant mental health issues that are diagnosed or undiagnosed. Excludes those whose main concern focuses on self-injury or suicidality.

*All mental health issues
Presentations of diagnosed mental illness as well as symptoms of a mental illness or mild-to-moderate diminishment in psychological, emotional, behavioural or social abilities. Includes a number of primary problem types including deliberate self-injury and/or suicide-related issues.

*Suicide-related concerns
Clients seeking help or concerned about their own (or others') suicidal thoughts or behaviours. Includes clients with general suicidal thoughts, specific plan, immediate intentions and those young people who are in the process of a suicide attempt at their time of contacting Kids Helpline.

*All suicide-related issues ('suicidality')
Any contact where the client was either seeking assistance for a suicide-related concern or presenting with suicidal ideation.
A similar story emerges across BoysTown’s employment programs. Traditionally, young people do not report having mental health issues due to a lack of trust by young people of those administering the screening tools and their fear that stigmatisation may restrict their opportunity to secure employment. However, BoysTown’s own targeted research confirms many participants are indeed struggling with mental health issues.

In a study conducted at one of our JSA sites it was found that 58% of Stream 4 participants had a form of mental illness. Almost all were dealing with more than one mental health concern, relating to anxiety, depression, schizophrenia, mood disorders, post-traumatic stress disorder and grief and loss. One-third of these participants were not currently receiving treatment. Mental health symptoms included anger, aggressiveness, mood swings, poor concentration and fatigue, all of which impacted on interpersonal interactions and work readiness. A consistent theme across these presentations was that poor mental health was linked with other forms of dysfunctional behaviour and disadvantage such as substance abuse, offending, anti-social behaviour and homelessness.

In our Youth Connections programs at least 11% of participants have a suspected or diagnosed mental health issue and 10% engage in alcohol, drug and/or substance misuse. Across all of our regional services the most frequent issues counsellors are presented with relate to anxiety and depression.

From this broad spectrum of experience in delivering counselling, crisis and employment services to youth, BoysTown recommends five key (5) priorities guide future societal reform:

**Recognition that specialist youth service providers are a critical component of mental health service delivery**

Recognition at both a policy and service delivery level that ‘kids are not small adults’ is critical. Contemporary Australian research clearly shows that young people are more likely than other age groups to experience a mental health disorder and are reluctant to seek professional help. Only about 31% of young women aged 16–24 with mental health disorders seek assistance. This figure decreases to 13% for young men. In fact, Rickwood finds that young men aged 16–24 with mental health disorders are the least likely to seek professional help than any other age group. The rate of help seeking by youth has not significantly changed over the last decade. Further to this, children with emerging mental health symptoms, including abuse related trauma at an age younger than 16, have limited options available to them to access support or treatment, relying on parents or caregivers to facilitate their access to face to face services.

Children and youth are more likely to seek assistance from services that are child/youth focused and conversant with contemporary youth culture, needs, and engagement preferences. Kids Helpline statistics indicate that despite national static levels of help seeking behaviour, increasing numbers of young people are seeking assistance about mental health, suicide and self-harm issues with this service. We believe that this growth in help seeking from children and young people is primarily driven by the fact that Kids Helpline is recognised by them as a trusted authentic youth specialist provider.

To some extent, current national mental health policy recognises the need for youth specialist services. The significant investment in Headspace demonstrates this commitment. However, there has been inconsistency in other service development areas, for example: the initial funding associated with the Gillard Government’s 2010 Mental health: taking action to tackle suicide strategy was predominantly given to a generalist service. This ignored the reality that young people are a high risk demographic in relation to suicide.

Mental health initiatives that include the provision of services to young people need to be delivered through authentic youth specialist providers that know the needs of this group and have been able to engage with them.

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through their specialised practice to develop focused responses. Currently, this is not always recognised in the roll-out of programs.

Increasing the accessibility and quality of Online Counselling services to young people

Young people are increasingly showing a preference to seek assistance and health information through the internet. BoysTown research suggests that web-based counselling is strongly preferred by young people. In a recent online survey, Kids Helpline users were asked to rank their preferred counselling modality. The findings are outlined in the graph below:

![Graph showing preferred counselling modalities]

**Figure 3**

Research indicates that online counselling is an effective form of intervention particularly for young people with limited access to other supports. However, there is also a range of risks associated with this form of counselling, including limitations on enacting crisis interventions in emergency situations due to a lack of identifying information through this media. Consequently, Kids Helpline has implemented a range of quality assurance, therapeutic and risk management measures to effectively manage these risks to ensure the best possible outcomes for clients. The need for well-developed quality assurance systems to support online counselling is not always recognised by either Government funding agencies or the sector. Quality assurance standards for online counselling services need to be consistently developed and implemented.

Inclusion of Intensive Placement and Support (IPS) within Job Services Australia

Contemporary research in the UK and USA indicates that IPS programs are effective in achieving employment outcomes for people with mental health issues. The key feature of these programs is that they are based around a multidisciplinary team approach to working with small caseloads of extremely high risk clients. A dedicated team comprised of a community mental health specialist and employment consultant work with a small caseload of 25 people.

Given the funding structure of the national Jobs Services Australia (JSA) program, it is not possible to introduce this model of employment support, particularly for vulnerable people classified in Stream 4. As mentioned, this group has a very high prevalence of mental health concerns. The Commonwealth Government needs to ensure that funding for the provision of IPS interventions in the JSA 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.

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20 King et al. 2010: 68
21 Department of Education, Employment and Workplace Relations (DEEWR) 2008. Employment assistance for people with mental illness: Literature review
**Government support for Intermediate Labour Market (ILM) programs through the use of social procurement budgets**

Intermediate Labour Market Programs are time limited labour market interventions designed to prepare unemployed people for mainstream employment\(^{22}\). These programs usually incorporate training, personal support, employment placement and post placement support. BoysTown’s social enterprises are consistent with this service model.

An Australian Research Council funded project undertaken by Griffith University in relation to BoysTown’s ILM (social enterprise) programs found they were effective in improving the self-esteem and mental health of participants\(^{23}\). Participants in these programs were long-term unemployed youth who were engaged in anti-social behaviour as well as alcohol and substance misuse. These programs provided an effective pathway into the mainstream labour market with more than three quarters (77.4\%) of participants completing their ILM program. Of those completing the program, 73.2\% had positive employment and education outcomes at exit. After 26 weeks from exit, 80.3\% of these participants were still engaged in their positive outcomes.

This research supports our contention that ILM – social enterprise programs – are a critical component in the recovery of young people from mental health issues. In fact, the Council of the Australian Government’s ‘Roadmap for National Mental Health Reform’ recognises the importance of social enterprises in improving the social and economic participation of people with mental illness (Strategy 43).

The development and delivery of ILM programs requires Government support. Social enterprises usually show a productivity deficit as revenue does not match operating costs. Social enterprises have higher cost profiles than similar commercial activities due to the need to provide case management, specialist counselling, training and other support to participants\(^{24}\). BoysTown’s social enterprise programs have an annualised productivity deficit of about $12,000 for each participant.

In our view, Governments can best support ILM programs through the use of social procurement budgets. Governments should allocate a proportion of their social procurement budgets to support ILM projects. This would provide ILM programs with a guaranteed work-flow. The short-term disadvantage for Governments could be a higher price for the goods or service being delivered by the ILM, however, the social value created by these programs, such as reduced welfare dependency and increased employment outcomes, would provide greater benefit. For example, a cost benefit analysis of a graffiti removal ILM program sponsored by Housing NSW and undertaken by BoysTown in Western Sydney showed an incremental financial and social value of approximately $680,000\(^{25}\). The budget for the program totalled $270,000. Increased support for ILM programs should be a priority for Local, State and Commonwealth Governments.

**Need for increased research into youth engagement with mental health services**

COAG recognises that facilitating youth access to mental health services is a reform priority. BoysTown believes that an essential step in developing a response to this issue is the implementation of a research program that is co-managed and implemented with young people. The Young and Well Cooperative Research Centre provides a good model for how a partnership with young people in a research program can be developed and implemented. However, this Centre is primarily tasked with researching online engagement strategies. Australia needs to have a Cooperative Research Centre (CRC) that investigates the whole issue of youth engagement with mental health services. The current COAG Roadmap needs to be amended to include the funding of this proposed CRC in its set of strategies.

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\(^{22}\) Bodsworth E 2013. Working Futures Initiative Evaluation.


\(^{24}\) Bodsworth 2013. p. 57.

In conclusion

‘Kids are not small adults’; they require a different mix of services to support them in overcoming their mental health concerns. As aforementioned evidence indicates, national reforms need to facilitate an increase in the service delivery capacity of youth specialist services; increased accessibility to online counselling that is supported by stringent quality assurance, therapeutic and risk management strategies; the inclusion of IPS interventions in JSA programs, improvement in the sustainability of social enterprises and most importantly, the funding of research into how youth can be more fully engaged with mental health services, creating further robust and innovative approaches to mental health reform.
8. Mental health and human rights

John Brayley

In 2012 the South Australian Office of the Public Advocate conducted a telephone call-in inviting people who had experienced or witnessed past abuse in psychiatric hospitals to phone our Office. Fourteen people responded, describing episodes of emotional, sexual and physical abuse in psychiatric hospitals occurring from the 1960s to the late 1980s. A lack of respect for the person was a common factor in these reports. We thought this small number was significant; while the abuse of children in state care has been well documented, much less is known about the abuse in the old mental hospitals of children and adults who either had a psychiatric illness or a disability, who without community care were forced to live for long periods in these closed settings.

It is tempting to look back and see these events as an artefact of history, particularly when looking at how services have changed from then to now. Yet abuse in modern settings still exists, but it takes different forms, and its presence is closely linked to a general lack of recognition of human rights.

In Australia, mental health reform has been driven by the recovery model. This is well regarded but in many overseas countries, the recovery model was implemented on the foundation of human rights for all citizens, codified in charters or legislation. Recovery's mantra for people with mental illness of "a life worth living" will more readily be realised in a society that upholds values of equality, dignity and respect. If this is the foundation, people with mental illness do not need to argue for special treatment or seek sympathy when asking for funding, but just expect and receive equality of opportunity along with everyone else.

Social and economic rights such as access to health care, housing and education and training, can keep a person well and provide personal fulfilment. If these rights are not upheld it can lead to the unnecessary loss of civil rights. For a person with a mental illness this can take the form of community treatment orders, civil detention, and restrictive practices, which in many instances might have been avoided if necessary care and support had been available in the first place.

Upholding human rights is scientific and makes economic sense. It is scientific because it involves providing evidence based interventions such as assertive community treatment, and holistic approaches that consumers want – therapies that address the psychological and social needs of a whole person, not biological treatments alone. It makes economic sense because providing for a person's needs properly can cut down an endless cycle of re-presentations to hospital, prison and other costly services.

Upholding human rights can also keep a person safe. Maximising independence and personal control and decision making will ultimately be protective if a person is empowered to take action to protect themselves. Even when involuntary treatment is invoked, strategies such as supported decision making can maximise a person's autonomy and personal authority by ensuring that people are supported to make their own decisions where possible, rather than having decisions made by others.

I began this commentary by referring to traumatising abuses in the past. The loss of rights today can create different risks. 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 person's health and longevity, as can lack of access to good general health care.

Underfunded forensic mental health systems struggle to keep up with the treatment needs of mentally ill offenders, failing to uphold National Forensic Mental Health Principles which promise equivalence of services to the non-offender; an ideal that should be delivered, but frequently is not. Abuse can also occur through a person being subject to avoidable instances of mechanical restraint, physical restraint or seclusion. In today's hospital setting women remain at risk as they were in the past, even though enhanced sexual safety could be readily delivered through practice changes, and providing women's only areas in inpatient settings.
Since 2000 South Australia has seen the highs and lows of reform. The high from the galvanising leadership of the late Dr Margaret Tobin was tragically cut short following her assassination. After a period of uncertainty interest in mental health across government surged – in South Australia led by the Social Inclusion Board based in the Department of Premier and Cabinet. New community services, new stepped community residential care, and new wards have been part of this work. I had the privilege to work as State Director of Mental Health in the mid-2000s at this exciting time of future planning, and putting in place the first steps of a new model.

Yet for all the work done back then and since by Governments, we are likely to look back with concern about large ongoing gaps, rather than take pride in successful reforms. Particularly when we see individual rights not upheld, and people suffering unnecessarily. In South Australia we now need a new plan, but if we could anchor this work in a human rights framework we would be more likely to get our responses right. Human rights should be the cornerstone of everything we as a community do for people with mental illness: – including developing policy, writing plans, operationally managing services and coalface practice.

Upholding equality, dignity and respect can promise better outcomes and personal safety for all people with mental illness. Rights would be upheld, abuses prevented, and the need to depend on the rights protecting role of the Office of the Public Advocate reduced.

Dr John 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.
9. The mental health of LGBTI communities since 1983

Alan Brotherton and William Leonard

1983, the year in which the Richmond report was released, was a significant year for the gay, lesbian and transgender communities of Australia. Only 5 years after the brutal break up of a police-approved street party in Oxford St, Sydney, resulting in the names and occupations of those arrested being published by the SMH, the annual Mardi Gras parade and party now attracted thousands of local, interstate and international revellers. The state Parliament was on the cusp of following South Australia, Victoria, the ACT and Northern Territory by legalising homosexual acts between males in 1984. (The notion of sex between women having been such an outlandish and unlikely proposition to the State’s Victorian era lawmakers, there was no law prohibiting such acts to repeal). Decriminalisation activism and advocacy preoccupied our communities, and there were regular face offs between pro-gay demonstrators and anti-gay Christians, declaring their fellow human beings abominations, outside the NSW Parliament.

In the 1950s and 60s the primary focus of advocacy and research was to demonstrate that homosexuality was not an illness or disease. At this time there was limited research about the mental health of GLBT communities. In 1973 the Australian and New Zealand College of Psychiatrists and the American Psychiatric Association declassified homosexuality as a psychiatric or mental disorder. For transgender people, however, the journey out of psycho pathology has taken much longer. ‘Gender dysphoria’ remains a diagnosis in the proposed DSM V and there is ongoing debate about where to place gender incongruence within the forthcoming ICD 11. In recent times, increased activism and advocacy on the part of Intersex people has drawn attention to a sorry history of forced gender assignment and ongoing issues of stigma, discrimination and lack of appropriate legal recognition.

1983 was also the year in which the first death from AIDS was recorded in Melbourne and the committees and action groups which morphed into the state AIDS councils were established. The spectre and fear of AIDS added fuel to homophobic fires and a number of extremely ugly public debates ensued. HIV rapidly became the overwhelming health issue to engage gay and lesbian communities. It led to new forms of GLBT activism aimed at challenging the re-pathologising of gay men as vectors of disease, contagion and death, ignited by the AIDS pandemic and fanned by the simmering resentments and prejudices of an assortment of conservative organisations.

Paradoxically, the annual Mardi Gras parade and party defiantly grew in size, popularity and audacity. It was a brash and vibrant refusal of homophobic and transphobic labels and the assertion of new, out-and-proud public LGBT identities. To the extent that the community engaged with issues of mental health, the focus was on maintaining self-esteem, building resilience and helping people to deal with at times formidable losses – many lost entire social networks. Attempts to link HIV acquisition to depressive conditions or psychopathologies were resisted – justifiably, given the lack of evidence; and the gaze of psychological research was largely directed to better understanding motivations for behaviour change.

Throughout this period, volunteer run gay and lesbian counselling services took thousands of calls through the evenings from young men and women struggling with coming out against the backdrop of AIDS and intensified homophobic discourses. AIDS Councils developed and ran peer education interventions aiming to give young gay men the skills and self-esteem to adopt protective behaviours. Mental health services struggled with the challenge of how to manage relatively young people with dementia, leading to the establishment of specialist HIV and psychiatry services. Where specialist services weren’t viable – primarily in outer metropolitan or regional centres – mainstream services shouldered the burden of prevention, grief and support counselling, in many cases engaging with openly gay and lesbian people for the first time.

26 While gender incongruence need not be viewed as disease or pathology at all, some authors argue that this ‘needs to be balanced with some classification which allows access to healthcare’. Others argue that disease classification is not a necessary precondition of access to health care.

The introduction of effective combination therapy in the mid-90s led to a slowing down of the death rate and gave some the time to review and repair the damage done to their networks and mental health. By early 2000, ACON had taken the decision to adopt a broader GLBT health approach, recognising that issues other than HIV were relevant to our communities. ACON recognised that, that engaging gay men in a broader health context would help to keep HIV prevention relevant, while sustaining broader community mobilisation to address other health issues. The Queensland AIDS Council became the Queensland Association for Healthy Communities in 2006, also adopting a broader LGBT health remit. Victoria established a Ministerial Advisory Committee on gay and lesbian health in 2000. The first task of this committee was to develop a paper outlining key health issues for GLBT people, drawing on the limited evidence base available. In 2007, a national LGBTI Health Alliance was founded to pursue work at a national level, and to support the development of organisations in smaller states and for smaller communities. All of these organisations identified mental health as a key issue for their communities.

A growing body of evidence from overseas and Australia endorses this concern and reveals significant disparities in the mental health status of LGBTI communities and individuals relative to either general community or heterosexually identifying samples. There is not the space here to enumerate all of these here, but among the most significant are:

- Higher rates of anxiety and depression among gay men, lesbians, bisexuals and transgender people
- Higher rates of attempted suicide, suicidal ideation and self-harm, especially among younger people
- Higher rates of suicidal ideation among GLBT adults than in equivalent studies of heterosexual adults

In a 2008 editorial published in the *Gay & Lesbian Issues and Psychology Review*, Hillier, Edwards and Riggs note that ‘when research findings like these are released into the community, responses are usually divided’ between those who express relief that a clear picture of LGBT mental health has been disseminated and those concerned that in releasing such data ‘we pathologise and marginalise our communities by hanging out dirty washing’. They note that one of the challenges for researchers is that funding is rarely available without a stated problem and conclude that the ‘problem is not the reporting of the association itself, but rather that….there is a lack of critique of the causes of poor mental health in LGBT communities, such as wide spread social homophobia’. They note the importance of moving the focus to unhealthy environments and to documenting creative strategies that ‘successfully resist homophobic subject positions’.

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29 Carman M Corboz J & Dowsett G 2012. Falling through the cracks: the gap between evidence and policy in responding to depression in gay, lesbian and other homosexually active people in Australia Australian And New Zealand Journal Of Public Health; 36(1)


32 Hillier L, et al 2010. Writing Themselves in 3, The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people. Australian Research Centre in Sex, Health and Society, LA Trobe University, Melbourne


34 Op Cit 2008
It should be noted here that there is an ongoing and lively debate about the use of terminology in achieving this end. ‘Homophobia’ and ‘transphobia’, (fear or hatred of sexual or gender difference) may identify the motivation for individual acts and behaviours and forms a useful basis for community awareness campaigns to challenge violence and discrimination. However, it is not always a helpful way to describe the behaviour of institutions or services, which rarely act out of fear or hatred.

‘Heterosexism/heteronormativity’ and ‘cisgenderism’ (the view that people’s own descriptions of their gender are less valid than those assigned to them by other people based on their assigned sex at birth) are argued by some as more productive ways to understand the issues that impact on the mental health of LGBTI communities. Understanding the heterosexist and cisgenderist basis of service systems and psychological/psychiatric disciplines enables us to identify the systemic and structural issues which shape the life experiences of LGBTI people and, in so doing, helps us to identify the organisational and practice reforms that are needed to guarantee that mental health services are LGBTI inclusive.

That said, 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. Fear of discrimination remains a powerful associate of anxiety across the age spectrum. The recent debate over the revised Federal Sex Discrimination Act, and advocacy to retain exemptions for religious service providers to enable them to freely discriminate against LGBTI elders, is unlikely to have a positive effect on rates of anxiety and depression in this age cohort. Young people still grapple with understanding and coming to terms with their own ‘difference’ and the potential personal costs of ‘coming out’, and struggle to find trusted, safe places where they can discuss and explore these issues.

Other factors associated with higher risk of depression for non-heterosexual populations have been identified as residential context (those living in rural, regional or outer metropolitan areas) victimisation (verbal, sexual or physical) and experiences of stigma and discrimination.

This list of potential pre-disposing factors presents a daunting prospect, ostensibly requiring significant changes in majority values and behaviours across a variety of settings. However, as Hillier and her co-authors note, ‘the majority of LGBT people live happy and fulfilled lives and make important contributions to society’. They note Australian research which has found a positive impact arising from a sense of belonging to gay communities. Carman and co-authors identify being in a relationship and a sense of belonging to GLB community as protective factors from depression for non-heterosexual populations. US studies of resilience among transgender youth and people of colour have identified common ‘resilience themes’ including self-worth and self-esteem, awareness of oppression, connection with community and a sense of personal mastery. These individual factors of resilience are influenced heavily by environments and the extent of social inclusion.

36 Authors note that, ‘unlike ‘transphobia’, cisgenderism describes a prejudicial ideology, rather than an individual attitude, that is systemic, multi-level and reflected in authoritative cultural discourses’
41 Hillier 2008 Op Cit.
43 Carman, 2011 Op Cit.
For instance, a recent study from Massachusetts\textsuperscript{46} shows a marked impact of marriage equality on the mental health and wellbeing of LGBTI people. In this study mental health service use among gay men and the attendant costs had declined in the two years since same sex marriage was legalised, regardless of whether men intended to marry or not. A study from California found significantly less distress among same sex married partners compared to those with no formal legal recognition of their relationships\textsuperscript{47}. Both of these studies suggest that the mental health dividends from acts of social inclusion such as marriage equality can be significant. The impact of relationship recognition has also been acknowledged by the Australian Psychological Society (APS), through endorsement of the American Psychological Association's resolution on marriage equality. In making this endorsement, the APS provided an overview of key arguments based on research findings which suggest that

- couples who are married experience less depression than non-married couples,
- social exclusion can have considerable mental health impacts and
- exclusion from marriage can have specific mental health impacts on non-heterosexual people

Despite the growing body of evidence of poorer mental health outcomes, and persistent advocacy on behalf of LGBTI communities, it has taken a long time for LGBTI people to be recognised under any Federal or State mental health policies. In an article in the ANZ Journal of Public Health published in 2010, the authors concluded that, while their literature review found that non-heterosexual people experience depression at higher rates.

\textsuperscript{48}Carman 2010 Op Cit.

The policy analysis found no mention of depression or the broader mental health needs of non-heterosexual people in key national mental health policy documents. These documents outline a policy approach for population groups with a higher prevalence of mental health problems, and stigma and discrimination are relevant associated factors, but only the National Suicide Strategy considers non-heterosexual people an 'at-risk group'\textsuperscript{46}.

Nonetheless, there are promising moves towards recognition in a number of policy settings, including the work of the new National and NSW Mental Health Commissions. The inclusion of questions on sexuality in general population surveys of mental health and broader health is also a promising step towards better understanding mental health at a population level. The National LGBTI Health Alliance received a significant DoHA grant in 2011 to enable it to map awareness of LGBTI mental health issues among mental health service providers and LGBTI organisations and individuals. Additional funding was provided to enable the development and rollout of national mental health and suicide prevention initiatives to effectively target LGBTI communities.

There is also great enthusiasm and interest among mental health service providers to develop staff skills and capacity to work effectively with LGBTI people. A recent collaboration between ACON and GLHV, piloting provider training as part of a broader community mental health literacy project, was enthusiastically received across NSW, most markedly in regional areas.

Another important area to receive attention is that of heteronormative 'practice' among individual practitioners\textsuperscript{49}. Clearly, a positive engagement with mental health services and practitioners in developing non-heteronormative and LGBTI-inclusive practice will have a positive impact on LGBTI—people’s use of these services, and, in the longer term, their mental health outcomes. In this light, the increasing interest across the broader mental health sector in recovery oriented and consumer centred
approaches bodes well for LGBTI people, allowing for a personalised approach which takes sexuality and gender expression into account as a positive and creative expression of our identity.

While addressing heteronormative/cisgenderist assumptions and building capacity to effectively meet the specific needs of LGBTI people in mental health service provision are valuable strategies, a more radical preventive approach to reducing mental health disparities between LGBTI and mainstream populations would be to address those structural determinants of poorer outcomes. These include bullying (especially in schools), discrimination, and legal and social prohibitions against the full legal and symbolic recognition of same-sex and non-heteronormative relationships. Reducing the high rates of mental health disparities – and accompanying high rates of service utilisation and loss of productivity – would presumably free up resources to enable an underfunded mental health sector to devote greater resources implement recovery oriented, consumer centred work for those who would most benefit from it. It is difficult to conceive of any government with the fortitude and capacity to take on homophobia/transphobia in schools, religious service provider discrimination exemptions and same sex marriage, at least not simultaneously. But there is a discernible shift in public sentiment on many of those issues – research by the Australia Institute shows an overwhelming majority of parents of private school students opposed to sexuality discrimination exemptions\textsuperscript{50}, and the proportion of Australians surveyed who support same sex marriage has been over 50\% for many years. The recent passage of the Sex Discrimination Act which provided anti-discrimination protections for LGBTI people at a national level for the first time (and includes amendments removing exemptions for faith based providers of Commonwealth funded aged care services); and changes to the Department of Immigration’s passport policy which allow a passport to be issued to ‘sex and gender diverse applicants’ in M (male), F (female) or X (indeterminate/unspecified/intersex) are very significant markers of social inclusion and protection of the rights of LGBTI people.

There is a long road ahead before the structural factors and environments which have had such a profound influence on our communities’ mental health and wellbeing are fully addressed, but the journey is well and truly underway.

Today we have a growing body of resources and support on which to draw in the ongoing drive for full legal and social equality and, with that, continuing improvements in LGBTI people’s mental health and wellbeing. These include research documenting the effectiveness of targeted health interventions for LGBTI individuals and communities, increasing LGBTI capacity and expertise in both LGBTI and mainstream health and community organisations, an increasingly LGBTI-engaged mental health sector, dramatic shifts in public attitudes to our communities, and, finally, policy frameworks that recognise us and our particular issues and needs. Most importantly we are and always have been vibrant and diverse communities, growing in strength, resilience and capacity over the last forty years. We have been the agents of change and will continue to be, as we work toward a time when our sexualities, intersex status and gender identities are affirmed and celebrated by the entire Australian community.

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\textit{William Leonard is Director, Gay and Lesbian Health Victoria and a Senior Research Fellow with the Australian Research Centre in Sex, Health and Society, La Trobe University}

\textit{The authors would like to thank Gavi Ansara, Mark Orr and Vicky Coumbe for their invaluable assistance in preparing this article.}

\textsuperscript{50} Wilkinson D Macintosh A Denniss R 2004. Public Attitudes to Discrimination in Private Schools The Australia Institute, Canberra.
10. The 1993 National Inquiry (part 1)
Brian Burdekin AO

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 1980s 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 out-dated, 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
Obsessive Hope Disorder

- 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.
11. The 1993 National Inquiry (part 2)
Brian Burdekin AO

What we 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 or 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 is currently Visiting Professor at the Raoul Wallenberg Institute in Sweden and Professorial Visiting Fellow at the University of New South Wales.

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.

In 1995 he was made an Officer of the Order of Australia for his services to human rights.
12. Acknowledging consumers past

Michael Burge

I feel both privileged and very humbled that I have asked to speak briefly here today (and contribute to this report to mark 30 years since the Richmond Report in 1983)\textsuperscript{51}.

I am very aware that I will not be able to give enough recognition to the consumers of the past, but I will try.

\textit{On behalf of consumers here today I would like to pay respect to everyone who has been touched by mental illness – their families, carers, the dedicated volunteers, and the many service providers who care for these people. I would like us all to pay respect to the courage, spirit, selflessness & vision of all the consumers past who have paved the way for a better future for everyone who has a mental illness.}

And for all of us to remember those who, despite no power or status...

\textit{Challenged, Spoke out, Created pathways, opportunities & environments that empower people to recover, that enable them to reconnect to themselves, others, & the meaning and purpose in life.}

To give us a voice they lived, suffered ignorance, abuse, humiliation, exclusion, isolation, incarceration and some even died... all of which has led to this time and place where we honour their efforts and nowadays stand tall and contribute as equals. So we can be treated like everyone else; not invisible, but part of the normal order of things.

So that people with a lived experience of mental illness can be part of a world that does not judge them, fear or pity them, but rather one where they are judged by the content of their character and what they can value add to society, not by their impairment, but instead judged by their ability, not their disability.

\textit{Nelsen Mandela – once said:}

\begin{quote}
You have mandated us to change from a place in which the majority lived with little hope, to one in which they can live and work in dignity, with a sense of self-esteem and confidence in the future.
\end{quote}

The consumers of the past have certainly done this for people with a lived experience of mental illness. Consumers here today are proud to acknowledge the consumers of the past. Because of people like Janet Meagher, Helen Connor, Merinda Epstein, and many, many others we can now look forward to a contributing future for people with a lived experience of mental illness – they courageously paved the way for all of us to have a voice.

\textit{In 2007 I was fortunate enough to read this on the wall at Recovery Innovations in Phoenix Arizona}

\begin{quote}
For those of you who are still battling with mental health issues PLEASE don’t forget to remember who you are where you came from, Where you have been thus far, Because it’s so easy for the hard times to leave scars, When you forget to remember who you are.
\end{quote}

\textit{I would now like to read out what I say at the end of all my presentations}

We all need to remember that people with a lived experience of mental illness may forget exactly what you said, they may even forget exactly what you did, but they will never, ever, ever, forget how you made them feel. (Reprinted with permission of the author.)

\textit{Michael Burge has been advocating for consumers and carers for approx. 17 years on numerous local, state and national committees and full time Mental Health Advocate since 2002. 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.}

\textsuperscript{51} Presented at the National Mental Health Consumers and Carers Forum on Rights, Disability and Mental Health, Canberra 30 November 2012.
13. A game changer

Jane Burns

I started working in Youth Suicide Prevention in 1993, the year that the Burdekin report was released. An industrial girl from the South Australian lead smelting town of Port Pirie, at 22 years old a young person myself, trying to make sense of an escalating tragedy that in 1997 saw Australia’s Youth Suicide rate peak.

In 1997 a seminal piece of work ‘The Keys Young Report’ was commissioned by the Australian Government’s Mental Health Branch. The aim of this report was to engage with young people to capture information about their attitudes, knowledge and behaviour towards mental health and mental illness and their experience when seeking help either from professionals or from family, friends and informal networks. As a National Health and Medical Research Council (NHMRC) Research Scholar and then Fellow working in mental health and then specifically suicide prevention, I had also enthusiastically embraced the ‘bible’ – a book by Mrazeck and Haggerty called ‘Reducing risks for mental disorders: frontiers for preventive intervention research’. The ‘bible’ argued that to reduce the risks of mental disorders a coordinated approach across mental health promotion, prevention, and early intervention, treatment and relapse prevention had to be embraced. This didn’t seem like rocket science to me.

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.

At the same time a new organisation entered the market. It had no evidence base, was built around this unknown entity called the World Wide Web, and was fundamentally about providing a service to young people that was created by them, with them and for them – it was called ReachOut.com. When I first heard a young Jono Nicholas (Jono is now the CEO of the Inspire Foundation) in 1998 talking about the potential of technologies to reach young people 24/7 and without stigma, in any location and at low cost, I had that almost evangelical sense that ‘wow, this is innovation at its best’. Moving beyondblue in 2000 and with the support of the inaugural CEO Professor Ian Hickie, an investment was made in building an evidence base to determine the effectiveness of the ReachOut.com service.

On my return from a Harkness Fellowship in Health Care Policy in 2004 comparing US and Australian approaches to suicide prevention, I joined the team at Inspire. It was pretty clear that the ReachOut.com service was unique and that an equivalent offering certainly didn’t exist anywhere in the world. Jack Heath (now CEO of Sane) convinced me to join Inspire with a vision of taking ReachOut.com internationally – it was launched in the US in 2007 and in Ireland in 2009. By then working with academic partners, Brain and Mind Research Institute and Orygen Youth Health Research Centre, we had started to build the foundations for an evidence base relating to the role of technologies in young people’s lives and the potential impact it could have on their mental health and wellbeing.


Today our message is still the same – young people must be involved in research and in the design of services that are built to support their mental health and wellbeing. Our challenge now is to keep pace with the ever-evolving and quickly changing landscape that is technology.

**Current state**

In the last decade the explosion of online social networking has fundamentally redefined how ‘communities’ operate for young people. This rapid transformation in social behaviour, combined with faster internet, has created an unprecedented opportunity to create new systems of e-mental health care. Critically, this growth comes when there is international recognition of the importance of adolescent and young adult health, acknowledgement that poor mental health is the largest health issue facing young Australians, and concession that provision of more effective and earlier intervention services to larger numbers of young people is essential if we are to reduce the societal burden of mental disorders.

In Australia, considerable resources have been dedicated to improving mental health, including large-scale community awareness campaigns to raise awareness of the symptoms of depression, universal school-based interventions targeting prevention and early intervention, extensive expansion of access to primary care based psychological services to complement existing medical care, and focused youth mental health services designed as a one-stop shop. Despite our best efforts, the prevalence of mental health problems in young people is still high and help-seeking is low.

Australian policy, including the Fourth National Action Plan on Mental Health, the National Health and Hospitals Reform Commission report, and the National E-Health Strategy all advocate that better use be made of ‘innovative services’ for mental health difficulties. At the same time, young people express a desire to control their own mental health care, access confidential advice and use support systems they trust. They expect services and support to be accessible regardless of location and time, and to be relevant and effective.

**Why technology?**

With 95% of young people using the internet, it has dramatically altered the way young people connect with one another, their families and professionals. While technology moves fast, societal responses are often delayed. Today, service providers, educators, mental health professionals and families are grappling with the way young people are using social networks like Facebook, Twitter and Tumblr. The knee-jerk, ‘safety-first’ response is an immediate call for a blanket ban or greater regulation. However, this reaction does not consider the reality of how young people use technology. First, any ‘ban’ will simply mean that young people will develop new ways of sharing devices, using aliases or smuggling phones into services. Second, it ignores the reality that technology is proving to be a valuable tool that allows young people to engage on their own terms, express concerns and use easily accessible online resources. These services may be adjunctive to existing clinical services (e.g. enhancing depression treatment through use of mood monitoring or medication side-effects mobile applications) or developed as a viable primary alternative service pathway.

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57 Burns J M, Boucher S, Glover S et al. 2008. Preventing depression in young people: What does the evidence tell us and how can we use it to inform school-based mental health initiatives? Advances in School Mental Health Promotion 1(2): 5-16.
Australia has been at the forefront of research into the development and delivery of clinically-effective, self-directed online therapy programs and online prevention activities\(^6\). While this work is cutting-edge, a massive challenge exists in translating this knowledge into practical and effective resources that young people find relevant and engaging.

With the introduction of a national broadband network that will connect 97% of Australia’s population, it would be negligent to ignore the potential opportunities afforded by internet-connected devices. This is not just about the provision of information but rather shifts the dynamic to a web 2.0 world which includes interactive, participatory and collaborative approaches that encourage self-expression and the building of online communities. Researchers and service providers need to stop making a distinction between online and offline worlds and explore the internet as a setting in which health services can be delivered to large populations at relatively low unit cost and tailored to match individual needs\(^8\).

**The game changer**

In response to this need, the Australian Government has funded the Young and Well Cooperative Research Centre (Young and Well CRC) – an Australian-based, international research centre that unites young people with researchers, practitioners, innovators and policy-makers from more than 70 partner organisations to explore the role of technologies in improving the mental health of young people aged 12 to 25.

The research of the Young and Well CRC promotes cyber safety, digital inclusion and mental health and wellbeing through 12 large-scale multi-partner projects and other complementary research activities to be conducted over five years. More than 20 universities in Australia and the United States are engaging with 53 non-government organisations, small and medium enterprises, government and commercial partners to build on Australia’s proven expertise in e-mental health.

Uniquely, the Young and Well CRC genuinely positions young people as partners with scientists, service providers and technologists to guide, build and co-create the tools and approaches needed to lead mental health systems reform and improve young people’s mental health. Getting this process right will result in service models that include low cost, self-directed and self-monitored support centres for disorders like anxiety and depression and behaviours like self-harm, alcohol and substance misuse.

Clearly, more complex mental illnesses like eating disorders and psychoses will require more intensive intervention and individual support. Widespread high-speed broadband in Australia will provide a remarkable opportunity to connect and work directly with young people over the internet – easily enabling a clinician and a young person to create their own personalised treatment and wellbeing plan online. Population-wide access to faster internet will enable young people to take part in supportive online communities; youth-specific online mental health programs including ReachOut.com and headspace.org.au; physiological mapping such as sleep-wake cycle monitoring automated through wrist devices connected wirelessly to smartphones; and joint consults bringing together multi-disciplinary treatment teams.

We simply do not have a large enough body of innovative research that helps us to mitigate risk for vulnerable young people or explore novel interventions that can be deployed to build new systems of mental health care – particularly those that could respond to the diversity and complexity of young people’s needs. This research is brave, requires cross-sector collaboration and, importantly, must – if it is going to fix a broken system – empower those young people who are at the centre of our concerns.

Associate Professor 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.

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14. Eating disorders: The invisible mental illness

The Butterfly Foundation

The Butterfly Foundation is Australia’s leading not for profit, national charity committed to supporting those affected by eating disorders and working in collaboration to bring about sustainable change in the eating disorders sector in Australia. Butterfly has been established for 10 years. It is currently managing a unique national project, the National Eating Disorders Collaboration funded by the Federal Government, to bring together expertise and experience from a wide range of stakeholders to develop and disseminate a nationally consistent evidence-based approach for the prevention, treatment and management of eating disorders in Australia.

Butterfly provides a range of services for people with eating disorders and their families, including a national telephone and web based support service, support services such as support groups and face to face counselling, and education services focusing on prevention and early intervention. From these and from its collaborative work, Butterfly has developed a wealth of knowledge in those areas where families and young people with eating disorders consider they need most support.

Eating disorders

Eating disorders refer to a group of mental illnesses which includes anorexia nervosa, bulimia nervosa, binge eating disorder, and atypical eating disorders. People with eating disorders have highly disturbed eating and exercise behaviours with extreme concerns about weight, shape, eating and body image. Eating disorders occur in both males and females from all cultural and ethnic groups and at all ages.

There is a prevalent myth, reinforced by media images, that the only eating disorder of significant concern is anorexia nervosa and that a person must be severely underweight to have an eating disorder. There is also a general recognition of bulimia nervosa. However, in Australia, most people with an eating disorder have binge eating disorder or atypical symptoms. These disorders are as clinically severe as anorexia nervosa and bulimia nervosa. However, because they are harder to detect and less well known in the community, people with these eating disorders are less likely to be diagnosed and get treatment.

All eating disorders are complex illnesses with high levels of psychological distress, risks of long term medical complications and an increased risk of premature death due to medical complications and an increased rate of suicide. Anorexia nervosa has the highest fatality rate of any psychiatric disorder.

Eating disorders most frequently start in childhood and youth and impact on education, identity formation and physical growth. Approximately 25% of people with eating disorders experience severe and enduring illness throughout their lives.

Eating disorders have one of the highest impacts on health related quality of life of all psychiatric disorders. They affect the sufferer and their family, their friends and colleagues, their communities and health services. No one chooses to have an eating disorder.

“My eating disorder has cost me my whole life. I am isolated from all the normal activities of a woman of my age. In many ways my life got stuck in Year 8 at high school and I haven’t been able to move on. I still live with my parents because I can’t afford to pay rent. I work part time because I am physically too unwell to take on a full time job. I cannot get involved in the sort of social activities that my sisters and peers engage in”

Eating disorders are relatively common when compared with other priority health issues. They are estimated to affect approximately 9% of the Australian population at some point in their lifetime, requiring clinical intervention. The rates of eating disorders may actually be much higher than this. People suffering from an eating disorder are very unlikely to seek help and studies suggest that identification of people with bulimia nervosa and binge eating disorder may be as low as 10% of actual cases. What the available
data does show however is that the rate is increasing, particularly for binge eating disorder, and that this rate of increase is in parallel with the increase in childhood obesity.

Research provides evidence that full recovery from an eating disorder can be achieved, including the development of normal attitudes toward food and the body, but it can take a long time to recover completely once the illness is established. Recovery is a long-term process that requires a multi-disciplinary team approach to treatment, integrating medical, nutritional and psychological treatment delivered in a supportive environment.

Early detection and intervention is critical to successful outcomes. People who have had an eating disorder for less than 2 years are likely to respond more quickly to treatment and experience fewer physical health consequences. Without early intervention, the long-term prospects are poor. Lack of access to appropriate treatment contributes to the severity and chronicity of the disorder, the impact on the individual and the costs to the community and the health system.

**The cost of eating disorders**

In 2012, Butterfly commissioned a review by Deloitte Access Economics on the total socio economic cost of eating disorders in Australia. The report of their findings, released in December 2012, estimates that over 913,000 Australians suffered an eating disorder in 2012 with a total annual socio economic impact of eating disorders in Australia for that year of $69.7 billion.

This figure includes health system costs of $99.9 mill. However, the most severe costs are in relation to productivity and burden of disease. The productivity cost in 2012 for those suffering from an eating disorder is estimated at $15.1 bill. The “burden of disease” cost, being the cost of the loss of healthy years of life from eating disorders, is estimated at an additional $52.6 bill. This cost is comparable to the estimated value of the burden of disease for anxiety and depression of $41.2 billion, and for obesity at $52.9 billion. Combining the burden of disease and financial costs, the total socioeconomic impact of eating disorders is $69.7 billion.

These are conservative estimates. The estimates of prevalence used in these calculations are lower than those from Australian studies of prevalence and the costs of treatment are based on limited Australian data collection.

**Perspectives on reform and service development**

Eating disorders are largely ‘invisible’ in health policy and initiatives, in training for health professionals and most notably in the provision of treatment. In policy, eating disorders tend to be grouped with ‘other mental illnesses’ or with mood disorders. Reliance on an understanding of other mental illnesses as the basis for policy development has led to initiatives that do not address the complexity and duration of eating disorders.

**Providing safe treatment**

Someone with an eating disorder needs a response to the full spectrum of the eating disorder.

The National Eating Disorders Collaboration defines safe treatment as treatment that “addresses all of the aspects of illness: physical, behavioural and psychological”. The experience of people with eating disorders is that:

_Safe treatment sometimes happens in private health eating disorder programs but I’ve never experienced it in a public hospital, not even in an eating disorders program._

Safe treatment for eating disorders requires the integration of physical, psychological and nutritional treatment, merging the need for both medical and psychiatric care in an integrated program of treatment.

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This challenges the way in which the health system is organised into separate streams of medical and psychiatric care.

**Attitudes and access**

Access to treatment is a challenge for most people with eating disorders at all stages in the progress of their illness; from getting an accurate diagnosis in primary care to accessing urgent medical treatment and accessing the recovery support and prevention that could help them avoid recurrence of illness.

Most people with eating disorders never receive treatment that is specific to their disorder, although they may receive extensive health services for the consequences of the eating disorder. Studies suggest that only 22% of people with eating disorders access the necessary specialist treatment for their illness.

For those who do access treatment, that treatment is frequently limited to something less than evidence based and is delivered by clinicians who have not been trained in the treatment of eating disorders.

There are a small number of specialist eating disorder services in Australia that put evidence based standards of treatment into practice. These services have developed on an opportunistic basis largely in isolation from each other and other health sectors, driven by individual expertise and commitment, perceived local need and funding opportunity. The health system in Australia has not yet systematically adopted these good practices.

There are too few services for the number of people experiencing eating disorders and a limited range of service options. No single Local Health District has been identified that delivers a full, integrated continuum of care for people with eating disorders.

Entry criteria for hospital admission and a lack of professional training in eating disorders treatment both contribute to difficulties in gaining access to treatment.

> I have been in and out of hospitals for years but I have also been refused treatment a lot because I don’t meet their entry criteria. I am excluded from physical treatment because I have a mental illness; excluded from eating disorders because I have a physical condition and excluded from eating disorder programs because of comorbidities.

> I couldn’t be admitted to a general medical ward because they thought I was at risk of self-harm but I couldn’t be admitted to a psychiatric ward because I was so medically ill. So I was sent home.

General misunderstanding about eating disorders amongst health professionals contributes to the difficulties experienced in getting access to treatment.

> People are treated as if it’s their fault; that they have brought it on themselves because they’re anorexic. They seem to think that we can just stop it if we want to. They don’t understand that someone with an eating disorder doesn’t have control.

> They seem to think that this is just behavioural. That we can change any time we want to. And then they don’t have any patience because they think we did this to ourselves. They say things like “just eat why don’t you?”

> All they did was rehydrate me and then they sent me home. I wasn’t properly assessed. They didn’t contact my psychiatrist. They just sent me home. I was back in Emergency the next week.

Psychiatric treatment has improved over the last twenty years moving from punitive approaches that isolated young people from their families and communities to more person centred approaches. Yet the people that Butterfly works with still experience punitive and inappropriate treatment in hospitals:

> Some hospitals punish you for not eating. It’s frightening and degrading and all you want to do is get out of there.

> My daughter was terrified of the treatment she received and terrified of re-admission which made her anxiety worse and so made the eating disorder behaviour worse as well.
The sharp change in treatment approaches between child and adolescent services and services for adults creates another barrier.

*The transition to adult care was traumatic. There are real problems for young people going into an adult psychiatric ward at the age of 18. There are problems for carers too as suddenly you can’t get any information on what is going on but you are still the one responsible, the one who has to provide the care.*

*If the family isn’t supported it affects the patient and how they respond to treatment*

*Nobody tells you a lot. There is a lack of information. I know this is probably a systemic problem but dealing with an eating disorder seems to make it worse. As a carer I am the one who is responsible when she is discharged. I really need to know what is going on and what I need to do.*

**Priorities for reform**

People with eating disorders have not yet seen the benefits of mental health reform in any consistent way in Australia. While a limited few have access to good services, the majority of Australians do not. There continue to be significant barriers to being correctly diagnosed, securing a referral to a skilled clinician, obtaining access to specific evidence based treatment in sufficient dosage to be effective, and receiving essential long term community based recovery support.

The federal Government’s support for the National Eating Disorders Collaboration since 2009 and for the Butterfly Teleweb support service in 2013 have been welcome signs of increased awareness of eating disorders and there is now emerging interest in eating disorders in public and private health in all states and territories.

There is an immediate and urgent need to improve access to safe, evidence based eating disorders treatments. The priority areas for development include:

- **Workforce development** – building capacity and capability in primary health care, emergency departments and in other professions which work with people at high risk, to ensure that people are identified and diagnosed early in their illness

- **Community based treatment** – ensuring that people have access to eating disorders specific treatment in their own communities, using flexible models of community care that can provide early intervention and long term recovery support

- **Services for adults** – ensuring that young adults between the ages of 16 and 30 years have access to care which is consistent with their development needs and the approaches used in child and adolescent health services; ensuring that older adults, whether experiencing an eating disorder for the first time or experiencing a recurrence of illness, have access to treatment

- **Family support** – ensuring that family education and support is provided as an integral part of treatment

Underpinning all of these areas is the need to take eating disorders seriously, recognising them as severe and life threatening illnesses that require an early intervention response. Australians suffering eating disorders deserve affordable, accessible, evidence based specialist care. The need is urgent.

*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.*
15. The voices of change
Joe Calleja

The Richmond Fellowship tradition is grounded in the right of individuals who experience mental health challenges to have access to support that enables them to connect with their community of choice. The very first Richmond Fellowship, founded in 1959 by Elly Jensen in Richmond London, was established to assist people leaving hospital to find a place in community and commence the work of building welcoming communities.

Since its formation in 1975, Richmond Fellowship of WA has, carried on this tradition. Its work is based on offering hope of recovery from mental health challenges and supporting individuals on their journey of recovery. This is based on the belief that recovery is possible (which builds hope) that an individual can be assisted in gaining or regaining control over their lives and be assisted finding and forging opportunities that all citizens should have for a good life.

Over the past thirty years in Australia, there has been increasing recognition of the importance of providing support outside of hospital settings and clinics to people who experience mental health challenges – that is support based in the community. The recognition of the importance of psycho social support has been demonstrated by the increased levels of funding being provided by state and federal governments to non-government organisations to increase the support they provide in the community. The community mental health sector has willingly accepted the crucial role of supporting increased hope, control and opportunity for the lives of consumers and families. It does so from a position of deeply listening to and responding to the experiences of consumers and their families.

Although the span of who can be thought to have a ‘mental illness’ continues to broaden thanks to the successive versions of the DSM, there are those persons whose diagnosis is rarely uncontested due to the nature of their levels of distress. Often people with the diagnosis of schizophrenia continue to be viewed as the most unlikely group to achieve what we call ‘recovery’. RFWA believes that this view lingers due to loss of hope and a misunderstanding of distress, and we argue that such a diagnosis gives negative messages and is far from uplifting or hopeful. All too often people labelled and written off as ‘schizophrenic’ rather than as individuals who have likely experienced trauma, and who also have strengths, dreams and hopes for a good life that could be fanned and enabled.

Their experiences of psychosis is often characterised as “illness” and their experience of hearing voices and other unusual sensory experiences are frequently considered to be “abnormal”. Mainstream biomedical mental health services provider responses to voice hearing have commonly been to medicate, encourage distraction, and deny the reality of the voice hearing experience. In short, they are not seen by many professionals to have any hope of recovery, control over their lives or to have the opportunity to live a meaningful life in the community. Alas all too often it is our ‘treatments’ and loss of hopeful responses that lead to the chronicity that is then cast as a ‘symptom’ of the very illness described.

It is an irony also to note that research shows that the experience of voice hearing is more widespread than generally acknowledged and that large numbers of people who have voice hearing experiences live productive lives in the community with little or no contact with mental health services. This group either have positive voice hearing experiences or they have a meaningful context for their experiencing – such as a family history of being ‘seers’. However, for those people for whom there is profound distress associated with voice hearing they frequently respond in ways which draws them either into a mental health service framework or a ‘justice net’ while others languish in subpar hostel accommodation or listlessly wander the streets.
The Hearing Voices Network

Recognising these less than hopeful options, in 2005, Richmond Fellowship of WA took the step of introducing the Hearing Voices Network to Australia. The Hearing Voices Network offered people who had previously been given a “life sentence” of being tied to maintenance based systems and revolving doors the opportunity to believe they could take back control over their lives. It offered a similarly liberating experience to many professionals who felt there must be other ways to assist people who had been written off because of their diagnosis.

The Hearing Voices Movement emerged in 1987 as a result of the work by Dutch Social Psychiatrist Professor Marius Romme, his partner Dr Sandra Escher (a journalist) and his patient voice hearer Patsy Hage. Patsy challenged Professor Romme during a consultation when she asked him why he didn’t believe her voices were real, yet he expected her to believe in a God she could not see. This challenged Marius to look further into the experience of hearing voices other than how he was trained to see voice hearing as a symptom of an illness. His thinking was further transformed after he and Patsy subsequently spoke about voice hearing on Dutch television and were astonished by the response which indicated a broader prevalence of people who experience voice hearing than the group of people with a mental illness diagnosis. Of significance was that many were living well and coping with the experience with no hint that their experiences might be couched as abnormal.

Professor Romme set up the world’s first Hearing Voices Network in Holland and networks have since been established in over 25 countries throughout the world. The hearing voices movement has enabled peer-driven, self-help groups to spring up in vast numbers throughout the world and it has been one of the great peer support endeavours of its time. The movement is made up of peers and allies – that is voice hearers, consumers, professionals and families.

The decision by RFWA to set up the Hearing Voices Network in Australia in 2005, in spite of the mainstream biomedical view in mental health circles that voices were not real and could only be managed by medication, was a major step forward in the support for peer driven ways of responding to mental health problems. The transformative effect of voice hearers helping each other to understand and manage their voice hearing experience was not something that mainstream biomedical psychiatry and mental health services would have previously thought possible.

In November 2008, RFWA brought Professor Dr Romme, Dr Sandra Escher along with other leaders of the Hearing Voices movement from the UK and Europe to Perth to hold their Annual INTERVOICE Meeting. This was the first time in their history they had met outside of Europe. The meeting of INTERVOICE (The International Network for Training, Education and Research into Hearing Voices), which is the overarching body of Hearing Voices Networks ran alongside the RFWA Recovery from Psychosis Conference. The presence of the 15 or more INTERVOICE leaders as conference keynotes had a transformative effect for those who attended the conference from all over Australia and many people since. To be able to listen to voice hearers, their family members and service providers talk about their experience of recovery from what had previously been considered a life sentence of little hope and a prognosis of chronicity, and the possibility of mastery over distressing voices has opened doors for many. These messages of hope have begun a major change process across Australia which continues today. There are now Hearing Voices Networks in 3 states and hearing voices groups within every state.

Noticing this burgeoning activity INTERVOICE has decided to meet outside of Europe for the second time, and will hold their meeting and conference in Melbourne from 20–22 November 2013. The World Hearing Voices Congress is sponsored by Voices Vic and Prahran Mission with the support of the Hearing Voices Network Australia (RFWA).
This congress will make visible the countless instances of victory over voices and reclamation of lives – it will tell the stories of many people experiencing psychosis and hearing distressing voices who were at one time considered never able to recover from their “illness”. Their stories are the evidence of recovery. And it is to these stories that health administrators, clinicians, service providers, policy makers and funders must listen. They are the experts by experience; if it were not for the voice of courage of Patsy Hage, in Holland twenty-five years ago being heard by her clinician, this new understanding would not have been developed nor so many lives transformed.

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 peer support programs. Let us hope that the current shifts away from the biomedical frameworks are steadfast and that we see a significant de-emphasis on the medical model being as the key driver of service delivery, instead 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.


The writer wishes to acknowledge the assistance of Lyn Mahboub, Coordinator Hearing Voices Network Australia (HVNA), and Amanda Waegeli, Coordinator, Hearing Voices Network WA (HVN WA), in the preparation of this article.

Joe Calleja has been the Chief Executive Officer of the Richmond Fellowship of Western Australia 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. He is currently on the boards of Community Employers WA (CEWA), the Faculty of Arts, Humanities and Social Sciences Advisory Board (UWA), WAAMH, Centre for Social Impact (UWA) and the Inaugural Mental Health Advisory Council in WA. He was previously a non government representative on the Project Steering Committee for the development of the WA Mental Health Strategic Plan 2010 – 2020 and is currently a Deputy Chair of an Expert Working Group on the National Mental Health service Framework Project. He was a high school teacher for five years before retraining as a Social Worker at the University of WA in 1980.
16. A thirty year family experience

Carer “C” – Sister and Carer

Thirty years is two thirds of my sister’s life and for all that time (and longer) she has been a recipient of various NSW mental health services. As a sibling and part carer I have watched the mental health “system” evolve from a pure medical model to a primarily community service model. Mental health services are now working flexibly, are more client-focussed, and are more holistic in their approach. But has the system actually evolved sufficiently to improve the health and wellbeing for clients who require ongoing support – I would say NO from my perspective.

For my family, the 70s was a time of pure medical model, where clients’ only form of care or medical support was through mental health units and facilities. With little to no consultation with carer families, no respite, and no real linkage for clients to the real world of socialisation or employment, the support system was grossly lacking. However, access to doctors and nurses, and units was available most of the time for clients when needed regardless as to whether situation was urgent or the client could feel an “episode” coming on.

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. We were lucky, my sister was able through my parents’ articulate and forceful lobbying, to access “group home” accommodation and she was able eventually after a number of years, to live independently in housing commission accommodation. This independence has required continuous family involvement and ongoing case-work management to maintain her in accommodation.

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.

So what has happened? Skilled mental health care by the health profession is less available (due to funding and staffing issues) and circumstances have to be almost at crisis point to engage. My sister has developed more side-effect symptoms and odd behaviours (e.g. hoarding) as a result of her long-term illness which require monitoring. Case management has been sporadic over the years with lack of continuity of workers and disjointed, often uncoordinated service provider arrangements.

On a positive note, finally, a not-for-profit health care organisation (which we only heard about through word of mouth and no-one had referred us to) has taken up her case management in the past year which is client focused, sensitive, caring and in which she has confidence. They will actually work with all the various government providers (housing, health, Centrelink etc.) on her behalf, and her stress in trying to deal with the different bureaucracies has decreased.

I do wonder like in all previous years, how long this continuity of care will last as governments tend to change policy and funding for treatment/care options on a regular basis! I am cynical about whether focus for mental health policy will really encompass client groups who aren’t in the high-risk category but who require continuity of care to maintain them at the lower risk levels so we are not moving from crisis to crisis. Then there is the big question – what happens when my sister becomes a senior in a few years’ time!! There is very little community awareness about what is involved in relation to transition into senior years for a “mental health” client. That is our next big hurdle.
Obsessive Hope Disorder
17. Sending out an S.O.S.

Carer “D” – Anonymous Parent
(Note: all names have been changed)

Susan’s experience: A 21st Century Mental Health System?

Tough times at school

Our daughter “Susan’s” journey started in grade 4 in 2007. She endured tough times at our local school. The difficulties were all-encompassing socially, both in and out of the classroom.

Our child wasn’t made to fit in a round hole like all the other children at the school, so the school didn’t feel they needed to address the everyday problems that impacted on her self-esteem.

We moved Susan to another school, for the last term of grade 4. Here they highlighted the importance of nurturing individuality. The school works with children to encourage growth and good social interaction, through play, how to interact and care about each other and to navigate independence. In principal that sounded great however Susan did not experience these school values through the 4 years she was there. Instead she endured physical and verbal abuse, bullying, peer exclusion, stalking, sexual abuse and being ground down by the peer group. As a parent I felt I was constantly talking to the school about the problems Susan was experiencing and asking them how they were responding to these issues as they came up. I worked hard at encouraging Susan to have kids from school home for visits and outings, encouraging Susan to explore lot of friendships.

Susan was also bullied by a group of boys on the way home from school for nearly two years. They would prey on her after school when she walked on her own and on the platform as she waited for her train. We knew nothing about this for at least six months as Susan tried different things to help herself. She was terrified as they chased after her down the hill calling her scooter girl, verbally making fun of her and grabbing her bag. At the station they pretended to push her in front of oncoming trains. I tried to involve the Police at one point however, unless there is physical evidence they are not really willing to do anything. I spoke to my daughter’s school; however the bullying never really stopped. Now I know I should have been insistent with the Police as these same group of boys acted in the same way many times which is classified as stalking and which the Police can act on.

The abuse

Abuse occurred on school camps where there was no reprieve for Susan and on Facebook for the whole world to witness. Susan approached Facebook to ask for a terrible post to be taken down. I have learnt now to listen carefully to what my daughter tells me as she was crying out for help, but no one really listened with open ears.

Susan was raped in year 7 (aged 12) and she hung onto this information for almost two years. It was someone at her school on a simple date to the pictures. I had done all the parent checks and organised supervision, but it still didn’t go right and Susan was the one that suffered. The day she told me it tore my heart apart and I replayed that night many times over in my head. I thought I had prepared Susan to understand the danger signs and what to do to keep herself safe, but when you are in danger it is different. When I look back now, that is the date I noticed a big change in her. Over time all the problems and abuse just built up and became too much for Susan to manage. It was like she fell into a hole that she couldn’t climb out of.

Initial service responses

I took Susan to our GP, who suggested we seek further help for Susan from the psychologist at our GP centre. She was assessed as having severe depression and started her on a natural anti-depressant and given a book to read on depression.
Susan’s world fell in. She would text me at school, telling me she wanted to die. She would sit in the toilets and cry all the time. She told me she had no friends and no one cared about her. Susan just wanted to die.

I started looking for different help and support for Susan. I spoke to headspace, Black Dog Institute and Kids Helpline. I wasn’t really sure where to turn. There is lots of information out there on what symptoms look like but when you look for help there are no active programs for adolescents under 16 to work and support them if they have a mental illness. I was mortified I couldn’t help her.

It was recognised that Susan needed to work with a specialist experienced with teenagers. We saw a male psychologist intermittently as he tried to tackle Susan’s social issues and herself image and body perception. Susan needed more intense therapy and Dialectical Behaviour Therapy. We then saw “Hayley” (an adolescent psychologist) in the early stages of the following year.

In year 8 (Year 2011) the bullying seemed to step up quite substantially for Susan and she couldn’t hide it any more. Susan started seeing her female psychologist once a fortnight until things took a much sharper turn in Susan’s mental health where Susan needed to see Hayley every week.

At school, I tried to encourage Susan to stick up for herself however, whenever she did the girls just told her to “shut up”. If she asked them why they were so mean to her they would get even ruder and more aggressive.

She changed her hair colour to feel and look different. The kids at school used this as a leverage point for further abuse. She wanted a nose job and to cut her body to pieces, as she was so ugly and obese when she looked in the mirror. She saw her reflection the way the girls had repeated again and again as they verbally and physically abused her.

Susan stopped going to school, stopped seeing anyone and stopped going anywhere.

**Specialist care**

I was given a list of Psychiatrist names by our GP that I rang with no success of engagement. None of the psychiatrists I rang would take Susan, as their books were closed. It was suggested, I try a psychiatrist who had just gone into private practice. Susan had started on Antidepressants, fluoxetine. Susan’s suicidal thoughts got stronger, until I got a phone call from Hayley that a plan to kill herself had been divulged. We had to lock all our knives and poisons away and keep a constant eye on Susan until she could go into hospital. We were mortified. I can’t tell you what it’s like to think, that no matter what you do, your child may not make it.

I sat at Hayley’s office and rang all the private hospitals to be told she wasn’t eligible for any except one clinic because of her age and the intake worker at clinic told me there was a 6 week wait on beds and a referral process, to get a bed in the adolescent unit. You had to know a psychiatrist or hope the team, in their weekly review session, would persuade someone to take your case.
The psychiatrist told us to ring the crisis assessment and treatment team. They told us it was too late to go to the emergency department (ED) at the closest hospital as they don’t accept mental health referrals late in the day (at 4.30 PM) and promised they would come and visit Susan the next day. I had Susan in the car in tears, white as a ghost, packed to go to the Children’s Hospital ED.

Susan was so distressed so we continued our path into the Children’s Hospital ED for an assessment, thinking surely they can’t turn us away. There were no beds vacant anywhere for adolescents in the state, so we either had to send the night in ED or go home and hope Susan was eventually given a bed. We decided to be the noisy wheel, Susan was given a sedative to help her sleep at 1.00am in the morning, I slept on the floor next to her.

**The specialist in-patient unit**

We were woken at 2.00am by one of the doctors to be told they had found a bed at another centre for adolescents with mental health issues at the hospital and we had to make our own way. We arrived at a locked gate at the unit to be greeted by an old man that looked at her belongings and said ‘you won’t need those’. At 4.30am Susan was beside herself with distress, she didn’t want to stay and was really frightened. With much persuasion Susan stayed.

During Susan’s stay at the adolescent unit we were given little information on treatment, diagnosis, medication or planning around how to help Susan and our family. She seemed to just languish with little change. Every week the focus was on when Susan would be discharged. Susan as an inpatient felt she was not allowed to talk about any issues or problems surrounding her or discuss them in groups or with other clients as there was a confidentiality rule. She felt there were no broad term discussions on managing anything-surrounding mental health or just everyday issues she has had to grapple with.

Sitting in front of the television and trying to help each other in secret was a large focus for her. There seemed to be little censorship on TV programs and watching horrible shows about death and rape or murder, affected Susan greatly. There was one group that Susan felt was worthwhile run by ex-patients who came back and talked about their journey. Susan had no idea what help looked like and if any one cared enough to help her.

We were struggling as a family to know how to help Susan and were falling apart ourselves. No family support or direction was ever offered to us. We are not the client.

We again revisited accessing the adolescent unit. Hayley helped set up an appointment with an adolescent physician at the adolescent unit. In November 2011, I took Susan drugged and almost unable to talk to see another psychiatrist.

**Another specialist**

He organised an appointment with a male adolescent psychiatrist for Susan. The adolescent psychiatrist told us that he was used to difficult cases and would be happy help with her care. We couldn’t just ask for help for Susan, this was all done as a favour; some one that knows someone that could help??

Susan was moved to the adolescent unit under the care of the male adolescent psychiatrist just before Christmas. She didn’t do well, as she just wanted to die, her self-esteem was so low that she couldn’t focus on help or what it might look like. The male adolescent psychiatrist and Susan had no therapeutic alignment and the only way he could work with Susan apparently was to make her angry, which he did on a regular basis. Susan had to come up with a goal that she could work on during her stay. What if you didn’t know what was wrong? That was where Susan was! Every day dragged for Susan, being made up of minutes that moved her closer to bed and sleep, and the hope she wouldn’t wake up in the morning.

Susan suffered from Bulimia and body dismorphia and didn’t want to do basic things for herself such as shower or eat. She was angry, sad and loathed life. After two-weeks she was sent home for Christmas even though she had no hope and was suicidal to reflect on her situation. The doctor was going on holiday and would readmit her at the beginning of January.
About two or three days after coming home Susan tried to overdose and then swallow a handful of pins. Here we were, with a child that lay on the couch or in bed and refused to shower; (she felt) she didn’t deserve to eat or drink and just talked about dying. I hovered close by all during the day and then went to sleep with her until 4am in the morning. This is when she saw people and the grim reaper on the walls in her room. I was a wreck. During that time she told me terrible things that had happened to her whilst at school. I rang the Crisis Assessment and Treatment Team to be told they did not deal with adolescents. When we approached the adolescent unit to go back early, they told us that wasn’t possible.

During Christmas, even on Christmas Day we needed phone support from Dr Hayley for Susan. Hayley saw Susan, as did the out-patients child and adolescent mental health service (CAMS) at the hospital. CAMS told us if they admitted Susan to the inpatient unit at the hospital it would hurt her chances of going back to the adolescent unit. So we just survived at home stressed and on 24-hour alert.

**Back to the specialist in-patient unit**

Susan was readmitted to the adolescent unit clinic as planned early Jan 2012. She was there for 5 weeks still under the same doctor.

Susan spent most of that time in crisis. There was a lot of talk around very difficult subjects in the groups Susan attended and she disclosed to me, that she had been raped two years ago. I sat and listened at first to outlines and then full details and my heart just sank. I told the nursing staff but they could do nothing to help her as the Psychiatric led her treatment.

Susan was very uncomfortable with the thought of talking to any male, nursing staff or doctor, so I started to look for a female psychiatrist as the male adolescent psychiatrist informed us no one wanted to take her case. He felt we were privileged to have his support and that we should be grateful as Susan was so difficult especially since her frontal lobe wasn’t fully developed.

I made contact with an adolescent psychiatrist in private practice. Again I just rang every female Psychiatrist that was listed in the city that worked with adolescents. Susan started an assessment process with the new female psychiatrist and saw her twice weekly until middle of March. Susan did not feel a real connection to her as she was used to a psychologist that packaged away the things they were talking about before finishing the sessions, so things were not so raw as they were with the new psychiatrist. After visits, Susan often became distressed and her suicidal thoughts increased and sometimes she acted on those thoughts.

Susan and I visited a centre for health care and family planning for full testing after the disclosure of the rape. Susan was terrified and had been hanging on to the idea that there was a way of knowing a person had been raped. I also made an appointment to see an organisation to help with understanding Susan’s rape as Susan was not allowed to talk to them directly as she was too young. I desperately rang around for advice on how to help Susan. I rang the Children’s Hospital to seek advice however we did not live in their catchment area. Susan kept replaying the rape in her head. She wrote suicide notes, tried to strangle herself and was desperate to talk to someone. I rang a hot line for her to talk to in desperation; however the adolescent unit policy said she was not allowed to do that. So Susan spoke to no one and still hasn’t.

The male psychiatrist could not work with Susan and could not force anyone to take her on. So we were passed back to the hospital in early February 2012 for ongoing care.
We were summoned to a meeting at the hospital with ten people, Susan, my husband and I. The first agenda item discussed was when Susan was going back to school and that this was to be a timed admission of two weeks with a clear goal to get Susan back home and back to school.

She remained in hospital until the end of April. Susan was bulimic, suffering anxiety, hearing voices, self-harming, suffering chronic depression, and suicidality. As an inpatient her basic rights were taken away. From the onset it felt like a battle. Susan felt no one cared and no one wanted to listen to her crying out for help. We had weekly meetings with the inpatient unit to be told that “we were the problem”. Our family discourse was a point of concern in their management of us as a family and the anxiety Susan held about her sister was put down to her insecurity of not growing up properly detached from me as a mother. These were hot topics to be debated rather than looking at the chronic problems Susan endured. This was confirmed when I read through my daughter’s nursing notes under freedom of information later in the year. Most of my daughter’s difficulties in the notes were focused on my inadequacies and our family discord. Susan was branded as a liar and that she embellished her symptoms.

No diagnosis or treatment was evident at any stage whilst she was an inpatient. Her care around her inpatient admission was about controlling our family and managing our visits and restricting her access to phone calls.

Susan was outwardly suicidal yet outings home were paramount. They had to be a minimum of 4 hours or Susan would be punished with reflection time in her room. The unit psychiatrist kept telling Susan they had to be careful she didn’t become institutionalised. The staff didn’t believe Susan couldn’t recall information. They felt she was lying to manipulate situations to her advantage. No consideration was taken into account that she was suffering from posttraumatic stress.

When telling nursing staff she wanted to hurt herself their response was just to stay visible. She was constantly told hospital was not a place for treatment only a place for containment and treatment was to start after the hospital stay. No one actually tells you how that is to happen or who will help your child and your family. Susan felt that the groups were not problem focused. The adolescents felt unable to talk about how they managed what was happening in their heads. Medication was never written up correctly. Medication on extended leave was not given to me. During her admission to the ward we had planned time out of the ward and at home. There was a constant battle with the doctors to give enough medication for us to use at home to help manage her anxiety attacks or meltdowns. She was questioned about how much medication I gave her on her return. Did I lie about the amount of medication I used?

Susan was having really bad, vivid, violent nightmares all through her hospital stay and her primary nurse started to work on her dreams however this was never carried through. Every day started with those memories of the night. Every night she was terrified to sleep. It was a vicious circle that had no end.

I spoke to staff about Susan’s eating issues. She had lost 14 kg since Oct last year by purging. She was bulimic yet staff did not write this information in the notes. When I approached staff they told me they had never seen her purge. They asked me not to talk about it as other patients ‘did’ having eating problems. Her bulimia and extreme body dismorphia continued to grow.

Medical issues came up whilst Susan was an inpatient and I had to address them.

A nurse trod on her 5th toe as she was taken to her ward, it was mangled and the joints damaged. We spent over $2,000 to have the joints in her toe fixed.

She had gastro combined with bulimia in March and had not eaten or drunk anything for nearly 10 days. She was dehydrated and couldn’t move from her bed. I carried her with the help of one of the nurses out of the ward and drove her to the Children’s hospital to be rehydrated even though the unit psychiatrist threatened to take her bed. Being physically well is equally is important as being treating a mental illness.
We reconnected with Hayley even when Susan was still an inpatient at the hospital, as Susan was having no individual therapy at any stage during her hospital stay. I had to fight to get permission from the hospital for Susan to see Dr Hayley. Susan saw her once a week.

**Discharge**

After discharge from the inpatient unit we were connected with an intensive management team through the hospital. We were told they were to work with our family to help us manage Susan back into everyday life. We were told the case manager would walk alongside Susan to help her manage the hurdles she experiences along the way and case-manage the other services for Susan and our family. This did not happen. I don’t know what we expected but it would have been good to have someone guide us in how to help Susan and support her needs and understand the process of treatment and stability a young person like Susan would need to be able to learn how to help herself back into health.

Susan became angry and intensified all her feelings internally. She didn’t feel she was getting anywhere and no one was listening to what she wanted. It was like walking on eggshells around Susan. Even basic conversations set Susan off. She ran out of the house and made several attempts to kill herself unsuccessfully at night. This made her more angry and out of control. Her anger overcame her and she attacked Brian and I. Brian sat on her after quite a struggle, as Susan was not responding to anything around her. We ended up at the children’s hospital, as there were no beds at the hospital. She spent 5 weeks in hospital. It was interesting dealing with the staff at the Children’s hospital. They very quickly had a handle on where Susan was in therapy and what type of treatment may allow Susan to move forward. One of the doctors made some significant suggestions to help us keep Susan engaged in the community.

Susan languished at home for about 10 weeks. Her case manager visited once or twice a week and I engaged two carers to help me look after Susan at the suggestion of the doctor at the children’s hospital. She could never be left alone, as her default setting was suicide. She didn’t really want to engage in anything outside the home. So these young people I employed brought a sense of relief and engagement for Susan. Susan needs constant care and someone to engage her in life skills. We constantly wondered how we could help Susan. It was like a bad dream.

I went searching for help around the middle of the year. Susan had not been managing and became uncontrollable. She had a five week stint at counselling centre to help her back again into the community. It was like the mental health care system was a revolving door. In for a crisis – admission – then out again. Where does the help start?

**Self-help and some hope**

One of the doctors had suggested more support for Susan at home. I searched high and low for a youth worker to work with Susan. I rang all the support agencies. Nothing popped up. So I organised a band of 4 students (21–28 years of age) that worked with kids in extremely stressful situations and remained calm. They came to us 3-4 times a week and became wonderful companions to Susan. They became her friends, her support and worked on engaging her in craft and walks and to live again. They engaged with her over Facebook and encouraged her to care again.

I went looking for support for us as a family. Firstly a support for me as the main carer to voice my concerns and to help me work on how to support and help Susan with her needs as they arose. I started work with a wonderful psychologist. He was practical and became my voice of reason. When things got tough for my husband and I, he was there for support.

I contacted a centre to try and connect with someone that worked with young people who had experienced rape and trauma. They were wonderful. We have been doing family work with a very experienced councillor who has guided us to manage in the face of adversity, allowing my husband and I time to be on the same page in caring for our family. We are still there still working on a journey with no known end.
Again we went looking for a way to help Susan. She felt bad but couldn’t really deal with why as it was locked inside her. We organised help with her Posttraumatic stress. After testing, she had Neurofeedback therapy for over six months to change her brain. Her emotional regulation was 4 times the size it was meant to be. Her frontal lobe was full and not able to process any information. With the work done over those six months her brain has now changed and her emotional regulation section has gone back to normal size and her frontal lobe is less busy and able to process information. She was able to sit still for the first time in over a year and listen to music.

Before this Susan would make herself so busy she couldn’t feel anything. She would watch television, YouTube, do craft and listen to music all at the same time so she wouldn’t feel anything engage with her in her environment. Slowly her memory came back and there wasn’t a picture of horror playing in her head all the time. She knew why she felt bad instead of just feeling hopelessness.

She attended a program run by the Education Department through the Hospital. These two special ladies worked miracles. She attended the program 4 days a week for 8 weeks. Susan flourished, learning to re-engage with peers, follow a goal, let herself be heard, manage herself and hold down a work experience job. After the work experience finished Susan was invited to stay on in her job part time and has just loved the independence and sense of community her job, her manager and her employees have given her. Her teachers still keep in touch.

She moved to a youth pathway program with 8 other young people. I was really worried how she would go, but she stayed and enjoyed her time last year. She was taken and picked up by carers and by me, but has made a good support network for herself with her peers. I rang 10 places that may have been ok for Susan to attend before the program. Each one had good and bad points but the thing I was interested in was finding somewhere Susan could spread her wings when she was ready. We didn’t want her to be in a place that was stagnant.

Susan started back horse riding. She loves horses. They need to be commanded. You need strength and understanding to ride. Horses don’t judge you. Susan found such freedom and care from being with the horses. She rides about once a week and loves every second. She talks to them and they understand where she is. Susan was doing well. She was relatively stable for a few months.

**A 21st Century health care system?**

Christmas was a hard time for Susan. She reported to the Police all the assaults that had happened to her over the long period at school.

January 2013 – I caught her as she was jumping off a 7-foot bridge onto rocks. She lay on the road and waited for a car to run her over. No one from Adolescent Inpatient Mental Health Services (AIMS) followed up. No collaborative care is met with her treating psychologist at any stage as an inpatient or outpatient. No Case Management is evident where case conference happens between the private and public sector of her treating team. Where is the case management from the AIMS team that was to liaise with the private and public system, to work together to help Susan? Nowhere.

The psychiatrist from the AIMS team rang and spoke to Susan on Monday morning 3 weeks ago (early February 2013), giving her more bad news with no regard for her mental wellbeing. She made recommendations about what would work for Susan without following up on how and where that could happen. She recommended group work as an outpatient yet did not check if that was available. After this information Susan received in the morning, on the Monday afternoon Susan was very suicidal and when I rang the AIMS case manager they were going to deal with it the next day. I rang after hours on call AIMS to wait 1 hour for them to ring even though Susan was really suicidal. I rang the Crisis Assessment and Treatment (CAT) Team and they talked about how to manage overnight.

No calls from AIMS to check on Susan the next day until I had rung several times to find out how they were going with the information to find Susan less of a bandaid solution and more of an intense treatment – TO HELP HER OVER THE HUMP.
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 form.

For us what stands out is each journey is fraught with all sorts of hurdles and I hope we can find a way for Susan to survive and enjoy the normal things that life will bring one day!!!
18. More cost-effective community housing

Carer “J”

Using SWAN VILLA CSRU model as the comparative benchmark

In this Design for a better mental health care system, Carer “J” provides a carer perspective – alternative design improvement considerations when building future medium density community housing for Mental Health (MH) consumers in need.

Serial state governments have failed to build enough housing for MH consumers in need. The current debt driven Global Financial Crisis of 2008 continues and will compromise our state’s ability to fund required delivery of services and accommodation well into the future.

We need strategies to optimise dollar outcome from scarce funds:

- Ideas on how more cost effective ideas can accommodate more people for less money.
- Build better and more cost effective community housing using whatever budget the state government is able to provide.
- Consider building architect designed community housing using shipping containers.

Below – Amsterdam student complex
Below – Multi-family condo in Detroit USA

Architectural designs:
City of Swan lot information - Swan Villa CSRU: 91 Patterson Drive, Middle Swan 6065

Present layout plan

Now 14 units = 25 residents and office with community area
Possible
- 13 units x 3 = 39 residences and office with community area
- 13 units x 4 = 52 residences and office with community area

What is possible – more people housed at lower per unit costs

Utilise well-understood design principles to lower costs per resident basis for accommodation, provision of site civil engineering infrastructure (public area paved roads, drainage, lighting), maintenance costs (gardening, periodic painting), water and energy use and help reduce support staff workloads.

The architects designed Swan Villa CSRU in compliance with the client brief instructions received from the directors of the previous MH Department. Swan Villa CSRU is architecturally of excellent construction. Unfortunately, the client brief was ill conceived.

The problem was further complicated by the ill-conceived service agreements together with inappropriate management concepts used to administer the CSRU.

Some design strategies for the MHC consideration:

Use suitably modified off-the shelf project homes since their economies of scale reduce construction costs.

Alternatively, design residential units (below) with less material and labour costs to produce modular templates for all community housing within WA.

Residential units

- Separate residential units by gender;
- Maintain either balanced gender or all male community at each community housing location to reduce undesirable social tensions;
Develop standardised modular designs optimised for offsite industrial fabrication and installation state-wide;

Alternative option is to build architect designed accommodation using shipping containers of a standard equal to the Amsterdam student complex;

Cluster the residential units to take advantage of minimum local government setback requirements. This strategy creates opportunities to reduce cost of service infrastructures such as sewerage, plumbing, the sharing of active and passive solar facilities between units as well as minimising relatively high cost landscaping features;

Each residential unit to have 3 or 4 bedrooms;

Redesign units so each bedroom has a personal frontage to open space. This layout strategy suggests the internal open plan for common public areas (kitchen, dining, living) will be surrounded by resident bedrooms for reasons of economic construction.

Consider skylights to introduce diffused indirect sunlight whilst avoiding heat transfer into the unit public areas. Heat transfer is all about limiting radiation of undesirable sunlight wave length spectrum into residential units.

Common walls reduce material and labour costs in construction;

No garage means more residential space;

Park resident car’s in the public covered parking area (patio style);

Cluster wet areas (including kitchens) to reduce plumbing costs and reduce hot water heat lost despite use of lagging;

Equip each unit with enough pantry storage, two stainless steel sinks and sufficient bench area for two residents to cook simultaneously.

This helps reduce potential irritants between residents living in the same unit;

Equip each residential units with a bathroom shared by two (4 bedroom unit) or three residents (3 bedroom unit);

Supply a small fridge for each residence;

Consider replacing double cavity brick walls, where appropriate, with alternative cladding and load bearing materials, modular ICF techniques using EPS formwork to construct reinforced concrete floors/walls/roofs, timber frame and cladding, post and beam techniques, concrete slab cladding, concrete bricks etc.

Use coloured render or surface treated concrete facing on external walls to design out recurrent painting and maintenance.

Potentials benefit gains include faster construction, economy, improved thermal and acoustic insulation as well as lower cost of ownership over the life of the residential units;

Reduce the roofing and ceiling construction costs resulting from hip and valley roofs (refer Swan Villa units) by using flat roof and skillion designs.

Use waterproofed flat roofs with suitable drainage covered by, say, 25mm earth external layer planted with succulents. Earth cover insulates and the flat or low pitch angle skillion enables, say, use of traversing solar panels to track sun trajectory to optimise power generation as well as hot water systems.

Include 600mm eaves (based on a standard ceiling height house) to help ensure residence interior is shaded from summer sun;

Insulate wall and roof and use minimal double glazing where appropriate;
• Use attractive exposed and polished aggregate concrete flooring to serve as winter thermal heat bank. Save on tile installation costs and the adhesives used retard heat transfer.

• Perth subsurface sandy soil summer temperature is circa 26o C or less at 3m depth (average long term mean max is 24.5o C ambient on the surface) and winter subsurface a 3m depth of circa 14.5o C (mean min 12.7o C ambient on the surface).

• The ground surface and subsurface temperature differential provides geothermal opportunities for both cooling and heating using horizontal slinky tube subsurface installation trench laid at a depth of 1m or more.

• Such tubing installed under the car park paving would keep all units warm in winter because the dark paving mass is a thermal bank storing solar heat.

• Mt Claremont Challenge stadium uses direct geothermal to heat its swimming pool — http://www.ga.gov.au/image_cache/GA10661.pdf);

• Optimise internal cross ventilation from SW summer cooling breeze and aided by optional solar chimneys for improved cooling air flow;

• Use passive and active solar design principles.

• Well-designed units with proper north orientation can enjoy internal unit temperatures within 17o C in winter and 26o C summer range year round;

Use material with acoustic insulation properties and attractive appearance to minimise maintenance painting and soundproofing;

• Use CFL or LED lighting to reduce energy consumption.

• MH consumers routinely forget to turn-off lights and water taps.

• Consider installing smart meters and monitor power and water consumption to encourage responsible use. Perhaps install smart meters with remote supply limitation capability to be monitored and operated from the site office. Another option is to consider infra-red sensor activated lighting;

• Use corner guards, skirting boards and other devices to prevent damage because MH residents are less situational aware;

• Use grey water recycling for gardening;

• Minimise gardens and landscape for low maintenance and water-wise purposes and encourage simple garden maintenance by residents as a collective community effort;

• Provide each unit with alfresco area covered with angled slats to retard summer sun heat exposure;

**Site infrastructure**

• Locate office and community area at entrance;

• Connect residential units by a network of footpaths (include rain shelter stations at intervals) optimised for intra-community meeting opportunities;

• Construct a single minimal bitumen paved vehicle access road and covered parking area as a hub;

• Use solar powered street lights;

• Dedicate some open area for gardening as a community rehabilitation project;

• Use low cost low maintenance common walls such as gabion structures and vegetation/trees/shrubs for visual and acoustic privacy where appropriate;

Less vehicle access roads means less paved areas, kerbing and public lighting = less capital and operating costs. Less units with road frontage means less costs as well.
Swan Villa CSRU residential unit perspective and elevation

The client brief for this CSRU failed to employ the high level creative capabilities and expertise possessed by their architects.
19. “Anna” – unrecognised and undiagnosed”

Michael Carr-Gregg

(Note: Names have been changed)

I never met “Anna” because by the time I first heard her name – the girl, described by friends as ‘having a thousand watt smile’, in an act of quiet desperation, went upstairs to her room and took her own life.

Anna was the third of five children of John and Gab Smith. As with all families, the Smiths have had their fair share of trials and tribulations. Their oldest son Sam is profoundly autistic and years ago was moved to a special accommodation centre and Gab was diagnosed with and had survived breast cancer. Aside from this, they were a normal family, living in a normal house in a normal suburb, yet they now live with the agonising questioning of what, if anything they could have done, differently to change the outcome.

Anna was in Year 12 at an outer eastern Melbourne Secondary College, had many friends, was a straight ‘A’ student and on the very day she died, had in front of a school assembly, accepted her prefect’s badge from a school she apparently loved.

Photo albums show that she grew up in a loving family, enjoyed a happy childhood and adolescence, even though impacted upon by the challenges of having an autistic older brother whom she loved. She engaged in almost every facet of life imaginable, she loved singing, playing the piano, making cards, writing stories and keeping her own journal. She was a ferocious reader and loved exercise especially hiking, cross-country running, table tennis and swimming. She played VFL football (youth girls competition), barracked for Geelong and was fond of Cameron Ling.

She loved her collection of textas, her beach “Wahoo” volleyball and her CD player. Regarding clothes – Anna wrote in one of her notebooks "Clothes must: let you jump and run". Her favourite top was a T-shirt from World Vision with the words "Stirring the world". As a big sister, she shared her time equally with all her siblings, listening and singing along to music and having heart to heart chats with sister Clare, discussing school and homework with Joel, and playing sport and games with Paul.

She shared with her family a deep spiritual faith, regularly attending evening youth services at her local church and teaching and helping children at Sunday school. She was an active member of TUNE a local youth group, where she occasionally played piano for the pop/rock band. She earned extra money by babysitting and working part time at Subway. She loved going to the movies and parties and zipping off to the beach with friends.

She appears to have had a solid base of warmth, friendship and love, all of which should have been a potent and positive amulet, a countervailing force – against future unhappiness. Despite all this, on Wednesday 30th January at about four o’clock, she finally slipped her psychological moorings and succumbed to a savage, lacerating, black, suicidal depression. It is only through reading her private diary, which she concealed from her family, that one gets clues as to what might have been going on inside her head. It seems as though that awful afternoon everything just came to a head. Reading between the lines, her diary entries throughout January strongly suggest that her mind, which had for years seemed sharp and clear, like a savage black dog, simply turned on her.

Despite Anna’s herculean efforts to maintain an outwardly brave face – she had reached a point where she no longer found anything interesting, enjoyable or worthwhile. Everything that was once sparkling in her life had now become flat. One is left to speculate to what extent she was capable of concentrated thought and how many times her private thoughts turned to thought of death.
She seemed to be engaged in an absolutely private, cognitive mortal combat. Every thought, word and movement had become an effort. This battle was waged within the corridors of her mind, where she was progressively besieged by a barrage of automatic negative thoughts, that plagued her with guilt and bid her regard herself and much of her life as worthless, dull and boring, simply draining her of her life energy.

By the end of the diary entries, it appears as though her depressive brain did little more than torment her with a dreary litany of her inadequacies, shortcomings in character and taunted her with the desperate hopelessness of it all.

To her credit, she mounted a brave, but ultimately futile, rearguard action against the illness, by writing list after list, forcing herself to exercise, and by sheer willpower, tried simply to wish the disease away. But the morbidity of her mind was astonishing and without the reinforcements afforded by anti-depressant medication, exercise and CBT, she could not overcome the power of the negative thoughts.

As Camus said, “suicide, like a great work of art, is prepared in the silence of the heart”, so we will never know precisely the nature and extent of Anna’s mental state. However, it is almost certain that Anna Smith, suffered an illness that distorted her moods, incited uncharacteristic behaviour, destroyed the basis of her rational thought and finally eroded her desire to live.

There are no simple theories for suicide, nor are their slick algorithms with which to predict it, and certainly no one has ever found a way to heal the hearts or settle the minds of those left behind.

Most young people who kill themselves have a mental illness, most often depression – as with Anna – usually unrecognised and undiagnosed. Chemicals in her brain, which regulated how she thought, felt and behaved, got out of balance. No amount of love and caring or trying to build up her self-esteem could have altered her misperception that her situation was hopeless.

While beyondblue has made giant strides in raising our awareness of this illness, Anna’s story reminds us that we still have a long way to go and that there are sadly, still many out there who await discovery.

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 & 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.
20. Low and no cost ways solutions

Graeme Cowan

For my forthcoming American book BACK FROM THE BRINK I interviewed 4064 people who live with depression. The finding showed that almost everyone can make a positive contribution towards improving the mental health of a person who appears to be struggling. Participants were asked to rate how important 60 different strategies were to their recovery. The desire wasn’t to find a definitive one strategy to help but to look at themes that occurred. It emerged that there are 4 ways that everyone can make a positive difference to someone who is discouraged. It is to CARE.

- Compassion – providing emotional support
- Access experts – finding mental health savvy GPs, psychologists, and psychiatrists
- Revitalising work – using your top 5 strengths daily for work is medicine
- Exercise – just a 30 minutes daily brisk walk has profound mental health benefits.

For the purpose of the Landmark report I want to focus on 2 missing low cost strategies that would have a profound positive impact on mental health in Australia.

Peer run support groups

Out of 60 recovery strategies evaluated, “Support group and/or peer support” was rated number 3 in effectiveness. To place this in context “Cognitive behaviour therapy” was rated number 11 and the most effective medication was rated number 23.

I have been an active participant in a support group for 10 years (the last 5 years as a leader), and have witnessed firsthand the dramatic results achieve. We recently had a reunion of past members and it was gratifying to hear most say it was the most important part of their recovery. Five said they wouldn’t have be here today without it. All are now employed full time. Over the last 8 years I’ve conducted hundreds of Q & A’s after my talks around Australia and almost universally people lament the lack of a professionally run national mental health support group structure. These were the group created mission and values which guided our 2 hour weekly meetings:

Our mission

Through compassion, courage and commitment, we encourage each other to bounce back and thrive from challenging times.

Values

- We promote a caring and supportive environment, acknowledging that we are here to help ourselves and each other
- We welcome all, irrespective of gender, race, religion or disability
- We acknowledge that what is discussed at meetings is confidential
- We treat each other with respect and dignity
- We encourage each other to think with clarity about our challenges
- We seek practical solutions.
- We learn from each other
- We practice what we learn
- We gently challenge
- We celebrate small steps taken, knowing that we are moving in the right direction
- We thrive as we help others to thrive.
Although nothing can fully replace face to face meetings, the advent of social media can help facilitate this support when physical meetings aren’t possible. We have run mental health support webinars with excellent feedback, and have created BACK FROM THE BRINK Facebook groups, and LinkedIn BACK FROM THE BRINK WORK SUPPORT Group dedicated to helping those with mood disorders have a thriving career.

If any organisation is interested in participating an evaluation of the effectiveness of 30 support groups run with the mission and values of what I have described, with a view for building a case for a national rollout please contact me.

**Exercise groups**

In the previously mentioned research, “Vigorous exercise (the equivalent of running for 30 minutes for 4-6 days per week)” was rated number 4 and “Moderate Exercise (the equivalent of walking for 30 minutes for 4-6 days per week)” rated number 7 out of 60 options.

The main issue for people who are depressed and/or anxious is that they are often lethargic and don’t feel like exercising. These are the guidelines we recommend to help conquer inertia.

**Find something you enjoy**

To sustain regular exercise, it is important to do something that you find pleasant. The traffic in gyms is 30-50% higher in January than other times of the year, as people are suddenly inspired to get fit and lose weight. By March, they have returned to normal levels. It’s not wise to sign up for a gym if you hate them!

I like walking because it allows me to get into nature, it’s free, and you can do it anywhere and anytime. Some people keep a walking journal so that they can write down the new things they see, hear, and smell each day. This keeps you present. If you prefer swimming, dancing, cycling, boot camps, or hiring a personal trainer, then do that. To experience the mood enhancement qualities of exercise it is recommended you do 30 minutes, 6 days per week. Although people with depression often don’t feel like exercising, it is important to go against that inclination by considering the following guidelines.

**Have modest goals**

Many people believe that to get the benefits of exercise you have to spend 2 hours in the gym or run a marathon. As highlighted above, this is simply not true. If you have been doing no exercise, start with 15 minutes per day. If you are spending all day in bed, just getting out to the letter box each day is a good start that you can build on. Build activity gradually.

**Introduce rituals**

As highlighted with the gym traffic trends above, changing behaviour requires more than intention. To make it stick, it is essential to introduce daily rituals that prompt the behaviour. For example, rituals could include:

- Laying your clothes out each night when you go to bed so that when you wake up you can dress without thinking and head off.
- As you brush your teeth each morning, put on a pedometer. When you brush at night, take it off and record the steps taken. Start by just monitoring your steps in the first week and then build the average daily count by 10% each week, until you get to 10,000 steps per day.
- Set a regular time to walk with a friend or work colleagues. Consider walking meetings. This kills two birds with the one stone.
- Consider using a free smart phone app like FitnessPal, which allows you to monitor your exercise and your calorie consumption.
Begin it now

We are in the advanced stages of creating a program that promotes mental and physical health though people joining groups of 5 and following fun daily rituals utilising mobile phone technology to strive to walk for 30–45 minutes each day. If any organisation or government is interested in participating in an evaluation of 100 groups with a view to building a case for a national rollout please contact us.

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
Obsessive Hope Disorder
21. Fixing the foundations
Sue Deacon

Choice Support Service Inc’s journey

On the surface Choice Support Service Inc (Choice) met the needs of those who used the service. How did we know that?

- There were minimal complaints by people who accessed our service, they loved it here
- Good responses to participant surveys in the past, everyone felt safe and comfortable
- Good feedback from key external stakeholders, we took referrals and helped people to fill in their days
- Staff were happy with the way they practiced, they felt good about being able to help
- Funders were happy – we reported and acquitted on time and we are accredited

So what’s the problem you ask? When we began to unpack a bit further we found that something didn’t add up!

As a newcomer to the organisation I found it very hard to make sense of what we really did. There were lots of important documents that seemed to say the right thing, and then they contradicted themselves. What we actually did wasn’t much like what we said we did.

How COULD we be Focussing on Recovery when we had people who had been accessing our service for 17 years, there was no education for Participants or staff on recovery, and we proudly promoted ourselves as a “safe” place, almost resort-like, where people hung out and asked for things like billiard tables and gym memberships?

We transported people around and had to send multiple workers with small groups of adults, even though they managed in the community without us the rest of the time. Most of the support workers prided themselves on how helpful they were and what they had done for participants! Our Strategic Plan seemed to be all about the service and hardly anything about the people who access it?

In fact, our key foundation document, the Constitution didn’t even mention recovery....

We met the Disability Service Standards but didn’t meet the National Standards for Mental Health Services 2010. Did it matter? Nobody was really asking about them and the majority of them overlap with the Disability Service Standards....well they do except in one crucial way – Standard 10 – Delivery of Care.

10.1 Supporting Recovery

The Mental Health Service incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery

When you looked harder at the other standards things weren’t right there either.
**Obsessive Hope Disorder**

**Standard 1 – Rights and responsibilities** – Mmmmm... lots of rights but not so many responsibilities

**Standard 2 – Safety** – Yeah but what about the dignity of risk?

**Standard 3 – Consumer and carer participation** – I heard a lot about wants rather than needs

**Standard 6 – Consumers** – Exit plan, who needs one when nobody intended to leave?

**Standard 8 – Governance, leadership and management** – The strategic plan has only a small aspect that relates to consumers, and HR processes clearly don’t have a strong recovery process either at recruitment or ongoing training

**How Could This Be So?**

Put simply – knowledge and skills about Recovery Orientated Practice did exist, but they were superficial and not embedded fully into the management and delivery of services. That is, there were no solid foundations to build upon...

**The Solution?**

A service framework would set out the proposed characteristics of the management and delivery of services to be provided by Choice

**What Did We Do About It?**

We saw the expression of interest to participate in ROMP2 and although it was out of our area were very keen to do it. We attended the first information session by webinar, received approval from the Management Committee to participate, and then the journey really began......

at least a 400km round trip to Logan for Training and 300km for Learning Sets

**Coincidentally at the same time...**

- The organisation was in a state of stress, the staff were traumatised, very defensive and not functioning well as a team, the members of ROMP Team commenced only a few months beforehand and we were new, an unknown quantity asking for change, there was no trust, no credibility, and questions around what was the hidden agenda.

- We were overhauling our entire Quality and Human Resources Management Systems – they were overblown and impossible to manage, a huge job!

- There were changes in our service agreements with our funding bodies and these changes required radical changes in our program set-up and delivery and required greater accountability.

- We had performance issues with a member of the team and these were being managed. However, staff felt they had a right to know what was happening and due to confidentiality we were unable to enlighten them. More suspicion and anger!!!

In the beginning, the resistance from the team was huge!!!

**What Did We Do?**

1. We conducted Pre-Project Evaluations of staff attitudes and beliefs, modified our usual Annual External Key Stakeholder Survey and modified usual Annual Participants Survey to include questions to illicit how recovery focussed the support team really were.

2. We invited Staff, the Management Committee, Students and ROMP Facilitators to Learn about Recovery through TeamLab, where each night new information and resources were prepared giving self-paced access to the same resources as the ROMP (Management) Team were being given by ROMP facilitators. When staff failed to take up the opportunity for self-education, we introduced face-to-face training sessions following each fortnightly Staff Meeting.
3. We identified Key Documents such as the Constitution, Policies, Strategic Plan, Brochures, Participant Handbooks, that speak to the values and principles of the organisation and analysed these for their level of recovery orientation and gaps and inconsistencies were identified.

4. We sought feedback by asking ‘Curious Questions’ to highlight the above issues and challenges, we developed a simple set of 21 questions based on the above issues with input from Participant Representatives, and we developed a Draft Recovery Oriented Practice Policy.

There was a range of additional stuff that just HAD to be Done to Make it all Work…

- Organisational culture improvement and team building strategies were implemented – we had to take the organisation on the road to recovery
- We reviewed and redeveloped the entire policy system, developing the first Recovery Oriented Practice Policy
- We conducted regular internal staff education every fortnight on Recovery using the resources provided by the consultants
- We provided participant education on Recovery using consultants with a lived experience
- Introduced Recovery principles to the broader human services network within the Gympie community through the Courageous Communities Conference
- We renegotiated our programs with the funder

CHECKING Our Progress

We analysed feedback from Participant Surveys, our Aspley ROMP Colleagues conducted interviews with Participants, analysed and reported the results, and we analysed Review Document feedback and drafted a report. By this stage the education with staff and minor tweaks to service delivery were clearly starting to impact on the Participants.

Time to ACT on Results

- A Service Framework Document was developed
- Recommendations were made for changes to the Constitution, Mission Statement and Logo
- A new Recovery Oriented Practice Policy was introduced
- We developed a range of new products
- Recovery Posters
- Revised Position Descriptions and Performance Appraisal System
- New Participant Education Program on Recovery and Recovery Principles

When we were through implementing the changes we conducted a Post Project Evaluation

The responses by the Support staff to the knowledge questions showed an increase in current knowledge about recovery based practice, they were more sure of their own recovery skills and knowledge, believed that the organisation was more supportive of their efforts around a recovery orientation, had a decreased focus on clinical recovery and increased focus on personal recovery, had an increased tolerance for risk, an increased belief that people can recover, be involved and make decisions/choices that contribute to recovery, an increased belief that most mental health practitioners do not work from a recovery orientation, and had gone from disagreeing to agreeing to the statement that “Recovery based practice means that I have to support people’s choices despite whether I think it is a healthy decision”.
Obsessive Hope Disorder

Two years later we can see how the changes we have made are helping people with mental illness take back their lives and live outside of their previous role of “mental health patient”.

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).
22. The failure of current employment programs

DES Employment Service Provider
(Name withheld)

I am writing as an individual who works for a DEEWR funded DES employment programme and I would like to take this opportunity in writing about my experiences in assisting people with severe mental health problems in the employment arena.

During my seven years in working in this field, I have seen and experienced a system which quite frankly fails and discriminates against the very people it is designed to assist!

Government funded NGOs have an almost impossible task in carrying out the fundamental contract obligations in really helping people with mental health issues, succeed in employment outcomes. The DES system and the providers of the service have difficulty in balancing their obligations without disadvantaging the cohort of people with mental health conditions. By the very nature of the deed into which the provider enters and agreed on, people with mental health issues cannot be fairly assisted. A prime example is the allowance of a permissible break during employment. If a person becomes unwell during their employment, the provider has a window of opportunity to recommence the individual into employment, this is known as a permissible break and can occur within 28 days of loss of job.

This can be a challenge for most people with a disability; however for mental health sufferers even the Government’s own research shows that after hospitalisation, mental health sufferers need 41 days to recover. This therefore stymies a DES provider in an important KRA and (dare I say it) affects performance to such a degree that it will make the provider think twice about commencing participants with severe mental health problems. In this area alone DEEWR are immediately causing untold difficulties and this in turn impacts the willingness of providers to engage fully with participants who are referred to the DES programme from mental health services.

Clearly employment is a very important part of the recovery and living with severe mental health issues. Research and experience shows that people with mental health problems have much better outcomes when gainfully employed in open employment. Employment with supportive employers, even in a paid position for just a few hours a week, improves so many aspects of the person’s life. It gives a better outlook, improves self-worth and esteem, confidence and inclusion, all in a society which values work and work ethics.

Here again a DES provider can be penalized by DEEWR as there is no acknowledgment for small gains and slow outcomes. The DES provider is not rewarded in its ratings for important education of employers and stakeholders when it comes to people with severe mental health, there is no recognition or support in this important area, for without education of businesses and employers we do not have a chance in securing more engagement with society in general.

I would like to see a separate programme within the DES arena that would give the providers who genuinely want to help people with mental health issues, time and encouragement and not to be benchmarked against the usual KRA for employment for people with disabilities. Although there are some providers who are labelled ‘specialist’ they are still measured using the same distorted methods which clearly do not encourage providers to assist this cohort.
Obsessive Hope Disorder
23. When it comes to mental health promotion

Rob Donovan

There’s a lot more said than done. A lot more.

That old cliché of ‘when all is said and done, there is far more said than done’, applies in spades to mental health in general, and to mental health promotion in particular. The same could be said about the oft-used slogan that ‘mental health is everybody’s business’, with the reality being that outside the mental illness system, mental health ends up as nobody’s business.

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 described below, there appear to be no comprehensive, population-wide mental health promotion programs in the English speaking world.

To be sure there are mental health promotion programs aimed at various sub-populations (or ‘at-risk’ groups), and programs and interventions exist that deal with related matters such as stress reduction/coping, encouraging help-seeking and de-stigmatising mental illness.

However, 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 Western Australia, and is now spreading to other Australian states and internationally.

Apart from the fact that mental health and illness fall far below physical health services, facilities and high-technology equipment in terms of governments’ (and medical professionals’) priorities, another reason why mental health promotion has not been implemented is because mental health/illness professionals have not had an easily understood and practical framework to facilitate implementation as exist for physical health. It is far easier for health professionals to identify and focus on specific causes of a physical illness, for example, smoking and lung cancer or saturated fat intake and heart disease, and then mount a campaign to change smoking and diet habits than it is to promote mental health.

Hence, while there have been many commendable documents setting out ‘frameworks’ for mental health promotion (e.g., the WHO’s Promoting Mental Health: Concepts, Emerging Evidence, Practice), these appear to be of little practical value to health promotion professionals ‘on-the-ground’. Mentally Healthy WA’s Act-Belong-Commit campaign was designed to fill this vacuum by providing health professionals with a practical mental health promotion framework. Furthermore, to give meaning to the mantra that ‘mental health is everybody’s business’, the framework was designed not just for health professionals but for any organisations offering mentally healthy activities.

What is Act–Belong–Commit?

Act–Belong–Commit is a comprehensive community-based health promotion campaign supported by Healthway, the WA Mental Health Commission and Curtin University.

In the tradition of Aristotle’s ‘virtue is cultivated by practice’, Act–Belong–Commit is focused on getting people to engage in behaviours known to improve and maintain good mental health. Aristotle claimed that “we become just by doing just acts, temperate by doing temperate acts, brave by doing brave acts”. The
Act–Belong–Commit ‘philosophy’ similarly states that “we become mentally healthy by engaging in mentally healthy activities”.

The campaign attempts to simplify the complexities of mental health by identifying three major sorts of things people can do to keep mentally healthy:

1. **Act:** Keep alert and engaged by keeping mentally, socially, spiritually and physically active.
2. **Belong:** Develop a strong sense of belonging by keeping up friendships, joining groups and participating in community activities.
3. **Commit:** Do things that provide meaning and purpose in life like taking up challenges, supporting causes and helping others.

These concepts are based on primary research with members of the general population and hence readily accepted by people in general as good for their mental health. There is also substantial scientific evidence that these three behavioural domains contribute to increasing levels of positive mental health (and in fact, to physical health). Furthermore, although different groups may articulate the domains differently and place different emphases on each, these three domains appear universal across different cultures.

The campaign has two primary dimensions:

(i) Targeting the general population to increase people’s mental health literacy and encourage participation in mentally healthy activities; and

(ii) Partnering with organisations that offer mentally healthy activities to assist these organisations promote participation in their activities.

Act–Belong–Commit’s overarching framework allows for implementation at the population level, as well as in specific settings and for targeted groups. Hence the campaign has a mass and a specialised media presence and is implemented through partnerships with local governments, schools, workplaces, health services, statewide government departments, community organisations and local sporting and recreational clubs. That is, the campaign actually ‘walks the talk’ that ‘mental health is everybody’s business’. The campaign has a number of resources, including a self-help guide (“A great way to live life: the Act–Belong–Commit guide to keeping mentally healthy”), and frameworks for application in workplaces, schools, general practice, psychological counselling and the recovery setting.

**Act–Belong–Commit: Who responds to the campaign?**

In keeping with its primary prevention emphasis, the vast majority of organisations requesting to partner with the campaign have been non-health related organisations (ranging from environmental groups to sporting clubs, local governments and recreational groups). However, in recent years, there has been a substantial increase in requests from physical and mental health/illness organisations about how the campaign messages could be incorporated into their services, either for early intervention, as part of ongoing treatment, or assistance in recovery.

On the other hand, the response from individuals right from the start included not only people simply wishing to enhance their lives, but also people suffering from mild depression or feeling an emptiness in their lives (i.e. ‘languishing’), people with a mental illness seeking something positive in addition to counselling and medication, and even suicide survivors seeking a way to restore meaning and purpose to their lives. Many individuals with mild disorders seemed to view responding to the message as a way of dealing with their problem before it developed to the stage of requiring formal psychiatric /psychological treatment. For many callers, the positive tone of the campaign appeared to neutralise the stigma around mental illness and facilitated their speaking up about their mental health problems.

Hence we introduced more formal measures of these effects: In the latest (2012) general population survey, almost 80% stated that they think the campaign will make people more open about mental health
issue (less than 1% said less open), and just over 70% said it would reduce stigma associated with mental illness (only 1% said increase). Of those who did something for their mental health in response to the campaign, just under 40% said they were ‘generally happy but wanted to enjoy life more’, just over a third said they were ‘somewhat unhappy and wanted to lift their mood’, and one in five ‘wanted more meaning and purpose in their life’.

In short, this positive mental health promotion campaign not only attracts mentally healthy individuals to maintain their mental health, but also attracts people experiencing mental health issues who want to improve their mental health. Furthermore, simply by presenting mental health in a positive rather than illness context, the campaign serves to de-stigmatise mental illness and encourage openness about mental health issues. These sorts of results suggest that we don’t need separate de-stigmatising campaigns – or even separate help-seeking campaigns – as these and other issues can be accommodated under an umbrella promoting mental health in a positive context.

What about suicide prevention?

By building individual and community resilience, Act–Belong–Commit has a primary prevention role for mental illness. However, Joiner’s theory of why people suicide suggests that Act–Belong–Commit serves as a powerful primary prevention intervention for suicide (if not secondary and tertiary prevention also). In keeping with most cognitive decision models, Joiner proposes that people suicide when they have both the desire and the ability to die by their own hand. According to Joiner, the desire or motivation to suicide is driven by two factors: low or ‘thwarted’ belongingness and perceived burdensomeness. The ability to suicide is a function of not fearing self-harm or dying. Joiner’s motivational factors have clear overlaps with ‘Belong’ (particularly) and ‘Commit’. ‘Belong’ is about building and maintaining connections with others, including community and civic organisations and institutions. ‘Commit’ involves doing things that provide meaning and purpose in life, including taking up causes and volunteering that helps society and other individuals. In Joiner’s theory, both of these are clearly protective factors against suicide and hence form the building blocks for suicide prevention interventions.

What about social inclusion and civic virtues?

Michael Sandel reminds us that for both ancient (Aristotle) and contemporary (MacIntyre) philosophers, the concept of belonging has very significant implications for a sense of community, civic virtues, social inclusion and moral reflection. MacIntyre argues that by acknowledging that we belong to our family, our community, tribe or nation, we not only have have rightful expectations, but we also accept various civic and other obligations. The ‘Belong’ concept attempts to bring people from various walks of life together in public spaces to participate in community events and to celebrate community achievements. Such public participation, including where volunteerism further brings people together who would not otherwise interact, reinforces social inclusion, neutralizes and reduces prejudices, and promotes solidarity. These characteristics promote strong supportive societies, that enhance what Aristotle might have called civic virtue, and what others would call harmony. In short, ‘Belong’ and ‘Commit’ promote good citizenship.

Conclusion

People know intuitively what is good for their mental health: Use it or lose it. Friends are good medicine. It’s better to give than receive. And so on. But it’s not reinforced, it’s not validated, and it’s not made salient. Government funded or directed campaigns constantly tell people what they can and should do for their physical health. Why is it so hard to get governments to support campaigns that tell people what they can and should do for their mental health? Why can’t we get past the rhetoric and the empty policy statements and just get things done?

It’s not difficult. It’s not complex. It’s as simple as A-B-C: Act–Belong–Commit.
Obsessive Hope Disorder

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 Sub-Committee.
24. Impediments to real reform

Learne Durrington

Mental Health reform has been underway in Australia in varying guises over many years. Yet while consumers and carers have advocated tirelessly for a system of care built on equivalence of access the nature of mental health service varies considerably around the country. Every jurisdiction articulates mental health 'reform' differently and at variable pace, scope and depth. However the impediments are as much structural as political.

The constant for the more than two decades has been the Commonwealth’s National Plan/s and overarching framework. Each Plan charted a five-year strategy and to aimed to capture both the emerging philosophical shifts and evidence base in contemporary mental health. And 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.

There is no better illustration than the physical health status of people with a mental illness. A marker of the functioning of the mental health/health systems is the poor physical health status of people with a severe and persistent mental illness. While the nature of the illness and the antipsychotic treatment regime impact on physical health, morbidity for a person with a severe mental illness is predominately related cardio vascular and chronic disease. However primary care assessment, treatment and care has been lacking due in part to structural issues across tertiary and primary care, fragmentation within the health system and no nationally agreed process to address the issues. Intergovernment funding arrangements, financing of the primary care sector and further impacted by health system reforms such as Activity Based Funding, compounds the problem.

As a case in point are people with a severe mental illness as in-patients in mental health acute, long stay, sub-acute or rehabilitation services receive little, if any, primary care assessment and treatment. While these services are governed by the state health system and are health services by way of operation the focus is on mental health, not physical health. The mental health workforce is trained in mental health not physical health. Up to date mental health facilities have employed ‘medical officers’ who largely support the psychiatry functions, thus primary care treatment is largely overlooked. Primary care perse is not delivered in state operated hospitals – if it were it would be at the cost of the State or Territory.

The State’s argue the Commonwealth is responsible for funding primary care and thus are reluctant to spend State dollars on Commonwealth responsibilities. Hence primary care, including physical health care, is not provided to mental health consumers in State-operated facilities.

The Commonwealth fund primary care predominately through the Medical Benefit Scheme (MBS) on a fee for service approach largely through general practice. Commonwealth/state funding agreements are such that the MBS cannot be used to provide primary care to in-patient in state operated facilities. Similarly, the MBS based on a fee-for-service type payment system and provided predominately through a small business model of General Practice also impede access and continuity of care for people with severe mental illness in the community. General Practitioners report that while they may ‘hold’ a number of mental health consumers in their practices the complexity of health issues, the requirement for long

65 The ABF sets a price for an acute episode of care – in mental health acute care services it is difficult for a suite of reasons to plan for discharge on admission as you might for a surgical intervention. There is much dispute about the impact of ABF on the mental health budget given the variability in length of stay for an individual consumer.
consultations and the occasional need for consult/liaison with psychiatry make it difficult to carry a larger patient group. GPs argue they do not receive the assistance they require from the mental health teams/NGOs to support people safely. Nor do they want their practices be overrun with complex mentally ill patients as they see themselves as generalists for the whole community. Integrated care is essential for people with a severe mental illness to effectively manage co-occurring illnesses – MBS does not sufficiently fund interdisciplinary care and coupled with the fragmentation in the system and the inherent difficulties in achieving interdisciplinary care plans, co-ordinated care becomes aspirational. Notwithstanding the stigma of mental illness also pervades the responsiveness of general practices to support this people with severe mental illness.

In the past decade we have seen the emergence of the Mental Health Minister in each state. The emergence of such a position can highlight a States’ recognition of the importance of mental health, but in and of itself a separate Ministry is not the answer. Clearly the rationale, purpose and mandate of each State Minister varies as does their capacity to join up a system to work better for consumers and carers. Separate Ministries may have inadvertently mitigated a better integrated and consumer focussed system. Separating mental health from health may protect its budget, may assist with reducing stigma and institutionalisation but it also exacerbates the divisions between tertiary health, secondary and primary health care. In some settings it has also reduced its capacity to influence and shape what and how public mental health services, particularly acute services, deliver care. State health systems hold a significant portion of the overall mental health budget for delivery of emergency, tertiary and clinical treatment services. The lessening influence over this budget by the relevant Mental Health Minister will not only affect how reforms such as ABF are implemented, but also reduces the capacity to shape a seamless continuum of care with recovery at its core.

The fact that mental health consumers die some 20–25 years younger than their peers is due in part to the divide between mental health and health, between tertiary and primary care, the Commonwealth and the States, notwithstanding the critical impacts of related systems such as housing and employment. Each ‘system’ argues the other is responsible. Many of the impediments are embedded in legislation and financing arrangements without full cognisance that the consumer in the middle suffers. The National Plan has not fully addressed the systemic issues that mitigate the structural impediments. Joining up systems of support is not simple, yet despite the evidence about the burden of disease and what will impact to achieve better outcomes, there is no agreed commitment to address the structural and systemic impediments between the Commonwealth and the States.

The sad reality in the past two decades is that while the Commonwealth become a funder of community based mental health services; it has been in a manner that has contributed to fragmentation. One example is the Personal Helpers and Mentor Program (PHAMS) which where funds were allocated to various community organisations many with little experience of people with mental illness and minimal if any connection to the public mental health service systems. The development and delivery if the program largely by passed state mental health policy and planning entities. The States and Territories on the other hand during this period continued to contemporise services but largely in an unco-ordinated way. That is not to say there have not been very successful initiatives implemented and while the developments are meritorious, in and of themselves they have not substantially improved access or met demand.
In summary, the national approach to date has not affectively addressed the structural and systemic issues. The leadership and governance conundrum that is the distance of the Commonwealth from the local environment, the idiosyncrasies of State commitments to reform will not be resolved through the current arrangements. 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. Yet the focus needs to be on the impediments as much as the new types of initiatives if in the next decade real progress can be made. Physical health care is discrete but very pertinent example of what can be different if collectively all stakeholders work together to make a difference.

Leame 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.
Obsessive Hope Disorder
25. The candles have long been extinguished

Senator Concetta Fierravanti-Wells

Liberal Senator for New South Wales

In 2006 when Health Minister in the Howard Coalition Government, Tony Abbott oversaw the biggest single investment of funding into mental health services. The Council of Australian Governments (COAG) National Action Plan on Mental Health provided $1.9 billion over the following five years to revitalise mental health reform in Australia.

The Coalition is justly proud of this investment during our time in government. At the last federal election we made a further $1.5 billion commitment. The Coalition was also successful in late 2010 in passing motions in both the Senate and the House of Representatives calling on the government to implement the Coalition’s policies.

Let’s fast forward to April 2011 and the five minutes to midnight campaign by Get Up with the symbolic 4,000 candles on the lawn in front of Parliament House in Canberra. Why? Because after enormous pressure from the Coalition and mental health experts due to the preceding COAG Health Reform agreements Mark I and Mark II which neglected mental health, Labor was then shamed into finally promising to spend big in mental health. At the May 2011 budget, we saw the announcement of $2.2 billion.

The headline figure looked impressive; it was designed to be. However, it was soon revealed that the net additional spend was only $583 million, including re-announcements of monies and programs previously announced. In fact most of the headline money was the clawing back of the Howard Government’s Better Access program, which was part of the $1.9 billion mental health package. The bottom line fell way short of what the sector required.

Despite Better Access being a successful program which has helped many thousands of Australians, Labor made the changes to Better Access with scant consultation with key stakeholders in the sector to properly assess their impact, most especially on patients. Their only objective seemed to be to cut costs in order to achieve a politically motivated budget surplus, which they now have conceded cannot be delivered.

Clearly, had the Government not squandered billions of dollars on pink batts and school halls, cuts to important programs such as Better Access could have been avoided.

So, how much of the so called big spend on mental health has actually been rolled out? Take for example the suicide prevention money. Remember the 2010 election promise of $277 million on suicide prevention? Like most of this Government’s funding announcements the bulk of the headline figure is usually allocated to be delivered in the fourth, or fifth year which is actually outside of the forward estimates, in order to avoid delivery, accountability and scrutiny. True to form, in the first year they were supposed to spend a minuscule $9.5 million of the $277 million to roll out these vital programs, and they could not even manage this amount.

It took Labor almost two years to spend some money to start addressing suicide issues in the Kimberley. This was after a long and laborious process involving committees and consideration. Meanwhile, on the ground in the Kimberley and in other areas the problems continue.
We have also seen funding for the Mental Health Nurse Incentive Program cut, although it was sold by Minister Butler as merely a cap.

Labor’ spin over substance in mental health, particularly in suicide prevention must be considered in the reality of what is happening in our communities and families.

Suicide is a major health concern, ranking 15th overall as the cause of death in Australia. Suicide is the leading cause of death for 15 – 24 year olds. Six people take their lives every day in Australia which is higher than the national road toll. Yet experts believe that this figure is grossly understated due to the underreporting of suicides.

Feelings of isolation or hopelessness can contribute to depression and other mental illnesses, which can result in suicide. Psychological autopsies have found that nearly 90 per cent of people who ended their own lives had been suffering from a mental disorder like depression. Men are three times more likely than women to end their own lives.

The Gillard Government cannot continue to play politics with this vital issue.

To top it all off, we have the 10-year road map for so called mental health reform. Eminent experts such as Professor Alan Rosen have justly been critical of it, saying “you don’t put out a road map if you don’t have a destination,” and Sebastian Rosenberg who described it as a “Roadmap to nowhere”.

Furthermore, may eminent mental health experts like Professor Ian Hickie are objecting to what is happening in mental health. So too Adj. Professor John Mendoza, the former chair of Labor’s National Mental Health Advisory Council, who resigned in frustration and has been critical of the government for not rolling out suicide prevention money in a timely manner.

Now, contrast this with the Coalition’s 2010 election policy, which was widely endorsed by mental health experts such as the 2010 Australian of the Year, Professor Patrick McGorry and Adj. Professor John Mendoza who described the Coalition policy as "the most significant announcement by any political party in relation to a targeted, evidence-based investment in mental health."

The Coalition has a proven track record in mental health and if elected, we will once again deliver for the one in five Australians who have a mental health issue, every year.

When the Prime Minister Julia Gillard and Minster Butler made their announcements, there was some initial optimism and praise. However no one is applauding any longer. Indeed, any applause has long faded and has been replaced with criticism, dissatisfaction and anger.

Like most things this government does, it is all spin and little substance. In this case, it was all designed to give the impression that mental health promises have been fulfilled. Sadly, however, this smoke and mirrors trick has been at the expense of the most vulnerable people in this country, the mentally ill.

The "so called" mental health budget of 2011 is a distant, dim and dark memory. The candles have long been extinguished like the raised hopes of mental health reform that really never was.

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.
26. “More of the same: No thank you”

Ivan Frkovic

Our mental health is critical on a personal, family and community basis. We must never forget that. I am confident that we have come a long way since the Burdekin Report in the early 90s through to the 2011 Supporting National Mental Health Reform Package. In fact, just the fact that we are discussing mental health rather than mental illness is in itself a major milestone to be recognised.

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.

It would be remiss to ignore previous mental health systems and approaches – there are important lessons for all. At times it is necessary to remind each other that what seems like the obvious to us now, has not always been the case. Whilst we have come a long way, structural reform has taken longer than those from all parts of the sector would want – consumers, carers, families, clinicians, bureaucrats and many politicians.

Only 20 years ago, the combined voices of consumers, carers and families, clinicians and allied health professionals, whether loudly spoken or softly whispered, combined to de-institutionalise what was largely the entirety of the mental health system in Queensland – just three tertiary psychiatric institutions.

Far more recently, the Queensland Mental Health Court was established in 2000. This was a significant milestone in recognising that those experiencing mental ill health are entitled to the same protection of their human rights that can be taken for granted by all of us. In addition, it served an important mechanism for dissolving incarceration, which exacerbates social exclusion of a vulnerable population, and paved a way for true recovery. Unfortunately there’s more to do in this space.

Subsequently, a strong foundation for the establishment of new and innovative approaches was formalised in the Queensland Plan for Mental Health 2007-17 (the Plan) and the complementary Supporting Recovery: Mental Health Community Services Plan 2011-17. The Plan’s priorities of promotion, prevention and early intervention; improving and integrating the care system; participation in the community; coordinating care; and workforce, information, quality and safety provided a framework for real reform. These reforms included the creation of the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention and the Queensland Centre for Mental Health Learning to support a state government community mental health workforce that increased by 569 positions between 2007 and 2011.

The Plan was by no means a minor investment – however we were still playing catch-up -even with an additional investment of $528 million over five years. In context, the Queensland Government was now investing more than $1 billion on mental health services, including those purchased from the community sector. Despite the seemingly large quantum of investment the mental health budget has not increased proportionate to the growth in the overall health budget. We must be cautious not to become complacent nor shift our attention to other parts of the health system. We are still playing catch-up.

The division of responsibility for public and community mental health across the former Queensland Health (now known as the Department of Health) and the Department of Communities respectively was unique in the Australian landscape. It lead to a tripling of the community mental health sector budget and provided the platform for a Ministry of Mental Health to be established. This also provided the opportunity for community mental health care to be further integrated with other programs that address the social determinants of mental health, such as secure housing and accommodation.
It was in this environment that Project 300, the Housing and Support Program, peer operated services and various other transitional support programs flourished. We know that these and many other community-based Queensland programs have reduced the number of avoidable hospital admissions and presentations to emergency departments and assisted with more timely discharge from acute settings.

Commencing in the sector as a social worker I am of the absolute belief that the community sector is where innovation can be delivered. Tertiary care is critical in many circumstances however we must continue the drive toward a system where this is a feature of last resort. The community sector, in collaboration with the traditional primary health care sector, should and can intervene earlier to support consumers, their families and carers to live meaningful lives and recovery with minimal hospital admissions. I will never criticise greater investment in the sector, but cognisant of fiscal constraints at all levels of government, we can achieve a greater bang for our buck through redistribution and equality of funding between the community sector and the tertiary system.

Care Coordination has been a flagship program for Queensland, and an investment in supporting recovery in the community. Care co-ordination was an innovative Queensland program, developed in response to the 2006 COAG National Mental Health Plan. I can see its design largely underpinning the Partners In Recovery Initiative, currently under implementation across the country and a powerful tool for systemic reform.

The quality, flexibility and efficiency of the community sector in delivering mental health services cannot be underestimated. Yes, there must be changes, but it will be necessary on both sides – community organisations and governments. Structural and funding reform go hand in hand. We shouldn’t be afraid of reporting but it shouldn’t be burdensome and it shouldn’t be restrictive. Evidence-based practice must be the foundation for what we deliver although sometimes we must take a leap of faith to create the evidence. Partners In Recovery presents the perfect opportunity for the community sector to demonstrate this.

Queensland holds its own challenges in service delivery. A dispersed population, facing a tyranny of distance is unique, though somewhat in common to our north-west cousins. Within Queensland, Aboriginal peoples and Torres Strait Islander peoples are only two groups who experience disproportionately high rates of mental ill health. Whilst now disbanded, the creation of the Aboriginal and Torres Strait Islander Hub was a positive step to reducing mental ill health and preventing and responding to suicide.

Blood, sweat and tears have delivered mental health responses to the natural disasters frequenting Queensland over the last few years. Community organisations and governments, across all areas of the social services sector, worked hard to integrate responses to those highly vulnerable and experiencing mental ill health. Importantly these responses were developed with an acknowledgement that something more than a short-term response was necessary. Disaster recovery provided the opportunity to implement community structures for the future. Community resilience is now on the map. That said, many challenges for the future exist and are in fact in many ways our present. Importantly these challenges present many opportunities for the community sector to lead reform.

The implementation of the National Disability Insurance Scheme will have a significant change on the current landscape and will compel all parts of the sector to deliver integral person-centred, recovery-oriented, community-based, co-ordinated and human rights-focused mental health care and support. Partners In Recovery similarly will assist over 60,000 Australians with complex care needs. It will be instrumental in the recovery of some of our most vulnerable and will further work to reduce the number of avoidable hospital admissions and emergency department presentations.

On the other hand, headspace, is an exciting initiative to intervene at a critical stage of psychological distress, providing prevention, early intervention and treatment. Whilst early in nationwide implementation, many headspace services have forged linkages with schools, assisting in continuing the momentum developed under the successful Queensland EdLinQ initiative. The consortium approach of
both Partners In Recovery and headspace are the ideal platform for the community sector to demonstrate leadership in co-ordinated care.

The possibilities for the type, mix and quantum of mental health services delivered by the community sector are endless. Recently the Newman Government has accepted the recommendations of the Independent Commission of Audit Report to apply a contestability framework across a range of mental health care services including sub-acute care and publicly provided community care. Applied correctly, this framework must consider quality of services and subsequent outcomes primary to any cost considerations. Now is the time for the community sector to step-up as modern, cost-effective, professional organisations ready to be preferred providers of innovative services.

So, in the present, what is the call to action? We need both words and deeds.

We must in many ways continue to preach to the converted, making sure stigma is ultimately eradicated from a grass roots level including those previously considered peripheral to the sector. In less than 10 years, over 10,000 front-line police, ambulance and Queensland Health workers have been trained to effectively deal with people experiencing mental health crisis. Aside from saving lives, this education is a powerful tool to extinguish stigma.

For the broader community, education is just as important. A quick Google search of “first aid courses” provides pages and pages of available courses whilst a quick search of “mental health first aid” produces far less. Even without first aid training, across the general community most know the “A, B, C” of first aid – do you know “ALGEE”? Families and carers fear for their children experiencing mental ill health as they age. On the reverse we need to remember Queensland children who have a parent with mental illness and are in fact carers. We need to remember those that are too young and end up in the child protection system. Regardless of where these children end up they are at risk and we must invest in supporting their resilience, continuing successful programs such as Evolve. Additionally, those who have spoken up should continue to support others to do so. Any process of reform will not succeed without the involvement of consumers, carers and their families. Mental health is an issue for the whole community. We must accept that mental ill health will always be present across the population however we can all act to minimise the harm that results for individuals and their loved ones. Governments alone cannot solve the mental health puzzle.

That said, governments must acknowledge their role – both in creating systems that funnel social exclusion and their role in providing continuing and necessary investment. We must consider the financial investment just that – an investment. The human cost, ignoring the significant economic burden of disease, is too great to allow the discussion to return to a drain on the bottom line of any government budget. With the National Health Reform as a trigger we must see the end of the blame game between the Federal and State governments and demand a clear delineation of responsibility for mental health as part of a modern primary health care system.

I hold high hope for the future of mental health reform in Queensland and across Australia. The establishment of the Queensland Mental Health Commission, drawing on the strengths of already established commissions, provides an exciting opportunity for another injection of energy for reform. There is much yet to come. Some challenges of the past have been righted, other challenges are yet to be discovered.

As a balding ‘elder’ of the Queensland mental health sector I am delighted by a new and energetic generation who view this sector as a genuine career path and display a dedication to continuing reform. I have witnessed this generation as committed to building systems of social inclusion. Displaying the optimism of youth and a world where mental health is openly discussed, they hold a dedication to turning tipsy turvy systems and processes that perpetuate social exclusion.
Finally, too many Queenslanders to name individually, and those whose names we will never know, must be acknowledged for dedicating their careers, and many times their lives, to systemic reform of our mental health system.

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. 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.
27. Re-building in partnership

Katy Gallagher

Mental health services in the ACT: Rebuilding with the community

Too often governments are measured in the area of mental health policy by perceived shortcomings or gaps in service delivery. As health minister in the ACT Government for the past six years I think it is also important to keep a focus on the steps forward and policy achievements that have been recorded and which are making a real difference in people's lives.

The ACT Government has a track record for delivering new services, programs and infrastructure to meet the needs of people living with a mental illness in our community. Last year the government allocated over $100 million dollars to mental health services in the ACT increased from $51 million allocated in 2006-07. This figure alone demonstrates our clear commitment to improving mental health service provision in the ACT.

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.

Some of the recent infrastructure developments in the ACT have included:

- A new 40 bed state-of-the-art mental health inpatient facility at The Canberra Hospital, which has being designed to create an environment that provides people with hope, choice, privacy and personal space. This facility is considered a primary example of Australian best practice and is a direct outcome of co-design between Government and mental health consumers and carers;
- A six bed Mental Health Unit operating within the Emergency Department at The Canberra Hospital to allow timely assessment and care of those presenting at the frontline of our health system with serious mental health symptoms; and,
- A commitment for a 25 bed secure mental health unit that will provide mental health treatment for forensic and non-forensic consumers in a secure environment.
- A five bed Adolescent (ages 13–17) Step-Up, Step-Down community based mental health residential care facility that was opened in March 2008. A five bed Adult (ages 26–64) Step-up, Step-down residential facility and a six bed Youth (ages 18–25) Step-up, Step-down mental health residential care facility also exist in the ACT.

Mental health services do not work efficiently in isolation. In the ACT we have a complex web of community and government services which, to meet the needs of those who use them, need to be developed in consultation with each other and delivered with a clear consumer focus. One of the major benefits of developing this mental health framework in a city like Canberra is the strong relationships and partnerships that currently exist.

In 2007 the ACT Government launched Consumer Participation and Carer Participation across Mental Health ACT: A Framework For Action. This Framework was a significant milestone towards the genuine inclusion of consumers and carers in the development of mental health services in the ACT. A first in Australia, this innovative Framework provided the necessary principles and structures for consumers and carers to become engaged at all levels of the organisation. The Framework acknowledged the work that needed to be undertaken to build capacity for participation both within ACT Health and in the community.

In terms of high level engagement with the sector, I established a Ministerial Advisory Council on Mental Health to ensure consumers of mental health services, carers and the non-government sector are able to provide advice directly to the responsible minister on mental health policy and services. The Ministerial Advisory Council meets quarterly to provide continuous direction and advice to Government on mental health policy and services. This council is crucial to informing government in its policy and legislative program.
A particular area where the ACT public mental health system has performed exceptionally well and is considered a national leader is when it comes to seclusion and restraint rates in inpatient facilities. The ACT Government is a participant in the use of National Seclusion and Restraint project and much of the success achieved through this project can be attributed to the genuine engagement of consumers who co-lead the project and the commitment and dedication of staff. A participative action research design ensured the consumer experience constantly informed the research and other aspects of the project. Consumers co-presented the research findings at The Mental Health Services Conference 2012. Additionally, consumers were active members of Seclusion Review Meetings held to review each incident of seclusion or restraint.

Canberra is a relatively young city and the ACT mental health system is still growing, as is our city and greater region. We have a strong base to meet growing demand and while we have some well established programs meeting consumer needs I believe that supported accommodation needs to be an area of priority for government investment both in the long and short term.

I am encouraged by the progress we have already made as a government in partnership with the broader mental health sector, but there is more to do. The ACT Government is committed to creating and developing a complete service system and service response to meet the needs of our community, particularly those living with a mental illness and those who support them.

Katy Gallagher is the ACT Chief Minister and Health Minister, She was elected to the ACT Legislative Assembly in November 2001 and has been Chief Minister since 16 May 2011. Katy Gallagher is the longest serving state or territory Health Minister in Australia, having been Health Minister since 20 April 2006. Her other portfolios are Minister for Regional Development and Minister for Higher Education.

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

Interior of New Step-up/Step Down Facility, Canberra, ACT
28. Stigma: still The One
Geoff Gallop AC

There’s no doubting that we have come a long way in our understanding and treatment of mental illness. More distinctions are made in respect of diagnosis and more options are available in respect of treatment. In fact, in the case of depression, we know treatment can work:

“Sixty to seventy percent of patients with depression will respond to initial treatment with mono drug therapy (usually after four to eight weeks of treatment) or to a complete course of psychotherapy (usually 12 to 20 sessions or about 12 weeks). Of the 30% who do not respond to initial treatment, the majority will improve on an alternative approach, and upward of 90% will eventually recover fully. Thus, the prognosis of major depression is among the best of any medical illness of similar severity.”

We know too that there are social factors at work and not just individual ones. For example our type of society and the aspirations it creates may not “cause” depression but they may increase the risk that someone with a disposition to depression falls victim to “the black dog”. Indeed we have been public witness to seemingly invulnerable high achievers struggling to cope, their minds hammering way relentlessly and without relief.

We now know that depression is associated with certain personality types. Those with high levels of anxiety, shyness and interpersonal sensitivity, those who seek perfection in all that they do and are highly self-critical and those who have a strong sense of personal responsibility are all vulnerable. They may even feel guilty about taking time off and looking after themselves. They are driven to perform, rather than drivers of their own health and wellbeing. Put these personalities into a high pressure and highly competitive work environment and some find it hard to cope, some just can’t cope. All too often feelings are bottled up and sometimes relief is sought in drugs and alcohol, thus compounding the problem and often leading to tragic consequences.

In reflecting upon these issues in my own case I keep coming back to a basic question: why didn’t I see the need to seek help earlier? I say this with the knowledge that the day we acknowledge our illness and seek proper medical treatment is the first step on the road to recovery – but it is the hardest to take.

Firstly I think it is important to note that change is always difficult and this applies across the board. It requires real effort and in the case of mental illness—courage, so much so that it is sometimes easier for a person to continue along the existing course even though they are aware of the costs involved.

This leads me to the most pressing issue of all – 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.

How, then, do we understand this phenomenon?

A useful starting point is the generally held view that we have about human nature and the freedom of the will. All too often when confronted with mental illness in the community we may think to ourselves “why don’t those who are ill just pull themselves together?” On the other hand we may picture it as a simple case of overwork and say to those who are suffering: “Take a few weeks off and re-charge your batteries”.

For many in our community these are the logical things to say as they too experience mood swings or even bouts of anxiety associated with the “ups and downs” of life and learn to cope by “getting on with it” of “re-evaluating priorities”. What is not appreciated here, of course, is the all-embracing nature and intensity associated with mental illness. As Tessa Wigney and colleagues put it: “Depression infiltrates

your thoughts and takes over your mind. It distorts your senses, as well as your perception of the past and future. It is a state of excruciating isolation."68 

However, when treatment is sought those who are ill start to recognise the meaning of “freedom” and the self-awareness needed to give it meaning. They start talking about their condition and exploring the various therapies that are available to help. All too often, however, this is not the option chosen and sufferers keep their pain to themselves fearing that openness will only make matters worse. That they think this way is a measure of the power of stigma and the shame it creates. “How can I expose my vulnerabilities and won't I be forever classified as weak and pathetic”, they say to themselves. 

Another starting point is an analysis of how we view society and what is necessary for it to work properly. All of us rely on the “reasonableness, intelligibility and predictability of people we, directly or indirectly, communicate with” in our everyday life. It’s all about trust and it follows that unintelligible, unreasonable or chaotic behaviour will be deemed “disorderly”, “threatening” or even “dangerous”. Such behaviour “challenges our social existence, and thereby threatens us”.69 

What happens is that we characterise all mental illness and all who are mentally ill in these terms. Ingrained attitudes, popular culture and the media all play their role in this stereotyping. It starts early in life and is hard to shift even when knowledge is gained. Stereotypes are about “selective perceptions that place people in categories” and, in the case of mental illness portrayals range from “the violent and unpredictable” to the “pathetic victim”70.

Byrne goes on to make the point that we don’t have a word for prejudice against the mentally ill. We use words like racism, sexism, homophobia, and religious bigotry but have no equivalent for mental illness. He suggests “psychophobic” to describe such an individual so prejudiced but it’s hard to imagine that word taking off in everyday discourse. Still his point is very well made. The challenge, he says, is to “confront the stigmatiser with his or her irrational beliefs” and enable direct contact with “one of them”. 

So it is then that tackling stigma is a most complicated business that goes to the heart of our social relationships and how we understand them – it’s an existential and emotional as well as an intellectual and moral issue. Yes there are certain features common to the human condition but still each of us is, in an important sense, unique in biological make-up, social experiences and character. It follows that we won’t react and respond the same way to all that surrounds and impacts on us, including the way we live, work and play. Even medical science battles with the reality of these differences in amongst the sameness that is revealed by statistical and scientific research.

Human beings find these differences and the ambiguities associated with them difficult to imagine and not just in relation to mental illness and the many forms it takes. The world is made up of different races, religions, nations, regions and localities. People live differently, play differently, eat differently and express themselves differently. Some are dour and passionless whilst others are gushing and excitable. Habits and cultures differ, as do expectations about what we can expect from life. Just as we’ve learnt to accept – if only imperfectly – that these differences are part of what it means to be human so too do we need to recognise that mental illness is too and that the deeply embedded idea of “normality” can cause unnecessary suffering in our community.

My conclusion – repressed feelings and unacknowledged illness on the part of the individual and inbuilt ignorance and unthinking bias on the part of the community can make for a toxic mix and we need to situate our discussions of mental illness in the context of reflections on human freedom and human difference. These deeper realities need to be part of the discussion.

70 Byrne P 2000. Stigma of mental illness and ways of diminishing it. Advances in Psychiatric Treatment, vol. 6, p.66
Geoff Gallop is presently Professor and Director, Sydney University Graduate School of Government. Prior to this role, Geoff was Premier and Minister for Public Sector Management, Federal Affairs, Science, Citizenship and Multicultural Interests in Western Australia. In January 2006, Dr Gallop resigned as Premier of WA citing his treatment for depression and inability to continue as that state’s government leader. He was widely applauded from all sections of the community for his open acknowledgement of his depression.

Editor’s Comment and Illustration. Stigma manifests in the quality of facilities and the language used by staff toward clients.

Below is a photo of a sign that is shown in the entrance to the Psychiatric Intensive Care Unit, Royal Hobart Hospital presented with Police style branding warning physical and verbal abuse is not tolerated.

Nurses’ Station, Baillie Henderson Psychiatric Hospital Toowoomba, Qld. Photo provided by a mental health consumer, early 2013.
Media portrayals of celebrities suffering mental illness and substance abuse are common place in news media and the daily fair of gossip columnists and magazines.


Mental illness just not quite so sexy for fund raising...

The stigma of mental illness means mental illness is far less able to generate community, philanthropic and public support.
29. Joy vs mental health

Amanda Gore

My own particular perspective focuses on joy as an outcome rather than mental health! Mental health is one small component of, and a result of, a vast array of varying aspects of each human. For the majority – the benchmark for mental health is happiness. But happiness is externally dependent. Joy is an inner state and comes from a blend of these 12 elements: gratitude, compassion, reverence, forgiveness, hope, energy and vitality, listening, laughter, love, cheerful enthusiasm, generosity and inner peace.

These 'skills' can be taught; if no one modelled these values they can still be learned. Teaching these at schools – specifically – would alleviate a great many of the 'mental health' issues of the future. Focusing specifically on joy at schools – and teaching children how to make choices that lead to states of joy; eradicating or at least working at uncovering the fears that are driving people's behaviours would create adults who had far more resilience, adaptability and a sense of control.

School is great for giving students information; fortunately they are focusing more on life skills as well but not to the degree that we can counteract the growth in 'mental illness'. Children are more exposed to stress and yet less capable of dealing with it. Their parents are overwhelmed and exhausted and not able to teach or model the aspects of a person that allows their joy to surface.

There needs to be a primary shift in thinking from depression, anxiety, mental disorders, mental disease, mental illness to joy development. Several countries have recognised the value of using a happiness index instead of GDP to rate the financial health of their country. Australia needs to do the same. A brief document like that cannot explore all the aspects that lay the foundation for this statement – but it needs to be done to demonstrate that this wellness approach is far more effective and economical than the disease /label/ drug based model.

**Mental health vs mental wealth: Is depression really a mental 'illness'?**

Too much is invested in 'labelling' people and their mental state and prescribing a drug for them. This makes companies very rich and individuals impoverished. Not only because they have their capacity to think clearly taken away, and the opportunity to deal with the real issues causing their problems, but also because they are labelled and now believe there is 'something wrong' with them or they are deficient in some way.

Their control is reduced as they are prescribed a medication, a pill for every ill; that is the only way to 'fix' their problem. When one drug doesn't work or ceases to be effective, we all too often just substitute a different drug. Easy. Over time the drugs can continue to reduce control turning an unhappy person, who needed a few life skills, basically into a drug addict. They cannot live without these drugs – the withdrawal effects are too great to manage.

We must turn away from this appallingly limited approach and once again see people as 'whole' beings and address every aspect of their lives – not just brain chemistry – which of course is where the money is made for the pharmaceuticals – instead of lives being reclaimed and people tapping into their own inner joy.

**Where the real money is made**

The money to be made for the government, society, and community by preventing mental 'illness' is far greater than the money the companies who sell drugs make. Which means it's ENORMOUS.

The ongoing consequences on society, communities and families are massive. Medicare costs will continue to grow unsustainably if we don't begin to focus on wellness. and not just labelling and drugging. The cost of dealing with people who have psychotic episodes when coming off drugs; the cost of the side effects from the drugs; the cost of addiction to the drugs and the impact on children – are just a tiny number of the staggering implications in terms of costs and consequences.
For example, is depression REALLY a mental illness? Do we have to label it an illness? Can we not view it as a sign that something in the life of that person is not right – and needs exploring. Starting with physiological issues and fears and relationship issues before we put them on Prozac? Surely long term it would be cheaper – by billions? One psychiatrist made all his patients go for an hour long walk before their appointment with him. Nearly everyone was stunned when they didn't have anything distressing to talk about those days – they all felt much better.

ADHD in many cases can be eliminated by changing the child's diet or doing a thorough nutritional panel of tests and fixing their imbalances. Yet we are filling hundreds of thousands of our children with a drug that is essentially speed – once an illicit drug but apparently now legal. How is that right? Or safe? Or a government taking care of its people?

We have clinical and scientific evidence that diet, exercise and gratitude are just as, if not MORE effective, than drugs – yet we continue to create more and more drug addicted individuals.

**Whole body wellness**

*Pay attention to our hearts, souls and spirit*

I would like to suggest we change from the concept of mental health – to whole body wellness which leads to joy – including body, soul and spirit. How wonderful if we had a focus on 'joy attacks' instead of depression or anxiety attacks.

Body, soul and spirit are all inextricably interwoven and cannot be separated. People die quickly once they decide to die or believe they are going to – it can have nothing to do with their physiological status. When one partner in a long happy marriage dies, it's very common for the remaining partner to die very soon after – of a broken heart – although there is nothing physiologically wrong. People live for months or years past a time they are expected to die because they are waiting for some event – like a baby's birth. How is this explained if we just use a separatist model – where we separate people into brain chemistry, body systems or organs?

We must address the human spirit. IT is the thing that carries us through tough times. Hopelessness is devastating and destructive. It is a spiritual quality. Loneliness is endemic. Fear is ruling us and is used to rule our behaviour. We crave love and acceptance. We all want to feel special. These are all aspects of our spirit and soul – yet what do we do about addressing them when we 'diagnose' 'patients' who are mentally 'ill'. Perhaps they just need to be given some help and hope that they are ok – that they will cope; they will be safe; they can do it. Once we have made sure there are no nutritional or hormonal imbalances, to quote the song – often 'all they need is love'! Not a drug.

**The critical role of nutrition**

Orthomolecular medicine developed by Dr Abrahm Hoffer (co-discoverer of the importance of Vitamin C), has accumulated a vast body of research showing the impact of poor nutrition on mental health (and of course other areas of health). He 'cured' people with schizophrenia and alcoholism for decades before his death, with high doses of Niacin – along with a regime of other appropriate nutritional (and some psychological) interventions. Many researchers are now giving clear evidence that the gut is the source of many of the health or lack of health issues – mental and physical.

I have had experience with this – where someone I knew was diagnosed as 'schizophrenic' and then drugged into oblivion basically until they visited the ONE orthomolecular psychiatrist in Australia. After being diagnosed as coeliac and suffering from what essentially was malnutrition, he transformed his diet and started taking vitamins. There was a total turnaround in his life – he became an interactive, engaged human being again.

Which is when the poor education kicked in; no one was monitoring this persons gradual drug withdrawal (it has to be VERY gradual or it induces psychotic episodes – a very common problem with most drugs given for 'mental illness'); in the final phase, the quarter of a tablet that was to be taken for a month was only taken for a week – and the result was devastating. A psychotic episode that 'proved' to the
uneducated this person needed to be on drugs – so he returned to a very poorly functioning state as a consequence of the drug regime.

What we need in this country is more open mindedness to acknowledge the role of disciplines such as orthomolecular medicine; to understand the critical role the gut, digestion, diet and gluten play in the development of 'mental' health. It really should be seen as a systemic issue – beginning in the gut. Followed by hormone assessments; and exploring how the person feels about themselves.

A simple explanation of just one aspect: Gluten is a 'giant' molecule in terms of other molecules in the body. It is the protein present in wheat and some other grain products, One doesn't have to be a coeliac (born without the enzymes to digest gluten); most of us are so overexposed to gluten which is in almost every processed food in our supermarkets, that we develop a sensitivity or allergy to it. The consequences of this are vast and can be dramatic. Apart from leaky gut syndrome which can lead to malnutrition, the gluten molecules in a significant percentage of cases cross the blood brain barrier causing havoc in the brain functioning. Typical symptoms are anxiety, depression, vagueness, unclear thinking, and tension.

"Life is not just about feeling good. It is about being good at feeling"

This is a quote from Prof John Jureidini, Professor of Psychiatry at the University of Adelaide. If we had a society where discussion about feelings was encouraged and not mocked – it we were not so 'blokesy' – perhaps there would be less alcoholism, drug use or other addictions in men. The whole mining community is rampant with mental illness issues because no one has given them permission to be open and honest about feelings.

Most parents are not even conscious of teaching their children how to feel. Or of helping children discover what they actually are feeling. Western cultures are full of people who are numb – unable to feel anything let alone know what they might be feeling – at a conscious level. Fear is ever present but we are living lives of habits and patterns ruled unconsciously by fear – and we are not encouraged to understand and acknowledge these feelings, so we have no real understanding of why we do the things we do or feel the way we feel.

We need to be educating people about feelings and fears and giving them skills to adapt, accept, forgive, control, understand and believe in themselves. We need to give them permission to feel.

Families

Families – or the lack of them – are often a big contributing factor to unhappy children, adults and appalling dietary habits. Poorly educated or unable to find appropriate support, people go to the doctor to be 'fixed' rather than being educated to recalibrate all aspects of their lives. They are poorly motivated in many cases – but perhaps we can work on that by working on self-esteem fears and issues.

Families need to be educated on the real causes of most mental 'illness' and the effects of stress and then given ways to counteract them. Teaching these are schools and focusing on joy is at least one way to prevent the bad habits and patterns of families being perpetuated. Family support is critical – either a biological family or family of friends. Without that connection and encouragement, doing the work necessary to resolve our own issues is much harder to commit to and persevere with. Having someone to celebrate your successes no matter how small is critical for the change process.

Education – The best 'treatment'? 

In all cases of mental health issues – I would much rather say of signs of whole body imbalance – the nutritional aspects (including gluten sensitivity) should be VERY carefully examined by doctors who have been educated in or specialised in orthomolecular medicine – or at least people who are willing to be open to the ideas presented internationally. Why do we not make this an integral part of all 'treatment' – education would be a much better word to describe what is the most powerful way of helping people overcome their 'whole being challenges'.
We need to be educating people about the different ways our diet can affect our mental capacity; to understand how and what we feel and what symptoms show that we are not coping well with life – e.g. turning to alcohol, depression, fatigue, adrenal exhaustion.

We need to be teaching them about the very specific ways our lifestyles and the way we are CHOOSING to live can affect our ‘mental health’/lives. Skills around stress management, resilience and the ability to acknowledge and recognise deep fears are essential if we are to truly help people to take back control of their lives. We need to be teaching them about facing fears and how to feel – and deal with those feelings.

Why don't people know that exercise and gratitude are just as effective if not more effective than drugs.

Why don't people know that the primary side effect of Prozac (a drug used for anxiety) is anxiety? Do most doctors even know this?

This needs to be common knowledge to give people more choices other than taking drugs.

Why don't people know that the primary side effect of Prozac (a drug used for anxiety) is anxiety? Do most doctors even know this?

We need a campaign to eradicate the fears that underlie our ability to ‘cope’. These fears are embedded by the time we are 5 and most often fall into three areas: I am not good enough or I am not worth loving; secondly, a fear of being unsafe in some way and third, a fear of death, separation or abandonment. These core fears are often the causative ruling factor in other than joyful mental states.

Much of mental health issues are really the result of poor coping skills from handling challenging life situations. These skills can be taught. They are not difficult to learn.

The desperate need for an integrated approach – Recalibrate your life

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.

When we educate people as we are evaluating their overall wellness levels, we empower and heal.

People are disconnected from themselves, from spiritual beliefs and disconnected from each other. The resultant unbearable loneliness added to the fears most people hold adds weight to the potential effectiveness of integrated centres.

Imagine a JOY centre that had a focus of helping someone 'recalibrate' their life – to get it back on track: It would consist of:

- an orthomolecular psychiatrist or doctor – or both
- a psychologist who specialised in fear and helping us feel – really feel – again
- a relationship or social mentor – someone who could help a person heal/develop life relationships
- a personal trainer/sports physiotherapist to develop a regular exercise routine
- dieticians/experts trained in nutrition and balanced diets and helping people change their eating habits
- complimentary therapies: Bowen therapy, meditation or massage and other stress reduction modalities
- spiritual counsellors – not necessarily based on religion or church structures
• social gatherings of clients (NOT PATIENTS) to support and encourage each other; to connect and make friends
• a training centre – teaching people all the skills they need in all aspects of their lives – stress management, building self worth, cooking, self control etc.
• community liaisons – teaching at schools; educating the general public – making it smart to attend a centre like this – not a stigma
• life coaches to help people explore and discover their hopes, goals, dreams and passions
• a laboratory that could provide the specific and specialised nutritional testing necessary to identify ALL the possible gut, hormonal issues or other issues influencing the body chemistry and functioning

In an article on Shamans in The Optimist (Jan/Feb 2013), they mention the Huichol, an isolated native tribe in North America and a shaman who was trained by them. He says that the Huichol view disease as an opportunity to discover what's off kilter in your life and thus what you can improve. This means that attention to health isn't something confined to periods of illness. "Healing is a way of life. It's a constant search for the balance between man and nature."

In the same way, we need to pay attention.

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.
Obsessive Hope Disorder
30. Schools and online mental health
Sarah Hardy and Jane Martino

A match made in heaven

What is Smiling Mind?
Smiling Mind is modern meditation for young people. It is a unique web and App-based program, which uses the clinically proven techniques of Mindfulness Meditation to help bring balance to young people’s lives. As an organisation, Smiling Mind is a relatively new not-for-profit initiative providing free online and education programs to young people aged 7–22 years.

Our vision is to see Mindfulness on the Australian Curriculum by 2020. The development of our vision is directly related to the lack of progress being made in providing schools and other settings that work with young people, with ‘easy to implement, evidenced-based tools’, to address youth mental health.

Smiling Mind takes an online, pre-emptive approach in the programs it provides for young people to assist with stress management, resilience and focus.

We strongly believe that online, freely accessible, individually motivated approaches should be part of the current and future direction of any strategy to address youth mental ill health.

We hope our views, expertise and experience adds value to your report; Marking 30 years of mental health reform efforts in Australia.

The need for online tools
The ever-growing presence of the online world has led to an increasing need within Australia’s mental health system to provide relevant, highly accessible and cost effective support to young people.

In recent years, the online mental health sphere has progressed rapidly, particularly with the prolific use of social media. Evidence now shows that high prevalence mental illnesses such as depression and anxiety can be effectively treated through online programs. However, in our experience, there is still significant progress to be made in order for mental health services to keep up with technological advances and remain relevant – particularly to young people. Technology is now the first port of call for most young people. Australia’s youth increasingly see the Internet not only as a portal to information and entertainment but as a setting in which they live their lives. It is “a core and fundamental part of who they are and how they connect.” With 67 per cent of Australian young people (aged 15–24) using smart phones and 91 per cent of Australian family households with young people (aged 8–17) able to access the internet, it is clear there is a demand and a continued focus needed on the expansion of online mental health services. We feel this is particularly relevant for disadvantaged groups of young people such as those in rural and remote Australia, same-sex attracted young people, and those young people with a family history of mental ill health.

Urgent attention is required to build accessible online tools that are underpinned by evidence that ‘speak’ to all young people.

Smiling Mind is aware that ‘e-health’ is now an issue within the health portfolios of both Federal and State Governments. While this has progressed the availability of online services, the Government e-health trend is still largely focused on infrastructure and record keeping, rather than education and service delivery.
Mental health education initiatives and pre-emptive tools continue to feature little and are not currently well funded at a state or national level for a number of reasons including the following:

- Lack of community understanding about the impact of mental illness on the Australian economy;
- Lack of recognition of the importance of social connection and its relationship to mental ill health; and
- Mental health’s isolation from education in mainstream education settings (i.e.: schools).

Through our work we have noted comments from key stakeholders that describe the gap in the Australian health system when it comes to addressing the mental health of young people. It is the view of professionals that this gap, in consultation with young people and using research findings, can be closed with the provision of online products and services.

**The need to work with and in schools**

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. We know 75% of mental illness has its onset during 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.

Schools are an obvious captive audience as most Australian adolescents are at school. School is where we should start, operating from a wellness perspective, understanding from the outset this is everyone’s business and we have a responsibility to equip all healthy young people with skills to address their biggest cause of disease burden – mental Illness. To satisfy the educationalists, this will also improve academic achievement.

Whilst there are currently many resources in the marketplace for schools to implement some form of mental health education, it is still, relatively ineffective and inappropriate for the education (school) environment and the curriculum. The current developed resources are underutilized due to:

- The excessive amount of professional development time required by teaching staff to understand and implement what is required;
- Teachers are not trained to understand or deliver mental health education;
- Teachers, like the rest of the community, struggle with stigma and their own or family’s mental health issues;
- The resources are printed in hard copy and are quickly out of date;
- Although health and education are intrinsically linked to academic outcomes, they are taught in silos and connections are not made. For example the subject of mental health is often only addressed in health subjects and is not part of understanding/affecting performance in a math’s class.

It is the view of Smiling Mind that the answer to these problems are:

- To provide evidenced-based/online tools that required minimal teacher professional development
- To adopt and enforce the view that pre-emptive online, mental health tools are easy to implement and do not require specific teacher expertise;
- Any implementation of online tools must not impact on the delivery of current curriculum or be substituted for other core material but actually enhance its delivery in the classroom;
- Online tools should be free and accessible to all young people across Australia.
These strategies define and drive the work of Smiling Mind. To date the huge demand from schools and other educational settings far outweighs resource capacity however we believe this response represents a current and large gap in the way this pressing problem in being addressed. Online pre-emptive, evidence–based tools, developed for and adopted by the Australian school curriculum should be part of any reform agenda that aims to reduce the excessively high rates of mental ill-health in young Australians.

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.
Obsessive Hope Disorder
31. The need for trauma-informed care

Jack Heath

Mental health policy and mental health services need to pay greater attention to the links between trauma, especially childhood sexual abuse, and mental illness.

My involvement in mental health stemmed from the suicide in 1992 of my young cousin who had been diagnosed with catatonic schizophrenia. I spent more than twelve years working in youth mental health before I learnt that he, like me, had been sexually abused by clergy at boarding school.

From 1997, I worked with outstanding people to establish the Inspire Foundation and its ReachOut.com online youth mental health service in Australia, Ireland and the United States.

Towards the end of 2011, I returned from the United States and decided to pass leadership of Inspire to others. After a brief stint with Foreign Minister Kevin Rudd, I was offered the role of CEO at SANE Australia. I knew that SANE spent more time dealing with people at the severe end of the mental illness spectrum and given my extensive family experiences with severe mental illness, I took on the role somewhat nervously.

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.

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.

Dr Cathy Kezelman from Adults Surviving Child Abuse (ASCA) put my anecdotal experiences in perspective. She said between a quarter and a third of children experience sexual abuse before the age of 18, mostly in the family setting. She pointed me to studies indicating:

- Around one third of men and almost half of all women with schizophrenia had a history of childhood sexual assault
- There were higher rates for PTSD in childhood abuse survivors than veterans
- Forty five per cent of homeless young people reported sexual or physical abuse to be a major factor in leaving home
- Nearly one-half of eating disordered patients in one Australian clinic reported a history of child sexual abuse
- Up to three quarters of individuals with Borderline Personality Disorder have experienced childhood sexual abuse
- Young Australian survivors of child sexual abuse have a suicide rate 10 to 13 times higher than the general population

The data on childhood sexual abuse screams out for a better response than we have provided to date.

In 2012, Federal Mental Health Minister Mark Butler launched ASCA’s Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care. The Guidelines draw on two decades of national and international research and inform us of the very real possibilities for recovery for the large numbers of people with unresolved "complex trauma," including childhood sexual abuse.
The Guidelines give us reason to be optimistic that recovery from complex trauma is possible, and that childhood sexual abuse can be resolved. 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**

Jack Heath is the CEO of SANE Australia – a national charity helping people affected by mental illness lead a better life. Following on from the suicide of his 20 year old cousin, Jack founded the Inspire Foundation in 1997 with the idea of using the Internet to prevent youth suicide. Jack was Inspire Australia’s Executive Director from 1997 to 2007, Inspire’s Global CEO from 2008-09 and Inspire USA’s CEO from 2010-11. While working with Inspire USA, Jack was appointed to the Executive Committee of the US National Action Alliance for Suicide Prevention, a position he retains today. Jack is also a director of the Mental Health Council of Australia; a member of the National Mental Health Commission’s Expert Reference Group on National Targets and Indicators; a Steering Committee Member of the Mentally Health Workplaces Alliance; a member of the Catholic Church’s Truth, Justice and Healing Council; and a member of the Asia Australia Mental Health Advisory Council.
32. Mental health and mental wealth
Ian Hickie AM

Can we address the mental health needs and mental wealth of Australia?

Over the last thirty years, reform of traditional mental health services has clearly been on the agenda of all Australian Governments. That is, recognition of the need to move away from limited asylum-based services to more inclusive and supportive community and home-based systems was first actively pursued in the 1980s. Sadly, in 2013, we are still debating whether this common sense and respectful approach is really at the heart of our current government-supported health and human services systems.

Most importantly, much of the debate is still centred on the roles and responsibilities of Government-funded systems rather than achieving better health, social and economic outcomes for those most affected. 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.

The period of reform in the late 1980s followed on from the development of more effective medical treatments for the major psychotic and severe mood disorders and a subsequent large reduction in the need to provide long-term institutional care for those affected by mental illness. That is, active ‘deinstitutionalisation’ did not suddenly empty the old asylums. It did, however, clearly articulate a new enthusiasm for providing appropriate medical, psychological and behavioural therapies in non-hospital settings and also responded to the social context of an increasing recognition that treatments should be provided in ways that respected the individual rights of those living with mental illness.

For the last twenty years in Australia, and following the release of the findings of the Burdekin enquiry in 1993, an agreed inter-governmental and nationally-coordinated mental health strategy has had the national responsibility to guide this process. In truth, while the Commonwealth has convened this approach, a rather narrow top-down agenda has been set largely by the various state-based specialist systems. While Australia frequently reports internationally that it is at the forefront of development of national mental health policies and innovative clinical practices, it is also frequently critiqued for its patchy implementation and ongoing lack of coordination of relevant health, disability, housing and employment services.

Subsequent major reports on progress by more independent bodies such as the Mental Health Council of Australia have repeatedly drawn attention to the gaps between Government-led reports of steady progress and the experiences of those attempting to use these health care and social services systems. As in 1993, each of these community-based pleas for greater investment, genuine reform and greater accountability has precipitated renewed political commitments.

The 2006 response of the Council of Australian Governments (COAG), led by Prime Minister John Howard and NSW Premier Morris Iemma was particularly notable as it attempted to lift the issue outside of the narrow health services perspective to a major piece of social, economic and health policy. This degree of political response also recognized the results of relevant community surveys that indicated considerable public support for effective actions to fast-track reform.

So, how did it come to be that in 2011 in association with a new suite of Federal Investments by the Gillard Government, that the community expressed so little confidence in the progress of national reform and implored the Federal Government to establish a new national Mental Health Commission to report


independently (and annually) on the state of mental health in Australia? One rather self-serving narrative often put by those close to the intergovernmental process is that mental health reform has been so successful that community expectations have grown at such a rate that the services sector now lacks the capacity to respond effectively.

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. Within this perspective, we are seen to be still providing a narrow range of dislocated services through the same rather ineffective infrastructure platforms (i.e. public hospital, community mental health and private primary care and specialist service systems) that were in place two decades ago. From a consumer or family perspective, key decisions still appear to be made largely by the providers of care in response to the various financial drivers that are overseen by the Commonwealth or states.

An even darker perspective suggests that critical care services are now even less engaged in non-hospital settings and that a culture of risk avoidance combined with over-reliance on compulsory treatment options has caused a deterioration in the experience of care – at least for those in need of the more intensive interventions typically provided by state-based service systems. This perspective tends to contrast growth in Federally-funded health enhancements focused on those with less severe or enduring disorders (e.g. access to psychological services under new Medicare arrangements), with the relative neglect of the extensive physical and mental health, social services, employment and accommodation needs of those with chronic or severe illness.

The current dialogue about the state of progress in mental health reform in Australia also needs to be seen within the context of a wider disenchantment with the process of the Rudd Government’s general health reform agenda. Further, the conceptual move away from larger top-down human services development to more person-centric support systems, such as those proposed by the new National Disability Insurance System (‘DisabilityCare’), has major potential implications for the future scope of mental health and related human services.

Despite the rhetoric of the Rudd Government in 2007–08, the outcomes of national health reform have been very limited and may, due to the unintended impacts of activity-based funding, result in an even more hospital-centric and procedurally-preoccupied health system than ever. The consequences for mental health may well be a renewed focus on the acute care and hospital-based emergency systems rather than enhancing supports for non-hospital based care and support.

So, in 2013, can we agree what have been the real achievements in mental health since the late 1980s, where things have gone astray and what are the new challenges we face? Further, can we agree finally to put those in need of care and support at the centre of the debate – as distinct from the short-term needs of current politicians, the intrinsic risk-avoidance of our administrative processes and the personal and financial preoccupations of our professional groups.

In my view, Australia does stand apart from other developed and developing countries in one key area – community awareness of mental health issues and support for those affected by common disorders such as anxiety, depression and psychosis. A wide variety of factors have contributed to this rapid and positive change – including high level political and community leadership, a responsible and engaged media sector and national recognition in the 1990s to focus on suicide prevention.

Other key factors included national engagement with the broad agenda of mental health and wellbeing precipitated by recognition of the economic costs of common mental disorders and the development of new medical and psychological treatments for common disorders such as anxiety and depression. This was enhanced by national commitment to engage the wider community through government and community support for organizations such as beyondblue the national depression initiative. In recent times, this has been further enhanced by a focus on youth mental health and the provision of early intervention services in person and via new internet-based technologies.
While there have been major changes in some other key aspects of service delivery such as the movement of specialist inpatient services from stand-alone psychiatric hospitals to general hospital settings and the inclusion of psychological services under Medicare funding arrangements, very large gaps in access to services, affordability of care, geographical distribution of both primary and specialist care providers and provision of integrated health and social services still remain.

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.

In my view, those structural deficits do not lie at the heart of our current difficulties. Instead, I would suggest that the more significant barriers remain largely the various public and individual private provider services systems that are principally responsible for care delivery. 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.

In Australia, however, we have only ever seen small in-roads down that purchasing path. The early phases of Australian-Government support for increased psychological services (2001: Better Outcomes in Mental Health) headed down this path. Unfortunately, under pressure from the key medical and psychological professional groups it gave away this focus in 2006 and returned largely to poorly coordinated fee-for-service models. In recent years, the new Headspace services for youth mental health have also espoused an integrated services philosophy.

By contrast, most new initiatives in the community sector have simply contracted with individual providers to pick up one aspect of care or social support and assumed that in some way or other, this care will link with multiple other services systems in the housing, employment, education or health sectors (for example, the introduction in 2006 of the Personal Helpers and Mentors Program, administered by FaHCSIA). The system is now so chaotic that the largest investment proposed under the 2011 Budget initiatives is a new assessment and coordination system (namely the $550million ‘Partners in Recovery’ program) rather than a focus on enhanced service delivery.

There are probably three steps that are urgently required now to make real progress.

The first is to have genuine independent reporting and accountability come under the auspices of the new National Mental Health Commission. This needs to be fearless and focused on the realities of delivering genuine improvements in the experiences of care for those who encounter our health and social service systems. The reporting should emphasise that enhanced outcomes, including better experiences of care, and not simple lists of activities are at the heart of our measuring systems. The key parameters of a ‘Contributing life’ as set out in the first report of the national commission, provide a high level structure for this process – with appropriate emphasis on suicide prevention, enhanced physical and mental health, secure housing, employment and education participation and a renewed respect for the human rights of all Australians – with a particular emphasis on the need to focus on the experiences of indigenous Australians.

The second is to hold the states and territories accountable for that part of the services system for which they will always have primary responsibility – namely the public hospital and related acute care services. These systems require new investments that have real commitment to providing acute care wherever possible in non-hospital settings.

The third is to have the Federal Government assume principal responsibility for the funding of the large and growing area of non-hospital based health, housing, employment and social services.
This does not mean Federal delivery of these services but rather the contracting of integrated services through relevant non-government or other private providers who have a real capacity to deliver enhanced care. To achieve this, the Commonwealth would need to listen far less to the traditional professional groups or state-based bureaucracies that have largely set the agenda for the last twenty years.

New models of care are available. What we really need are new financing systems to support those models and Governments with the intellect and capacity to drive through the structural changes that can deliver for those who encounter mental ill-health at any stage of their life.

In 2003, Professor Hickie was appointed as the inaugural executive director of the flagship Brain & 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 a Fellow of the Academy of the Social Sciences in Australia. From 2007-12, Professor Hickie was one of the first round of NHMRC Australian Research Fellows, recognising excellence in Australian Medical Research. From 2008-2010, he was appointed to the Federal Health Minister’s National Advisory Council on Mental Health and then in 2010 to 2011, 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. Additionally his work supports expansion of population-based mental health research, enhanced primary and secondary care mental health services (particularly focused on evidence-based early interventions for young people with anxiety and mood disorders and development of international mental health strategies.
33. Developing a 21\textsuperscript{st} Century model of care

Aram Hosie

Effective, Accessible, Affordable

Meeting the demand for mental health help and support in Australia is not a new challenge nor is it one that shows any sign of abatement in the near future. Whilst recent years have seen a welcome increase in the level of public and government attention given to mental health in Australia, it is clear that there remains a far greater need for services than there is supply. Young people, and people living in rural and remote areas, remain especially disadvantaged when it comes to accessing good quality help and care.

Our existing models of service planning and delivery will simply never be able to meet this demand without a truly massive injection of financial and human resources. Such an investment would impose a very significant cost-burden across society and, in all reality, is unlikely to ever materialise.

Despite this, there is reason for optimism.

Right now, we have the opportunity to create a new mental health care system that can deliver the right support, at the right time to whomever may need it, regardless of where they may be. We could transform mental health services, creating a 21\textsuperscript{st} Century model that expands access, increases flexibility and improves outcomes – if we have the foresight to make the right investments and policy decisions now.

Fifteen years ago Inspire became the first organisation in the world to utilise the internet to deliver a mental health service. ReachOut.com was powered by young people, research and technology, and pioneered on-line information and service delivery for young Australians with mental health concerns. From small, experimental beginnings, we have been excited to be part of a rapidly expanding ecosystem of online and e-health options that are proving to be accessible and effective. Young people in particular describe online services as accessible, anonymous, engaging and informative, and as providing a space in which they can share feelings and experiences and get information without excessive cost, without travel, and without fear.

Today, it is still possible to find information and support, and share thoughts and questions, in the same way as those first users of ReachOut.com did in the late 1990s. But it is also possible to now access a whole number of e-health programs for a range of mental health disorders and problematic health behaviours – programs that have been shown to be highly effective. \textsuperscript{73} Meanwhile, social networking platforms refer users to peer-rated (and often peer-created) resources based on key words in status updates; GPS devices (including phones) provide information, and motivation, for physical activity; apps in smart phones remind users to monitor their moods, and even give feedback on the places, and activities, associated with different mental states.

Right now, such self-help approaches are already offering ways to fill service gaps for people with limited access to traditional clinical and other support services. However further infrastructure improvements, like the national deployment of high speed broadband, and the increasing sophistication of technology, will make all of our existing e-health options richer and deeper. Such possibilities are exciting and will deliver unquestionable improvements in access for many Australians, just as the original ReachOut.com website

\textsuperscript{73} (Christensen, Griffiths et al. 2004) Mitchell, Vella-Brodrick et al. 2010)
and forum improved access to mental health information and peer support for many who had previously had no options other than geographically distant and emotionally intimidating face-to-face services.

The mobile internet, and the web of social networking and applications that come with it, challenge us to recognise the increasing role the ‘virtual’ world plays in people’s everyday life. A 2008 national survey of internet use showed that almost all (95.1%) young Australians use the internet or a mobile phone to source information, communicate and interact, while at the same time, over 55’s are the fastest growing users of social networks such as Facebook. Our community is highly, and increasingly, technologically engaged. The services they need, and the type of service access they prefer, must be key considerations in shaping mental health service systems in the future. Comprehensive, best-practice health care, delivering high-quality services to all, must, in the future, involve a combination of multiple modes of service delivery.

We have to imagine, and then create, a future of mental health service delivery which includes e-health not as a stop-gap substitute for traditional face-to-face services, nor as a second-best remote-delivery method for those services, but as part of an integrated and sophisticated mental health response which gives everyone access to the services they need.

To reach that model, we need to think in terms of enhancement rather than replacement and of effectiveness rather than equivalence. Services delivered virtually – however sophisticated the technology of virtual presence may become – will not be the same as those delivered in a traditional, face-to-face clinical environment. Nor will a smart phone app, however personalised and sophisticated, be the same as one-on-one professional care. However, thinking about the potential of technology only in the light of how much new services look like traditional ones will miss the real opportunities ahead. If ‘virtual’ services can enhance traditional care, then treatments can be both more effective and less resource-intensive.

We need to create a system of stepped care, where accessing help does not necessarily require a person to first make physical contact with a mental health professional. A system which reconceptualises help to encompass self-help and peer-support, managing and diverting the demand on clinical services and professionals so that they are free to assist those requiring a higher level of support. We need to reorient our service systems from being expert-led, to being person-centred and driven, and explore what funding and policy adjustments are required to facilitate this change.

This also means that mental health care in the 21st Century will have to be one of partnerships and networks. The more options there are, the less possible it will be for any single service provider to meet each and every need. Technological advances have made, and will continue to make, co-ordination and co-operation easier: but they will also make it more and more essential to delivering quality services. Integrated networks of public, private and not-for-profit organisations will be not only the most efficient, but in many cases the only possible, way to get the right care to the right place in the right way.

Taking full advantage of technology to meet the needs of all Australians will, however, remain science fiction unless governments, service providers and stakeholders come to grip with some key challenges. The most basic is the increasing divide between the connectivity-rich and the connectivity-disadvantaged. Such a divide can’t be ignored in any discussion about the use of technology in mental health service delivery, especially as it is the poor, the already disadvantaged, and the residents of rural and regional areas who are most likely to be on the downside of that social digital divide. Those of us who work with marginalised young people already hear stories of meals skipped to afford internet access. We must address connectivity-disadvantage as a priority, or those least able to access traditional face-to-face services will suffer the double burden of also being the least able to access e-health as well. In many cases the only possible, way to get the right care to the right place in the right way.

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74 Ewing, S. Et al 2008. The Internet in Australia, ARC Centre of Excellence for Creative Industries Digital Futures Report, Melbourne.
75 Whilst historically in Australia, geographical distance and remoteness have long been a barrier to internet access, we believe this will significantly diminish from 2015 when NBN Co launches two massive satellites currently being built in the USA. These satellites will double the broadband speed for people living in rural and remote areas of Australia, in many instances offering better internet speed and performance than is available to those living in metro areas.
cases addressing this connectivity disadvantage will still be a more cost-effective strategy than the provision of traditional face-to-face services.

A second key challenge will be the need for skills development and hardware upgrades – and not just as a one-time commitment. Ongoing training and education for staff, and ongoing hardware assessment and upgrades, will need to become the new normal for mental health service providers, whether in the public, private, or not-for-profit sectors. This will be a significant investment, but making all our mental health services able to take full advantage of the changes to come will ultimately save money through greater efficiencies.

The third challenge in the mental e-health field is one already confronting us, and that is the challenge of not only delivering quality, evidence-based services but in making those services known to those who need them in a virtual world increasingly filled with digital ‘noise’. The traditional gatekeepers of mental health ‘best practice’ such as peer-reviewed studies are unknown, inaccessible, or mistrusted by many of the people seeking help and information online – who increasingly rely on social networking and peer referrals instead. The very essence of the Web 2.0 is collaboration and interactivity: a publication model that expects passive consumption can’t survive.

Services such as ReachOut.com, e-headspace, and moodGym are high-quality, tested and evidence-based resources, but the continuing challenge remains making sure people know about them. Social media in particular will be absolutely essential to building credibility and reputation in the on-line contexts that, increasingly, serve as referral gateways for both e-health and traditional clinical care. This only reinforces the need for mental health services to operate in and engage with ‘virtual’ life. If we fail to establish a strong, engaged on-line presence, that gap will be filled by others.

A collaborative, engaged approach will also be crucially important in any development of future e-health services. Technological innovation and on-line developments are fast, diffuse and highly flexible. The development of effective e-health services in the future will depend as much on partnership between service providers and the community using those services, as it will on partnerships between service providers.

We must also always be aware that the organic, innovative nature of the internet that leads to incredibly valuable developments, is not without its risks. We know that contagion exists online as well as in person, as does bullying. Our challenge now and in the future – a challenge by no means unique to the mental health field – will be to find ways to address the potentially negative effects of connectivity as well as to harness its tremendous positive power.

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 is the Director of Research & 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.
34. The ADF and mental health reform

Angus Houston AC

In my opinion the Australian Defence Force (ADF) has come a very long way in acknowledging and treating mental health conditions in the recent past.

Mental health conditions like post-traumatic stress disorder (PTSD) have always existed, even if they were not acknowledged.

When I read books about our military history it is very evident that many of the original ANZACs suffered mental health conditions. They talk of shell shock and nightmares. In the Second World War you read about aircrew who were discharged due to what they called at the time a ‘Lack of Moral Fibre’ with their service records marked ‘LMF’.

When I joined the Royal Australian Air Force in 1970 mental health was never discussed. Illnesses like depression and PTSD were never acknowledged. Mental health issues were regarded as a weakness. Individuals suffering conditions such as PTSD were expected to ‘harden up’ and overcome their illness without assistance.

As Chief of the Defence Force from 2005 to 2011, my top priority was the welfare of our people.

That meant Defence doing its utmost to look after the health and wellbeing of our servicemen and women – physical and mental.

During my time as the Chief of the Defence Force, we did a lot of work to reform health care delivery within Defence, including in the area of mental health.

We actively tried – and I think made great progress – in breaking down some of the stigmas associated with mental health, in what remains a predominantly male workforce.

Audits of Defence health care had repeatedly found that responsibility was fragmented throughout the organisation so in 2008 we established Joint Health Command.

Under the leadership of the then Commander Joint Health, Major General Paul Alexander, we set about integrating quality health care services and dramatically improving our approach to looking after our people. Many of whom were young veterans with complex needs.

In 2009, Professor David Dunt conducted a review into ADF mental health services and made 52 recommendations, all of which were accepted.

As a result of the Dunt Review, we implemented initiatives to enhance prevention strategies and rehabilitation and to ensure ADF Members had easier access to best practice mental health services.

A real emphasis was placed on the development of improved mental health services, through research, innovation, reduction of stigma and increased retention of traumatised personnel.

The ADF’s mental health programs were refined and developed in areas including prevention resilience, minimising the use of alcohol and other drugs, critical incident management, research, readjustment, peer support, treatment of early symptoms, suicide prevention and transition services between Defence and the Department of Veterans’ Affairs.

In 2010, the ADF introduced the Mental Health Prevalence and Well Being Study which surveyed over 22,000 ADF personnel indicating prevalence of psychological distress, suicidality, alcohol use and abuse, depression and anxiety, including PTSD. It was the first comprehensive investigation of the mental health of an ADF serving population. The goals of the study were to establish a base-line prevalence of mental disorder, to refine current mental health detection methods, and to investigate the specific occupational stressors that influence mental illness. The results also allowed our programs to be tailored to needs.
Unlike times gone by, Defence now recognises that PTSD, depression and other mental health issues are the same as a physical injury and it is in everyone’s interests if those suffering come forward and seek help early.

During my time as the Chief of the Defence Force, we worked extremely hard to get the message out to all those in the ADF that seeking help for PTSD or other mental health conditions is not a sign of weakness or mean that you are any less of a man. It also won’t automatically signify the end of your ADF career. Just like a physical injury, it needs treatment.

While a great deal of progress has been made in the ADF in the area of mental health in recent times, it doesn’t mean we can’t do more. Indeed, we must do more.

Over the six years I commanded the ADF, we conducted more than 65,000 individual deployments to 58 operations from Afghanistan and Timor to the disasters in Queensland and Japan.

No matter what the circumstances, the men and women of the ADF never let me down. They consistently delivered beyond my expectations.

I believe we have an obligation to all those who have served our country so admirably to support and improve effective treatment for veterans suffering mental health issues.

Next year, we will begin commemorating the Anzac Centenary – 100 years since Australia’s involvement in the First World War. By 2014, the bulk of our servicemen and women will also have returned home from Afghanistan.

In my view one of the most fitting legacies of the Anzac Centenary would be the establishment of an Australian Centre of Excellence to conduct research and to facilitate treatment and prevention of veteran mental health conditions such as PTSD.

We owe a great debt to all those who have served our country in uniform. The least we can do is ensure they get the best possible care when they return home whether it be for physical or mental wounds.

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.
35. Indigenous mental health

Ernest Hunter

The costs of ‘business as usual’

Arguably the most impressive gain in Indigenous health across northern Australia occurred some four decades ago as perinatal mortality rates fell dramatically from levels that had been greater than non-Indigenous Australians by an order of magnitude. Within a decade rates had settled at two to three times higher and have remained around that level since. Saving those pregnancies and infants was not the result of therapeutic breakthroughs but, primarily, about ensuring Aboriginal women had access to primary care and perinatal services. The problem in the period up to the 1970s, then, was service equity and the solution was an intervention paradigm. It can be argued that the same approach has driven thinking in the decades since in an attempt to close the intransient ‘gap’. Well, it can also be argued that this is the wrong paradigm and that the problem over recent decades is driven by the continuing burden of social adversity – it is about social determinants rather than service capacity.

Now, that is not to suggest that therapeutic and service improvements are and will not be important. But it is to say that they will almost certainly not be enough. This is not news. In the 1990s I was fortunate enough to visit Central Australia with a party accompanying the then Minister for Health (Michael Woolridge) who was responding to a request from David Sacher, Harvard Professor and Surgeon General of the United States, to see Aboriginal health issues up close. Sacher came with enormous research and intervention experience in disadvantaged populations, but what he found in that remote community was still shocking. At one point he turned to Woolridge and remarked: “you don’t have a health problem; you’ve got an education problem”.

Sacher was NOT questioning health sector investments but was, rather, observing that without addressing the social drivers there would be little likelihood of real change. By pointing to an “education problem” he was not suggesting that schools, alone, would fix everything, but drawing attention, in a Rawlsian sense, to the importance of the key drivers of ‘equality of opportunity’. In this view social justice in the community as a whole is based on many factors but with certain key social preconditions, amongst which health and education are preeminent. In a just society these social goods should be so distributed so as to ensure access to the normal range of opportunities available in that society.

Well, over the last decades there has certainly been massive investment in Indigenous health and education – that is certainly the public view and some might argue that Indigenous Australians are unfairly favoured.

But in considering ‘equity’ in terms of resource allocation, both the burden of need and compounding factors (such as location) need to be considered and with that in mind it can be argued that in terms of resource allocation, remote Aboriginal Australians are far from ‘favoured’. Regardless, there is a not unreasonable perception that outcomes given inputs are poor.

Aboriginal and Torres Strait Islander mental health has followed a quite different trajectory. In the decades in which service investment was bringing down infant mortality rates, Indigenous mental health was attracting virtually no attention and was not considered a priority. Since then the situation has changed dramatically – for the worse. This worsening is not unique to mental health and there have also been
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alarming increases in certain other conditions, notably diabetes and cardiovascular diseases. Indeed all of these are sometimes referred to as ‘lifestyle’ conditions, a term which conjures personal responsibility and ‘choice’, which may be quite misleading in welfare dependent environments of powerfully constrained ‘real’ options.

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. Without attracting the same political and service attention, through this period anxiety and depression have become very common and the broad excess burdens of neurodevelopmental problems in childhood and cognitive decline in the elderly are only now being determined.

Tracking this cascade have been a series of what might be considered ‘siloed’ policy and program initiatives at State and Commonwealth levels targeting each issue in turn, with scurrying activity after some key events – the Royal Commission into Aboriginal Deaths in Custody in the 1980s, the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Family in the 1990s and the Little Children are Sacred report in the 2000s. It is fair to say that responses (and investment) to date have, largely, been reactive.

That might be understandable if these were not linked processes – but they are. Alcohol exploded as a problem in a particular social context in the 1970s and the increases in violence – largely in the domestic arena – was a direct consequence of the accompanying social chaos. Those young adults who began harming themselves in the 1980s were of the first generation to be raised in that environment. The children who have been doing the same in the 2000s are of the first generation to be exposed to self harm threaten and behaviours – including suicide – during their formative years. The young adults presenting with psychoses now were born into environments in which alcohol and cannabis use were rife (sometimes including intrauterine exposure) and often introduced to substance use in childhood. The common denominator is the neurodevelopmental environment of pregnancy and early life.

This is NOT news. In different ways and with very different levels of consideration, consultation and community support the Emergency Intervention in the Northern Territory, the Cape York Welfare Reform initiative in northern Queensland, and the Commonwealth’s Australian Nurse-Family Partnership Program trials all seek to optimise developmental potential by environmental change. Other outcomes are sought and there are other programs with similar goals, but suffice it to say that there is activity in the area.

But is this really mental health sector business? Well, from the foregoing it will be clear that there is a powerful argument linking this area with mental disorders later in life. Further, it is about far more than specialised perinatal mental health services. It is, rather, about the main opportunity for gain if we are serious about prevention at the population level in Aboriginal and Torres Strait Islander Australia. And to be effective (and effectively evaluated) that will require effort, real resources – and sufficient time.

And there lies the problem. Anything that is going to have enduring impact on the environments of pregnancy and early life will need to be sustained for at least a generation, probably more. This is about social norms and cultural change, and such broad social programs will not have universal support and are likely to be divisive – that is certainly the case with each of the interventions mentioned earlier. Consequently there will be pressures for changes in direction regardless of results or sufficiency of time to judge, that will only be resisted by bipartisan support and a long term view. If that were not enough, support for such investments would need to be maintained in the face of competing economic and political priorities.

Unfortunately, such support cannot be taken for granted. Indeed, 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. Indeed, the latter is particularly salient, as a key element to ensuring reasonable stability in family settings that will enable changes in social norms to improve developmental outcomes, is containing the chaos associated with substance use, the like of which preceded and precipitated the Queensland restrictions in the first place.

Optimising developmental potential is, I believe, absolutely necessary but clearly not sufficient. Major gains in education participation and outcomes, and opening up real employment options are needed. While it is fair to say that there is movement in these areas with room for optimism, the picture is uneven and remote communities lag way behind rural and urban Indigenous populations. Thus it is all the more important to maintain the political will to invest in the start of life across remote Australia. To that end the manifest mental health outcomes of NOT redressing Indigenous developmental disadvantage should be put on the political table.

Of course, it might be argued (and has been recently) that population health investments do not result in commensurate improvements – health promotion programs don’t reduce the illness burden. However, from my opening statements it should be clear that there has been a significant increase in mental disorders across Indigenous Australia over the last twenty years, during which time there has also been a dramatic increase in mental health investment in clinical service provision. We do not judge this a failure in the clinical paradigm because it is understood that the overall burden of mental disorders in Indigenous settings is ‘overdetermined’. That is, there is a greater than necessary burden of causal factors (historical, developmental, contextual…) and there is a limit to what clinical interventions can do. The same applies in terms of prevention and mental health promotion; our failure to develop the evidence should not be cause to abandon the field but to renew effort, refine interventions and evaluation, and ensure we make a difference.

If the mental health sector is to contribute to making a difference to the overall wellbeing of Indigenous Australians I believe that three essential investments are required. First, while I have attempted to demonstrate that clinical services are not, in themselves, sufficient, they still need refinement to ensure that they are accessible, acceptable and effective. That is core business. But so is mental health promotion and prevention. So, second, the sector should focus political attention on the environmental and developmental factors that drive the burden of mental ill-health and disorder in these populations – the family context of pregnancy and infancy/childhood. And third, while responsibilities for interventions in this area are likely to be uncomfortably borne across the multiple sectors and political interests involved, the mental health sector should lead by example. That includes demonstrating and quantifying the costs of inaction, facilitating cross-sectoral understanding and commitment, developing models of effective intervention that are culturally and socially informed, and advocating for realistic timeframes for implementation and evaluation. That may be at great cost, but so will be ‘business as usual’.

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.
36. Stigma: consumers and carers treatment experiences

Rachelle Irving

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 upon anyone, regardless of profession, education or standing in the community.

For a person with a mental illness, stigma impedes recovery by negatively affecting social status, self-esteem and social networks, making treatment and recovery unlikely. This can result in poor outcomes for the individual, including issues such as unemployment, isolation, delayed treatment seeking and hospitalisation. These impediments are likely to lead to feelings of social isolation and exclusion for a person with a mental illness. Contending with these issues while seeking treatment for a mental illness will likely affect self-esteem and levels of distress, making recovery all the more difficult.

Mental health professionals often serve as role models and opinion leaders, they are who consumers turn to for help, understanding and support when they are at their most vulnerable. How people with mental illness view the various mental health professions, and vice versa, can have serious consequences for treatment and quality of life for these people.

A national study, Consumer and carer experiences of stigma from mental health and other health professionals (2011), was recently undertaken of 413 mental health consumers and 200 mental health carers to establish the nature and extent of their experiences of stigma from health professionals. The study found that mental health consumers do experience stigma often, from health professionals, mental health professionals as well as the general community. It also found that consumers and carers have very different experiences at different times, depending on diagnosis.

Given the role of health professionals, their training and the position they hold in the therapeutic relationship, the impact this can have on a consumer’s treatment and recovery may be devastating. This short paper provides an overview of the findings from this study.

Mental health stigma research in Australia has primarily focused on the general population rather than the attitudes of professionals providing care to patients and clients with a mental illness. The aim of this study was to identify the scope and nature of stigma experienced by mental health consumers seeking treatment from mental health and other health professionals. This meant looking across the broad spectrum of workers and practitioners offering services to those experiencing mental health issues, not just limited to practitioners specialising in mental health.

This issue was examined from the perspective of both mental health consumers and carers, by asking questions about their experiences of stigma from both health professionals as well as the general population. Because so little research has been done in this area to date, the results of this study provide an Australian context and base for measuring the experiences of stigma for consumers and carers of consumers receiving mental health services.

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When consumers and carers were asked about their most recent visit to a health professional for a physical or mental illness, there were six professional groups reported upon including: GPs, counsellors, psychiatrists, psychologists, social workers and mental health nurses. Respondents were asked a variety of questions in relation to particularly good and/or poor care received by the consumer, as well as whether the care provided varied according to professional grouping and/or whether they were mental health specific. The results showed that there were significant differences between health professions and the level of care provided.

When comparing mental health professions, consumers generally rated mental health professionals higher than carers in terms of providing respect and good care, with both groups rating psychologists highest. Interestingly, consumers rated GPs treating a mental illness and mental health professionals similarly whereas carers rated GPs substantially higher than mental health professionals. Carers also rated GPs the same regardless of whether they were treating a physical or mental illness, whereas consumers rated GPs treating their physical illness slightly higher than GPs treating their mental illness. Further analysis indicated there was no significance difference according to consumer’s diagnosis.

The results were quite different when consumers were asked about any experiences of particularly poor care they had received from a health professional. Consumers most often reported that GPs delivered particularly poor care, with a similar number reported for psychiatrists. The professional groups least likely to provide the consumer with poor care were counsellors, social workers and psychologists. The survey results indicate that consumer and carer views about treatment being provided by health professionals can vary considerably in relation to both positive and negative experiences. These results suggest that there is great variance between most professions and also between individual service providers. Psychologists were the only professional group to receive consistently positive comments, with only very few negative ones.

When considering why certain professional groups tend to receive more positive or negative feedback than others, it should be noted that certain professionals may be more likely to provide treatment to people with certain disorders. For example, psychiatrists may be more likely to be treating the more severe end of the spectrum of disorders such as schizophrenia, borderline personality disorder and bipolar disorder, while psychologists may be more likely to see consumers with less severe disorders such as mood and anxiety disorders. Another possibility is that certain disorders may have certain behaviours or characteristics associated with them that trigger negative responses from the treating professionals.

What this study found is that many people with a mental illness have experienced or observed the person they care for being subjected to stigmatising attitudes and beliefs from both health professionals and the general public. The results suggest that the training of health professionals regarding mental health issues may be lacking. There was also evidence that consumers and carers view different professional groups differently, although it is unknown whether this is related to the mental disorders and the severity of them, or whether there are some inherent issues with particular professional groups.

The findings of this research have identified a number of deficits and scope for further work, including the need for a detailed examination of the individual health professions to establish the structure and content relating to mental health training and any ongoing professional development courses.

Further studies such as this should be repeated to compare results over time, but with the specific inclusion of marginalised groups those with limited education, homeless, Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people. Until this is done, it will be impossible to measure whether the situation is improving or worsening. What is clear is that stigma is a profoundly negative experience for mental health consumers and the impact will seriously interfere with their recovery, particularly when that stigma experience is received from a treating health professional.
Rachelle Irving undertook this study as part of her Master’s thesis but also as part of her previous professional role as Director of Projects and Research and then the Deputy CEO of the Mental Health Council of Australia. The detailed findings of this research can be found in the original publication Consumer and carer experiences of stigma from mental health and other health professionals (MHCA 2011) at the following link: http://www.mhca.org.au/index.php/information-and-publication/159-stigma or by contacting the Mental Health Council of Australia.
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37. Time to stop the rhetoric

Rachelle Irving

This article is not intended to evoke shock in the reader or to again talk about the horror and tragedy that befalls so many remote living Aboriginal Australians. What this article does intend to do is provide the perspective of a service provider regarding the changes needed to enable measurable and meaningful improvements in the social and emotional wellbeing of Aboriginal people in this country.

It may be hard to read and difficult to accept the words contained within but it is time that the issues were laid bare regarding what the true experience is for the majority of remote living Aboriginal peoples living in Australia. Until decisions and policies are based on these harsh realities, nothing will improve and that elusive gap that we hear so much about might close, but this will more likely be due to the eventual extinction of all but a strong and fortunate few.

I wear a few different hats while working in an incredible part of the world, the East Kimberley, Western Australia. In my professional role, I am charged with the responsibility of defining the nature and extent of homelessness in the East Kimberley and coming up with solutions and recommendations, as part of the National Partnership Agreement on Homelessness. To achieve this, my colleague and I sat down on land with a couple of hundred Aboriginal people from around the region from 2012–2013 to ask them about homelessness. It was immediately clear that ‘homelessness’ here is actually concealed through overcrowding, the level of which is incomprehensible. The research revealed that there is an average of seven people living in every house with the majority if not every person we spoke to experiencing a number of issues including social disadvantage, grief, loss and trauma.

Forty-one per cent of people interviewed indicated they do not drink at all. Of the 59% who do drink, many drink more than 40 standard drinks on one or more days per week. The majority of respondents who drink consume at least 8.4 standard drinks per day and often this pattern is repeated several days per week. What isn’t spoken about is that although close to half the population don’t drink, they are deeply negatively impacted by the alcohol consumption due to the violence and other social issues such as humbugging and having to look after children, the sick and elderly.

The median age of respondents was 40 years with 56.5% males and 43.5% females. Sixty-eight per cent of respondents are currently in receipt of some form of unemployment, CDEP, disability or other government benefit. Almost half of the cohort indicated they have health or medical problems with many indicating they have multiple health issues. Almost two-thirds (62%) have prescribed medication although less than half (40.3%) are compliant.

My other role in the East Kimberley is as a volunteer ambulance officer with St John’s Ambulance. Western Australia has only limited paid ambulance and paramedic personnel with the majority of ambulance services throughout WA provided by volunteers. Volunteers receive training which enables them to provide a full ambulance service to communities. In my role as an ambulance officer I regularly treat community members, of which the overwhelming majority are Aboriginal. Many of those who I treat were also participants in my research, or at least relatives of or similar in demographics to them. Alcohol is present in close to 100% of patients that I attend, with the majority of those being intoxicated. It is not unusual to transport patients to the hospital with BAC readings of between four and seven times the legal limit. What is surprising is the level of physical and cognitive functioning patients have when so heavily under the influence of alcohol. This speaks to the level of tolerance that comes from consistent daily intoxication. What I see when I am dispatched to houses to render assistance to people is the reinforcement of the data collected during the Homelessness Project.
Walking into the majority of houses I am confronted with this scene ad infinitum: a three-bedroom basic government owned/leased house with a large number of people present. Yards littered with empty green (VB) cans and a stench that permeates the air, consisting of stale beer and disregarded rubbish and food scraps. Sitting amongst this are family groups often competing to get their words heard among the yelling and general chaos that is taking place. On sight alone, any number of people could be the patient, so it generally requires more information and advice from someone.

Walking into the houses the sight is more sombre, with the patient usually lying on a mattress which is heavily stained with blood and other secretions. There is little to no furniture in these houses, only babies, toddlers and dogs furnish the empty space. As soon as kids are old enough to walk and get away they do. It is safer being on the streets at night than to remain at home in a volatile alcohol fuelled environment where everything is unpredictable. It is little wonder that so few go to school let alone perform – it would be hard to do so when constantly tired from so little sleep or appropriate nutrition.

As an outsider walking into this scene time and again, the feelings of despair, shame and anger at the situation are omnipresent although even that does not adequately describe the level of hopelessness. The pervasive trauma that exists for the majority of Aboriginal people living in the East Kimberley (and likely many other remote Aboriginal communities in Australia) could be viewed as insurmountable, and I think often are.

Where do policy makers start with bringing Aboriginal people back to any level of social and emotional wellbeing or functioning? Spending time inside these communities, it is easy to understand why so many, ranging from the precious young to the invaluable old, reach breaking point and decide that suicide is the only answer. Most likely they don’t want to die, but have given up on finding a solution to such constant unbearable pain.

What I have realised during my time here as a service provider is this community is traumatised beyond the comprehension or recognition of any of the current or shadow governments. What lies as an insidious partner with that trauma is self-medication in the form of alcohol, cannabis, amphetamine and volatile substance misuse. What culminates is a cacophony of medical problems, unemployment, sexual and physical violence, foetal alcohol spectrum disorder etc. until the circuit breaks, usually in the form of someone taking their life, ending up in prison or just surviving until they no longer do.

Unfortunately this is not only a Kimberley problem and likely to be the case in many other remote Aboriginal communities in Australia. Meanwhile the governments of the day, probably with the best of ignorant intentions, are trying to get this same cohort of people into training courses and employment without acknowledging the foundation problems of trauma and substance abuse.

The point of this article is not to bring shame upon anyone, particularly not Aboriginal people. The aim is to bring these issues out of the dark to enable a conversation, and to emphasise that the Aboriginal people who are most-affected need to be central to that conversation. The solutions cannot be pre-empted but certainly it must be recognised that until the issues of trauma and substance abuse are addressed with a long-term bi-partisan (government and government departments) commitment, the so-called gap will never be closed.

Rachelle Irving has worked with extensively with Indigenous peoples in both urban and remote areas in both Queensland and Western Australia. Her studies to date have included a Master of Suicidology, Master of Health Promotion and a Bachelor of Psychology. She has had a diverse career including work as a Detective in the Queensland Police Service, working with Indigenous homeless youth, suicide research, mental health project and research management, to her current roles with Indigenous homelessness and as a volunteer ambulance officer.
38. My journey, My recovery

Personal Consumer Story – “JJ”

I am a 35 year old single male with no children, I suffer from depression, anxiety and a mild case of borderline personality/bipolar disorder.

As a child I was not aware of my condition until what I thought about myself and life became apparent through my behaviour in my early twenties. From a young age I was always the extravert, life of the party and did well academically and was a natural at sport and music, but something was just not right though I managed to mask it brilliantly so that no one suspected a thing.

I’d always thought about suicide from as young as 10, seeing it happen before me at a train station in year 7 really brought it to my attention and always seemed like a “backup plan” if the misery of disappointing everyone got too much. On the 28th of November 2002 at approximately 5pm I drove my car at top speed into a pole with no seatbelt on, I remember that day making the decision to carry this out and feeling a huge sense of relief like the weight of the world lifting off my shoulders and that I would soon be free (dead). I woke up in hospital with a broken neck and many other injuries including a subdural hematoma to my frontal lobe. There were two overdose attempts soon after which both landed me in intensive care and very ill. There was no follow up from the Princess Alexandra Hospital following the car incident.

I managed to avoid the public psychiatric wards of the Royal Brisbane and Princess Alexandra Hospitals which frightened me, it looked like prison and many of the patients or staff there did not look friendly to me. I ended up in Bellmont Private Hospital where my insight and treatment to my condition began.

At Bellmont I had sessions with 2 psychiatrists that worked together, it seemed their objective was to find out about my childhood which they believed was where my condition stemmed from. Within a day of being admitted I was prescribed with the drugs Cypramil, Nuelactil, Largactil and Xanax all in heavy doses. I felt like so numb like a walking zombie I could hardly think or talk. I became addicted to the Xanax I remember when I left this hospital I felt like if I left the house without them I would have to go back and get them because at the hint of feeling anxious I would just pop a few Xanax. None of this helped my depression, I felt alone and the way some of my family behaved made me feel like I was intellectually impaired, my friends were supportive and all I noticed was a bit of space from them socially but they always wanted to know how I was doing. My mother was my saviour and was the only person I felt I could talk to.

All I took from Bellmont when I discharged was the medicine prescribed to me and I learnt to journal, I found writing down my feelings and thoughts worked for me better than anything so far. I researched cognitive reasoning and function and found learning about how the brain works and reacts was more helpful than medicine too.

My condition got worse, I still thought of death as an easy way out and I felt very much alone and like I would never function again in the workplace or society. I began to drink a lot to numb the pain and escape my thoughts, I would binge drink until unconscious and this after fighting depression would then be my next challenge in life.

My parents had me institutionalised at a facility for people with acquired brain injuries and the disabled. This facility was clearly not for me, I immediately started helping out around the place and within a month of being there I was employed as a carer, I got a blue card and took up a certificate 3 in disability care whilst working there. I’d found an apartment down the road from the facility to rent and became independent, I found working with the disabled made me appreciate what ability I have, that the people I cared for had it so much harder than me but were happy in life and with what they had. This changed my mindset more than any drug or psychiatrist could attempt to. I then went cold turkey off the medicine prescribed from Bellmont which was hard but I got through it. After a year of working in the disability centre I moved back home and got back into real estate which was where I left with the car incident. I
became in contact with a psychologist that a family friend saw for anger management treatment. I saw the psychologist for once a week over 4 years, he immediately had me see a neurologist about my head knock from the car incident because the Princess Alexandra Hospital did not follow up and after tests found that I had a mild case of epilepsy which was treated with 400mg of Tegratol twice a day. I found through phycology I learnt to understand myself and why I react the way I do to certain emotions, I’d developed a better understanding of who I am and through this insight I began to love myself and care for myself better. I developed coping strategies that help me deal with thoughts of nonsense and negativity, a spam filter for my thoughts if you like and my depression was put to rest.

At the end of my treatment with the psychologist and having recovered from my depression all I had to deal with now was an impulsive behavioural problem and drinking problem. With managing a busy real estate office I used to treat my stress’s and celebrate my achievements with drinking, I tried to conquer this like I did depression but found it very hard to resist temptation. A lovely old lady that lives in my building put me on to a local GP that helped her daughter deal with an addiction to Xanax, this GP specialises in addictions and pain relief. Since seeing him I’ve gained more insight into how my brain reacts to feelings of success and achievement and how now rather than the low emotions in life being a danger to me that now the highs in my life are more of a danger in that my brain reacts with impulsive behaviour i.e. excessive spending, drinking, sexual behaviour, eating.

Since finding this GP I’ve halved the dose of Tegratol and the only other medication I take is Seroquel, I take 100mg to 200mg at night with the Tegratol and it helps me relax and get to sleep, I’m able to adjust how much I feel I need to take as I’ve learnt how I feel when I’m on a high and possibly unstable. I find Seroquel stabilises my moods and helps with that impulsive behaviour. I am now very physically active with training 5 days a week, surfing and I’m back to playing guitar, my concentration levels last much longer and I can get through more work, my thoughts are clear and I am genuinely happy in life and have love for myself.
39. Pay attention! (to the customers)

Jan Kealton

Mental health reform has come a long way since the David Richmond and Burdekin reports 30 and 20 years ago respectively, hasn’t it?

We’ve all heard stories about the service inadequacies and shockingly inhumane experiences of many people during the periods under investigation. My own experiences, from the middle 1990’s until 2005, as a carer for my precious son who had developed schizophrenia as a nineteen-year old, was largely one of exclusion. We can’t share any information with you, I was told. This is his business, not yours, they said. And, weekly, But he didn’t give us permission to tell you. Not that anyone had asked him…

I tried hard to engage with the journey of reform, to be part of the solution. I believed – and still do – that families need to understand what is happening for their loved ones; to be educated about the nature of the illness and the options for treatment; to learn coping strategies and effective ways to provide appropriate support; and, most importantly of all, to learn that, although every journey is different, recovery is always possible and we should never, ever give up hope.

My first formal experience was as a member on the Queensland Consumer Advisory Group (QCAG) from 1999-2003. Consumer and carer participation was in its infancy then, but it seemed the Queensland Government of the day was trying to do the right thing, albeit without increasing mental health funding.

QCAG gave me some unique insights and enormous respect for the consumer representatives in the group; for their experiences; for their courage; and, especially, for their wisdom. I learned to value and appreciate their perspectives, and to realise that we ignore the consumer voice at our peril.

If we do not listen to the consumers for whom we care – and by we, I mean doctors, nurses, case managers and everyone involved in service provision, as well as carers – we will inadvertently hinder their recovery.

We don’t always listen. We’re busy; we believe we know what needs to happen. Sometimes we find it difficult to start a challenging conversation. Perhaps we’re stressed; or in a hurry; we don’t explain that they have choices; we don’t think about their feelings. Carers who feel dismissed and unsupported may be among the worst offenders, but are, by no means, the only ones.

From 2006, I gradually became more involved in speaking out as a carer representative, at a time when consumers and carers in Queensland began to be valued for their perspectives.

At first, it was daunting. But it soon became clear that many clinicians in decision-making roles were listening. We rattled many cages; sometimes we were considered to have gone too far. Sometimes we probably did.

As local services began to embrace the concept of consumer and carer participation, the feeling grew that we were on the right track. It seemed that many carers and consumers started believing they had a voice, which was valued.

In recent times I have heard many more stories of hope from long-term carers and from new carers, as well as stories of crises; of just-in-time and skin-of-the-teeth interventions; and of frustrations with the system. It seems that the contemporary experiences of care remain patchy.

For example, recently I heard of a case where, at the request of his grandmother, police attended a young man who was in crisis. Clearly, the officers were unskilled but, by some miracle, a tragedy was avoided. Our carer group requested a meeting with the local mental health service and additional strategies have since been implemented. Two weeks later, I was asked to do something, please help her, by the friend of a young woman who was becoming extremely unwell. When called, their local mental health service responded promptly, efficiently and sympathetically.
Yet we continue to hear other stories of pleas for help going unheeded. While technically the service may be unable to respond to specific concerns, carers are making these calls because they feel unable to cope and are terrified that something will go dreadfully wrong for the person they love. Sometimes things do go wrong. Is there really no better way to manage this situation?

In April 2013, it appears that carers are not as confident about mental health reform as we were. Perhaps we’re cynical; perhaps it is inevitable that any hiccup in the reform process will cause carers in general to assume that we’re going back to the bad old days. Or perhaps we’re simply unaware of the Grand Plan because we’re neither part of the process nor is the message reaching us.

We know that change is necessary. While there were improvements in recent years, the old-fashioned top-down system of either hospitalisation or nothing, wasn’t working. Many carers reinforce my desire for more resources in the community; the opportunity to be part of the reform process; to do our bit.

We’ve seen the establishment of the National Mental Health Commission as well as Commissions in WA and NSW. The legislation for the Queensland Mental Health Commission has been passed. We’ve also seen the introduction of 17 Health and Hospital Services in Queensland and 11 Medicare Locals. These new initiatives are good, aren’t they?

Yet a few days ago I was asked: What happens to my consumer if we have to move to a different area because of Harry’s work? I’m told that the services Johnny needs aren’t as good in XYZ area, so what do we do then?

Who are the real leaders of our new mental health world in Queensland, in Australia? How can we ensure easy access and consistency of service for all?

Given the State/Commonwealth divide and the territorial imperative of the States and Territories, we’ve all seen that a marvellous model developed in one State is not necessarily considered for adoption in another State, even with a truck-load of supporting evidence. Why not?

We’re still reliant on individual Champions for advancements in mental health reform, aren’t we? And, given the propensity of new personnel to want to make their own mark, it seems that we often lose the reforms they progressed once they move on.

Who will advocate for consumers and carers? Funding for the Queensland Voice for Mental Health, the peak advocacy body for consumers and carers, ended in June 2012. We recognise that we can’t expect advocacy from any NGO which receives government funding. They wouldn’t want to take the risk, would they? Who else might advocate on our behalf?

There are some practical and political realities here, which may be fanning the fears of consumers and their carers.

Am I hopeful for the future? Undoubtedly, 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 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 The MHS Carer Day.
40. Improvement since Burdekin? Yes, but …

Jayashri Kulkarni

I am writing to express my views in particular about the many issues that still require improvement in the mental health systems in Australia.

Yes – there has been improvement since the Burdekin review, but there are still many areas of concern.

1) Inpatient Psychiatry Units: Many are still unsafe places with little privacy. In particular, women still experience assaults, and it is very important to have women only areas on the inpatient units.

2) Poor research into the treatment of mental disorders. We can continue to try to discuss recovery, rehab issues but until the basic treatments that are available are improved, the recovery work is extremely difficult. Governments need to invest in clinical research with a view to developing new treatments now!

3) Youth mental health is important – but it is also important to fund other ages too.

4) The system is far too fragmented still, with confusing entry points.

5) Carer mental health and support needs to be increased.

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.

Jayashri Kulkarni completed her MBBS degree in 1981 at Monash University and worked mainly in Emergency Medicine before deciding to specialise in Psychiatry. 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.
Obsessive Hope Disorder
41. I’d like some good service please

Mary Lawson

The harms, failures and lack of eating disorder services in Australia: My experiences since 1988

My name is Mary. I am 39 years old and have suffered mental illness, and the consequences of Australia’s inadequate mental health system, for 25 years. Despite the release of 4 mental health plans in Australia since I became unwell, I have not experienced any benefits at a patient level. Outcomes for eating disorders have not improved over the past 25 years, which is hardly surprising considering treatment options have barely changed. In QLD, quality community-based services for sufferers of chronic eating disorders remain non-existent. There remains only 5 public and 10 private hospital beds allocated, within 2 highly ineffective programs, to an approximate 423,000 Queenslanders suffering from eating disorders. Other states and territories are in a similar predicament.

The best way to describe my personal journey is like being lost and alone on a mountain trudging through a blizzard; cold, tired, helpless, and overwhelmingly hopeless.

In February of 1988, when I was 13 years old, I was diagnosed with anorexia nervosa. This followed 6 months of desperation on my parents’ behalf, watching their daughter starve herself to the point of severe emaciation, and seeking help from a variety of specialists who had no concrete advice. Finally my parents took me to a child psychiatrist, who at first glance of my malnourished body immediately admitted me to the Child and Family Therapy Unit (CFTU) at the Royal Children’s Hospital, Brisbane. Here I was subjected to a very harsh and punitive treatment program that was not only unethical, but a violation of many of my rights; as a patient, as a child, and as a human being.

Moreover, it disregarded the medical oath to “First Do No Harm”. It included being placed on “total bedrest” for weeks at a time if I did not make my weight on “weigh day”. This meant being isolated, in (with the exception of a bed) a completely empty room, with nothing to do except stare at the ceiling and walls 24 hours a day. It meant sensory deprivation; no contact with the other children in the unit; no attending the hospital school; and no visits from my siblings. I was allowed only one visit from my parents per week, for 15 minutes – time I would spend begging, sobbing, and pleading for them to take me home. I began to pull my hair out in clumps and huddle in the foetal position while locked in that room. I was forced to use toilet pans and be sponge bathed by nurses which, for a 13-year old girl going through puberty, was humiliating to say the least. I was provided with meal trays, with no choice of food, and had to eat alone. And all of this was supposed to “encourage” (or coerce) me to eat and gain weight. At no time during this merciless treatment was my history of childhood sexual abuse ever considered, investigated, or addressed.

Needless to say, this treatment was harrowing, and severely detrimental to both my physical and emotional wellbeing, and further damaging to my already fragile and depleted self-esteem. Documented in my chart (obtained in 2009 though the FOI Act) is the fact that I continued to verbalise a desire to shoot myself in the head. I had never expressed any suicidal ideations prior to my treatment at the CFTU. The very place in which I was supposed to get help to overcome my illness only served to exacerbate and compound it. Yet, against my will, and with more compassionate alternative treatments available, it continued for 5 years. In the 21 years since it ended it has not only played a significant role in exacerbating the anorexia, but also in the development of bulimia, chronic depression, severe anxiety, and post-traumatic stress disorder; and my inability to recover from each of these.

In 1992, 2 months after my 18th birthday, I apprehensively sought help for the first time as an adult. I was admitted to New Farm Clinic where it was extremely difficult for me to trust people to treat me compassionately and appropriately. The traumatic memories of the CFTU caused me to resist other treatments for many years, therefore prolonging my illness. Consequently, for the past 21 years I have required and continued intensive psychiatric treatment. Therapy has involved attempting to resolve the
trauma, sadness, anger and pain not only from the sexual abuse and issues that initially triggered the anorexia, but also from the treatment I received in the CFTU. Through working on these issues I have experienced long-term, intense suicidal ideations; have required numerous hospital admissions; have almost died from malnutrition on at least 4 separate occasions; have required very high-dose antidepressant medication; and have been unable to become an independent and “normal” functioning adult. While most women my age went through an “ordinary” adolescence, I spent most of mine in and out of hospital; enduring this inhumane treatment. While most women my age grew up, travelled, pursued careers, fell in love, got married, bought houses, and had babies, my illness prevented all of life’s usual joys and achievements.

One thing I wish to highlight is that my suicidal tendencies have never reflected a desire to actually be dead. As I’m sure other people experiencing chronic and severe mental illness will relate, contemplating suicide has always been about a desperate desire to end the torture of the harrowing flashbacks, and the grief and sadness of all I have missed out on in life; including the “me” I could have been had I not experienced such trauma. At times it has also been the result of knowing I have tried all available treatment options, several times over without success, thus feeling there was no hope left. The health care system that had failed me as a child, subsequently offered me no adequate care to help me deal with and heal from the consequences as I transitioned into adulthood. While treatment for children and adolescents with eating disorders has improved (to a degree) since my treatment in the late 1980s and early 1990s, this was too late for me. After more than 20 years of treatment as an adult I began to believe I was a failure; and that all was hopeless because I was too damaged to be helped. However, I began to observe as other women also bounced in and out of hospital, following in my footsteps, with no positive long-term outcomes, and realised that it was the system, not me, that was failing. Available treatment options and the inefficiencies of the system for adults suffering from eating disorders are, quite frankly, pitiful; especially considering anorexia has the highest mortality rate of all mental illness.

Rather than channelling my anger and hopelessness into self-destruction, as I would have in the past, I now intend to use it to ensure others do not have to suffer the blizzard that I have. In 2006 I returned to university. Now, having recently completed two degrees, I am determined to use my adversity, and the struggle to find adequate help, to be instrumental in changing the system for those afflicted by mental illness; beginning with those battling eating disorders. This determination has helped me to heal myself.

Having spent 6 years studying health care, and the past 8 years designing and developing a new treatment option for women with eating disorders, my battle now is to obtain funding to be able to bring my vision into fruition. While nothing can undo the past, this would go a long way towards helping me feel that the injustices done, and all my anguish, have not been in vain. What frustrates me now is that on both a state and federal level, governments squander funds on red tape, self-interest, parliamentarian pay rises, and relatively trivial issues, while they incessantly claim to have no money to fund the reform of a desperately abysmal and failing mental health system; not to mention its inefficiencies that are a devastating waste in themselves. The fact that over 90% of suicides are committed by people with a diagnosed mental illness speaks volumes; not only about the unbearable plight, but about the lack of adequate, high quality, accessible and effective services available to those suffering. Yet again Labor has backed down on its pledge to “make mental health a priority”. This pattern of big promises with little delivery is one we have swallowed from successive governments – both state and federal – time and time again. When will they wake up to the extent of social, economic and personal costs of their discard? Commiserate the approximate 4.5 million (1 in 5) Australians who suffer every year.

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).
42. Red House model
Mary Lawson

RED HOUSE is a not-for-profit organisation, whose primary goal is to provide a community-based, residential and day clinic for women suffering from chronic eating disorders; the likes of which does not currently exist anywhere in Australia and is sorely needed. RED HOUSE exemplifies the type of community-based service that was supposed to replace institutionalised care four decades ago – a promise that has never been delivered.

RED HOUSE is an acronym for Recovery from Eating Disorders – Hope, Optimism, Understanding, Support, & Empowerment. This acronym underpins its compassionate approach and evidence-based, recovery-oriented framework. This will be based on the outcomes and final report of the National Recovery-Oriented Mental Health Practice Framework Project80. RED HOUSE will comply with the relevant national standards set out as a part of the Fourth National Mental Health Plan, including the National standards for mental health services81 and the Implementation guidelines for non-government community services82. On a state level RED HOUSE is in alignment with the goals set out in the Queensland Plan for Mental Health 2007-201783(particularly priority 3), and the Supporting Recovery: Mental Health Community Services Plan 2011-201784.

Patients will undertake individually tailored programs within the overall RED HOUSE program. This includes a comprehensive evaluation plan, and a relapse-prevention strategy based on the Pathways of Recovery 4As Framework for Preventing Further Episodes of Mental Illness85. The house has been specifically (purpose) designed to provide a supportive environment that is conducive to recovery, and a more appropriate, specialised, efficacious alternative to hospital for those who do not, or no longer require acute medical intervention.

Until the mid-1990s, the majority of eating disorder treatments completely disregarded the 4 basic principles of biomedical ethics; being respect for autonomy, beneficence, non-maleficence, and justice86. In many cases, the oath to “First Do No Harm” was severely and ruthlessly breached. Current services for people with eating disorders in Queensland do not meet the terms of any of the 5 core health planning principles of quality, accessibility, efficiency, effectiveness, and equity, as outlined by

Eagar, Garrett and Lin (2001)\(^8\). As demonstrated in the full proposal, RED HOUSE was conceived out of these realisations, and has carefully and very deliberately paid special attention to these moral, ethical, and planning principles.

While there has never been a residential option, a number of eating disorder day-clinic houses have been set up in Australia in the past, only to fold a few years later. This has been due to poor foundational planning and implementation, and/or funding models that were not sustainable. The planning of RED HOUSE has been a meticulous, 8 year process, developed from the perspective of someone with a 20+ year history as a consumer in the (mental health/eating disorder) health system, who is now a public health and mental health professional. It has had input by current consumers of eating disorder services and their carers; as well as psychiatrists and psychologists, experts from the not-for-profit sector, and business and financial advisors. It demonstrates careful consideration and mitigation of a number of risks, and adds the imperative issue of sustainability to the 5 core health planning principles mentioned above.

**Partnerships and collaboration with existing services**

Through partnerships with both corporations and Government, RED HOUSE will not only possess sustainability, but also the means for diffusion of innovation. Dependence on funding from a single source, or from a limited number of sources engenders vulnerability, un-sustainability, and no means for growth. For this reason RED HOUSE will obtain its funding in smaller amounts from a variety of sources.

RED HOUSE will collaborate with other sectors, including housing, and education and employment. Recovery and relapse-prevention programs will incorporate encouragement of vocational pursuit, and assistance for the patient to find housing conducive to maintaining their wellbeing upon discharge. This will involve partnerships with The Department of Education, Training and Employment, and The Department of Housing.

Additionally, RED HOUSE will complement existing eating disorder services, at both state and national levels, with the intention of ensuring no gaps in service delivery through which patients may fall. RED HOUSE will collaborate with the Butterfly Foundation and contribute to the research conducted by the National Eating Disorders Collaboration. Figure 1 provides a visual overview of how the co-ordinated and collaborative, multidisciplinary, step-up/step-down treatment alliance would operate in QLD, where the 3-year pilot period of the program will be carried out. It is followed by a more detailed explanation of the gaps in service delivery that RED HOUSE will fill. Once successfully established in QLD the vision is for RED HOUSE to expand its operation to other Australian jurisdictions, using a similar (state-by-state adapted) model to that illustrated in Figure 1.

**Current issues addressed**

- The increasing rate of women suffering from eating disorders (doubled in the past decade);
- A number of state and national needs assessments indicate that residential treatment for eating disorders is both needed and wanted by consumers;
- The lengthy hospital stays (up to 24 weeks per admission, intermittently for up to 25 years for chronic sufferers) generally experienced by people with chronic eating disorders;
- The cost of treatment for an episode of anorexia nervosa has been reported to come second only to the cost of cardiac artery bypass surgery in the private hospital sector in Australia;
- The number of eating disorder sufferers hospitalised in any given year is a fraction of the number being treated, and the number of those being treated is a fraction of the number who actually have an eating disorder. Many are not receiving the help they desperately need, and deserve due to inaccessibility;

• The high mortality rate experienced by people with anorexia nervosa (YLL's; 1 in 5 of which are suicides) in comparison to all other mental disorders;
• The exceptionally high YLD's and exceptionally poor quality of life experienced by people with chronic eating disorders;
• The high mental and physical co-morbidity experienced by those with eating disorders, including depression, anxiety, self-harm, and potentially fatal medical complications,
• The social impairment, isolation, and inability to function in the workforce experienced by those with severe eating disorders;
• RED HOUSE will lead to a reduction in Burden of Disease caused by eating disorders;
• RED HOUSE will lead to a reduction in hospital admissions and length-of-stays for people with eating disorders;
• RED HOUSE will lead to a reduction in suicides, and death from physical complications, of people with chronic eating disorders;
• RED HOUSE will lead to reduced isolation, increased socialisation and measurable improvements in disordered eating behaviours for people with chronic eating disorders;
• RED HOUSE will lead to significantly improved quality of life for people with chronic eating disorders.
• Data collected through evaluation of RED HOUSE programs will be relayed to the NEDC, contributing to the national research database of evidence-based practice for eating disorders.

Implications of Red House not being implemented

• Outcomes for eating disorder treatment will remain poor and unchanged, as they have for the past 30 years;
• Women with chronic eating disorders will continue to suffer prolonged poor quality of life due to a lack of appropriate, adequate, and effective care;
• Current services for eating disorders will continue to be overwhelmed by a level of need that they are unable to meet;
• The specific, identified gap in services that RED HOUSE is designed to fill will remain;
• Many women with eating disorders will continue to be admitted unnecessarily to hospital;
• Hospital stays for women with eating disorders will continue to be unnecessarily lengthy and exceptionally costly;
• The rate of post-hospital relapse for eating disorders will continue to be extremely high;
• The already astronomical BOD caused by chronic eating disorders will continue to rise;
• Quality, equity, accessibility, efficiency and effectiveness of care for people with eating disorders in Australia will remain poor.

Summary

As a new treatment option for adults with eating disorders, RED HOUSE will improve the efficiency, effectiveness, accessibility and equity of current service provision. It will provide a high quality alternative that will reduce the burden on hospitals, freeing up the precious few beds allocated to eating disorder patients for those who actually require acute medical intervention. Also, as a recovery-oriented service with an emphasis on relapse-prevention, RED HOUSE will assist individual patients in attaining recovery (as personally defined), and maintaining it long term, breaking the “revolving-door” cycle and thus, eliminating recurrent and perpetual costs. Most importantly, in the longer term this will reverse the currently growing prevalence and mortality rates for eating disorders.
Obsessive Hope Disorder

Figure 1. A Coordinated and Collaborative Continuum-of-Care Approach:
Step-up/Step-down Treatment Model for Adults with Chronic Eating Disorders in Queensland
To expand on figure 1, and detail RED HOUSE’s proposed role as a part of the Eating Disorders Network, the house is designed to act as a utility for:

1. Secondary care (referred from EDOS, GP or psychiatrist) – Patients with long-standing eating disorders can be referred to RED HOUSE by a GP or psychiatrist any time they recognise that they are struggling in their usual home environment and require extra support. This will aid in the prevention of health deterioration to the point where hospitalisation is necessary. Patients who present with a BMI* of 16 or below will be referred back to the RBWH eating disorder unit (or catchment public hospital) or New Farm Clinic (for private patients) for e-feeding under the care of a psychiatrist until they are deemed physically stable enough by a medical professional to return to RED HOUSE. If a patient’s BMI drops below 15.5, or if serious medical complications arise (or self-harm occurs) while residing at RED HOUSE, they will be transferred to hospital for re-feeding and/or medical attention (or psychiatric care in the event of self-harming** behaviours) until they are deemed stable by a medical and/or psychiatric professional.

*While BMI is not necessarily an accurate measurement for determining the health of children and adolescents, it is an appropriate general measure for adults.**

**While eating disorders are intrinsically harmful to the self, “self-harming” in this context refers to cutting and other self-inflicted injury.

2. Post-tertiary/transitional care – For those who do require hospitalization for medical or high risk psychiatric reasons, RED HOUSE will act as transitional care upon leaving hospital, before they return to their usual home environment. This will enable significantly shorter hospital stays. As the RANZCP CPG team for AN advises, patients who return home before returning to a healthy weight have a higher rate of re-lapse than those who reach a healthy weight prior to returning home. Rather than remaining in hospital for the full duration of weight gain, RED HOUSE will enable patients to transition into a supportive community environment once physically stable. RED HOUSE will act as a professional and therapeutic environment conducive to continuing the weight gain process and/or normalising eating behaviours before returning home. Since full weight restoration can take around 12 weeks (or more in some cases) this will reduce the length of hospital stays significantly; and prevent relapse. Moreover, in their Practice Recommendations for the Nutritional Management of Anorexia Nervosa in Adults, Wakefield and Williams of the Dieticians Association Australia place emphasis on normalising eating behaviours and attitudes. The RED HOUSE program will involve patients in shopping for, cooking and preparation of evening meals, and ALL meals will be eaten in a social setting. This is in contrast to hospital environments where weight gain is the major focus (as opposed to normalising eating behaviours) and patients usually order from a menu and often eat meals alone from trays at their bedside. Historically, such hospital programs have failed in terms of long term sustainability, since patients are sent home to an environment where meals are not prepared for them, social eating behaviours have not been restored, and they return to their disordered eating behaviours or starvation; thus, relapsing. Shopping for, and preparation of food is especially important for adult patients as they will need to continue this upon their return home. The aim is to encourage food to become a ‘friend’ to be enjoyed rather than an ‘enemy’ to be feared.

3. Post-program non-residential day clinic – Once a patient reaches the ‘maintenance stage’ of her individual program she will cease residential treatment and step down to the day program. The day program may also be utilised by patients who have been referred to the residential program at a time when it is at full capacity. In this situation the patient will be placed on the waiting list and attend the 5 day/week day clinic until a residential place becomes available. There are 3 levels of attendance for the day program – 5 days per week, 3 days per week, and 1 day per week. The 5 days per week program

will be reserved only for patients on the waiting list for the residential program (i.e. stepping up; requiring intensive meal/behavioural therapy). The three day and one day programs are designed for patients stepping down from residential care. Upon exiting residential care the patient will attend the 3 day program for a maximum of 6 weeks, then step down to the one day program for a maximum of 6 weeks. The 5 day program will run from 7am to 7pm and include breakfast, lunch, snacks and dinner, until a residential placement becomes available. The 3 day program will run from 9am to 7pm (including lunch, snacks and dinner) and 1 day program will run from 9am to 5pm (including lunch and snacks only). At this point patients in the 3 day and 1 day programs should also be accessing services by the Eating Disorders Association (EDA) and/or ISIS, as well as their individual psychiatrist or psychologist and GP in preparation for exiting RED HOUSE programs, and as a part of longer term maintenance and relapse prevention. Ultimately, the goal is that once these women exit care at RED HOUSE they will be ready to become, and remain as, functioning and participatory members of their families, communities, and/or workforce. This will reduce their status as an isolated population which has remained largely dependent on welfare for decades.

4. Respite for families and carers – RED HOUSE acknowledges that in addition to the support needed by those struggling with eating disorders; their families and carers also have needs. Eating disorders have far-reaching effects on others, and families and carers experience a particularly tremendous burden. The need for respite outside of the home is perhaps most relevant to families of child and adolescent patients who are being treated in the home; for example, through the Maudsley approach. Since RED HOUSE will cater for women over the age of 18, the need for family and carer respite outside of the home will not be as great. Many of these patients will no longer be living with their parents and siblings, although, due to the often regressive nature of the illness and the inability of many to gain and/or maintain employment, adult women with eating disorders often do live with, or rely heavily on their parents, or a partner who inadvertently becomes a carer. While RED HOUSE does not include a specific respite program for families and carers it is important to recognise that by providing the patient with residential treatment, families, partners and carers will experience respite without having to leave their own home. This is just one of many benefits in offering a residential service to patients as opposed to just a day clinic.

While RED HOUSE certainly cares about the plight of families and carers, no single service can cater for all needs. This is why collaboration with other organisations is imperative. In addition to the respite that RED HOUSE will offer, families and carers who require further assistance in the form of group support, education, and/or counselling will be referred to the EDA where services for families and carers are already available. With a growing acknowledgement of the burden on carers, both state and federal governments now also provide and/or fund various services designed to help ease this.

For a copy of the RED HOUSE Plan – including needs analysis, budget and cost-benefit analysis, evaluation plan, and board and company structure – please contact Mary at redhouseaustralia@gmail.com.

43. Mental health from 70 years of living

Consumer “M”

(Name withheld)

I often find it difficult to understand my feelings, physical or mental, and to put them into some kind of context. How do I know what the general feeling of unsettlement, of discomfort comes from: too much chocolate and alcohol, or having been left in several institutions when I was three to five years old?

Sometimes I make a protective covering over the wounds I receive and they simmer quietly below the scab – then something tears it or the simmering explodes and I am dealing with a volcano of chaotic, incomprehensible images, feelings and I feel I can’t cope – I am frightened of losing control and don’t know where to turn.

There is one advantage I can gain from these unsettling times – by experiencing these feelings myself they can sometimes allow me a glimpse of the pain and chaotic feelings felt by others and to offer, tentatively, some empathy and support. Sometimes my own pain can be triggered by the pain of another. Somehow this is not as negative as it sounds – experience has shown me that in fact it is as though I am allowing myself to feel some of the other’s pain and so be willing to share it and hopefully also lessen it.

Since getting into my fifties I have been getting strong uprisings of emotion when thinking of, hearing of or seeing other people’s pain, or serious injustice. It is embarrassing and drains my energy greatly but sometimes other people feel their own pain is validated in some way. I also have come to realise that these incidents are also beginning to drain my own reservoir of pain.

For me personally, these moments come mainly from things to do with the Second World War, where three of my uncles died in camps or were killed, my father fought, my parents divorced, and my mother took me, the youngest, and left behind my sister and brother with my father. An ongoing saga of a stolen child, siblings separated, father grieving, and a decision to transform a little French girl into a little English girl, with a step-father (a good man) two little sisters and no French relations.

This cultural change – which meant that my French sister and brother cannot relate to me comfortably, nor forgive me for having been chosen by my mother, helps me to empathise in a particular way with my Aboriginal friends. On Sorry Day when they mourn the disruptions and traumas inflicted on their families for several generations I can share some of the feelings of those people coming back to the their families, and those who searched for their lost relations. We can all share both the universal pain of disrupted families worldwide and the particular pain of the people present and their own circumstances.

I have focused on pain because I believe that the existence of painful wounds and the fear of more greatly influence our lives, particularly our subconscious lives. I have found the ability to allow myself to feel pain, particularly in empathy with the pain of others, to be very helpful for me, and they tell me, to others. So this essay seemed like an opportunity to share these thoughts and feelings more generally.

I would like to acknowledge the help I have received in the past twenty years from some members of the counselling profession and also from my family. Also the Alternatives to Violence Project, for which I have been a volunteer facilitator for 15 years is a great process through which we learn to understand ourselves and others and to recognise the good in others and in ourselves. I have developed some wonderful friendships and some real insights into the importance of identity and culture while working with Aboriginal and Torres Strait Islander people for justice, rights and reconciliation which have greatly helped me on my life journey.

These comments may make sense to you and be helpful – I hope so. If they sound weird or don’t make sense, just ignore them – we all see through such very different windows and cannot always understand each other.
Obsessive Hope Disorder
44. The journey of mental health caring

Dee McGrath and Doris Kordes

The role of families in a person’s recovery has changed dramatically over the last thirty years. Whereas family involvement was once seen as contributing to a person’s mental illness, today the role of family and support people in promoting mental health and wellbeing is positively acknowledged – recognising the wider interplay of biological, psychological and sociological factors upon a person’s mental health. We know that the role of families, carers and support people has been demonstrated as important in helping the person they support to recover.

National Mental Health Commission

2013 marks the thirtieth anniversary of the release of the Report of the NSW Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (the Richmond Report) and the twentieth anniversary of the Report of the National Inquiry into the Human Rights of People with Mental Illness (the Burdekin Report). The Richmond Report provided a blueprint for deinstitutionalisation and the dismantling of the NSW psychiatric hospital system. Asylums were emptied, with many patients transported to next of kin who were largely unprepared and ill-equipped for the responsibilities of the caring role. Ten years on, as outlined in submissions before the Burdekin Inquiry, carers were still struggling with the emotional, financial, and physical impacts of the caring role; the lack of carer supports, including information, education, respite and counselling; and the attitudes of mental health professionals.

As noted by the National Mental Health Commission above, carer recognition and supports have substantially improved over the last thirty years. In 2010, the Commonwealth Government passed the Carer Recognition Bill. Schedule 1 of the Carer Recognition Act recognises the valuable social and economic contributions made by carers, and states that, based on their unique knowledge and experience, carers should be regarded as partners in the care team. The ACT Carers Charter similarly recognises the contributions made by carers ‘to the economic and social welfare of our community’. The National Standards for Mental Health Services 2010 articulate the role of carers as partners in the delivery of care. More recently, the Australian Government has developed the National Carer Strategy, and the Roadmap for National Mental Health Reform 2012-2022, endorsed by Council of Australian Governments (COAG) in December 2012, affirms carers at the heart of a person-centred approach, as partners in care.

The mental health carer movement, which may be traced to 1975 with the establishment of the Association of Relatives and Friends of the Mentally Ill (ARAFMI), continues to play a significant role in carer recognition and rights. Government recognition of carers has also involved funding of carer services, in particular, carer associations in all jurisdictions, and their national peak body, Carers Australia (1993).

In the Australian Capital Territory, 2013 marks the twenty-first anniversary of the establishment of Carers ACT, which currently provides direct support to nearly 8,000 families through counselling, information, respite, education, social supports and case coordination services.
Carers, it seems, have much to celebrate in terms of their recognition as a valuable member of the care delivery team enshrined in national and local policy frameworks, and symbolised through Commonwealth Government funded carer pensions and allowances. Or do they?

There is no doubt the recommendations of the Richmond and Burdekin inquiries heralded new ways for responding to mental illness and its impact on families and carers. In the midst of major social policy reform agendas such as, for example, the National Disability Insurance Scheme (NDIS), it is timely to reflect on our progress. But it is also timely to remind ourselves that with the best intentions today's policy solutions may quickly become tomorrow's policy problems. For 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.

The responsibility of caring for someone with a mental illness often comes at great personal financial, physical and emotional health costs. Mental health carers expend on average 104 hours per week caring. This limits carers' capacities to participate in the workforce. 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.

In addition to the personal costs of caring, carers continue to be frustrated in their interactions with mental health services. The National Mental Health Commission observes that a significant percentage of support people (across a range from 20 per cent to 60 per cent) consider that they were rarely or never made to feel part of the caring team (2012:36). The reluctance of some health professionals to involve carers may be related to the norms governing the traditional doctor-patient relationship; and to a risk-averse and simplistic application of privacy and confidentiality legislative guidelines. This occurs in situations where an inflexible focus to protection of privacy means that carers are excluded from treatment planning, discharge and transfer information, but are still expected to manage the day-to-day care when the person returns to the home environment or the care situation. At the launch of the Mental Health Council of Australia publication, Recognition and Respect: Mental Health Carers Report 2012, the Minister for Mental Health, The Hon Mark Butler MP, indicated that in many ways mental health caring responsibilities are quite unique because of the episodic nature of mental illness, and the role carers and families play in the relationship of client and clinician is unlike any other relationship in health. Carers aren't a comfortable fit with the traditional clinician and client relationship. While Carers ACT agrees that the rights of all individuals to privacy and agency is a fundamental human right, principles can sometimes lead to poor outcomes for carers and the people they care for.

Compounding this issue is carers' lack of confidence in the capacity of the current mental health services to provide adequate care for people living with mental illness. In Carers ACT 2012 annual client survey, fears about the future was a consistent theme for carers, with the types of fear focused very much on what lies ahead for the person for whom they care. This fear revolved around the continued paucity of service options to meet the needs of people with mental illness. Carers noted that they will not always be around or well enough to provide the care which they currently do; as noted by one carer: 'What will happen when I get sick or too old and can't look after my daughter?'

A fear about a future where the carer is physically unable to maintain their caring role was also the key reason underpinning carers' concerns about the lack of appropriate supported accommodation services. In 2012, Carers ACT hosted a Summit on this issue. Carers stressed the need for options appropriate to need and preference. Carers for people with a mental illness emphasised the need for supported accommodation options adapted to the particular requirements of the person being cared for.
Carers ACT is encouraged to note that the importance of housing, including supported accommodation, as well as education and employment opportunities are key principles of the new Roadmap for Mental Health Reform. The Roadmap will play an influential role in shaping policy directions of mental health care across Australian jurisdictions over the next ten years. Carers ACT looks forward to viewing the implementation plan, in particular the successor to the Fourth National Mental Health Plan in 2014, and in participating in the development of ACT mental health services planning for 2014-2019.

It is heartening to note COAG's commitment to achieving the Roadmap's vision by working closely throughout the sector, in particular with consumers and carers. We hope that the Commonwealth Government adopts a similar consultative approach for ensuring that the design and roll-out of NDIS services recognise carers' role as part of the care team, and consider carers' needs for tailored and flexible supports. Our position is endorsed by the National Mental Health Commission recommendation, in its Report Card for 2012, for more family and support person inclusive approaches in health services and programs.

Finally, it has been Carers ACT experience that, unless there is a clear commitment to and explicit recognition of carers within policy, procedural and legal instruments, then the rights of carers are easily ignored in practice. Therefore, we endorse the acknowledgement by COAG and the National Mental Health Commission, of the need for indicators to track progress. Carers ACT believes that the development of appropriate carer indicators to evaluate services across the mental health sector, and to measure carer satisfaction with services and supports, will provide an important contribution to the momentum for ongoing mental health reform in Australia.

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.

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.
45. Mental health and law enforcement

Quentin McDermott

On Wednesday 22 May 2013 in Woolwich, south-east London, a British soldier, Lee Rigby, was hacked to death by two alleged attackers, armed with knives, a machete and a handgun.

Fourteen minutes later, a specialist armed response unit carrying Tasers and Heckler and Koch submachine guns arrived and shot the two suspects as they charged at the police. These officers are highly trained, and there is little doubt that if they had wanted to, they could have shot the two men dead. But they didn’t, and the suspects were taken to hospital.

The murder of the British soldier was gruesome and horrifying, made all the worse by being witnessed, photographed and filmed by onlookers nearby. It has been universally reported as a ‘terrorist’ outrage perpetrated by two ‘jihadist’ fanatics whose minds were twisted by fundamentalist Islamic preachers propagating a message of hate.

That may be true. But there is also anecdotal evidence – which may or may turn out to be well-founded – that the lead suspect, Michael Adebolajo, suffered a profound change in personality as a teenager; that “Adebolajo's dark side seems to have been awakened in his mid-teens,” as the UK’s Daily Mail newspaper described it.

The courts no doubt will decide whether Adebolajo and his alleged accomplice were of sound mind when they carried out this horrific attack. But the two men will at least face the courts. It is hard to imagine that they would be alive today if they had been confronted by armed police on the streets of Parramatta or St Kilda.

In Australia, the history of police interaction with men undergoing a psychotic episode, whether aimed at themselves, with suicidal intent, or at others, is that police officers shoot to kill first, and defend the strategy later.

In Victoria, more than half of all fatal shootings between 1990 and 2004 involved individuals with a mental health problem. In New South Wales, in 1997, police officers on Bondi Beach shot dead Roni Levi, a young French photographer in the grip of a psychotic episode – and to this day, continue to defend the killing despite clear eyewitness and photographic evidence that Mr Levi was several metres away from the officers, and posing no immediate threat, when they opened fire and shot him in the chest.

Since then, very little has changed. In December 2008, in a skate-park in the Melbourne suburb of Northcote, three Victorian police officers loosed a barrage of ten bullets at a fifteen year-old boy, Tyler Cassidy, who was waving two knives he had stolen from a nearby store. Five of the bullets struck him, and he died. He was Australia’s youngest ever victim of a police shooting.

“This happens in a matter of seconds,” Assistant Commissioner Tim Cartwright told the media. “You've got police who are backing off. You've got a young man extremely agitated with two knives. Three of them obviously saw the need to fire on him.

“They have to protect themselves and other members of the public at the end of the day, so they've ultimately had no choice.” That statement of course, was untrue. The officers did have a choice, as the highly trained marksmen in Woolwich demonstrated.

So too did the American police officers on a crowded sidewalk in Seattle some years ago, when a dramatic stand-off unfolded between the heavily armed police and a mentally ill man who was wielding a Samurai sword.

As a SWAT team arrived, the public was ushered away and the area cordoned off. Three hours later, as the man advanced towards them, officers fired canvas bags filled with lead-shot in an effort to bring him down. The tactic failed. Still, they didn’t shoot him dead.
The man was sprayed with a chemical agent – but in his psychotic state, he refused to lie down and continued to confront the officers. Finally, as night fell, the officers turn fire-hoses on him to unbalance him, and pinned him to the wall with a ladder and a pole. At last, he was subdued.

The stand-off had lasted 11 hours – proving how tough it can be for police to handle crises where a man is armed and psychotic and is posing a threat to the public. But at least he was alive.

What a contrast to the scene in Northcote, where the police took 73 seconds to shoot Tyler Cassidy dead. And what a contrast with the scene in Armidale, New South Wales, where on 2 June 2009, a 24 year-old man armed, not with a Samurai sword, but with a bread-knife, was shot dead with a single bullet in his chest. Elijah Holcombe’s mother Tracey Holcombe described him to Four Corners. “He was a pacifist, he was a musician, he was a philosopher, he was a thinker, he was such a kind and generous person.”

But he also had a paranoid fear of the police, and when a plain-clothes officer chased him down the streets of Armidale, Elijah bolted into a cafe, picked up a bread-knife and disappeared through the kitchen. The officer chased him down an alleyway, and shot him dead. Elijah Holcombe hadn’t attacked anyone, but that didn’t stop the police officer killing him.

Research by the Australian Institute of Criminology argues that the vast majority of interactions between police and people with a mental illness end constructively. But it also reveals that 40 per cent of those who have been fatally shot by police since 1990 – including such high-profile cases as Roni Levi, Elijah Holcombe, and Tyler Cassidy – were suffering from a mental illness.

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.

Sometimes, as in the case of Tyler Cassidy, the police justify their actions by arguing that the young man wanted to die – that it was ‘suicide by cop’, as if in some way that justified the actions of police officers in fulfilling a young man’s death wish.

In the United Kingdom the vast majority of police still patrol the streets unarmed. On occasion, they disarm dangerous men without resorting to firearms. When armed response units arrive – as they did in Woolwich – every effort is made not to shoot to kill, but to shoot to disable a suspect. The aim is to restrain and arrest the suspect, not to kill them. While some mental health training is given to Australia’s police, it isn’t enough, and it certainly isn’t enough to bring about the fundamental change in attitude which is needed. History shows this, from Roni Levi in 1997 to Adam Salter in 2009.

Professor Ian Hickie, from Sydney’s Brain and Mind Research Institute, puts it this way: “If you look over the last 20 years in Australia, you can find an incident in each state, in each year, where a coroner does another report, where the police do another report, where there’s another state government enquiry. What is entirely predictable is if there is no serious system change to this hard end of the business, these tragedies will recur.”

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.
46. The ultimate goal: Equality in care

Patrick D. McGorry AO

Australians now recognise that mental ill-health poses one of the greatest threats to our health and wellbeing across the lifespan, as well as to the social and economic health of the nation. We now understand that mental health is everyone’s business, and want a better deal for those living with mental illness, whether it be a family member, friend or colleague. 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.

The World Economic Forum recently calculated this waste worldwide, highlighting the enormous cost to world economies. This is because mental disorders are the chronic diseases of the young, with maximum impact across the main productive decades of life.

Despite loads of rhetoric, endless process, and some genuine but modest funding initiatives, Australians still have to tolerate a mental health care system that is nowhere near appropriate to the true scale of the problem, and is consequently fragmented, beleaguered and cannot, despite the dedicated efforts of countless clinicians, produce the required results. Dr Thomas Insel, the Director of the National Institute of Mental Health in Washington DC, has pointed out that unlike in cancer and cardiovascular disease, where there have been substantial improvements in outcomes in recent decades, people experiencing mental ill-health have not benefited from improvements in premature mortality and disability.

What is needed is not only more research, but an immediate, genuine and sustained root-and-branch reform process that is transformational, not incremental, and which gives a lot more weight to prevention and early intervention. Crucially, this reform must deliver equal access to quality care for mental and physical health conditions.

Today, most of the 19th century asylum model has been swept away through a process of “mainstreaming” of the mental health care of people with severe mental illness. This, like the asylum model itself was well-intentioned but has been poorly designed, funded, executed and maintained. From the 1970s, beds were created within acute hospitals and a minimalist community mental health system was established as a “base camp” for ongoing care. State governments never really got beyond this base camp and have actually retreated down the mountain.

The post-asylum system was not built to scale, and has buckled under the strain of rising demand and population growth. Mental health care has retreated from its embryonic community base, with risk management now overshadowing care and the magnetic pull of the emergency department taking over. The ambulances are all at the bottom of the cliff.

The system has largely abandoned acute care in the community to the ambulance system, the police and the emergency departments, in that order. The poorly-targeted investment in NGO-based programs has fragmented care further, with poor coordination and widespread confusion the rule. Rather than dealing with the fundamental problem here, we are apparently to have more coordinators. Even the grossly inadequate budgets that are allocated to mental health within the public health system have not been ring-fenced, and in the cash-strapped environment of acute hospitals, the block funded community mental health resources are a soft target for the insatiable needs of other health areas that are perceived to be more pressing. Things are likely to worsen unless community mental health care is included in activity-based funding.

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. It is in urgent need of root-and-branch redesign, with a serious review of work practices and an expansion of alternatives also needed.

However, there has been more positive evidence of transformational reform from the Federal side, though its future is in the balance. The advent of much stronger support for the role of primary care and allied health in mental health care and for a wide variety of psychosocial programs was a major contribution of the Howard government. The establishment of headspace, Australia’s National Youth Mental Health Foundation, in 2006 was a major innovation that built on these reforms.

The Gillard government, through the leadership of Mark Butler and with the personal support of the Prime Minister, has continued and added to these reforms, producing a significant initial package of investment and reform in 2011, which did cover the full lifespan. This was claimed to be a first step in a ten-year program of further growth and investment in mental health care, though competition from other policy initiatives has distracted from this commitment. This risks following the old familiar pattern for mental health reform: a surge in advocacy and community concern, followed by a loss of interest and momentum.

The National Mental Health Commission, of which much is expected, has yet to hold government accountable for implementation of its reforms. Rather than yet another unfunded plan, next time it must compile a real report card on the government’s performance rather than that of clinicians and services. It should use as a benchmark the access and quality on offer for cancer and other physical illnesses. It remains unclear whether the Commission mechanism on its own will really help. In Canada and New Zealand, the impact of mental health commissions has been relatively modest and they don't appear to have stood the test of time. Many in Australia now believe the Commission needs to become a true commission, to be strengthened and made more independent of government, so its report cards are unconstrained. This independent voice needs to be backed by a large-scale grass roots voice for hundreds of thousands of people with mental ill-health, powered by internet-based platforms and large scale community activism.

Furthermore, in contrast to other fields, notably disability and cancer, mental health advocacy lacks maturity and unity, and we have been unwilling to prioritize and offer government a range and sequence of achievable reforms that we as a sector will back with solidarity. We simply cannot afford to waste money on new poorly conceived programs which, while stakeholder-friendly, are untested and not informed by evidence. There are several examples of this. This is especially so when assertive community treatment, employment programs, “housing first” programs and early intervention for young people are all ready to go national.

We must go with the best buys and the transformational investments. While we have had an overdose of plans, talkfests and roadmaps, all with little sustained impact, what we really need is a high level National Inquiry with real teeth, perhaps via the Productivity Commission this time.

The partnership between EPPIC and headspace, which has bipartisan support, represents an emblematic transformational reform in the provision of mental health care not only in Australia, but world-wide. There is intense interest in this Australian innovation in Europe and North America, where youth mental health is increasingly seen as a major priority. In addition to completing this reform agenda, we also need similar Federally funded and led initiatives in housing, employment and primary care-based community mental health care for children, older adults and the elderly.

My personal view, fuelled by the harsh day-to-day experiences of so many ordinary Australians, is that while we have solutions at hand we need to mature as a sector, fight a lot harder for those impacted by mental ill-health and not merely for our own organizational goals, and in the current financial environment ensure that we invest wisely in transformational evidence-based programs that will be successful and represent the “best buys” in mental health care. While Australia leads the world in the development of innovative responses, we still have a long way to go to reach our ultimate goal of equality in care and
providing the right care and supports for not only some of the most vulnerable people in our community and their families but for every one of the 4 million Australians with mental ill-health, who deserve a vastly better deal than they have now.

Patrick D. 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 specialized literature, and his contribution to academic psychiatry and health service reform has been recognized 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.

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.

**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).
47. Talking it to the streets!
Medicare Local Perth Central and East Metro

StreetDoctor in-reach to the City Mental Health Clinic

Background
StreetDoctor is an accredited general practice service which has developed a model of care to provide an easily accessible, non-judgmental, multidisciplinary medical service for homeless, disadvantaged and marginalised groups within various areas of Metropolitan Perth.

In late 2010 a number of meetings were held between City Mental Health Service (CMHS) and StreetDoctor to build an understanding of what each service was able to offer and clarify referral pathways. During these meetings the difficulties CMHS case managers had in linking their clients to a general practitioner were discussed. Some of the barriers identified included:

- Many clients are homeless or live in supported housing and present looking dishevelled and/or have challenging behaviours at times;
- Few GPs offering bulk billing services which cause financial barriers to engagement;
- GPs not accepting new clients;
- GPs feeling they lacked confidence in dealing with people with complex needs particularly as there are high levels of illicit drug and alcohol use in clients. In addition a number of clients have cognitive deficits and difficulty communicating their physical needs and problems or are unaware of their physical health issues;
- Clients being unwilling or unmotivated to attend appointments.

It was identified that a number of CMHS clientele were already engaged with StreetDoctor and working together would be of benefit to the clients of both organisations. It took another 12 months to identify a funding opportunity for the service with the clinic commencing on February 17 2012.

The StreetDoctor/CMH Clinic
The StreetDoctor vehicle is fully utilised so the clinic is an in-reach service. Case managers and clients book appointments with reception staff and StreetDoctor staff book clients in for follow up appointments. Reception staff reminds clients of appointments the day before and case managers assist with transport as required. There is room in the clinic appointment list for opportunistic sessions with clients if they drop in unexpectedly or are at the clinic to see psychiatry staff and have a physical health issue.

Above: Dr David Hofman and Practice Nurse Frances Hearn in a patient consultation.
The StreetDoctor service addresses the physical health needs of clients including screening for metabolic syndrome indicators and blood levels of psychotropic drugs. StreetDoctor provide all treatment and consumables such as medications, wound care materials while CMHS continue to manage the client’s psychiatric care. Consistent with StreetDoctor policy, no Schedule 8 medications or benzodiazepines are prescribed to clients.

The GP Liaison Nurse/Clinical Nurse Specialist meets with the StreetDoctor clinic nurse at the end of every clinic to discuss a brief summary of the visit and any referrals or follow up appointments required. Case managers provide assistance to encourage clients to take any medications prescribed by StreetDoctor and follow up with referrals to allied health professionals or medical specialists.

The relationship between the two services has been very harmonious and there is a mutual trust and respect for one another.

An audit of 740 ICMHS consumers revealed that only 28% were linked to a GP at the commencement of the clinic and after 9 months another audit revealed 64% of clients had been seen by a GP with StreetDoctor the main provider of primary care services.

Part of what contributes to the success of the clinic is that StreetDoctor has long standing agreements with SJOG pathology and SKG radiology to bulk bill diagnostic investigations; this overcomes the barrier to access of cost.

StreetDoctor nurses are trained in phlebotomy so blood for pathology investigations is taken at the point of contact in the clinic, therefore reducing the need for the client, who may be quite demotivated or in the grip of negative symptoms, to present to a pathology clinic.

The service does require subsidising with additional funding as the appointments are regularly 30 minutes to allow time to build rapport and address complex issues. Although bulk billing through Medicare provides some income additional funding sources are required to cover costs.

Both Francis and Sally are happy to discuss and provide information and support to any organisation which would like to develop a similar service. Francis is GP Liaison and Clinical Nurse Specialist at City Mental Health Service and his contact details are: francis.pimentel@health.wa.gov.au, Sally Willmott is the Manager of Primary Care Services her email is sally.willmott@pcemml.org.au
48. It doesn’t have to be this way

David Meldrum

Discussions on Mental Health Reforms often distract from the reality that many routes to recovery are not to be found in mental health services. The most obvious example is physical health.

The landmark survey ‘People living with Psychotic Illness 2010’ showed very clearly what many of us already knew — the physical health of people with serious mental illness is the worst of any large population group in Australia. In fact, the 1800 people surveyed rated their poor physical health as a greater challenge than their mental illness. Added to the appalling suicide rate of people with serious mental illness — up to 20 times higher than the general population — the result is life expectancy around 25 years less than average; at around 55 years. This figure has not increased in the last 100 years.

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. Research and pilot programs, particularly in the early stages of mental illness, to tackle obesity, poor fitness and very high rates of smoking (60%-75% across many surveys) have shown repeatedly that these risks can be quickly and significantly reduced. Interventions are not complex or expensive — but they need focused attention from health professionals and the non-government mental health sector to ensure ongoing access to programs tailored to the specific needs of people with mental illness.

Policy is important — but most of the current national policies on these issues barely make mention of serious mental illness, even though this may be the largest population group at risk. The latest National Tobacco Strategy is a notable exception, recognising for the first time that people with mental illness are now more than 40% of smokers in Australia. Policy on obesity, diabetes and most of the other issues raised here fail on this point. Real change for the better will be driven by policies at state and national levels, so proper recognition of serious mental illness is just as important as specific attention to indigenous, CALD, rural/remote and other special needs groups. People affected by mental illness and their advocates are not asking for special treatment — just equal recognition of their needs for good physical health.

There are more than 600,000 people in Australia living with severe and persistent mental illness. Hundreds if not thousands of these people (and their families and friends) in every electorate are dealing with the consequences of inadequate responses to their physical health needs. As the Mental Illness Fellowship of Australia’s poster for Schizophrenia Awareness Week 2012 said — it doesn’t have to be this way.

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 non-government 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.’

As well as being a very proud grandfather, David is a keen cyclist and is studying to improve his Indonesian language skills, which he currently rates at just above basic tourist.
Obsessive Hope Disorder
49. Fine words are not enough

Senator Claire Moore

When I “Google” information about the approaches by government to the issues of mental health in our country I am bombarded by a series of plans, strategies and frameworks. There are common commitments, some outrage and regret about inadequacies and pain in the system and the urgency to coordinate action and funding as well as the priority to engage across the community particularly with people who experience mental illness, the “consumers” as well as carers and professionals in medical practice.

The first strategy endorsed by Australian Health Ministers in March 1992 acknowledged that “people (with problems of mental health) have often felt stigmatised and disadvantaged against, and society’s attitudes have shown little understanding: and that “equity, access and social justice have frequently not been available to them”. The strategy reinforced a statement of rights and responsibilities and committed to the need for “regular review and updating”.

The first National Mental Health Plan in 1993 established the importance of the consumers in any decision about mental health in our community. I remembered this statement when I had the privilege to be a member of the Senate Community Affairs Committees considering mental health in Australia in 2006 and 2008. So many people had the courage to tell us about their experiences in our meetings across Australia – people who lived the “stigmatisation and discrimination”. Families and with carers who watched in anger and frustration as the services were unable, or unwilling, to provide support and safety; medical professionals, whose knowledge and commitment were under used or marginalised, academics whose research was under funded or ignored, educators wanting to work with young people struggling with mental illness or loss and politicians at every level whose communities were demanding reforms.

Somehow the years of policies, statements and strategies had not ensured that people received the rights identified as “fair and equitable”. Now in 2013, we have seen more plans and commitments – all have stressed the importance of a whole of community response.

The first National Mental Health Commission Report Card highlighted the importance of a “contributing life” – where we care about people whose health and opportunities are worse than those in the general community and whose voices must be heard and respected.

The Report Card continued to deplore the problem with effective data collection across the system, so that we struggle to document the impact of our services and to quantify the effectiveness of the system determined to provide equal access. I know that it appears to be a bureaucratic demand for effective data administration, but I strongly believe that the problems of data investment reflect the systemic problems of priority for mental health in our country. Both Community Affairs reports, as well as many of the reviews, and plans, stress the importance of a responsive, effective database. How can you assess progress or develop necessary goals and measurements if there is not an agreed transparent data tool? It is too easy to hide or to fudge if the methodology is not accepted and engaging.

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 national commitment is there and we must never let it be diluted or diminished.
The hope of the first National Mental Health Plan must be maintained and bolstered by the development of clear outcomes with agreed assessment. There will be problems, goals may not be achieved, but the scrutiny and the shared audits of need and unmet need must continue and then the "regular reviews and updating" will be meaningful. 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) became a Senator for Queensland in July 1, 2002 after a career that had 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 Deputy 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.

**Editor’s Comment & Illustrations.**

**State of the Art in Therapeutic Mental Health Care?**

**Campbell Street, Hobart** Below is a photo of the Campbell Street Mental Health Unit, which provides ‘Extended Treatment Mental Health Services’. May 2013.
The 19th Century built Baillie Henderson Hospital Toowoomba: 206 mental health ‘patients as at 6 March 2013.92

92 Reported in Toowoomba Chronicle, 7 March 2013. Statement by Darling Downs Health & Hospital Service chief executive officer Dr Peter Bristow
Obsessive Hope Disorder
50. Mental health and social change

Stephen Mugford

A long, winding road … with pitfalls ahead

Back in 1968, I got a summer job as a porter in a large mental hospital in Bristol, UK. I needed an income before I started graduate work and, given an ambition to do a PhD in medical sociology, a hospital job suited well. I learned a lot in those months, principally what a sad place those institutions were. In criminology it is said that offenders are ‘warehoused’ when they are sent to jail with no effort at education and rehabilitation. Well, it was ‘warehousing’ that I saw that summer. There were large day-rooms with a row of chairs all along the edge with the patients, frequently elderly, parked in them for hours at a time as if every person there was waiting for an invitation to dance. It never came. Instead, the staff doled out drugs several times a day and the folks whiled away the hours rocking back and forth and (sometimes) moaning softly. Even more sadly, for most of the older people it seemed that the only prospect of leaving came when a couple of us porters arrived to carry out their corpse. We used a double-decker gurney and put the deceased out of sight inside ‘so as not to upset the others’. In that hospital the old saw about that decade has a different edge: “If you can remember the ‘60s, you weren’t there.”

Things have changed a great deal since then, many of them I think—as something of an outsider—for the better. In the same way that this sad scene was, nonetheless, a lot better than the ghastly stories and illustrations about Bedlam found in the history books, so the lot of those who suffer some form of mental health disability today has ‘progressed’ compared to that time in 1968.

Nonetheless, I want to sound a note of caution before we construct a narrative of ‘progress’. While I eschew negative accounts full of dark warnings of ‘power’ and ‘control’ fashionable in some schools of thought I do want to argue two forms of limitation that we need to pay close attention to in linking mental health practice (and reforms) to overall social change. First, I will make a more philosophical-theoretical point about possible narratives and then I will look at some big picture issues in social change that might be impacting in negative ways on mental health and on those who experience disabilities in this respect.

Narratives of ‘progress’ are flawed

Since the seventeenth century we in the West have lived under—and exported—the sign of ‘progress’. Enlightenment philosophies spawned various revivals of an Aristotelian idea of telos—things moving towards some implicit (and perhaps perfect) end state. The ‘Whig theory of history’ and Hegelian ideas of immanent reason are all descendants of this, resurfacing recently when, in a triumphal moment after the Soviet collapse, Francis Fukuyama93 announced that we really were at the end of history with the victory of liberal democracy (an idea that looked rather misplaced on 11th Sept. 2001 in New York).

When this notion of ‘progress’ exchanges genes with (simple) scientific ideas of ‘truth’ we need to be cautious about the resulting virus for it may well have pandemic potential. In the area of mental health this can all-too-easily lead us to imagine that we know where we need to go, we are going there bit by bit and given a bit more time, good will and resources, all will be well. My argument is neither that this is ‘wrong’ nor (which would be worse) that things are going backwards rather than forwards. It is simply a note of caution to pay close attention to the complexities that are involved. Without, in this short space, fully arguing the case I want us to remember that:

1. What constitutes ‘mental illness’ or disability remains controversial. As a dramatic example, look at the current furore over the DSM-5, with critics attacking it from a wide range of viewpoints, not least the idea that its painstaking descriptive approach is unscientific.

93 Free Press 1992. The End of History and the Last Man,
2. What causes mental illness(es) remains unclear and contested. From non-scientific myths (e.g. the alleged vaccination-autism link) through a host of scientific possibilities (gut flora, environmental pollutants like lead, defective genes, to mention only a few) the case is not closed.

3. How we respond to mental illness or disability is also uncertain. A gold standard treatment one day (CBT for depressive disorders, perhaps) is argued the next to be not much better than placebo, while drug responses wax in and out of favour. If one cannot be sure what ‘it’ is nor what caused it, perhaps treating ‘it’ is unsurprisingly difficult.

I do not mean to be pessimistic nor to oppose effort and hope. I’m simply arguing that while we are in quite simple ways, ‘doing better than we were’ the road in front of us is neither straight nor well lit.

Social changes can undermine ‘improvement’

A treatise on social change and related theories would fill several volumes, so I’ll pick two brief themes only. The first—the resurgence of liberalism—is a backdrop to the second—slender resources.

The resurgence of liberalism: it is a truism of political sociology that the 19th and 20th centuries saw the rise two great political philosophies—liberalism and socialism. At the core, the former emphasises individual action and responsibility within ‘freedom’—free markets, free polities and free societies which protect free speech, free inquiry and socio-legal rights. Socialism emphasises, in contrast, some degree of central control of all these elements in the pursuit of equality and overall social justice. While the theory does not denigrate individual rights, it does not make them central in the same way.

The outcome of these two approaches is well known. Liberalism delivers dynamism, change and economic growth. When Karl Marx wrote that commodities were the heavy artillery that would break down the Great Wall of China he was on the right track: said artillery was a core weapon that broke the Soviet bloc before the collapse of 1989-1991. It also delivers inequality. In contrast, socialism does not deliver the same degree of freedom or dynamism, as we know from the ‘gulags’ on the one hand and the stockpiles of unwanted tractor tyres on the other. And we know it delivers oppression.

Notwithstanding this hindsight about oppression, we can make a very rough characterisation that much of the 20th Century brought elements of socialism to political life word wide. While these were extreme in Russia and the later Soviet bloc, PRC, etc., they were mild but widespread elsewhere. This was the epoch of welfare states, health insurance, New Deals, etc. Under this sign, with myriad variations, governments followed what US Republicans sneer at in Democrats: ‘tax and spend’.

In the Western countries the effects of this peaked in the post WWII period associated with economic growth and social conservatism – for example: women went back to ‘the home’ after wartime factory work and co-created the ‘baby boom’ and when ‘black’ music began to infect popular culture desperate attempts were made to find wholesome (Pat Boone) or even edgy (Elvis) white singers to maintain the accepted racial profile. By the 1960s, with the ‘boomers’ driving a youth revolution this began to break up. Freedom was a catch-cry in many ways, linking popular culture (‘drugs, sex and rock ‘n roll’) with varied political movements from Civil Rights in the US to anti-war sentiments there and elsewhere.

Returning briefly to 1968 this was both an emblematic and a pivotal year. Early on Alexander Dubcek led the Prague Spring: for “socialism with a human face”. French students and workers occupied factories and universities, attacking ‘bourgeois conformism’ and challenging acid slogans like “Consume, be silent, die” on the walls of Paris. But by year’s end Bobby Kennedy was dead and Mayor Daley had loosed his thugs at the Chicago Democrat convention, opening an easy passage for a Nixon election; de Gaulle was in power in Paris and the Russians had crushed the Prague Spring.

94 It is important not confuse this, in Australia, with the Liberal Party (LP). The LP has espoused and implemented many liberal policies but so did the Hawke-Keating government. And the LP and its NP allies have a strong conservative streak at odds with liberalism in this strict sense.

95 In the sense conventionally used. It can remain blind to the ecological consequences of ‘growth’.

96 When the Wall came down, East Berliners went … shopping!

97 Recent warnings that wealth and income inequality are now at the highest levels since just before the 1929 Wall St crash are a signal here.

98 It too is often blind to the environment—see the disasters of pollution, Chernobyl and the destruction of the Aral Sea.
Yet within a decade, freedom was back. Now it was Thatcher and Reagan with a radical agenda to set business, markets and citizens free, free from red tape, bureaucracy, government oversight and a tax burden that (they claimed) stifled innovation, energy and growth. Unlike the ‘cultural’ movement a decade before, this succeeded (in the political sense) much better and from around 1980 onwards the dominant tendency has been market liberalism. The question then is, what does market liberalism mean for mental health today?

**First**, it means that it is easy to talk of rights: rights for people with mental health issues and for carers. This sounds nice but rights are relatively ‘empty’. I have the right to buy a Lear jet, hire an aircrew and fly to Paris and so does everyone else. So what? In the absence of any resources or power to make this come true the right remains abstract and of little value. Thus beware the ‘rights’ discourse as an easy road but a blind alley.

**Second**, in conjunction with other changes, such as the growing isolation/privatisation of life, it is important see that liberalism is a powerful ‘solvent’—it readily dissolves pre-existing relations. Marshall Berman, citing The Communist Manifesto as the title of his book made this point 30 years ago and very recently Waleed Aly touched on it in the Sydney Morning Herald. Noting the role of ‘conservative’ politicians he writes:

> ... *[market liberalism]* isn’t very conservative at all. It undermines exactly the kinds of social institutions conservatives celebrate – family, for instance – by making us work more irregular and unpredictable hours. It opens the door for the commodification of whatever will sell – even if that means unconservative consequences like the hyper-sexualisation of advertising.

This is important because we believe that a positive response to mental health issues lies in a supportive family and community. Liberalism translated into active policy is rarely a friend of communities in this sense.

**Third**, and linked to the previous point, liberalism encourages an individualised discourse and practice of ‘responsibilisation’. This is a complex topic but suffice here to say that the implication is people being expected to self-govern and self-solve their problems in self-funded ways. It is not hard to see how this sits oddly with how we think it best to respond to mental health issues.

**Slender resources**: these (and similar) trends are exacerbated by the idea that resources are scarce. The issue is complex. Are we in a time of limited resources? Objectively we know we’ve been hurt by the ‘GFC’ (itself brought to you by the excesses of market liberalism—i.e. rampant ungoverned greed) and for Australia the resources boom may be about to run out. It is also true that, closely examined, the fastest rising area of government expenditure here and in similar countries is health expenditure—rising medical costs and rising expectations conspire to expand this apace. Ideologically, the cost of liberalism has been a shared loathing of taxation. The idea that citizens ought to pay taxes has largely vanished, replaced by the notion that governments ‘take our money’ (for no good reason except the greed of politicians). Both ‘sides’ of politics have had a race to the bottom on tax rates.

As a result, we need to be somewhat pessimistic about the extent to which positive initiatives in the mental health area will really be funded. Unfortunately, this may not be a ‘sexy’ area. In summary, I know I have been a bit pessimistic about the road ahead but we know from psychological research that pessimists are, on average, more realistic than optimists. In this area, this might usefully temper our expectations.

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100 Berman M 1983. All that is Solid Melts Into Air: The Experience of Modernity, Verso.
103 See e.g. http://www.opendemocracy.net/article/responsibility_and_neoliberalism
104 A recent estimate is that without the last round of Howard government income tax cuts, the 2013 and previous budgets would all have been in surplus.
Obsessive Hope Disorder

Dr. Stephen 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.
51. Suicide prevention: taking a new approach

Sue Murray

Browsing the titles of Suicide Prevention Australia position papers offers an interesting insight into suicide prevention – it is complex. And it is a complexity that is often overshadowed by a focus on mental health.

Certainly mental health, or rather ill-health has a significant place in many people’s decision to think, plan and take their own life, but it is not the only factor. This is starkly played out when you line up the topics of our position papers.

- Aboriginal and Torres Strait Islander peoples
- Social inclusion
- Alcohol and other drugs
- Youth
- Men
- Gay, lesbian, bisexual, transgender and intersex communities
- Rural and remote communities
- Chronic illness and pain
- Stigma
- …and so on

No one factor can be held to account for the decision a person makes to take their own life. It is this multiplicity of factors that have made it so difficult to gain traction in reducing suicides in Australia. A review of the statistics published by the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW) show us just how hard it has been to make headway in reducing deaths from suicide. They have plateaued. Certainly the effort to focus on the reduction of youth suicide has seen a decline in young people taking their own life and this is extremely laudable. It must also be sustained because every year there is another cohort of young people who are seeking to define their sense of self, face the challenges of gaining an education and securing employment, maintain strong and supportive family structures and stay connected to those who can help in troubled times.

Most surprising, especially for those who have not been working in the sector, is that each year the highest numbers of suicides occur in working age adults, predominantly men aged 35–50 years. Over the last decade some 65–70% of suicides were in people between the ages of 25 and 60 years and four out of five of those people were men. Men who are likely to have young children. Men who are likely to have ageing parents. Men who are likely to supervise younger people in the workplace. All of whom will be affected by his death. The ripple effect is vast and all too often there are many unanswered questions that remain in its wake.

**The evidence base in suicide prevention**

It is a challenge to determine what works in suicide prevention given that we cannot implement randomised clinical trials and suicide is a relatively rare event. Similarly it is hard to know what would have happened in the absence of any intervention.
However, Suicide Prevention Australia agrees strongly with the World Health Organization and the National Mental Health Commission that suicide prevention requires an innovative, comprehensive multi-sectoral approach, including both health and non-health sectors, e.g. education, labour, police, justice, and needs to sit above politics, culture and religion. Reducing suicide rates requires action at the whole population level, targeted interventions in high-risk groups and settings, and appropriate and effective responses to individuals identified at imminent risk of suicide.

Evidence supports strong components across a set of key areas – improved awareness and skills for front line personnel, especially GPs but also police and ambulance services, families, school or work communities; improved mental health care; restricting access to means by which individuals may end their lives; implementing media reporting guidelines to prevent contagion; and maintaining contact with those who have attempted suicide after discharge to significantly reduces risk of further attempts and hospitalisation.

In Australia we currently have a range of new evidence-informed initiatives which offer hope of successful outcomes and should be watched with great interest. These include but are certainly not limited to community plans for preventing and responding to suicide clusters, support for schools affected by suicide, coordinated community response to the bereaved and various e-health services. And importantly we now have a focus on reducing the toll of suicide on Indigenous communities via the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

We are learning a great deal but there remain significant gaps in our knowledge.

**Challenges to reducing suicides in Australia**

There are so many challenges that face society all requiring legislative, structural and/or social reform if we are to truly see a decline in suicides in Australia. 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. The number, breadth and diversity of suicide prevention services is unknown as is the effectiveness of such programs. There is a lack of quality assurance standards by which individuals, professionals, workplaces and communities can assess programs against needs. Investment is needed to ensure our frontline workforce is sustainable and effective.

There is a lack of political and bureaucratic strategic thinking. Australia’s federated system means resources are not close to the ground in communities where they can most effectively be utilised. It promulgates the ‘blame game’ and provides an easy cop-out from not adequately resourcing suicide prevention programs. Suicide prevention continues to be seen as an adjunct to mental health rather than a cross-sectoral responsibility.

The voices of people with lived experience of suicide too often go unheard. They, in partnership with the voices of suicide prevention professionals, need to influence the direction and the way in which programs are delivered and suicide is spoken about in communities.

These systemic issues are further compounded by social mores which contribute to a greater risk of suicide. Alcohol consumption which is so ingrained in our culture; a heavily accentuated focus on body image for young people; an ageing population that is increasingly losing their social connections; and ongoing problems with racial and sexual discrimination as well as bullying. These are just a few examples of the many social issues that play a role in suicide.

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The stigma of suicide has a profound impact on suicide prevention. It contributes to reduced community awareness of the issues related to suicide and suicide prevention, restricts help-seeking behaviours for people who are suicidal, impacts the resourcing of appropriate services, inhibits the grieving of those bereaved by suicide, and adds to the burden of those with lived experience. Challenging stigma requires confidence in discussing suicide on the public stage yet we still don’t know how to safely and effectively talk about suicide.

Finally we face the challenge of understanding and prioritising where we should need to focus our efforts. What is it that will work most effectively? What are the gaps in knowledge? What are the strengths of the Australian research community and how can these best be utilised to deliver new knowledge relevant to the Australian context.

**So what does the future hold for suicide prevention?**

Suicide is a *wicked problem* i.e. one characterised by complexity, interdependencies and multiple causes; constant change; no clear solution; requires behaviour change and commitment from the general public; and responsibility for sits across government, business and the community. We must continue to invest resources into this intractable and wicked social problem. Why? Because human lives are at stake. We must meet the challenges outlined above and change the way we work. That change is already on the agenda: SPA is leading its implementation through the National Coalition for Suicide Prevention which has been created within the principles and framework of Collective Impact.

Collective Impact is a structured and sophisticated approach much more valuable than the sum of the parts. It has shown great promise in US communities in addressing intractable social problems and members of the National Coalition firmly believe that it has potential to make a difference in suicide prevention. Collective Impact is an approach which can tackle the challenges of a wicked problem like suicide.

The most successful initiatives in the US have been those that engage all three sectors – community (like SPA), businesses and government (local, state and federal). There are six elements which are integral to successful Collective Impact:

1. An agreed common agenda to which all participants will commit
2. Shared goals and measures
3. One common reporting framework

To complete the framework we must also have:

4. Mutually reinforcing activities
5. Continuous communication
6. One backbone organisation to drive the common agenda.

At its heart collective impact enables us to solve challenging social problems with the resources we already have at our disposal.

**Setting the agenda for suicide prevention**

*We want to halve the number of suicides; we want to halve the number of attempts. That is the agenda:* a 50% reduction in suicides in Australia over the next decade. The formation of the National Coalition for Suicide Prevention includes more than 20 not-for-profit organisations including beyondblue, Lifeline, Black Dog Institute, RUOK? Day, SANE, National LGBTI Health Alliance and many others are all committed to making this change. SPA is the backbone organisation driving the agenda, building continuous communication and managing stakeholder expectations. We are under no illusion of the challenges we face but, with suicide statistics plateaued, the change in our approach cannot come quickly enough. Collective Impact is the way ahead and we call on all those working in suicide prevention to sign up to this ambitious agenda.
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.
52. The smarter way: Partnership broker model

Lydia Najlepszy, Queensland Youth Industry Links

Partnering can be defined as the act of collaboration based on mutual trust; it can be complex and involve many people of different opinions and motives.

QYIL is a not for profit community organisation that has been providing quality services to the Sunshine Coast region for over 14 years, and is currently funded by the Department of Education, Employment and Workplace Relations (DEEWR) to deliver the School Business Community Partnership Brokers Program across the Sunshine Coast and Moreton Bay Regions.

The aim of the National Partnership Broker Program is to increase year 12 attainment or equivalent to 92.5% by 2015, and support young peoples’ transition into employment or further learning to assist them to reach their potential. As part of this goal QYIL partnership brokers work to actively address the need for cross sector partnering at a strategic and organisational level so that systems and processes can better address the education, industry, community and family needs essential to achieving the target. The partnership broker aims to bring together interested stakeholders from different sectors to enhance the outcomes achieved. The process breaks down silos, prevents duplication, increases efficiency and supports collaboration to achieve a more comprehensive and significant outcome, while at the same time assisting individual organisations to meet their needs more effectively. It is in essence a change management process.

At Queensland Youth Industry Links (QYIL) we utilise a simple step-by-step cross sector partnering process that ensures: the capacity of people to partner improves, quality partnerships are developed, and that by making changes in organisations, effective outcomes are achieved. Drawing on the Dixon Partnering Process, and our experience in working across various sectors, our partnership model is comprised of three distinct stages, all of which have key outcomes and questions, outlined briefly below:

- Creating – initiate and build relationships, develop a common purpose, clarify expectations of each partner.
- Developing – map available resources, set key milestones, resolve conflicts as they arise.
- Sustaining – monitor commitments, evaluate the outcomes and impact of the partnership, consider whether to finish the partnership or look at different structures.

In this form of partnership, each partner contributes not only their own resources, knowledge and skills, but they also share the risks and benefits by achieving their own, and the overall partnership’s objectives. While a number of principles can be developed for particular partnerships, there are three basic principles that keep recurring within our partnerships:

- Equity – the equal right to be at the table, and a recognition that contributions to the partnership can come in different forms.
- Transparency – All relationships are based on openness and honesty, and where people will be truly accountable.
- Mutual Benefit – All partners can achieve specific benefits over and above the benefits to all.
In delivering the School Business Community Partnership Brokers program, QYIL aims to build partnerships that support:

- Education Providers
- Business and Industry
- Parents and families
- Community groups

The role of the broker in a partnership is as a facilitator, rather than a manager. The broker demonstrates leadership and acts as a coach: creating the space and time for collaboration, and generating a framework for how the organisations can work together. Two key elements of partnership broking are capacity and resourcing. Although resourcing is usually referred to as a financial commitment, time is also a valuable resource. Many partnerships have progressed and achieved their partnership goals through the investment of time and available resources, with the partnership broker providing organisational and administrative support in some instances to support the partners to maintain momentum.

An example of a partnership QYIL staff have brokered is the Moreton Region Youth Alliance (MYRA) an overarching partnership that effectively fosters a strategic whole-of-community approach to supporting young peoples’ learning and development. Since 2010 the MYRA have developed plans targeting ways for industry, schools and community to link up effectively and support Youth Attainment and Transitions in the Moreton Bay area. 24 partnerships involving decision makers from 124 businesses, industries, community and education organisations identify regional issues, potential solutions and drive the actions needed to bring about sustainable change. QYIL also leads the evaluation of the partnership progress and supports the partnerships to maintain focus on key initiatives.

While QYIL has developed a partnership brokering process that has successfully focused on engaging education and families with industry, community and government sectors to achieve the national youth attainment goals, the utilization of a partnership process with the support of a partnership broker, can be applied to any region or sector.

Collaboration in almost every aspect of mental health services is now recognised as essential to achieving good outcomes for people with mental illness. No one service, no one provider can provide the diversity and quality of care necessary for each person with a mental illness to achieve optimal care and recovery. Collaboration for prevention, early intervention and optimal and sustained recovery from mental illness is an optimal strategy that could be incorporated at: Whole sectors levels (health, housing, employment and education); Inter-agency levels; Intra or within service providers; and at multi-disciplinary team levels.

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.

QYIL supports organisations that support young people and it is often at times of transition when we see young people struggle the most. The utilisation of partnership models in the mental health sector with the support of a neutral, skilled and experienced partnership broker would provide a catalyst for systemic change, increasing the capacity of organisations to work more effectively in partnership with better utilisation of limited resources. In essence, a model of collaboration, rather than one based on competition, would benefit the industry, and the people who access the sector, by creating opportunities for the development of best practice, with comprehensive and innovative solutions.
Ultimately partnership processes would impact positively on individuals who would be better supported to make changes in their lives, resulting in a smoother, more effective transition period, with more efficient use of resources.

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 maximize 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.
Obsessive Hope Disorder
Beyond confusion: A global perspective

Stephen Niemiec

I have worked as a registered psychiatric nurse for 37 years. During my career I have held a variety of positions at differing levels within three different countries all of which were at varying stages of development in terms of their mental health service delivery. I would like to share some of reflective observations over the years as a mental health/psychiatric nursing professional involved in service delivery, as a junior then senior clinician, then as a middle manager then as a senior manager with responsibilities for national development in strategic and local clinical environments.

I trained in an asylum where 1200 people were detained (usually against their will) with a wide range of disorders and some that had none, most people had little to do with psychiatry but were nonetheless the domain of care for psychiatric professionals at that time. I learnt on the job as it were, attending lectures in the School of Nursing and doing practical placements throughout the institution. The scary thing about this is that I was left in charge of wards during my second year. Trained staff were uncommon and the organisations were keen to utilise what experience and training it had to deliver care. Thankfully, nothing untoward occurred but these experiences provided me with a confidence and ‘can do’ approach. These institutions were great socialising campuses for staff. During my time as an active politicking student nurse we managed to open up some wards so that they weren’t locked, and questioned many practices that were routinely accepted e.g. giving electro convulsive treatment to men with homosexuality.

The closing down of stand-alone institutions in NZ occurred in the mid to late 80s. This meant that community models of care were developed often without precursor knowledge or expertise. Staff learning was mostly experiential and it is a surprise that more things did not go wrong during these transitions of care implementation. The utilisation of typical antipsychotic medications assisted in the transition to community models of care, particularly the use of depot medications. In itself, although these medications were often given as the reason for closing down institutional care the reasons were more financial and socially driven, and as mentioned earlier there were many people with learning disabilities and people in need of tertiary care who required a different approach to their needs.

Deinstitutionalisation was a welcome change for many of the younger staff and brought with it opportunities of working with people in their own homes.

These days see an altered focus of care. If anything we fail our inpatients because of poor resourcing, lack of infrastructure and poor allocation of inpatient beds, whilst treatment in the community enjoys good resourcing (in comparison) but still far from ideal particularly in Queensland where I currently work. Most studies recommend that around 23 inpatient (or acute care) beds per 100,000 population is adequate with additional capacity and options for recovery in community settings. We are far short of that level of resourcing and hence mental health care appears to be in a state of constant crisis.

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. We are fortunate that there sufficient numbers of trained specialist staff still working in Inpatient units 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? A question I have used often when involved in reconfiguring services in NZ and UK is: “would you be happy to admit your sister/daughter to this ward”.

The answer more often than not sadly, is no!
In my opinion funding models of care have cleaner clinical accountability in the UK than in Australia and this is because there is a clear funder-provider split in roles and responsibilities. The National Health Service (NHS) provides care at no cost at the point of delivery; money is distributed according to population and deprivation modelling through the Department of Health to primary care trusts (run by GPs) who in turn purchase services from mental health trusts, and other providers for acute care or tertiary care, or NGOs.

This arrangement protects corporate and clinical governance from political interference and prevents health, including mental health, becoming a political football. Whereas in Australia we have a good proportion of money going to directly through the Medicare Benefits Scheme (MBS) to private practice care with significant disparities in access, quality and cost, little or no requirement to report outcomes or link with other service providers. Then there are other Federal programmes that are administered by each state or territory or directly by selected non-government and private providers and then there is State funding. These multiple funding streams create layers of bureaucracy, waste and confusion with little certainty for clinicians and patients.

A fair proportion of my time in Queensland Health was spent writing answers to complaints and other matters on behalf of the organisation because politicians wanted to protect themselves from criticism. State funded services, the public mental health services are left to respond to the most acute needs, are burdened with slow unresponsive bureaucratic structures, are slow to adapt and slow to uptake innovative clinical practices. MBS funded private care (both individual providers, hospitals and other organisations) on the other hand, function with minimal clinical governance and minimal accountability in the place and with the client they select.

Until the funding models and roles and responsibilities are reformed, mental health services in Australia will continue in a state of constant crisis.

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. Stephen is an Adjunct Associate Professor for the University of the Sunshine Coast.
54. Crisis? What crisis?
Paul O’Halloran & Nick O’Connor

Problems in the community – a reflection on progress in developing the model of care for community mental health services in Australia

Reflecting on the progress over the last 20 years since 1992, of taking forward national policy and attempts at implementing an effective model of care, what stands out at this present moment in time, is that despite many positive steps forward, on many different fronts, there remains within the core public community mental health services, an unacceptably high level of fragmentation, with great variability in approaches to care delivery and with little or no fidelity to more evidence based models of care.

This is not to say that there have not been significant moves forward over the last two decades in Australia. Welcome improvements have included increased access to psychological therapies in primary care, as well as preventative oriented care through early detection and intervention services for young people with first episode psychosis, including increased roll out of Headspace services. Other developments have included more NGO, non-government services, providing practical support, plus better access to secure housing through the various state/territory Department of Housing, as well as enhancements to vocational and educational intervention, suicide prevention support and increased acute beds within hospital settings. In addition, the establishment of a National Mental Health Commission along with several state commissions provide additional possibilities and hope for effective implementation of policy.

The UK experience and approach

The UK has experienced similar efforts at reform of services. Over a 10-year period commencing in 1999, Mental Health Services in the UK underwent major transformation, progressing from a largely institutional base to more comprehensive and integrated community based systems of care. The National Service Framework provided a map for this reform, including seven standards for service delivery. This progressed to a more detailed implementation plan with adequate funding and detailed description of the models of care: the NHS Plan, which enabled a much more rapid national roll out of evidence based and community centred services. Building on the best evidence available at the time and drawing heavily on overseas experience of implementation, particularly Australia, the NSF/NHS Plan for Mental Health set out, for the first time in the UK, a clear and progressive national model of mental health care. This national approach to developing a model of care has led to high levels of consistency in service provision, based on a nationally agreed set of mental health standards.

A UK–Australian comparison

In Australia however, the same degree of consistency, coherency and community focus with high levels of fidelity to evidence-based model of care has not been achieved. While the states and territories vary in their level of development, the key difference between the experience in the UK and here in Australia is the state of under-development of core clinical community mental health services within the public sector. From observations gleaned through development work with six Local Health Districts within NSW, the following issues emerge as a consistent pattern and provide a brief diagnostic summary of key issues facing the future development of community mental health services in Australia.

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. The community focus and primary orientation of the system is thus compromised by a distorted balance of investment at various levels, including financial, into institutional
services, creating more traditional hospital-centric systems and cultures of care. With no blueprint of what constitutes an effective community mental health service, gaps in evidence-based care provision consistently emerge, both in delivery mechanisms such as with the necessary core multidisciplinary teams, as well as in direct clinical practice, including lack of widespread access to such therapies as CBT, DBT and family interventions.

Structurally, the most obvious gap, with regard to delivery mechanisms, such as through multidisciplinary teams, is the widespread and consistent lack of an intensive and short term, home treatment function offering an alternative to hospitalisation for people with acute mental illness. This concentrates excessive acute demand on key pressure points such as the Emergency Department and the psychiatric inpatient unit, a major issue for most services Australia-wide. Further, the function of assertive outreach to engage the most disabled, vulnerable and at risk consumers into a process of long-term recovery, treatment and care, is notable more by its absence than its existence as part of the core spectrum of community services. Additionally, there is little consensus as to what constitutes an evidence-based model of case management, despite this function being the glue that binds the service together and enables effective continuity of care, resulting in widespread variation and fragmentation of practice and with little or no fidelity to effective models.

These core functions of community mental health including crisis intervention and acute home treatment, assertive outreach and case management, are necessarily provided through the building blocks of contemporary public mental health systems, which are the multidisciplinary teams. However, in many cases these core functions are either absent or highly variable in their operations and display little fidelity to the evidence base.

With regard to process and the delivery of direct clinical practice, there is a widespread lack of implementation of evidence-based psychosocial interventions for people with severe mental illness, including such approaches as Cognitive Behaviour Therapy with psychosis, Dialectical Behaviour Therapy for people with personality disorder and Behavioural Family Interventions for schizophrenia.

Cumulatively, this lack of effective structure and process embodied in an evidence-based model of care, results in clogged care pathways within the public system, lack of progression and stasis for many consumers and their families and loss of morale and frustration for many practitioners.

Further, there is a need for a more strategic approach to developing the culture, morale and capability of the public mental health workforce, the “key personnel" for effectively delivering the process of treatment and support. This issue is reflected firstly in the generally low levels of investment in training and supervision for practitioners and secondly in the lack of strategic alignment of what limited training monies are available, with the core staff development needs of community mental health services. Many community mental health staff were trained in the large psychiatric institutions and this culture has in many services crossed over into community teams.

Staff capacity issues are also apparent. The staffing levels of multidisciplinary teams in certain key functional areas, particularly within acute community care, are not informed by international best practice, as in the UK, or rational staffing algorithms based on demand or need, with many teams requiring staffing enhancements. Another especially critical issue is the current low levels of Psychiatrists in many of the multidisciplinary teams, along with the part time, or “fractionalized” nature of their involvement, creating major problems of consumer access and the effective functioning of the core teams.
Conclusion

If there are lessons to be learned from the UK experience, it is the need for the clear articulation of an evidence-based and recovery oriented model of care, with a detailed implementation plan, at strategic and operational levels, including workforce development and with adequate funding to make the system work. The UK achieved a rise of funding in mental health to approximately 11% of the national health budget, with the majority, around 70%, being invested in community mental health care.

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 & Training at the Sainsbury Centre for Mental Health, Kings College London; Regional Director of Workforce & Service Development with the National Institute for Mental Health, NIMHE; Head of Service Improvement & Practice Development within Hertfordshire Partnership Foundation NHS Trust. His work has also included consultancy with the World Health Organization 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 organization, 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 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.
55. New headsets needed
Dawn O’Neil AM

Achieving the world’s best mental health system

A fundamentally new mindset is required if Australia is to deliver the world’s best mental health system within a decade. In October 2012, 90 groups met for the first Council of Non-Government Organisations (CONGO) on mental health. Delegates came not just from the mental health sector, but from those intersecting in so many people’s lives – the employment, housing, justice and social welfare sectors. That meeting resolved Australia would lead the world in mental health by 2022. By then, we would be the acknowledged frontrunner in services, programs and outcomes.

Yet, in fact, we don’t have a ‘mental health system’. We have a complex mix of services and programs, which are unevenly distributed, and sometimes missing when and where they are most needed. Overall, our efforts remain ineffective or too small to meet the vast need.

Valid questions as we embark on this ten-year challenge are: can we design an ideal system for people with complex needs, which is effective equally across our vast country and over whole life spans? Are 90 organisations capable of reengineering our current mix of services and supports into a coherent system? Can they work together to make a tangible, measurable difference?

To answer ‘yes’ will require a clear plan and the unflinching resolve not only to collaborate, but to learn to think in new ways. Building a seamless, accessible, culturally appropriate and holistic mix of services and supports will require honest assessment and humility. Yet, if you have ever asked yourself, ‘why have we been working so hard, for so long, for such little enduring change?’ then you are ready for this journey.

In 2009, the World Health Organization (WHO) published Improving Health Systems and Services for Mental Health. It described the optimal mix of services for any population-wide mental health system. To date there is no system design or framework in Australia’s vast arsenal of policy documentation. This is desperately needed. Our well-intentioned impulse, often, when faced with obvious need, is to patch in another program. Until we can articulate the optimum mix of services and supports, we will continue to add layer upon layer of programs, projects and measures without clearly understanding why we are prioritising one over another. Without systemic change, we risk adding to an already bewildering tangle.

Further, there is no comprehensive, publicly available analysis of just how much Australia spends, directly and indirectly, on mental health treatment and support, across all tiers of government, the public and private sectors, NGOs and within communities. Informed estimates put the combined annual bill at more than $25 billion – a staggering amount. Governments have responded to a groundswell of concern with increased funding. This, of course, is welcome and essential, but without a systemic understanding, we risk throwing ever-more money at an ever-expanding problem.

How best to nurture community-wide resilience and provide a robust mental health system falls under the banner of, “a wicked problem”. Systematic design theorist Horst Rittel coined this phrase, citing several characteristics of complex social issues. Wicked problems bleed into one another, therefore resisting definition and simple solutions e.g. the crushing and costly nexus between mental health, homelessness and the criminal justice system.

Wicked problems are interconnected and do not respond to simple solutions or templates. No winning line
is clear but, with a flexible approach, they can be mitigated. Inevitably, different players in a complex “wicked” landscape have different explanations for problems and solutions, making cooperation challenging. Wicked problems are of indeterminate scope and scale. Most social problems are wicked and our ‘non-system’ is unarguably one.

In his article, *Wicked problems ... problems worth solving*, John Kolko notes they are characterized by: “... incomplete or contradictory knowledge, the number of people and opinions involved, the large economic burden, and the interconnected nature of these problems with other problems.”

If we want the world’s best mental health system we must clearly understand the wicked nature of our challenges and find new ways through the maze. Previously successful ways of dealing with our public health problems do not and will not work for “wicked” or complex problems. If we do not grasp this, we will continue to apply the wrong solutions, leading to ever-more frustration, expense and chaos.

As Phil Hanlon, of the University of Glasgow’s Public Health and Health Policy Section so eloquently puts it, modern society itself means we can no longer rely on the methods that triggered previous waves of improvement: clean water, sanitation, antibiotics etc. ¹¹²

“You cannot use the same ‘understand, predict, control’ mindset that characterised those four previous waves of health improvement to solve problems that are generated by modern society itself,” Professor Hanlon urges. There is “…a gap between the problems and our ingenuity or ability to solve them. We constantly dreamed that there would be one further turn of the policy wheel and, if only we could invent it, we would solve these problems. But it is not so.”

In their article, Four Waves of Public Health¹¹³, Prof Hanlon, Sandra Carlisle, Andrew Lyon, Margaret Hannah and David Reilly argue that modern populations are overwhelmed, evidenced by rising depression, anxiety and declining wellbeing. They define “dis-ease” as a “modern epidemic”, with modernity itself at its root.

The World Health Organization says depression is the fastest growing cause of global disability, yet, Hanlon et al argue, “neither current nor historical approaches to public health offer ways to meet these needs... We need different solutions … public health faces a series of challenges that are not amenable to current strategies, despite our best efforts.”

Hanlon et al argue that successive waves of public health improvements each reached a trough, before the next wave gained energy. However, rather than waiting for a fifth wave to lift us above our current malaise, Hanlon argues a sea change is required. The first four waves can be viewed as one and we are in the trough preceding the birth of a second super wave. We will need to think our way out.

It is time for the mental health and related sectors to look outwards to schools of thoughts we may traditionally, culturally, shy from. We must not be afraid of turning advances in education, system design and business analysis to the social sector’s ethical advantage. Creative problem solvers in many sectors have embraced systemic thinking and some of these strategies can be translated into the social sector. These thinkers have understood that we cannot solve complex problems with simple solutions – yet this, too often, is how policy makers have responded to mental health.

To respond simplistically in a complex business world invites costly failure, even collapse. Without suggesting the mental health sector should be run “as a business”, we would be remiss not to profit from strategies such as the Cynefin Framework. ¹¹⁴ ¹¹⁵

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¹¹² Hanlon P. Afternow, online resource accessed from: http://www.afternow.co.uk/
¹¹³ Hanlon P. Afternow, online paper, Four Waves of Public Health, http://www.afternow.co.uk/papers
¹¹⁴ Snowden D. The Cynefin Framework, online resource: http://www.youtube.com/watch?v=N7oz366X0-8
¹¹⁵ Wikipedia. Cynefin online resource: en.wikipedia.org/wiki/Cynefin
see things from new viewpoints, assimilate complex concepts, and address real-world problems and opportunities”.

The framework defines five states in which decisions must be made. In the simplest state, an answer is not hard to find. Complicated problems require analysis, but even more complex problems require the net to be cast much wider. Snowden offers the example of a leader, in a crisis, calling in a vast number of creative thinkers, from diverse backgrounds, in that hope that excellent new ideas will be thrown up. This is known as “emergent thinking” when all acknowledge the old ways no longer suffice and we must reach for something new.

Another state is chaos and Snowden argues that simplistic thinking is closer to chaos than we may like to think. “The boundary between simple and chaotic is a cliff, you fall off it and recovery is costly,” he writes. Who in our sectors does not understand the intrinsic truth in that statement, regardless of its genesis?

To understand our mental health ‘non-system’ and transform it will require both emergent and systemic thinking. This is not useless jargon: systemic thinking combines analysis and synthesis. In synthesis, we seek common themes across a system or situation. In contrast, analysis looks for differences. Transforming or creating a system means we can no longer rely on traditional analysis. We must add synthesis to the mix to create sustainable change.

Howard Gardner is professor of cognition and education at the Harvard Graduate School of Education. In his book, Five Minds for the Future he argues citizens will need "out-of the box" and non-linear thinking to solve increasingly complex challenges. A single discipline and its tools will not solve “real-world problems”. Rather, complex problems require interdisciplinary expertise and problem-centred teams working on common goals. Whatever the challenge, five minds must be brought to bear within each of us: the Disciplined Mind; The Synthesising Mind; The Creating Mind; The Respectful Mind; and The Ethical Mind.

As Pete Laburn writes of Gardner’s work: “In a world that shows no signs of slowing down, no individual or organisation can afford to rest on his or her intellectual laurels.” This applies to the mental health and related sectors as much as any others. “The future belongs to those that have made an active lifelong commitment to continue to learn,” Laburn says.

“The synthesising mind is able to select crucial information from the copious amounts available, arraying that information in ways that make sense to self and others. Accumulated knowledge is reportedly doubling every two to three years ... (yet) individuals crave coherence and integration. Nobel Prize-winning physicist Murray Gell-Mann has asserted that the mind most at a premium in the twenty-first century will be the mind that can synthesise well.”

Gardner and Laburn are writing in the educational sphere, but such a mindset is sorely needed if we are to make sense of our sectors and reach the goal we have, with such goodwill, set ourselves. The social sector has itself thrown up answers. One to consider is Collective Impact, a highly adaptable framework pioneered in the United States to help diverse NGOs and communities cooperate on systemic, complex, social challenges.

117 Tomorrowtoday, Online blog, 5 minds for the future-a summary, online resource: http://www.newworldoffwork.co.uk/2011/02/26/5-minds-for-the-future-%E2%80%93-a-summary/
119 O’Neil D Graham K. Collective Impact, online resource: Collectiveimpactaustralia.com/
Our “wicked” problem will not respond to simple solutions, no matter how well funded. We will not be able to “coordinate” our way out of the tangle that is our non-system. We need a radically different approach, one that will challenge and stretch us in new ways. The alternative is to remain stuck in chaos and further entrench disadvantage for more and more people. It won’t be an easy or express journey, but the time to start is now.

Dawn was previously CEO of Lifeline Australia and in 2009 was appointed a Member of the Order of Australia for services to the community and to Mental Health. Dawn has a background in business management and marketing and is a member of the Australian Suicide Prevention Advisory Council (ASPAC).
56. One old organisation’s journey

Open Minds Queensland

Open Minds is a community managed organisation which provides support services to over 900 people living with mental illness, disability and acquired brain injury in Queensland. Open Minds has been delivering services to the community for over 100 years and as such the organisation has, alongside service users, ridden the wave of significant change that the mental health sector has experienced in Australia, particularly over the last 30 years.

Open Minds was established in 1912 as the Queensland Wattle League and primarily focused on supporting young artists through granting scholarships. Following the First World War the League’s focus shifted toward supporting injured returned servicemen and their families, many of whom were experiencing mental health issues as a result of trauma. From the 1950’s the organisations focus moved toward providing opportunities for people with psychiatric disabilities to engage in paid employment and established a workshop. It is with pride today that Open Minds looks back and appreciates the foresight of our predecessors in recognising the vital role which access to employment plays in the lives of people with mental illness and disability.

The release of the Richmond Report in 1983 really was the catalyst for major mental health reform, recommending the decentralisation of services and resources away from institutionalised care towards community based alternatives. While a shift to community care or ‘deinstitutionalisation’ was already beginning to occur across certain areas of the sector, the Richmond Report provided the sector with a much needed framework to facilitate this in a systematised way. Further impetus for systemic change came with the Burdekin Enquiry into the human rights of people with mental illness which again highlighted the need for major changes to mental health policy.

In Queensland one of the most significant reform processes was Project 300 (P300) which was aimed at moving people from three main long stay psychiatric hospitals in Queensland into the community living. For its time P300 was a rather ground-breaking initiative as it brought together the Queensland Government agencies of Housing, Disability Services and Health with the non-government sector to ensure people with mental illness returning to the community had the support and infrastructure necessary to maximise participation and integration in their chosen community.

From the mid-1990’s Open Minds has supported over 50 people under Project 300. Evaluations of P300 suggest it has been successful in supporting people to maintain community tenure, reducing their re-admittance into hospital and maintaining their participation in community activities. On a broad level P300 is a success, particularly as it has been shown to cost (approximately) $53,000 per year less than the cost of keeping someone with a similar level of care and support need in a Community Care Unit.

However, it is important not to lose sight of success on a more micro level. Over the last 18 years Open Minds has witnessed people truly flourish and reclaim their lives after years of institutional living. We have seen P300 clients reconnect with family, travel, develop friendships, join clubs, engage in paid employment, start their own businesses, and study. We have countless examples of personal achievement which would have been unlikely if they had not been provided with the opportunity to live and be supported in the community.
The transfer of key resources from the old psychiatric hospital system to the community has seen the establishment of many national and state based initiatives developed to support people with mental illness in the community – housing and accommodation support services, Personal Helpers and Mentors (PHaMs), day-to-day living supports, mental health respite services, consumer-operated services and youth mental health initiatives like headspace (the national youth mental health foundation).

Through the delivery of these types of services Open Minds has the benefit of witnessing daily how community based services can improve the lives of people with mental illness, their families and carers and the wider community. Whether it is people transitioning into community living after long periods of hospitalisation; re-connecting with family and friends; or re-entering the workforce or perusing education goals – we see how services delivered in the community have real and lasting impact and it continually serves to strengthen our belief in, and commitment to, community based mental health services. As a service provider we take our responsibility very seriously. It is a privilege to enter someone’s life and work alongside them as they explore goals, make choices, participate actively in the community and move forward in their recovery.

Much of the success of these community based services is linked to collaboration. Open Minds understands how vital it is for community based mental health supports to be wholly collaborative responses which include clinical services and non-government service providers. Clinical and non-clinical supports cannot exist in isolation – it is the partnership approach which leads to truly effective services and positive outcomes for service users.

With the shift toward community care has come the important shift towards placing the service user in the community at the centre of the mental health system and an emphasis on recovery orientated service delivery. Previously seen as passive recipients of care, the power imbalance is diminishing with personal recovery being recognised as separate from clinical recovery and seen as:

- self-determined,
- self-initiated and
- self-defined.

Open Minds, like other community managed organisations, have clearly defined recovery orientated practice guidelines which help staff develop learning partnerships with service users and create environments which foster the principle of ‘nothing about us without us’.

Along with the move towards community care, another significant shift seen over the last few decades has been the growing recognition of peer support within the mental health sector. While the concept that someone with a lived experience of mental illness could help other people experiencing mental illness is not extraordinary it has taken parts of mental health sector time to embrace the very real value of peer support – but this is fortunately changing. We have seen a number of programs, like PHaMs, build peer support roles directly into models of service and we are seeing the professionalisation of the peer workforce continue to grow and evolve. As an organisation we continue to build and strengthen our peer support approaches. While not surprising, it has been our experience that service users don’t question value of peer support – it is entirely natural and intuitive to them. It is still facets of the sector which often struggle with coming to grips with the professionalisation of a peer workforce.

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 or so with the establishment of the National Mental Health Commission and its first Report Card on Mental Health; the momentum of the NDIS and debate about where psychiatric disability will fit; health and hospital service reform and the establishment of Medicare Locals; the release of the Partners in Recovery Initiative; and moves towards activity based funding and concerns about what this means for mental health related interventions.
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. The service system still feels entirely fragmented for many people, as one service user reported to Open Minds:

‘There are lots of programs and services around out there, with good people working to do the best they can for me but they don’t always know about each other or seem to even want to work with each other to help me’.

So many reports, enquiries, plans and policy initiatives and we are still in a situation where we hear of people falling through the gaps in service or feeling services are inaccessible – highlighting that it may not simply be more services that are needed but a more coordinated and cooperative ways of delivering services. The Partners in Recovery (PIR) initiative has set about addressing this and while still in its very early stages, the hope is it creates the beginning of the systemic change required to ensure services are delivered in a more coordinated way so each person with a mental health issue receives services in the way they require it. PIR appears to be the first initiative of its kind that is attempting to bring together all facets of the mental health sector in a truly collaborative way.

A great deal has happened in Australia in the mental health sector over the last 30 years and each will have their own perspective on whether it’s lead to positive change, negative outcomes or a mix of both. From Open Minds perspective, there is still much work to be done.

This year Open Minds is leading Mental Health Week in Queensland with the theme ‘We’re all in this together’. The theme promotes how mental health is everyone’s responsibility and we all need to respond (government, business, service users and their families, community managed agencies and the general public) to ensure those experiencing mental health issues are heard and know they are not alone. We are sending a clear message that mental health is everyone’s responsibility and it takes collaboration at all levels to make lasting and meaningful systemic change.
57. It’s good news week

OzHelp Foundation

What does Ozhelp see as the issues among the workers in the construction and other industries you work with?

OzHelp is aware of the concerns around poor rates of health literacy and help seeking behaviours especially amongst the male blue collar work force. The exciting thing that we have observed that given the right circumstances and environment men will ask for help, speak about their problems and will engage. The challenge is to find innovative ways to engage with them. Our programs have worked well at challenging the stereotype that men won’t ask for or seek help. The challenge is to expand this message in workplace setting to other work environments, where similar challenges occur.

What has changed in the past 13 years?

We have had many examples of positive change in the behaviours of individuals, although a certain apathy still exists with employers that they have a role in influencing changes in behaviours. Where workplaces have embraced the principles of proactive engagement in both physical and mental wellness there are good news stories of increased productivity and positive changes in wellness. Levels of health literacy and suicide awareness have certainly increased in areas where OzHelp has been involved, although there is still so much to be done. The main area of change that we have experienced relates to an increased general acceptance that mental health and suicide awareness need to be considered and that people will benefit from being informed, although this is still often difficult to translate into action.

What are the issues for workers in these industry settings

The big issue for the workers that OzHelp works with are generally related to resilience matters and coping strategies stemming from financial stress, relationship matters, long working hours and high risk/stress working environments. The OzHelp model builds understanding in relation to coping strategies, develops referral pathways and empowers workers to keep an eye out for their mates.

Feedback on OzHelp’s programs and approach...

OzHelp Foundation – NT Project, Good News Story 1

‘A 45 year old worker arranged a meeting with an OzHelp Field Officer as he was becoming very confused and frustrated with ‘time’. He also described that he would become angry as he felt no one was working as fast as him and that recently he experienced a moment where he thought he had only been brushing his teeth for a few minutes when in fact he had been brushing them for half an hour. He stated that this had scared him.

During conversation he stated that he consumed 15 full strength beers a night for the last few years and occasionally smoked marijuana, he also described feelings of anxiety. He also stated that he ate take-away every night. Luke stated that he would like to get some support with his anxiety, anger and drinking habits.
OzHelp has provided the worker with information on Anxiety, some coping strategies, the role alcohol and marijuana has on anxiety and some strategies to reduce the amount of alcohol he is consuming and to take vitamin B products. The OzHelp Field Officer has referred the worker to a withdrawal clinical for counselling and mental health support for his anxiety but still supports the worker regularly. The worker has worked to reduce his alcohol intake, bought vitamin B and organised time off work to attend the withdrawal clinic.

**OzHelp Foundation – NT Project, Good News Story 2**

Following a Tradies Tune up, a site manager contacted OzHelp as one of his workers aged 26 had approached him stating that his marriage was not going well as his wife was using drugs and partying and he had found a text from another guy. OzHelp attended the worker on site within 20 minutes. He stated that his wife would be interested in couple counselling. OzHelp was able to book them a counselling session for 2.30pm that afternoon. The worker was followed up by OzHelp and he advised that the counselling session went well and he is hoping to continue to attend these.

**OzHelp Foundation – NSW Regional Project, Good News Story 3**

'A 26 yr old plasterer was referred to OzHelp by his employer at an onsite OzConnect BBQ. It was known to the employer that his employee's two older brothers had completed suicide and it was noticed that the employee in question had also been showing some warning signs of suicide after experiencing several adverse life events including the breakdown of his relationship with his fiancée. OzHelp's response was twofold 1) direct (and ongoing) contact with the employee to support him through a difficult phase in his life, and 2) providing targeted information to the employer about how he could best support and keep his employee safe. OzHelp understands that the employee in question is now travelling well however we encouraged both employer and employee to contact OzHelp in the future if there is any further support required.'

**OzHelp Foundation – NSW Regional Project Good News 4**

'I would just like to thank you guys again for spending the time you did with us here at Shellharbour TAFE last week.

The class and I appreciate the effort you all put in to ensure everyone felt relaxed and comfortable with what was going on at all times.

Your program is delivered very professionally and to such a high standard that I wish it could be rolled out state wide. To have three people on hand to make sure everyone is OK is fantastic. The information packages that Denise put together was invaluable, some of the students who passed them on to their children and grandchildren.

I look forward to working again with you all in the near future.

“A HUGE THANKS! “ From us all.
58. And the beat goes on ... stigma

Ingrid Ozols

30 years on ... still the biggest challenge in families

Vague memories of my early childhood birthdays include a rose or a flower from my much adored father on waking, stir a deep sadness.

After my parent’s separation a few years later, I began to feel very differently about my birthday’s and other family special occasions. I was enveloped in extreme indescribable shameful pain and distress which I tried to hide from everyone else around me as any special event was upcoming. But on my birthday I wanted to hide as I was too self – conscious and aware of what was broken. There was nothing to celebrate.

Dad and I had been estranged for many years when I was growing up and then would experience a few more such episodic estrangements when I was an adult.

The many traumas of my childhood had left their mark (parental separation, divorce, re-marriages/readjusting to new family structures, school bullying) along with genetics (my late mother had bipolar disorder) unsurprisingly, developed a range of mental health problems including suicidal ideation as a young child of 7 years of age. Extreme, all-consuming anxiety that would never leave, paranoia that I was so deeply ashamed of and something others thought I could “rationalise my way out of” would ultimately take many casualties over my life. I so didn’t want to burden anyone with my intense pain and psyche ache. I tried desperately to hide behind my loudness and laughter. But inside my psychological prison I thought the pain would kill me.

On the morning of my 40th Birthday, Dad and I shared a few French bubbles for the first time in years and what would ironically be the last time I would ever see him again. My father didn’t die – he is still very much alive and well – thank goodness. A few short weeks later, the price of stigma, misunderstanding, shame and anger from a broadsheet article appeared in The Saturday Age about my journey from illness to wellness, was the death knell to an already fragile relationship.

I had been an active advocate sharing my journey of illness to wellness publicly and via the media for several years. But this was it. It was too much for my family to see my story in writing. The ½ page article of the then A 1 Section was one you couldn’t miss – gulp. Sharing my suicide attempts, some editorial misinterpretations and an email later, I would hear the news that “My father didn’t wish to have contact with me. How could I bare such negative and morbid information?” Years later the word’s still filtered through the family grapevine that “They had wiped their hands of me.”

I had blamed no-one, as no-one is to blame for my mental illness, but yes there were many contributing factors. I didn’t wish to cause anyone pain. It was my story, my reality. Today, I am still not sorry for what was written, I am however sorry for the pain those words and behind the scenes that my mental ill health caused and that our psychopathologies were not compatible. Love was never going to be enough.

This incident made me question if I should stop or continue the work of an advocate and educator that I loved doing. Years later I am still continuing my crusade with many others in the mental health sector to try and make the journey for other people, their families, friends, workmates and community just that little less painful. Mental illnesses cause enormous pain to the person and the people most closest to them.

I am not ashamed of who I am or what I do. I remain an even more passionate advocate who has the lived experience of a mental illness. In my case my bipolar disorder is a part of who I am. I have turned a vulnerability into a strength. At times I am still vulnerable and don’t always manage my health and wellbeing as well as I could, but I am aware of my triggers and am a work in progress.
After years of grieving and regular nightmares, I love my father and his family from a distance. We have no contact at all and haven’t for nearly a decade. This won’t change. I have come to a space of peace and forgiveness of them and myself. This lifetime wasn’t meant to be for us – maybe the next one will be. Out of respect to my father, his family and my own, the door is now forever closed.

*I share this deeply painful experience in the hope that other families may learn to communicate lovingly, more patiently, less judgementally. Walking away was horrendous on so many levels, it was one the hardest most painful experiences of my life, it was like experiencing a death. Eventually it would prove to be the most empowering thing I could have done for myself. It would take me years to realise I had re-traumatising myself over and over again walking back into that space. None of us understood this – we all did try our best. Nor does that mean any of us are bad people – far from it. My father has a beautiful family – we just couldn’t get through some big painful issues to do with mental ill health – we didn’t even know it was that, but I do in my heart of hearts know full well that this is what caused the damage. The impact of post traumatic stress disorder, acute distress, severe anxiety, suicidal thinking and attempts, severe depression, waves of mania – that’s a lot to ask of others to get and understand. Especially resilient well balanced people who have never experienced what it is to be emotionally and psychologically broken. It’s like looking at a whole egg and comparing it to a glued one that was once broken. I recognise that in trying to hide some symptoms, I exacerbated other ones that were more noticeable than I imagined. The paranoia was a biggy to family and friends, my intensity, neediness, obsessiveness, mood swings, distorted paranoid thinking, emotional fragility, anger, such distress that I did think about dying and felt unsafe and on occasions acting out on those thoughts and feelings. I didn’t know how to deal with it, so how could I expect others to know what they didn’t understand? My self-stigma didn’t help. I thought I had to always show a brave face – I did because I knew that others wouldn’t be able to deal with this. They and other family members to this day can’t still understand it totally. And yet I am far more informed, connected and educated.

We maybe more aware of mental illnesses but our families are still struggling with what it means. To this day I have other members who won’t ask me what I do or how I am going at work? 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 their as an unsexy stigmatised 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. “I don’t get this” and “what do you have to be depressed or anxious about?” Still echo in families homes around Australia. I know because I still hear it too regularly in amongst arguments and conflict in our extended families’ homes.

We have a long way to go to really get this. Family members are coping as best as they can – some stay, others walk away. Either decision brings heartache and consequences.

Though there is more awareness around these issues, 30 years on we still have a long way to go for changes in attitudes and behaviours from the privacy of our homes and families to our broader community and society. In reality this may take decades. But we have to start somewhere – we have to work with families to help them to learn to deal with the uncomfortable, at times confronting and complex and all too often traumatic and distressing situations.

*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.*
59. Message in the bottle
Mick Palmer AO

A Policeman’s perspective on Australia’s mental health environment

I am in no sense an expert in the field of mental health and wellbeing and my commentary is no more than the observations of a layman in the field. These observations, however, give me little confidence that mental health reform is in the state we would desire or has progressed to the extent some commentators may suggest.

I recognise, in saying this, that my involvement has been only peripheral and that I am focussing on a small fraction of the mental health problem. Nevertheless, I suspect the words of reform progress are still, all too often, not reflected in the actions.

When I first went to the Northern Territory as a very raw recruit police constable in the early sixties, I found myself policing an offence known as Ward Drink Liquor (WDL). Under this legislation Aboriginal people committed an offence by simply consuming alcohol unless they were classified as “citizens” and their names appeared in a bible-like book known as a Citizens Register. Even to a very young, naive, male from eastern New South Wales, the legislation seemed hugely discriminatory and punitive.

I did, however, quickly come – rightly or wrongly – to understand that many of the Aboriginal people who came to police attention under this legislation were alcoholics or had serious alcohol related problems, and that, while misconceived and misguided, the legislation may have been initially well intentioned. Even as young recruits, however, the enforcement of the legislation made most of us extremely uncomfortable. It seemed to us that it made the fatal mistake of treating victims as offenders, addressing the symptoms rather than the causes and presuming that one size was likely to fit every case.

Under the WDL provision, it was not unusual for 80–100 arrests of Aboriginal people to be made in a single night in Darwin at a time when the population of the city was only about 13,000. Similar, if not higher, comparative percentage rates were the norm in Alice Springs and other rural centres. Often the same person would be arrested two or three times in the same day. In many cases the person apprehended was not under the influence of alcohol but had been seen, and reported, frequently by publicans wishing to remove certain patrons from their premises, for consuming alcohol.

Some of the people brought to notice were simply walking through public bars of hotel premises draining the dregs from discarded beer glasses on bars and tables, their behaviour, in itself, an indication of the medical health and social problems they were suffering.

Many of these people, I realised later, were not simply consuming alcohol but were suffering underlying health or mental illness problems which were the primary causes of their behaviour. Sadly, these possibilities were not generally identified or considered unless absolutely obvious and police and other likely first responders received little or no awareness or skills training which may have caused questions to be asked or more effective assessments to be made. Essentially, if someone exhibited the characteristics of being drunk or impacted by liquor, they were treated accordingly without further question or analysis.

When the WDL provisions were repealed in 1964, the government in reality addressed a symptom and redressed a recognised discriminatory law, but did little to address the cause/s. This failing in my opinion has been repeated with monotonous regularity in the 50 or so years that have followed.

Public drunkenness offences and ‘restricted area,’ and ‘dry area’ alcohol consumption regulation within Australia have continued, either intentionally or accidentally, to effectively target Aboriginal people and to ensure their monopoly of the arrest rate figures. Again, too often, people who presented as drunk were treated as being drunk regardless of other factors that could be contributing to the person’s state of wellbeing.
This is not to criticise the police officers and other first responders on the ground who, in the vast majority of cases, deal with such cases with care and sensitivity, but rather to emphasise the difficulty of the problem and the apparent political reluctance to genuinely address the underlying causes.

Police officers are not health workers and the amount of training and expertise they can realistically be expected to receive and achieve in the identification of health, particularly mental health, conditions, is limited. Work pressures, community expectations and arrest rates are high and resources and access to third party assessment are frequently inadequate or unavailable.

This situation was starkly illustrated by the Black Deaths in Custody Royal Commission conducted during the early 1990’s, nearly thirty years after the abolition of the WDL liquor laws. In a disturbing number of cases Aboriginal people who died in custody within Australia, including particularly those who committed suicide, were found to be suffering medical and mental health conditions which, for a range of reasons, had either not been known, identified or considered as an area of concern at or during the time of their incarceration. Many of the suicide cases involved young people who, it later became clear, were suffering depressive and other mental health problems at the time they committed the offences which led to their ultimate arrest.

In an article titled “Heartbreak And Hope: A son’s reflections, 20 years on” which appeared in the March 2011 edition of the Australian Options journal, Tim Muirhead, the son of the late James Muirhead, the initial Black Deaths in Custody Royal Commissioner, reflected that his father’s experience may possibly have broken his father’s heart. Inter alia, in his article, Tim Muirhead made the following observations:

“Early on the Royal Commission found, through simple maths, that one of the key reasons why so many indigenous people were dying in custody was that so many were in custody. As a result Dad did what, in my view, was the single most important act of his working life – he met with Bob Hawke and insisted that the Royal Commission would be meaningless if it did not explore the underlying issues that were leading to such high rates of incarceration, (and of course other disadvantages such as illness, mortality, substance abuse and so on) …. 

“So it’s good to ask 20 years on, what has been achieved from this heart-break?

Raw numbers give a mixed report card, but indigenous incarceration rates are scandalously high, and avoidable deaths continue, each of them unacceptable. We must constantly ask: are we diligent enough?”

It is an excellent question. Twenty years on and many of the Royal Commission’s recommendations have not been implemented. Nearly twenty years on and Mr Ward, a respected tribal elder from Warburton, Western Australia, was virtually cooked to death in the back of a custodial van whilst being transported hundreds of kilometres to appear in court on a traffic offence. As Tim Muirhead observed:

“The Coroner’s report is distressing – not just for its summary of what led to this death, but for what it reveals about the lack of basic justice, diligence and respect being played out within custodial authorities in relation to Aboriginal people …

“the (Coroner’s) report adds:’ A question which is raised by the case is how a society, which would like to think of itself as being civilised, could allow a human being to be transported in such circumstances’. It’s a good question; a heartbreaking question.”

If my some 35 years of police experience are any indication, I suspect very similar questions could still be asked in the area of mental health despite the aspirations of the recently released Roadmap for National Mental Health Reform (2012). Many people with a mental disability live in the community and rely enormously, upon family support for even basic care and protection. In circumstances where this family support is not available, or the person, due to his or her condition, will not accept family support or guidance, they are frequently left in an extremely vulnerable position. If they are unable or unwilling to seek and engage mental health support, such support is unlikely, in many instances, to seek and engage with them.
During 2009 I was privileged to have the opportunity to serve as a member of the National Human Rights Consultation Committee (the Committee) appointed by the Federal Government under the chairpersonship of Father Frank Brennan. The brief of the Committee was essentially to consult widely with the wider community and identify which human rights should be protected and promoted; to determine whether these rights were currently sufficiently protected and promoted, and to suggest how Australia could improve its human rights performance. The Committee travelled extensively across Australia, visiting many remote and rural as well as urban communities; met with some 6000 persons in community consultations and received submissions from about 35,000 people.

Many of the people who attended consultation forums or who made submissions to the Committee raised the issue of the human rights of people living with mental illness. People living with mental illness were seen as among the most vulnerable members of the community and among the most at risk of “falling between the cracks”.

Many examples of inadequate mental health care and support were given to the Committee including: the downside of the move within the mental health system to a community based care and treatment approach which involved the closure of many care and treatment institutions; the consequent lack of support, resources and infrastructure to replace previous treatment centres; many mentally ill people living on the streets or being found in prisons because of a lack of support and protection, the huge burden being placed upon families to provide care and treatment and the inability of the system to effectively deal with co-morbidity cases where people have co-existing mental health and alcohol or drug problems.

In recent months I have had two encounters with the reality of contemporary mental health care as it has impacted on the families of personal friends.

In the first case, a mentally disadvantaged young man formed a relationship with a similarly disadvantaged young woman who fell pregnant. Shortly after the woman gave birth the pair separated and dispute arose over custody and access. The dispute escalated and, despite the intervention of legal aid, strong and loving family support for at least one party and the utilisation of formal Counselling services, the issue remains largely unresolved and unproductively bitter. Essentially, it seems to me, this situation is a consequence of the mental health problems of both parents, the lack of any genuine and on-going mental health engagement and support and a confused understanding of the intent and scope of the privacy laws.

With the aid of a mental health case worker the young man had secured casual, part time employment with a large retailer. However, the young managers at the retailers, despite the understanding reached with the case worker, did not provide the support and direction the young man needed to perform effectively. They were intolerant of his limitations and quickly reduced his shifts to very basic hours.

The case worker who had secured him the employment did not maintain contact with either the young man or the retailer or demonstrate any interest in the young man’s progress. The result has been that the young man has no respect for his case worker and is despondent about his work situation and prospects.

In the 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 wellbeing, 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.
Cornelia Rau is, perhaps, the most notorious recent example of a person with a mental illness being treated abysmally because of a lack of diagnosis and ongoing care and management while in an institution.

Rau, an Australian resident of German descent who had a long history of mental illness, including what had previously been diagnosed variously as ‘schizoaffective bipolar’ and ‘chronic schizophrenia’, was detained as a suspected unlawful non citizen under Section 189 of the Migration Act in March 2004 and held in Immigration detention for a total of 10 months, including 6 months in a Brisbane prison, before being identified and released.

The publication of Cornelia Rau’s case led to an inquiry to determine the facts surrounding her detention. The Inquiry faced the conundrum; how could an Australian resident be detained for 10 months and not be identified for all that time, how could her long standing medical condition remain undiagnosed and why were her psychiatric assessment and diagnosis processes apparently so flawed.

The Inquiry findings and recommendations are quite complex but essentially, while in detention, Cornelia Rau suffered from a lack of comprehensive ‘cradle to grave’ case management, grossly inadequate review and inquiry, flawed assumptions and a lack of basic care and compassion. While her initial detention was understandable and probably quite reasonable in the circumstances, as Cornelia Rau, gave a false name and assumed a false identity, her ongoing medical and mental health care and assessment was totally unacceptable under any circumstances.

The situation where people with a mental disability come into contact or collision with the law remains, I believe, fraught and in need of further dedicated attention.

In 1995 Warren L’Anson, a person known to be suffering mental illness, was tragically shot by police in Canberra during attempts by police and members of a mental health crisis team, to resolve an incident in which grave fears were held that Mr L’Anson was about to commit suicide.

Whilst the Coroner Mr Ron Cahill cleared the police of any wrongdoing and the incident was attended not only by police but by trained members of a Mental Health Crisis Team, the findings of the Coronial Inquest in 1998 emphasise the nature and complexity of the mental health reform and improvement process.

As Mr Cahill recommended, inter alia, in his Coronial Report:

“Appropriate levels of funding for non government community agencies providing mental health care and accommodations to persons in the community are a vital consideration. If such groups are not appropriately funded, mental health crisis will increase and exacerbate and the need for mental health intervention will become greater.” (Recommendation 24)

In the L’Anson case it is absolutely clear, it seems to me, that both the mental health crisis team members and the police were totally committed and focused upon Mr L’Anson’s health and wellbeing and were motivated only by a desire to prevent him harming himself and to take him to a place of safety as quickly as possible. Nevertheless, despite all the effort and goodwill employed, the incident ended in tragedy. The result of this tragedy was not simply enormous grief for Warren L’Anson’s family but significant and prolonged trauma for the mental health responders and attending police.

Mental health, in all its dimensions is a complicated and difficult challenge. Whilst progress clearly continues to be made and the reforms implemented to date are moving Australia in the right direction, it is important we recognise and accept that we are still in an unsatisfactory place and that much more remains to be done.

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 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.
Obsessive Hope Disorder
60. Forty years on – What have I learnt?

Anita Phillips

My first experience of a Psychiatric facility was as a Social Work student on placement in a major teaching hospital in the 1960s. My sketchy memories from that time are dominated by the fact that the use of LSD and ECT were common practices – but also that Social Workers were treated as valuable members of the therapeutic teams.

In 1970 I worked in the Psychiatric Ward at the Townsville Hospital – a brick “outhouse” that had cell-like rooms, a sole private psychiatrist who visited when required, and my role as the Social Worker was to arrange air evacuations of seriously ill patients who couldn’t be treated at TCH, to major hospitals in Brisbane. In 1975 the Psychiatric Ward was moved to the top floor of a purpose built building. By 1976, it was clear to me as the Senior Social Worker, that the challenging and often confronting practices did not appear to be always in the patient’s best interests, but it wasn’t until 1988 that the full extent of these was revealed in the Commission of Enquiry into the Treatment and Care of Patients in the Psychiatric Unit at Townsville General Hospital (1975–1988).

Commissioner Bill Carter found that the care and treatment of patients were negligent, unsafe, and unlawful. His recommendations lead to the suspension of some senior staff (some of whom declared that it was a ‘witch-hunt’), and the abandonment of unethical practices, not unlike those exposed about the same time at the Chelmsford Private Hospital. (Evidence from these Enquiries was cited by Brian Burdekin as one of the reasons for undertaking his National Inquiry some years later.)

In the early 1980s I found myself as the Social Worker in the Psychiatric Unit in Canberra at the (then) Woden Valley Hospital. My memories from that time may be challenged by others, but, based on my previous experiences, I found this facility a revelation. It was a bright, open sunny building with lots of “program” rooms where all sorts of therapies – such as art and drama – were attended enthusiastically by many of the patients, and counselling and individual therapy were a central part of the treatment and care. But I also have sad memories of the many parents of bright young people, often high achievers, devastated by their child’s sudden onset of schizophrenia, for which at the time there was little pharmacological treatment, and a very poor prognosis.

And then, in the mid-1980s, I was working in rural NSW when the Richmond Report opened the doors of the old “asylums” such as Morrisett and Kenmore, and there was so much hope for the new care model to assist people with mental health issues to move out into the community. However, it wasn’t long before we found that the funding needed for accommodation and regular treatment and care, just wasn’t available, and community agencies were soon overwhelmed by the demand. In addition it was clear that many, many people still needed facilities where they could be hospitalised, at least in the short term, or where they could live in a supported environment. Many could not cope outside and became homeless and often suicidal without any recourse to treatment.

By 1993, Burdekin’s Inquiry found that hundreds of thousands of Australians affected by mental illness were living lives of deprivation, discrimination, marginalisation and stigmatisation. (Burdekin, B (1993) National Inquiry into the Human Rights of People with Mental Illness.) By then I was working in inner Sydney, and daily confronted with the negative effects of deinstitutionalisation, but there seemed no genuine political will to do anything about it. Eventually I came to the personal conclusion that the only way to make significant change was to be in a position to influence the political decision makers. So in the early 2000s I returned to live in North Queensland and found myself as a Member of Parliament (MP) in the Beattie Labor Government.
Maybe, I thought, I could really make a difference by persuading the relevant Ministers to adopt policies that would translate into the right services for people suffering mental health issues. It wasn’t long before I realised that often State governments, while developing appropriate policies, were hamstrung because of limited access to the funds to implement these policies. Going to the Federal government, who controlled the purse strings, felt like being a school child asking for more pocket money. I took the personal decision that it was only at this national level that real change could be effected, and left the State for an ultimately unsuccessful tilt at federal politics.

In the mid-2000s I became a researcher, and was once again confronted by the paucity of services for people with mental health issues in rural Australia. Disturbing examples were one country town of about 40,000 people, had only a visiting psychiatrist who came for a couple of days a month to support people trying to live in the community and one large State had no psychiatrist actually living outside the capital city. We put a very strong submission to the Federal Government, crying out for funding for rural Australia, but nearly ten years later, little has changed.

My current position puts me in constant contact with people suffering the whole spectrum of mental health problems – from acute care to long term chronic needs. Here in the nation’s Capital we still don’t have the services, programs and practitioners desperately needed. Have we learnt anything?

What I have learnt over this past forty odd years is a strong belief that the first answer to solving mental health issues, is in influencing the political will at the federal level. Too often economic constraints overcome philosophic ideals – hopefully DisabilityCare will be a flag bearer for this approach in the future. The second answer is in overhauling the way we deliver services and programs. While modern day miracle drugs really do allow some people to live a healthy life in the community, they are only part of the jigsaw. It seems to me that acute care facilities have gone backwards instead of providing positive, therapeutic and safe environments. We also need to find a way that allows us to properly care for high dependency and forensic patients.

The ultimate goal should be that mental health is treated the same as physical health, with the same positive approaches from health systems, and education for the community to be embracing rather than stigmatising. There are many new and exciting developments that can learn from the past and direct and help us to achieve this in the future – and hopefully not take another forty years.

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 protecting and promoting 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.
61. What’s missing from our reform efforts?

Queensland Alliance For Mental Health

Background

Guided by global human rights frameworks and the National Mental Health Strategy of 1992–2011, the human rights of persons with a mental illness were placed front and centre of service planning. Within this emerging framework a shift from hospitals to community care began and patients, now referred to as consumers, started to weave their way back into mainstream society. Expenditure shifted dramatically from acute care to community services and evaluations claimed Australia led the world in stigma reduction. By the publication of the second plan 1998-2003, however, it was clear that the more things had changed, the more they remained the same.

The National Mental Health Reporting process that began in 1993, instead of reporting on outcomes of the structural changes – such as key advancements in participation of consumers in the treatment they received – reported only on the structural changes, themselves. For example, the mainstreaming of acute psychiatric beds into general hospitals and increasing shifts of psychiatric beds to community placements were seen as the indicators of progress, but the reality was that institutional practices were simply transferred to a different setting. The reports were about the services, not the persons served. And the services began to grow dramatically. By 2005 the number of clinical staff employed in ambulatory community centres was nearly double inpatient full time equivalent staff. While this growth in numbers of staff was seen as key to addressing mental health needs in the community, planners realised that these needs were growing beyond the capacity of the services. The focus on service-first policy was beginning to show its cracks. Interestingly, the percentage of mental health services with formal consumer participation mechanisms between 1993 and 2003 remained unchanged. Recovery had begun to ossify into a regulatory framework where consumer participation was tokenistic, seclusion and restraint practices were hidden unless the result was lethal and community care in many cases merely replicated what used to happen in psychiatric hospitals.

Despite this, in what could be described as a sea-change for consumers and their realisation of full citizenship, the Council of Australian Government’s (COAG) Mental Health National Action Plan 2006–2011 described unprecedented actions that addressed not only health needs, but made commitments to key areas of housing, employment, education and correctional services, all of which play an important part in addressing the mental health needs of Australians. Not only did the Plan deliver agreed outcomes for better access to services and early intervention, it also committed the States to guarantee citizenship to persons with a mental illness by:

*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.*

Emerging problem

However, in the ensuing reports on progress the only reference to accommodation was the Supported Accommodation Assistance Program (now National Affordable Housing Agreement) which is explicitly a crisis accommodation service, not stable accommodation. One national survey, in 2008, reported that all persons in Australia who reported as having been homeless also had mental health issues, with nearly half of them having had a diagnosis of an illness. Employment indicators were no better as the June 2010

data show – for every 1,000 adults of working age, 16 were on a disability pension due to mental illness – “… ‘Mental disorders are associated with the lowest likelihood of being in the labour force.’”

While no-one realistically expects the lofty goals of past or current plans to undo in one generation what centuries of thought and practice have created nor is it unreasonable to ask if the progress has been worth the billions of dollars spent; a more productive question, proposed by the Queensland Alliance for Mental Health Inc., may be: what’s missing from these efforts?

This is an important question, because the value added to the public and clinical sector by the outcomes of community managed mental health sector is not insignificant. In light of the funding provided to the sector compared to planning estimates required by the sector the value of these outcomes is actually very significant. In response to the documented evidence of the effectiveness of many of the community sector’s non-clinical support activities, many services remain underfunded. But more important than the funding issue are the challenges of the sector’s relationship with the public, clinical sector and the imperative to forge an identity, practice and workforce that can provide alternatives to hospital admissions, without turning over-servicing into our premium product.

Recognition as an engine for alternatives to hospital admission is a fundamental challenge to the community managed mental health sector. Positive changes have been measured where the Plan has been applied well and the community mental health sector has coordinated the care of consumers. But these positive outcomes haven’t been attributed to the community mental health sector, largely due to its fragmented relationships with key stakeholders, e.g. general public and hospital staff, as well as its own lack of clarity about expressing what it does. 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.

**Serious problem**

By being able to describe the community health sector, to attribute an identity to it through clearly established practice ethics and measured outcomes, we can avert the serious problem of the service-first approach that characterises the clinical sector – an approach where first response is to offer what we know how to do rather than what the person needs or chooses.

The Beacon Project, the national program funded by Department of Health and Ageing (DoHA) to reduce rates of seclusion is now in its eighth year, without a sense of transparency of results. The absence of reliable data collected by the States on the most traumatic of their practices, seclusion, undermines the trust of the public in inpatient services to provide non-traumatic service. Compulsory treatment has fuelled a generation of demands to end the practice and make services available to people who need them when they choose them. The community mental health sector has met this demand but to continue to do so in fiscally difficult times, the sector must renew its focus and promote itself as the viable alternative to hospital admission.

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121 Ibid. P 35
**Hoping for change**

There are models of person-first/service-last practices that are emerging or are already established that show how the NGO sector and clinical sectors, working together, can move services to the periphery of the consumer’s life, support her full citizenship, and provide alternatives to hospital admission. The most researched of these models is the Soteria House system established by Lauren Mosher. Recent findings found that most persons with acute schizophrenia episodes recovered at least as well as those treated by standard hospital therapy, but with little, sometimes no antipsychotic medications and significantly lower daily costs. Further, the approach provides advantages in that it supports the integration of personal emotions, family and social integration. There are other models based on “earn or learn” practices where participants must be engaged in educational, training, volunteer or paid employment during the day, returning “back home” to their group residence after their work when development and debriefing services are available. This service model provides support during those hours when most services are closed, but are available only “after hours” from 4pm–9am.

Some of the Queensland Alliance for Mental Health Inc. members operate a clubhouse model providing transitional employment and housing as social enterprises in partnership with realtors and landlords. These enterprises provide a service that puts the service on the periphery so that the person’s self-righting ability is the first option to secure employment and stable accommodation.

**Our challenge**

Despite the early tokenism, progress in promoting the human rights of persons with a mental illness has been made, albeit slow, if viewed over the thirty years since the Richmond Report. To increase the pace of progress, the community mental health sector needs to clearly define its ethics and professional profile while strengthening collaboration with multiple stakeholders. It needs to capture what we know and see every day and lead the public sector into its proper role as our back-up clinical support as we provide diversity of service choice, on the periphery of our customers’ lives.

The essence of investment in these recovery approaches is twofold: to provide an alternative to hospital admission – examples of the economic value of which has been demonstrated in the UK; and the development of our communities to accept and support persons with mental illness. In addition to using the minimal funding the NGO sector receives from the State (at least in Queensland) to operationalise these recovery approaches, the next challenge for the sector is to develop the discipline of demonstrating the return on the value of that funding while refocussing our service delivery ethic. Our ability to do this implies the need to commit to agreed outcome measures and their routine collection. The development of communities requires the strengthening of grass-roots local organisations to promote the normalisation of persons with mental illness. This may take the infusion of funds to support stigma reduction campaigns but it can also happen through simple promotions through existing civic resources such as libraries, churches and civic groups. More important than support from the public purse for these two approaches is the unification of existing leadership, and the emergence of new leadership. But that is the subject of another paper entirely.

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62. Ozzie first: mental health nursing charity

Toby Raeburn

ROAM communities

Established in 2005 ROAM communities is Australia’s first dedicated mental health nursing charity. We are dedicated to helping people overcome mental illness in the community, avoiding hospitals, jails and homelessness. After several years working out of a variety of medical clinics last year we were proud to open our first independent nurse practitioner led mental health recovery centre. Made possible by generous donations from family, friends and our local community our centre is located in NSW fastest growing local government area, Camden, South West Sydney.

As the only bulk billing mental health service outside hospital in the LGA our centre has been extremely popular, currently operating with a 7 day wait for appointments. The patients we see are typically socially isolated, poorer and less educated than the general population with fewer resources to get better and a large part of what we do is about offering mental healthcare in a tailored, personalised way. We conduct psychiatric assessment and diagnostic evaluation, prescribe medications, teach patients and families about mental health and engage in social advocacy regarding housing, finance and criminal justice concerns. When it’s too much for patients to visit the centre we conduct home and hospital visits. We train university students and facilitate a weekly mental health peer support group with a free BBQ lunch to offer a psychiatry free social support approach.

It might seem like setting up a mental health recovery centre staffed only by nurse practitioners is providing second rate psychiatric treatment. It’s not. Before we opened, despite having a population of over 60,000 people and being NSW’s fastest local government area Camden had no private or public psychiatry. People from the area suffering severe mental illness or experiencing mental health crisis had to travel over half an hour to Campbelltown hospital and wait in the emergency unit. Or they kept silent – and then often ended up in the emergency ward anyway, much sicker.

A further example of the need for our mental health recovery centre emerged recently when we were approached by a group of consumers seeking a space to hold their weekly mental health support group. Previously meeting at Campbelltown Private hospital the group had been informed that the hospital’s mental health ward would be closing, with a plan to expand the hospital’s surgical beds as they bring in more money. Our focus on optimising consumers’ quality of life and providing opportunity to find socialization, friendship, and peer support was attractive to the group and we have been only too happy to assist by providing a free space and facilitation of their weekly therapeutic group.

Our centre has not only increased access to care for people with severe mental illness, it is also cost effective. We cost Medicare $68 per hour to provide skilled mental health treatment and interventions for severely mentally ill people. That $68 per hour keeps people out of hospital, out of the jails and off the streets. It supports people to contribute to society by remaining in or gaining employment, going back to education and being a contributing member of society. The cost of any other treatment vastly outweighs this meagre amount. For example Medicare rebates for General Practitioners and Psychiatrists are three times more expensive than our service at $69 per 20 minute consultation.

While delivering healthcare to people with severe mental illness is challenging, the most difficult part of our enterprise is the business side. We face regulatory and financial obstacles that traditional psychiatry and psychology clinics just don’t face. Due to our medication prescribing rights powerful doctor’s groups such as the Australian Medical Association have used national media to oppose our practice. Perhaps in response to this lobbying, as part of the last 2012 May budget the federal government froze our Medicare funding stream called the “Mental Health Nurse Incentive Program”. This freeze has stopped us from being able to employ any more nurses and restricted our wages which already fail to provide enough to pay for rent or reception assistance.
One of the creative ways we currently get around our lack of funding is through the use of volunteers and facilitation of university student nurses from local universities. Volunteers currently help out two days per week on reception and students get involved in mentoring and psycho education. They will sit down with patients to talk about their diet, social and housing situation etc. They will accompany patients to Centrelink appointments etc. while learning the reasons behind the complex challenges of living with severe mental illness.

In summary 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.

Despite the challenges we believe our model of care provides an example of a quality community based mental health service and hope that the government will support us by improving funding for nurse practitioners so we can develop our service further. In the long term our vision is to build a centre of excellence in mental health recovery, based in Camden in South West Sydney. Our dream is of a service operating 7/52 days of the year, offering a full suite of nurse led clinical psychiatry, psychotherapy, mental health education and urgent care accommodation services. If you would like to contact us please visit www.roamcommunities.org.au

ROAM Communities Mental Health Nurse Practitioners Matthew James (left) and Toby Raeburn (right)

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 Altruism Award.”
63. A rightful entitlement

Rob Ramjan AM

Sometime in late 1993 I shared the stage with the Human Rights Commissioner, Brian Burdekin, following the release of his report on the inquiry into the human rights of people with mental illness. My task was to enumerate past Australian Inquiries, Royal Commissions and Reports, their potency and outcomes, before introducing Brian. There were so many that were recent and some that were truly inspirational and should have been game changing for people with a mental illness such as the Callan Park Royal Commission, the Eisen Wolfenden Report and the Richmond Report. Generally they were not. We had such great hopes for the outcomes from Brian’s report.

We knew many of the answers and yet we were not moving forward.

Sadly this situation is not new. Look to the Alleged Lunatics Friends Society (England 1845-1863). This group of English consumers campaigned for basic rights and may have been the first to use the concept of recovery in their manifesto. They campaigned for changes in the lunacy laws, which would reduce the likelihood of illegal incarceration, improvement in the condition of asylums, and for help to discharged patients. It also became a matter of principle for the ALFS that the stigma attached to ex-asylum inmates should never be a barrier to normal integration. They suggested that they were rarely given the chance to exercise their will or judgement, which had a very material effect in impeding their recovery. (Nicholas Hervey Medical History, Vol 30, Issue 03, July 1986, pp 245-275).

At the heart of our failure in Australia is the failure to adequately fund mental health services. At best we have achieved about 50% funding. Currently these services receive about 7% of the Health budget, it should be a minimum 14%.

Despite this there have been improvements. The COAG reform process led to the introduction of innovative federal programs such as Day to Day Living, albeit drastically underfunded, Personal Helpers and Mentors and for the first time a respite program for carers of people with a mental illness are advances that are making a difference. There have been improvements in the available medication, but this has been matched by the retreat of state funded community mental health services back to hospital campuses.

However the biggest improvement and one that cannot be ignored is the engagement of the community at large. There are votes in mental illness – a lot of votes – and this can no longer be ignored by the major political parties.

It is time now for an indelible line in the sand.

We must keep what we have been given, pitiful as it is.

We must get what we have been promised.

And we must demand what is rightfully the entitlement of any citizen of this country – comprehensive services that address the holistic needs of a person with mental illness and their families and carers.

Rob 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.
64. “Must try harder”

Alan Rosen

Australia’s half-hearted attempts at transition from hospital-centric to community-based mental health services

There is widespread and increasingly consistent international recognition that institutional hospitalization does not offer maximal therapeutic support or care; a movement towards provision of mental health services in the community; innovation in community care, including housing; work; legislative reform; the need for committed leadership, adequate funding, and stigma reduction; and the imperative nature of increasing the mental health workforce and enhancing its skill-set to encourage recovery-oriented treatment.

Evolution of Australian psychiatry

The history of Australian psychiatry is entwined with the impact of European (British) invasion and settlement, initially in Australia, in 1788, to form penal colonies to alleviate the overcrowding of English jails, which generated a masculine-dominated, individualistic culture. As European settlement in Australia expanded, the colonists tried to come to terms with the remote, vast landscape of Australia. Some were detained in our early asylums with diagnoses like “Bush Madness” and “Sunstroke”. They fought over land and resources with the original Aboriginal inhabitants, who had been there between 40,000 and 60,000 years. Dispossessed and displaced Aboriginal communities became doubly colonised: once by European invasion and then by incarceration and forced treatment if they were deemed to be mentally ill. Loss and grief were often mistakenly diagnosed and treated as depression, and protest and defiance as psychosis. Forced removal of mixed heritage children by government policy resulted in trans-generational mental disorders.

More recently, culturally congenial methods of working with indigenous people are being integrated into mental health services, for example professional training, qualifying, mentoring and employing of Aboriginal mental health workers. With accelerating European and Asian immigration, particularly since the 1950s, Australia has become increasingly multicultural in its approaches to mental illness. More recently however, Australian governments’ policies have again artificially manufactured and exacerbated mental illness through the stresses of remote detention and uncertainties of fate that they place upon asylum seekers and their children.

Australia: A cautionary tale

Australia serves as an example of a country whose mental health provision structure is evolving from institutional to community-based care. It has struggled with translating plans into service, and reflects how programs can degrade without consistent leadership, funding, and coordination.

By the mid-1950s, occupation of psychiatric institutions reached its peak in Australia. Deinstitutionalisation occurred in the 1960s and 1970s but without significant community supports in place. In a move to appropriately shift mental health care from institutions to the community with adequate planning and funding. The Richmond Report was tabled in 1983 and implemented in NSW from 1984-7. Subsequently, unjustly blamed for unbridled deinstitutionalisation in the state, David Richmond had only clearly pointed out and sought to correct the pre-existing imbalance: that 90% of individuals with severe mental illnesses had already been deinstitutionalised before his study and were living most of the time in the community with only 10% of the public resources devoted to mental health being available to support them. Meanwhile, only 10% were still based in hospitals with 90% of the expert staff and all these resources.

So the money was not following the patients and, as NSW Secretary of Health, Richmond attempted to correct this, but this was thwarted politically by a subsequent government, which diverted the promised resources for the further development of community teams and resumed investment in the stand-alone institutions. Many NSW people, who unjustly condemn Richmond for deinstitutionalisation without adequate community support, do not realise that he is the same clear and independently thinking leader, widely celebrated, who saved the Sydney Olympics from chaos, as the head of the Olympic Coordinating Authority.

Nevertheless, the important mental health reforms he began led to the First Australian National Mental Health Policy, which was endorsed in 1992 by all Australian health ministers. It provided transitional funding in the national budget through the accompanying National Mental Health Strategy. There have been four distinct phases of the National Mental Health Strategy\(^\text{130, 131}\).

**First National Mental Health Plan (1993–1998)**

Services were to be shifted from stand-alone psychiatric hospitals to become largely community-based, ‘main-streamed’ services, integrated with and accessible via general health services, although remaining distinct as specialised mental health services. This included 24/7 mobile community-based mental health crisis intervention services, assertive community treatment teams, a range of supervised community residential facilities, community vocational rehabilitation services and social recovery services, integrated with local psychiatric in-patient units based in general hospitals. They were to develop strong links with groups of consumers, families, general practitioners, the non-government service organisations, and other non-health services, such as housing, disability services, social security and employment\(^\text{132}\).

**Second National Mental Health Plan (1998–2003).**

This plan focused on the principles of mental health promotion, prevention, partnerships with other (non-health) providers of services, and quality. A new emphasis on early intervention programs began to emerge based on the internationally pioneering work of McGorry and colleagues in Melbourne (http://www.orygen.org.au)\(^\text{133, 134}\).

**Third National Mental Health Plan (2003–2008)**

There is now broad agreement that the Third Plan, despite a welcome focus on service responsiveness and partnerships, lacked real accountability mechanisms, and provided few incentives to the states to complete even the first two Plans\(^\text{135}\). Accordingly, the substantial early achievements of the National Strategy began to fray, and gaps in services began appearing as evidence-based community services were short-funded, diluted and/or retracted increasingly to hospital sites\(^\text{136}\). There was also an unanticipated growth in acute presentations of co-morbid drug abuse and mental illness\(^\text{137}\), which overwhelmed emergency and inpatient departments.

Media glare on the human consequences of these problems led to serial national inquiries by the Mental Health Council of Australia\(^\text{138}\), the Human Rights and Equal Opportunity Commission\(^\text{139}\), and the

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137 Gurr R 2005. Drugs and Australasian government policies have created a crisis in public mental health services. Submission to the Senate Select Committee on Mental Health Services from CASP: Comprehensive Area Service Psychiatrists’ Network. http://www.aph.gov.au/sen-ate/committee/men-talhealth_ctte
138 Groom G Hickie I Davenport T 2003. ‘Out of Hospital, Out of Mind!’ A Report Detailing the Mental Health Services in Australia in 2002 and
Australian Senate. In response, a substantial injection of federal funding occurred, focusing on paying largely for non-professional support workers to be provided through the non-government sector, subsidising private fee-for-service counselling for higher prevalence milder mental health disorders. The states were unsuccessfully challenged by the Federal Government to match funding to enhance core public services for lower-prevalence severe conditions. Unfortunately, in order to maintain party political control of them, these new federally funded services were deployed in new silos without any articulation or coordination with existing state operated public mental health services.

**Fourth National Mental Health Plan (2009–2014)**

Accompanied by a new national mental health policy and revised national mental health services standards, it signalled 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.

**Advocacy**

The Mental Health Services Conference of Australia and New Zealand has evolved over the last 23 years into a “strong independent movement” conducting national forums twice yearly, led by a broad coalition of all mental health professional, mental health leadership and management, consumer, family, trans-cultural and indigenous networks. It organizes bi-national forums for evidence dissemination and debate that push for greater momentum in mental health service reform. In 2010 a pervasive on-line national public lobbying network (“Get-Up”) took on mental health and campaigned strongly, particularly for youth mental health.

**Politics**

As time progressed and deficiencies and outright gaps in mental health services became more obvious as they fragmented, public awareness was expanding. The (temporary) National Health & Hospitals Reform Commission found in 2009 that mental health, among other long-term conditions, badly needed public funding for a more consistent shift to 24-hour continuous community services, equitably deployed across the country. This priority was ignored or postponed by the new Prime Minister, Kevin Rudd, who had established the Commission. Rudd focused almost entirely on acute high-tech hospital care and primary care. Shortly, after announcing his ‘health and hospital s reform package, he was dumped by his Labor colleagues.

For the first time in Australia the need for better funded mental health services became a hotly contested issue at the August 2010 Federal Election, with all 3 major parties competing with well-publicised mental health policies, bearing fruit in 2011 with enhanced funding in the national budget. So far, funding created very few evidence based community services, except for early intervention in young people, with more silos between public, NGO and private fee-for-service funding streams, questionable mechanisms for the low-level expertise coordination of vocational, residential and clinical services. However, several independent statutory mental health commissions have been forming (one national, plus 3 state
commissions so far), following new governmental commitments to revive and transparently account for evidence-based, consumer and family congenial, recovery oriented mental health care reform.

**Implications**

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.**

After a period of sustained growth in spending on mental health services, and, following a lull, even with the Federal enhancements announced for 2011-16, Australia still lags behind similar Western countries in terms of the proportions of gross domestic product and national health budget spent on mental health services. **For example, New Zealand’s per capita expenditure on mental health far exceeds Australia’s, now spending 11% of its health budget on mental health services, whereas in Australia, this proportion continues to hover around less than 8%, in spite of the fact that the average burden of disease due to mental ill health is more than 14% (and growing in proportion) of all diseases internationally.** Strong independent advocacy from several new reform-oriented Australian mental health commissions may be able to convince governments to remedy this.

**Current state of play in Australia**

Most Australian governments, state and federal, do not provide incentives or pricing signals which will shape more community based integrated health systems. **New federal pricing mechanisms favour hospital-related services, and therefore are regressive in terms of where mental health service reform needs to go. Their initiatives often appear to be piecemeal and to primarily serve political expediency.** They rarely seek, build or abide by any unifying vision, model or trajectory.

Rather they leave dis-articulated silos of public, NGO and private fee-for-service elements, trying to support and grow both archaic stand-alone institutional mental health services, psychiatric beds in general hospitals and emergency departments, without any evidence of their effectiveness, and community mental health teams all at the same time. Most of our states have uncritically backed all of these approaches simultaneously. Spreading your resources too thinly while trying to be everything to everyone is not much of a clinical strategy, and even a doubtful theological one. Consequently, we have ended up in most states, possibly excepting Victoria, with “ambivalent non-systems of care”, rushing off madly in all directions at once, and ultimately petering out. Meanwhile our human and financial resources are soon dissipated, becoming ineffectively but completely spent.

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

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other, and failing to plan or work together. This is as if Governments have “a reverse sausage machine” which starts with a well-formed sausage at one end, and produces a limp pile of mince at the other, leaving it to service providers on the ground to pick up the randomly spat-out bits and desperately fashion them into a vaguely useful system of care, which may provide some rough semblance of a service. It sometimes seems like governments are embarking on an absurdist enterprise, finely mincing a good steak in the attempt to reconstitute and recreate a facsimile of a fairly ordinary soya bean.154

**Conclusion – Australia must be squarely part of the global movement towards Community Based Mental Health Practice**

Evidence-based global health initiatives for both developing and developed countries are now encouraging a shift of focus from hospital-centred and institutional care to community-based care155, with closer linkage to or co-location with primary health care.

Much work has been done internationally on the roles, teamwork, leadership, training, and future scope of the work of community mental health practitioners. The terms ‘community psychiatrist’ or ‘community mental health practitioner’ should signify an exhortation to ‘go wider’ in seeking rigorous training and experience in both the microsphere of direct holistic clinical and functional care, and the macrosphere of improving the wellbeing of whole communities156. Many of these experiences, particularly for those who came to terms with old institutional care and thinking, are now emerging as practice-based evidence and outline a real paradigm shift from an illness-focused psychiatry to a person-centred mental health and wellbeing paradigm157.

We must acknowledge a new landscape in mental health services with a very different funding environment, inviting partnerships across the traditional divides of public, NGO and fee-for-service funded services. We need to rebuild the presently withering evidence-based modules of mental health services into teams that meet all the fidelity criteria and therefore work well and reliably for service-users and their families. The contemporary models with effective outcomes include crisis teams, one-stop shops for every age group co-located in shopping hubs with primary health care, community based residential respite facilities and assertive community treatment (ACT) teams. These teams should be interdisciplinary, including clinicians, peer support workers, drug & alcohol, vocational, housing and family specialists, dieticians, sports physiologists and visiting community pharmacists, Aboriginal & Transcultural mental health workers as required, and counsellors drawn from all those sectors.

Finally, are community mental health services caught in a recurrent time-warp? Are we destined to fight the same battles to save community mental health over and over again? A shift of gravity of mental health services to community based care is squarely supported by worldwide evidence, and is long overdue in some countries. However, community teams and facilities do not have a high public profile, unlike salient and brooding hospital complexes, so they are vulnerable to variable and chronic underfunding and recurrent attempts to dismantle them on the spurious basis of economy of scale158159. Some argue that mental health reforms with a marked ideological component and extremely dependent on charismatic leaders are especially vulnerable, given leadership changes and the political powers on which they depend160. However, there is no monopoly on ideology: institutionally centred services have been

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159 Rosen A McGorry P Hill H & Rosenberg S 2012. The Independent Hospital Pricing Authority and mental health services: it is not a matter of "one size fits all". MJA, 196 (11): 675-677.m
defended on the basis of ideology and without evidence for several centuries. Similarly, there remains an
evidence-free reactionary zone defended by a vocal minority of hospital-based clinicians arguing against
a shift towards community care. Furthermore, many pioneers of community services state that they were
never characterized as charismatic until they succeeded, and prefer that their reforms be judged not on
their theories but on evidence of improved outcomes.

Key lessons from all these initiatives relate to planning for sustainability and the need to undertake pro-
active and progressive reform of existing institutional structures such as the old style asylums. We need
to not only redistribute limited resources to the community, but prevent the regressive influence that a
traditional institutional mentality or clinical elite can exert, even after institutions have been downsized or
even closed, causing a loss of momentum and transformative culture. This can often result in a return to
stasis once the project is complete and the energy for reform has dissipated. We must get beyond
isolated great models of best practice in the community separated by vast wastelands of poor service, but
instead to achieve regional arm’s length purchasing and extensive roll-outs of evidence based service
modules or teams, on an equitable and sustainable basis of reform. These must be protected by
permanent mental health commissions and local community mental health consortia (like headspace) or
boards. The latter, by continuing to evolve, should be structured to withstand changes of governments
and political flavors; monitor the quality of services; advocate and report, and represent the consumer
voice, to the highest level of governments, legislatures and the public; and work hard to earn and retain
the trust of consumers, families, and the community.

Acknowledgement: Based in part on a chapter by Rosen A O’Halloran P & Mezzina R on International Community
Mental Health in The Handbook of Community Psychiatry eds. McQuiston H Sowers W Ranz J Feldman J Springer:
New York, 2012

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International Mental Health Commissions for the Mental Health Review Journal (UK) published in December 2012
65. Don’t stop til ya get enough!
Lesley Russell

Mental health reform must be a continuing activity

In July 2010, Prime Minister Julia Gillard stated: "I want to make it clear that mental health will be a second-term priority for the Government." There was a promising start with the appointment of a Minister for Mental Health, the establishment of a National Mental Health Commission in the Department of Prime Minister and Cabinet, and a commitment in the 2011–12 budget of $1.5 billion in new funds over the next five years to build a better mental health system.

It would be churlish to criticise the amount of funding provided. However given the magnitude of the burden of mental illness and the scope and extent of the needs in mental health, even this significant down payment on new services will provide just $407 million more in 2014–15. It could not be considered the endpoint of work in mental health but only the beginning.

There are a significant number of key issues that remained to be addressed, including: the implementation and ongoing sustainability of current initiatives; ensuring better integration of mental health, substance abuse and physical health services; addressing out-of-pocket costs that limit access and compliance with treatment regimes; putting a focus in prevention; and tackling the unmet needs – many of which go beyond health care – of people with mental health problems, their families and carers.

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. People living with a mental illness are at greater risk of experiencing a wide range of physical health problems. The reverse relationship is also true: people living with chronic physical health conditions such as diabetes, asthma and heart conditions experience depression and anxiety at twice the rate of the general population. Failure to treat both physical and mental health conditions results in poorer health outcomes and higher health care costs.

However hopes that the Australian Government will return to the unfinished task of mental health reform are fading. The Government’s priorities have moved to education reforms, the National Disability Insurance Scheme, and the exigencies of balancing the budget and campaigning for re-election. The COAG 2006-11 National Action Plan in mental health which was funded at $5.5 billion is gone and in its place is a much smaller National Partnership Agreement worth $200 million over five years. Although the total health budget continues to grow, mental health’s share of the budget is in decline.

It seems that every year my federal budget analysis is critical about the Government’s mental health policy – of lack thereof. The policy landscape at both the Commonwealth and State and Territory levels is as fragmented as always. There is no national approach.

Since 2006, Australian governments have committed to spending around $8 billion of new money on mental health, but as my colleagues and I outlined in paper published in 2012 in the Medical Journal of Australia,[16] accounting for mental health funding is not easy. Federal and state budget announcements (and re-announcements) and the lack of publicly available reports perpetuate an environment characterised by opacity rather than transparency. 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.

A recent report from the Inspire Foundation with Ernst and Young highlighted the impact of mental health problems in one segment of Australian society – young men. Mental illness in young men aged 12–25 years is estimated to cost the Australian economy $3.27 billion annually and account for 9 million lost work days. These young people have much lower rates of educational attainment and, too often, end up with lifelong disabilities and problems. Yet only 13 per cent receive any care for their mental illness.

The Better Access scheme, is not without some serious flaws (and it has been subjected to endless and mindless Government tinkering), but it does provide the main means to access Medicare-subsidized mental health services for those Australians fortunate enough to receive such care. But as analysis of Medicare data by Sebastian Rosenberg shows, Better Access services are disproportionately used by women. With research showing that Australian men are four times as likely to die from suicide as women, it is clear that our mental health care services need to be better targeted at men. Given the recognized male reluctance to seek mental health care, this means that primary care services need to be better at recognising and providing access to the mental health services that men of all ages need. That’s an ideal role for the mental health nurse – but now the Government has capped the Mental Health Nurse Incentive Program.

There is little evidence to show that new mental health investments are driving improved health outcomes. For people with mental illness, the spectrum, capacity and quality of services available depends on where they live, and the quality of care goes largely un-assessed. Not all the needed reforms require new funds. Much could be achieved by a shift in public policy that sees mental health as an issue that needs to be tackled through a whole-of-government approach, a shift in medical culture and training that equips primary care clinicians to deliver mental health care as an integral part of primary care, and a shift in how services are delivered that breaks the cycle of acute care and homelessness (and often jail) experienced by those with chronic mental illness.

Maybe an appeal to the hard economics of business productivity will ensure the needed reforms. Mental disorders represent the largest cause of disability and account for substantial lost productivity in the workplace. In Australia it is estimated that absenteeism due to depression accounts for around six million working days lost each year, at a cost to employers of approximately $1.2 billion. In addition, depression is estimated to reduce workers performance by at least 40 per cent. For the Australian workforce as a whole, this equates to around 30 million working days per year with reduced productivity, at a cost to employers of approximately $2.3 billion.

What is missing is national leadership to drive this forward. The National Mental Health Commission has an important role here, but the federal government cannot abdicate its responsibilities in this regard. The national health reforms have failed to encompass mental health and we are all the poorer for that. The National Mental Health Commission’s first report card, released late last year, argues that addressing mental health needs is a ‘life and death issue’ that is everyone’s business. That is the challenge that governments, service providers, professionals, business and the broader community must accept.

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163 Sweet M 2012. To improve men’s mental health, focus on education, employment and providing services that men want to use online resource: http://blogs.crikey.com.au/croakey/2012/06/01/to-improve-mens-mental-health-focus-on-education-employment-and-providing-services-that-men-want-to-use/

66. The more things change …

Regional Manager, NGO Service Provider – “S”

There has been an ongoing shift from institutional and state care, though we continue to fall short in meeting the full needs of those experiencing mental illness. The ‘State’ has slowly divorced it’s self from the longer term responsibility for ensuring appropriate care and support are provided. There has been a shift to the person being responsible for accessing services, even when they may not be available. We then blame the individual as being a ‘bad’ patient for not self caring or committing an offence.

Those with a severe or major mental illness continue to have overly high representation in both Homelessness and Correctional services. This is partially due to the lack of ongoing long-term appropriate treatment and support for this group. The recent increases in community services has been much anticipated and greatly appreciated by consumers and service providers. Though there remains the ongoing uncertainty around funding, 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.

There remains a major lack of clinical services to support those with severe mental illness outside of involuntary tertiary treatment. The current options through general practice fall short. There are a few dedicated and very hard working services and practices, though generally the majority lack the time or specialised knowledge to meet the needs of those experiencing severe mental illness.

There has been little discussion or movement towards the introducing a single National Mental Health Act. A single Act would benefit consumers, careers & service providers. The varying Acts across States causes confusion and hinders good continuity of care. Of the services that have received ongoing funding as well as those that have been introduced there has been a severe lack in Evidence based practices, the use and collection of meaning full Outcome measures. Of the data collected this is not being used to optimum benefit in the direction & delivery of services.

There has been a generalising of ‘Mental Health’ through a variety of means, including the community education programs and new services such as ‘better access’. This has led to those with a severe diagnosed illness/disorder becoming ‘too hard’ and those with general stress and poor skills receiving services over people with a major illness.

There has been an increase in awareness of mental health achieved through the varying campaigns. This has not yet achieved a similar decrease in discrimination and ongoing stereotyping of those living with a mental illness. There has also been a generalising of mental health through these campaigns shifting the view of mental illness to equate to general stress and reactions to life events. The skills and knowledge base across the sector has declined in one sense, we have gone from a predominately clinical/academic trained staff to large members of the workforce now only attaining a Certificate level qualification.

This has an impact on their ability to have a wider awareness of the issues facing those with more severe mental illnesses. There are pros and cons for the change to staff with lower or no formal education around mental illness. They can come without preconceived ideas and expectations allowing for greater engagement and hope for the outcomes of consumers. The ongoing tension between the 2 major models of recovery – the conflict in how the term has been generalised though the practice and beliefs are widely differing. The medical model drives the clinical view of recovery; recovery is objective and understood to be a return to a former state of health. Outcomes include reduced symptomatology, hospitalisation and medication use.
The personal view of recovery is driven by people’s lived, subjective experiences of mental illness and recovery, and challenges the notion of permanent mental illness. Outcomes include empowerment, hope, choice, self-defined goals, healing, wellbeing and control of symptoms. Between the differing definitions of ‘recovery’ we can achieve an approach that meets both the needs of the State and clinical services and those of the individual. Allowing a person a level of control an input into treatment even when under tertiary involuntary treatment. There also needs to be an acceptance of risk and self choice, this would allow clinical services to not have to act out of fear of litigation or discipline.
67. Getting people the help they need earlier on

SANE Australia

For more than 25 years, SANE Australia has been at the forefront of championing a better life for people affected by mental illness.

Started by a group of courageous pioneers, who advocated for those affected by mental illness at a time when to mention the term “mental illness” would shut down conversations and cause people to walk away, SANE Australia has always sought to ensure that people’s ‘lived experience’ informed every aspect of our work: campaigning, research, education, support, and training.

With this experience, SANE Australia has witnessed the evolution of the mental health system to where it is today. Twenty years on from the Burdekin Report, now is a good time to assess the mental health system and make a call for key system reforms that will get people the help they need earlier on.

Each year more than 3.2 million Australians will live with some form of mental illness at home, at work, or in the general community. Unfortunately, 65% of Australians with a mental illness do not access services available to them, and of those that do, they often come to help far too late in the piece – the delay between the onset of symptoms and treatment for common mental disorders is around ten years. Of perhaps greater concern is that one in three people with severe mental health disorders do not access any form of help. So while Australia has come a good way in addressing mental health issues these last twenty years, there is so much more still to be done.

Our national spending on mental health has increased significantly in recent years and, according to the Federal Government, currently stands at $6.8 billion per annum. If you take into account the total dollars that are spent across the board in supporting people with a mental illness then the number increases markedly. The recent Medibank Private Report, “The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design”, suggests Australia spends as much as $29 billion per year – $13.8 billion directly and $14.8 billion indirectly. But, whatever the precise funding level, in human terms, an unacceptable number of people are not getting the help they need in a timely fashion.

In short, we have a sub-optimal mental health system that is not meeting people’s needs anywhere near to the extent they deserve.

Against this background, SANE Australia has identified five key issues to be addressed twenty years on from Burdekin.

First, we need a better understanding of how mental health funds are currently being spent and the extent to which existing funding allocations are helping to prevent mental illness arising in the first place and then improving the lives of people once it has. In this regard, we strongly support the commissioning of a report by the Productivity Commission into the Australian mental health system.

In the context of such a report, we advocate for a clear delineation of responsibilities between hospital and community-based mental health services and adequate investments in both. Today, we have too strong a focus on hospital-based services at the State level – this derives in large part from the funding arrangements between the Federal and State Governments. We see benefit in the States retaining sole responsibility for the delivery of hospital-based services and the Federal Government having the oversight of community-based mental health services. The latter should not preclude State Government agencies from tendering for the delivery of community mental health services where they are best placed to do so.

What is essential is that we have a well-designed system whereby people get the help they need early on. The failure for people to get effective treatment and support in a timely fashion leads to a blowout in mental health expenditures to say nothing of the added challenges faced by individuals and their carers. This is also a reason why early intervention and prevention programs are such a vital investment. We should agree on a certain percentage of mental health funding to be allocated to early intervention and
prevention activities while overall mental health funding needs to align with the burden of disease. When it comes to mental health, a stitch in time saves both lives and dollars.

Second, we need to set national targets for achieving specific mental health outcomes. It is not enough to say how much funding has been allocated to a particular area of mental health as if that means the job has been done. Accountability must be around results. We need to see that people’s lives are improving in a measurable way: that rates of common mental disorders such as depression and anxiety are coming down; that less lives are being lost to suicide; that people with a severe mental illness do not die a premature death; that people are not discharged from hospital into homelessness; that workforce participation rates for people with mental illness increase markedly; that more people access quality services when symptoms first arise. Having set these targets, we need to track progress against them and then adjust programs and policies whenever and wherever necessary.

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 Australia also advocates that these targets should be placed within the context of a bigger vision for Australia to lead the world in mental health by 2022. We see a national commitment to leading the world in mental health as a rallying call for the entire sector. Achieving it would be as good a legacy as any individual, organisation or government could ever hope to leave.

Third, we need to do a lot more to reduce stigma, especially in regard to severe mental illness. Stigma is often a major contributing factor to people not getting help early on – for far too many it is only when problems reach absolute crisis level that help is eventually sought. Furthermore, many people cite the stigma they experience around their mental illness as more debilitating than the illness itself. While significant progress has been made in the area of reducing stigma around depression, people with severe mental illness feel little, if any, progress has been in reducing stigma towards those with psychotic illnesses.

There is also a vicious cycle between a lack of effective treatment and increased stigma. The overwhelming majority of people with a psychotic illness, for example, are not more likely to perpetrate violence than the general population. But when a small number of them fail to receive effective treatment and support, then the risk of violence increases, usually directed towards themselves and, on rarer occasions, towards others. In the latter case, however, it only takes one dramatic event to be widely covered in the media for the stigma reduction cause to be set back yet again. To counter this, we need to build a compendium of stories showing how people living with mental illness lead normal, contributing lives. We need the general public to see the norm for what it is rather than as the exception. We also need to find ways for people with lived experience to share their stories more often with more members of the wider community. SANE Australia’s extensive experience in this area tells us that these types of interactions play a powerful role in reducing stigma.

Fourth, we need a better appreciation by policy makers of the vital contribution that can be made by those organisations that interface between the general public and the formal mental health system.

These organisations constitute what the World Health Organization describes as the “Informal Community Care Sector” and include the consumer, carer and grass roots community-based mental health organisations. It is this group of organisations that often provides the crucial early access to mental health services and reaches the largest number of Australians. We know that seeking help early in symptom development is critical to reducing both the severity and duration of mental health problems.

These organisations, therefore, play a critical role in early intervention and reducing the overall mental health burden yet to date policy makers have not fully appreciated their contribution or their potential to help even more people.
Since the Burdekin Report, we have also seen a global revolution in communications and technology that has rendered the Informal Community Care sector more important than ever before. The opportunities now presented by technology to address mental illness and improve mental health are huge. Policymakers need to understand the way in which technology can be harnessed to deliver more effective, timely and efficient services. Used strategically, technology can free up professionals to deal with the more complex and difficult cases. It can help build a nurturing community of peers and carers who can support one another. It can also help those that no one else can reach.

Consider the situation with young people where 1 in 4 will experience a mental health problem over the course of a year yet less than 30% access any professional help. A recent survey of 3,600 young people accessing the Inspire Foundation’s ReachOut.com service found that 75% of participants were experiencing high to very high levels of psychological distress on the Kessler 10 scale. This contrasts markedly with the general youth population where a mere 9% of young people exhibit such high levels of distress. After visiting ReachOut.com, 41% of young people said that they were more likely to seek help from a mental health professional. ReachOut.com is visited by hundreds of thousands of young Australians every year.

Other organisations, such as RUOK, have also harnessed technology to engage the wider community on mental health issues on a scale never possible before. Over the coming years, SANE Australia will make additional major investments in our technology capacity in a quest to assist one million Australians affected by mental illness each year.

For those in, or assisted by, the Informal Community Care organisations, it is clear that there needs to be much stronger government investment in the sector so that the mental health needs of the Australian population can be fully met at an earlier stage. There also needs to be greater investment in the deployment of technology by these organisations. If the full potential of Informal Community Care sector is maximized through policy recognition and adequate investment, this should reduce the overall costs of the mental health burden.

Fifth, we need to do much better on self-care – the sector in the WHO pyramid that touches more people than any other. As carers, professionals, family and friends we all need to stay healthy and strong ourselves. When we take good care of ourselves, we increase our capacity to care better for others. This is a challenge because as we fully open up our hearts to the suffering of others, it is easy to be
overwhelmed by the huge challenges so many people face each day. We know, for example, that far too many carers develop mental health issues themselves. This needs to change. We need to find better ways of supporting the carers and building online communities of carers is one way to address this challenge. At the same time, we can draw inspiration from the heroic daily achievements of the many people living with severe mental illness along with the pioneering efforts of those champions of mental health reform upon whose shoulders we stand today.

SANE Australia believes that, for all the current shortcomings in the Australian mental health system, we can, if we set our collective mind to it, build something truly remarkable over the coming ten years. It will take time and it won’t be easy but it can be done. We at SANE are committed to doing all we can so that less people become unwell in the first place, that those who do recover quickly and that those who don’t at least know that, if you have a mental illness, you are better off living in Australia than anywhere else in the world.
68. Give me a dollar, dollar is what I need

Sally Sinclair

Mental health and employment services policy – where to from here?

We know that much has changed since The Richmond Report of 1983 and The Burdekin Report of 1993. Governments invest more funds annually into services now than they ever have. Mental health has a dedicated Federal Government Minister and is a significant part of the national policy agenda. Where decades ago mental illnesses such as depression and anxiety were never spoken openly about, awareness campaigns now feature heavily within mainstream media.

These are all changes for the better – and it can definitely be said that we have come a long way in the last 30 years, but we also have a way to go in some areas and employment participation for people with mental illness is one of those areas.

Data suggests that people with mental illness experience disproportionately higher levels of unemployment than the general population. While Australia’s welfare system provides a necessary safety net for citizens who find themselves in need, we recognise that in addition to greater financial independence and a better quality of life that can be provided by employment, participation in the workforce also contributes to social inclusion and community cohesion. Employment is an important goal for people impacted by mental illness. We need to do more to assist those people who can more actively participate in the labour market to realise their individual potential and aspirations while also contributing to the Nation’s wellbeing. This requires a diversity of strategies that support individuals, employers and the wider community to address barriers to participation and inclusion. Employment and related services have a significant role to play.

Breaking down isolation from the labour market, building opportunities and encouraging people with mental ill-health into, or to re-enter, the workforce is a key challenge which can only be achieved by a whole-of-government and partnership approach. We need to ensure that services connect across policy silos. Recent initiatives such as the Partners in Recovery (PIR) program, which is aimed at more targeted and coordinated approaches to support people with significant mental illness, can only be expected to increase successful outcomes like employment and community participation.

Conservative estimates indicate that at least 30% of the 930,000 plus individuals accessing employment services have a mental or psychiatric illness recognised as their primary barrier to work. Personal experience and feedback from the industry suggests that many more suffer from mental ill-health as a comorbidity to other barriers to employment. Many fall into the categories of the long term (LTU) and very long-term unemployed (VLTU)\textsuperscript{165}. While reforms to employment services in recent years have focussed on increasing the resources to the most highly disadvantaged, it is essential in order to break the cycles of disadvantage and exclusion that we adopt preventative and early intervention strategies as well as tertiary responses. The better we can connect these responses, the higher the outcomes are likely to be.

\textsuperscript{165} Long Term Unemployed (LTU) is where a person is receiving income support due to unemployed for 12 months or more. In 2010, there were approximately 370,000 LTU Centrelink clients. Very Long Term Unemployed (VLTU) are those persons who are receiving income support for unemployed for 2 years or more. In 2010, there were approximately 230,000 persons listed as VLTU clients of Centrelink.
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 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. The assessment process should not only detect barriers quickly and accurately, but also the supports needed to aid success, and where they can be accessed.

Gaining employment cannot be the only goal of policy improvements. Changes to the framework that allows for better ongoing supports for people once in work will help reduce the often fragile connection people with mental illness can find themselves having to the labour market and increase long term outcomes. While this also requires increased resourcing, evidence demonstrates that the returns both socially and economically from improving participation and inclusion of people with mental ill-health are greater than the investment. According to the Mental Health Council of Australia166:

- Preliminary research shows that Australian businesses lose over $6.5 billion a year by failure to provide early intervention/treatment for employees with mental illness.
- A 2006 report for the Victorian Government estimated that mental illness led to about 4.7 million absentee days a year, of which 80% was due to mental illnesses such as depression and anxiety. This equated to about a $660 million yearly loss to the Victorian economy. This roughly equates to over 18 million absentee days Australia wide.

Being able to ensure people can better negotiate barriers as they arise while they are in work and access required supports to help them stay in work makes economic and social policy sense.

Finally, policy targeted at better equipping employers, and businesses generally, to work with people with barriers to participation is essential. The more employers are exposed to the supports and assistance available to them to aid the employment of people with mental illness, the less daunting situations involving mental health will become. This is not only good for their business, but for anyone they may come into contact with that experiences mental ill-health, reducing stigma and future barriers to participation as a result.

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.

69. Working class men
Anthony Smith

Unemployment, men and suicide

It is time to extend suicide prevention beyond its focus on individual mental health problems, to understand the social and cultural context which contributes to people feeling they wish to die (Samaritans 2012)\textsuperscript{167}

Unemployment is recognised as an important factor in suicide both internationally and in Australia\textsuperscript{168}. People who are unemployed are at a higher than average risk of suicide\textsuperscript{117} estimated as ‘…a twofold to threefold increased relative risk of death by suicide, compared with being employed’\textsuperscript{169}. Data from the Coroner’s Office on the Central Coast of NSW shows that, across a number of years, consistently about 30% or more of all suicides are unemployed people\textsuperscript{117}.

Length of time in unemployment further increases the suicide risk with ‘…unemployment duration being the dominant force in the relationship between employment status and suicide’. This is especially concerning for mature aged workers, as the average duration of unemployment for people over 45 years is 62 weeks\textsuperscript{170}.

Cumulative life event stressors are acknowledged as a significant factor in severe mental health issues\textsuperscript{171}. This is important for men and suicide as many of the crucial factors that impact on men and suicide are not ‘mental health’ issues\textsuperscript{117,120,119,172} and account for a significant proportion of all suicides. However, the statistics on ‘mental health’ factors appear to be boosted considerably by references to ‘depression’, without necessarily any clinical substantiation of the ‘depression’ as a genuine clinical ‘mental health’ condition\textsuperscript{31}. Many of the ‘mental health’ factors are clearly linked to other factors that are likely to have been precipitated by the cumulative life event stressors\textsuperscript{174}.

While there are difficulties for all unemployed people, there are particular challenges for mature-age unemployed. This was recognised by the Federal Government in a paper on Ageing and the Barriers to Labour Force Participation in Australia published in December 2011\textsuperscript{173}. The range of issues include discrimination in employment on the basis of age, mismatch of skills and experience with industry demands, re-entry issues, barriers of the Very Long Term Unemployed, and care-giving responsibilities.

There is also a broadly held belief that the Centrelink/Job Services Australia (JSA) system compounds the difficulties for mature-aged people. Several papers and reports\textsuperscript{174,175,176} have come to similar conclusions about the ineffectiveness of the CentreLink/JSA system. A 2012 paper published by the Salvation Army expresses concerns over issues such as\textsuperscript{177}:

\begin{itemize}
  \item Unemployment, men and suicide
  \item Cumulative life event stressors
  \item Ageing and the Barriers to Labour Force Participation in Australia
  \item Centrelink/Job Services Australia (JSA)
  \item Salvation Army
\end{itemize}

\textsuperscript{168} Ibid.
\textsuperscript{173} Temple J Adair T Hosseini-Chavoshi M 2011. Aging barriers to labour force participation in Australia, National Seniors Productive Aging Centre, NSW.
\textsuperscript{175} Refugee Council of Australia 2012. Discussion paper: Job services Australia: refugee community and service provider views, online resource: http://www.refugeecouncil.org.au/r/rgp/2012-JSA.pdf
\textsuperscript{177} Gallet W 2011. Much to offer: A mature age job seeker’s perspective of the workforce. The Salvation Army. Australia.
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- the incentive-based model... encourages agency staff to direct resources and effort into quickly placing easy to place job-ready clients into employment
- processes which provide irrelevant and inadequate training
- inappropriate job matching and inadequate employability training

In general, ‘mental health’ conditions such as ‘depression’ have been focused on to try to understand suicide at the expense of looking at crucial social factors such as unemployment. The focus on ‘mental health’ may not only limit the potential to provide effective preventative measures for men, but appears to compound the difficulties for many men who may be already distressed120.

Recent development in the understanding of men’s issues means that it is generally understood that the appropriate domain for improving the ‘mental health and wellbeing’ of men in Australia extends beyond the boundaries of the ‘mental health’ system117,120.

There are a number of factors that apply particularly to mature-aged unemployed men, which include:
- Considerably more men are made redundant than women.178
- The rate of suicide for men is four times that of women.179
- The lack of an appropriate ‘men-friendly’ approach for men, including by some mental health practitioners, can lead to increased isolation.120

To ensure the mental health and wellbeing and facilitate resiliency of unemployed men and those facing redundancy, programs are required that can operate within the appropriate settings to ensure a ‘men-friendly’ approach. There is a widening acceptance that not only is there a need to push the settings for suicide prevention and research beyond the ‘mental health’ boundaries, but that there are major short-comings within the mental health approach itself. A study on the psychological autopsies in suicide published in the Informahealth Journal of Mental Health180 concludes, ‘A predominately medicalized view of suicide may prevent the adequate consideration of influences other than diagnosis which may have more importance in analytical and practical terms for prevention and policy in the area of suicide’

One of the most effective measures to ensure the ongoing mental health and wellbeing 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.

Realistically, how can a GP or mental health practitioner such as a Psychologist or Counsellor effectively help a distressed and despairing unemployed man deal with the enormous burden of even a moderate duration of unemployment for the impact this has on financial stress, increasing social isolation and degradation of the self-esteem with the loss of the core self – identification with work? It will only exacerbate the distress for men and cause further isolation to push the ‘help-seeking behaviour’ mantra without having appropriate ‘help’ in place.

Anthony Smith has achieved a national profile for his work in Suicide Prevention and Men’s Issues. Anthony has been a member of the Board of Suicide Prevention Australia, 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.

70. Let’s jump!

Maria Smith

Helping those with mental health problems bounce back through better approaches to employment

Director of Bounce Consulting

Bounce Consulting have been operating since 2006, providing training and support services to job seekers and Employment Service Australia organisations across Australia and the United States.

Bounce Consulting work with Employment Service Providers to:

- train and develop consultant skills
- assist in the development of effective consultant relationship skills with job seekers
- work with consultants to develop effective engagement techniques of their client base
- implement strategies for working with difficult clients
- develop action plans for working with clients who face multiple barriers to life and employment including:
  - Recognising skill deficiencies
  - Supporting requirements of clients with mental health issues
  - Working with clients with disabilities
  - Very long term unemployed
  - Youth unemployment
  - Homelessness
  - Language, literacy and numeracy challenges
  - Motivational and attitudinal issues.

A large focus of Bounce Consulting’s operations include working with job seekers, in the delivery of a 5 week motivational and life skills program to Stream 2, 3 and 4 Job Services clients. Bounce Consulting’s statistics, and those of Employment Service Providers, show that clients with mental health conditions are largely predominate in Stream 3 and 4 services, and are a significant part of our client base.

Bounce Consulting deliver multiple program across Victoria and to interstate clients who face multiple barriers to employment. Students undergo Nationally Recognised training in Certificate I in Vocational Preparation. This course delivers employment guidance and skills assessment activities blended with Neuro Linguistical Programming techniques to motivate clients and assist them to understand their own behaviours, values and attitudes towards work, relationships, health and life situations.

The Bounce Program delivers significant employment and training outcomes to job seekers as well as professional development opportunities within the Employment Services industry.

Given the sometimes challenging and diverse market that Bounce programs operate within, Bounce Consulting sees a need for reform of employment programs to assist more job seekers with mental health problems and related barriers into employment. We collect significant data from our clients on the effects of mental health conditions and the role they play in looking for work and when dealing with employers.
We welcome the opportunity our perspective to support reform efforts that will see more of our clients with moderate to complex needs access the services they need to recovery and take up or re-join the open employment market. Reforms of both employment programs for people with mental illness and reforms of the mental health care system are essential for these outcomes to become the norm and not the exception.
71. Racism, mental health and an iceberg metaphor

Melissa Sweet and Pat Dudgeon

Racist incidents have been hitting the headlines regularly in recent times. Media reports have told of people being abused on buses, trains and in other public places, and being sprayed with vitriol online.

The ubiquity of smart phones and online publishing platforms means that such incidents are now far more likely to be documented and shared, and thus made more visible.

But such incidents represent merely the high-profile tip of an enormous iceberg, whose bulk stretches deep and wide, and often out of sight of the mainstream debate.

Racism is not only the work of a minority of noisy bigots (studies show that about 10 per cent of Australians hold blatantly racist views\(^1\)), but is deeply entrenched across our society and its institutions.

As the ABC presenter Waleed Aly wrote recently, in the wake of yet another publicised incident of abuse, “our real problem is the subterranean racism that goes largely unremarked upon and that we seem unable even to detect.”\(^2\)

Aly referred to “the polite racism of the educated middle class” and cited an Australian National University study that found people with a non-European name were significantly less likely to get a job interview.

With this type of racism, he wrote, “there is no event to film, just the daily, invisible operation of a silent, pervasive prejudice. It does not get called out. It's just the way things are; a structure of society.”

When considering the mental health impacts of racism, it is important to consider not only the effects of interpersonal racism, but also the more systemic impacts of the sort of institutional racism described by Aly.

This occurs when society’s institutions – such as economic, justice, educational and health care systems – function in a way that disadvantages particular groups of people.

The consequences of entrenched institutionalised racism are felt, for example, by Indigenous Australians in their high rates of unemployment, lower average incomes, high rates of arrest and imprisonment, poor health, low education and low life expectancy.

In addition to interpersonal and institutional racism, “cultural racism” refers to the established ‘common sense’ that is shared by most or all members of a society.

Researchers have described it thus: “The public chatter in taxicabs, pubs, football matches and barbecues is replete with evidence of assumed essential racial differences, and of victim-blaming attributions for poor health, educational and employment outcomes and misconceptions about ‘government hand-outs’ and ‘reverse racism’.”\(^3\)

As well as these categories, racism can be intentional or unintended; and overt or covert.

When the full extent of the iceberg is thus unpacked, it becomes clear that for many Australians, racism is not the isolated incident of headlines, but an everyday experience.

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It is not a one-off assault but a cumulative experience that becomes part of the narrative of an individual and the community, shaping behaviour, expectations and understandings of life, with profound implications for the health and social and emotional wellbeing of individuals, families and communities.

Indeed, when researchers surveyed 755 Aboriginal people in Victoria in 2011, they found that 97 per cent reported experiencing racism in the previous 12 months, and over 70 per cent had experienced eight or more racist incidents.79

Racist incidents occurred in shops, public spaces, and healthcare and other institutional settings. Around two-thirds of participants reporting being spat at or having something thrown at them, and more than half reported vandalism of property. Thirty per cent of respondents reported avoiding situations in daily life because of racism often or very often.

While considered by many to be an under-investigated field of inquiry, the health impacts of racism have been shown to be particularly detrimental for mental health and wellbeing.184

Yet the health impacts of racism appear not to be a headline issue for many policy makers.

An electronic search of the 2009 report of the National Health and Hospitals Reform Commission, A healthier future for all Australians, fails to find a single mention of “racism.”185

There is one mention of “discrimination” but in a very narrow context: “Care should be provided in a manner that does not support discrimination against any individual or group and, indeed, is organised to positively foster access and improved health outcomes for the most disadvantaged and marginalised in our society.”

One might have expected a greater focus on the health impacts of racism in the Senate committee’s March 2013 report, Australia’s domestic response to the World Health Organization’s (WHO) Commission on Social Determinants of Health report “Closing the gap within a generation.”

However, an electronic search shows only one explicit mention. This was in the context of a suggestion that the National Health & Medical Research Council develops a social determinants of health research funding stream, which would address areas such as “the social determinants of Aboriginal health including racism, the impact of colonisation.”

Nor is racism addressed in many national mental health policy documents.187

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A notable exception, however, is the *Supplementary Paper to A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention*, which stresses the importance of tackling the various forms of racism in a wide range of settings, in order to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.\(^{188}\) The importance of action to address racism as a determinant of mental health is also highlighted in some other reports.\(^{189}\)

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.

And while much work has been done to redress media representations of people with mental illness, the Australian Indigenous Psychologists Association has called for media campaigns to reduce racism, and to reduce negative media stereotyping of Aboriginal and Torres Strait Islander people.\(^{190}\)

**Broad-ranging action needed**

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.

As Dennis McDermott, Director of the Poche Centre for Indigenous Health and Well-Being at Flinders University, wrote recently in *The Medical Journal of Australia*: "Although living in the same country, many non-Indigenous Australians would have difficulty recognising the world of corrosive attitudes that many Indigenous Australians report. If you’re neither target, nor witness, you miss racist events. The more invisible the racism, the harder it is to comprehend its pervasiveness and potency as a social determinant of health."\(^{191}\)

In a similar vein, Western Australian researchers, who investigated the impact of racism upon the health of Aboriginal people in one country town, concluded that lasting improvement in Indigenous health was unlikely to occur without explicit action on racism.

They said: “Without fundamental changes in how members of the dominant Australian culture behave towards Aboriginal people, initiatives to improve health services, educational and employment opportunities may have limited impact on health inequalities.”\(^{192}\)

In addition to the need for population-wide action, a particular responsibility lies with the research, medical and health professions, which have demonstrated a long history of institutional racism.\(^{193}\)

Health and medical researchers, educators, professions, services and policy makers need to explicitly examine their contribution to both addressing racism, and to being more engaged in preventing and addressing its health impacts.

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The mental health text, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (soon to be released in second edition) provides much useful content and advice for health professionals, services and policy makers.\(^{194}\)

It notes:

“There are pervasive effects of cultural and institutionalised racism that exist within professions, disciplines and institutions. These are often invisible and can take the form of the dominant group being seen as normal or the standard against which all else are judged, while those who are not part of the dominant group are viewed as abnormal or inferior and in need of correction. All disciplines need to examine their role within the social and political structures and systems that give rise to, and perpetuate, racism.”

This text describes efforts to address such concerns, including the founding of the Australian Psychological Society Interest Group of Aboriginal Issues, Aboriginal People and Psychology, and the Australian Indigenous Psychologists Association.

Recommendations for research and policy action to address racism towards Aboriginal and Torres Strait Islander Australians were put forward by a meeting of more than 40 leading researches and academics in Perth in 2009 hosted by the Australian Indigenous Psychologists Association and the Australian Psychological Society.\(^{195}\)

Participants said that “high quality research and evidence must be at the heart of our endeavours to inform public policy and everyday practice in order to understand and combat racism in all its forms.” Such calls are being taken up by organisations like the Victorian Health Promotion Foundation (VicHealth) and the national charity All Together Now.

The Australian Human Rights Commission is undertaking a national consultation which will result in a National Anti-Racism Partnership and Strategy.\(^{196}\)

The Australian Indigenous Psychologists Association has urged the Commission to ensure the strategy addresses racism at multiple levels, including a lack of culturally appropriate and culturally safe mental health services.\(^{63}\)

The rise of social media is also enabling citizen-generated action and advocacy. When a Federal Liberal MP from WA, Dennis Jensen, recently made some racist remarks on Twitter, he faced a swift response from Indigenous and non-Indigenous people via Twitter.

The exchanges led to mainstream media coverage, an online petition calling for the Opposition leader Tony Abbott to stand down Mr Jensen and an apology of sorts by the MP.\(^{197}\)

Initiatives such as the @IndigenousX Twitter account are also enabling many people to talk about their experiences of diverse forms of racism, and to share these stories with the wider community. The rise of social media is not only enabling the viral spread of clips documenting racist abuse, but is also enabling new connections and conversations that may help all of us to reflect more usefully upon racism – and to recognise the iceberg that lurks beyond its most visible tip.

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\(^{195}\) Statement from meeting held at University of Western Australia 2009. National Roundtable on Research on Racism towards Indigenous Australians online resource: http://www.psychology.org.au/mpsych/roundtable_racism/


As Waleed Aly wrote: “That self-examination is crucial. Without it we have nothing to fix, and only other people to blame.”

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Professor Pat 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.
72. Youth suicide and mental health

Colin Tatz AO

1. My studies of Aboriginal, Maori and Inuit youth suicide have been conducted over a period of twenty-four years. The researched communities were in New South Wales, the Australian Capital Territory, New Zealand and Nunavut in Canada. The findings are reported in a book, Aboriginal Suicide is Different: A Portrait of Life and Self-Destruction (Aboriginal Studies Press, Canberra, second and revised edition 2005) and in several journals. These studies have enabled some observations about non-Aboriginal suicide among the young.

2. Mental health in general, and the service providers involved, have been seriously mistaken in attributing Aboriginal youth suicide solely to one or more forms of mental ill-health. My research has one important, perhaps unique, facet: I have read the local coroners' files and witness depositions in situ, and not relied on the two-page summary reports of suicides held by the State Coroner in Glebe and in Canberra, or the New Zealand and Canadian counterparts. Had there been evidence of 'mental health issues', it would have been plain enough from medical, nursing, social worker, pharmacy or police personnel statements. Many witness statements often assume that some disorder must have been present, but there are very few actual records of depression, bipolar disorder, schizophrenia, psychotic episodes and the like. Our society has so medicalised most of human behaviour that every suicide — in real life, in the media, in films, and on television — is met with an immediate reflexive and predictable response that there must be an underlying 'mental health issue'. This is not the case in some 95 per cent of the suicide files.

3. A great deal of Aboriginal youth suicide is what Louis Weckstein (Handbook of Suicidology, 1997) calls 'rational suicide'. That label is usually ascribed to the man who has lost a wife of 60 years, can't live without her, who quietly puts his affairs in order, without her, who quietly puts his affairs in order, writes a good explanatory note and then shoots himself. But rationality also comes into play where a person hits the ultimate brick wall, where he or she can see no solution, or there is no one available to suggest one, or because there isn't one, or at least, an acceptable one. The way out of the incessant pain or conflict, or the brick wall that confronts, can be achieved by ending it all. This is not about depression or some other biomedicalised 'mental health issue', particularly of the kind that infers that the suicide is not really aware of what he or she is doing.

4. Al Alvarez, the noted English literary critic, wrote The Savage God: A Study of Suicide, in 1990. His analysis of suicide in history is brilliant analysis of attitudes to that behaviour across the centuries. He examines the eras of suicide as initially the one of badness in church eyes, then of sadness, and the present epoch of 'mental health issues', or madness. I have yet to come across a biomedical professional who has read any of that history or who can articulate why it is that his or her profession has become sovereign in this domain, and why it should remain exclusively so.

5. 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. It is worth noting that some senior psychiatrists associated with the organisation, Suicide Prevention Australia, are coming round to this perspective. Several prominent researches have come to recognise that there is no future in looking for a 'suicide gene', and that if there is one, how impossible it is to demarcate which racial or ethnic group such 'gene' belongs to in the progeny of mixed-descent unions. Nor is there any future in looking for 'chemical imbalances' in the brain as an explanation. Given the latest fad of brain scans, it is ludicrous to think of scenarios where all youth are asked to walk through airport-type security gates in the hope of setting off a 'depression' or 'suicide' bleep. Even so, the public will take a long time to 'unaccustom' the ingrained view that suicide equals mental illness and belongs squarely in the mental health domain.
6. 'Closing the Gap' and similar programs have yet to show any signs that self-harming, parasuicide and actual suicide are reducing in Aboriginal communities. Suicide Prevention, Life-Be-In-It and similar strategies have yet to show any 'returns' for their labours and expenditure. Young suicide not only escalates, but will be found to be much more prevalent as coronial and police reporting — now under scrutiny and proposed changes — uncover more of this behaviour.

7. The time has assuredly come to look outside the medicalised box for alternative explanations and strategies. Medical self-interest blocks the way, as does a public propensity to want to find a cause in 'illness' rather than in the societal and familial contributory factors involved in most cases. I have given evidence to Senate, Northern Territory Parliament and House of Representatives inquiries on young suicide. In each submission I have highlighted the use of sport — not as a 'cure' — but as a deflector and alleviator of this behaviour ('Aborigines, sport and suicide', *Sport in Society*, vol 15(7), September 2002). It will be of interest to see how long it takes governments and their mental health agencies to get round to thinking about strategies that have been shown to work in other societies.

8. There are several strategies for change:

(a) A series of professional workshops in metropolitan and regional mental health services on suicide, its history, our inability to pinpoint a cause, the treatment of those who (visibly) seek self-destruction, alleviation and deflection strategies and, perhaps, prevention.

(b) The introduction of a short suicide module in the training curricula of personnel who will become the mental health professionals. Once upon a time, medical students were given courses in the social history of medicine. No more. Such a module requires a broad canvas, including an historical conspectus of suicide prevention efforts and their efficacy.

(c) Public education, by way of documentary and media materials that unhappiness, sadness, grief, despondency, despair and gloom are not abnormal emotional states, that 'feeling down' is not always clinical depression, and that self-harm and suicide ideation can be deflected or alleviated by means other than therapy or pharmaceuticals.

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73. Never so clear … Never so far
Simon Tatz

The Mental Health Council of Australia (MHCA) was established in 1997 by then Federal Health Minister Woolridge specifically to corral the views of the mental health sector into a manageable and useful whole.

After six sometimes frustrating years looking after communications at the MHCA, the priorities for reform have never been clearer, or further away.

There is almost unanimous agreement on the major areas requiring investment and transformation.

If governments are serious about delivering a mental health system that meets the needs of all Australians, most of us agree that they need to:

1. Substantially increase their investment in mental health services;
2. Ensure that these services are based on solid research and are evidence-based;
3. Have in place services that properly reflect the demography and epidemiology of mental illness;
4. Support housing services for people with a mental illness;
5. Improve employment support and opportunities; and
6. Create genuine accountability and quality improvement processes.

Some will have different priorities that reflect their own particular interest; some might add another issue or two, but there would be almost total agreement in the mental health sector that these six things are of the utmost importance.

It's simply not correct to say that there is widespread discord or disagreement within the mental health sector about what reforms are needed. Some may place different emphasis or lobby for a particular focus or sector, but this is experienced in all policy areas. Perhaps the never-ending rounds of ‘consultation’ and constantly asking consumers and carers to retell their experiences rather than more forcefully advocating on the agreed on issues feeds the view that the sector is fractured.

And even when divergent views do emerge, is this wrong?

One factor that can create a schism is very basic: the label ‘mental health’ is a misnomer. The term mental health is really a euphemism for mental illness and ill-health. In no other field do we use the word ‘health’ to mean ill-health.

I once saw a document from a health department which interchanged ‘mental health’, ‘mental illness’, ‘mental health consumers’, ‘mentally unwell’, ‘mental health problems’ and ‘mental health issues’. There isn’t even a consistent and agreed on way to describe people with lived experience in mental illness.

A starting point would be to let people decide how they want to be ‘labelled’, if indeed they want to be labelled at all. An inability to settle on how to describe the sector may seem an insignificant issue but it is critically important when it comes to advocacy and input into government policies.

It’s not a dissimilar situation to the way Indigenous Australians have been labelled by successive administrations: Aborigines, Aboriginal and Torres Strait Islanders, Indigenous Australians and First Australians – and then governments and their agencies point to the divisions and multiple voices among the 100 plus language and tribal groups as evidence of a community beset by apparently competing and conflicting goals and lack of unification.

In an environment characterised by complexity, such as Indigenous or mental health, there are several ways to approach reform.

One is for lazy governments to hide behind this confected confusion and succumb to the politics of volume. ‘We hear your many concerns’, says government, ‘and we recognise the various issues, but we can’t possibly fund all of the areas of need, so we’ve chosen to invest in X or Y….'
In this case, X or Y is very often addressing the needs of only the most active, noisiest lobby group and as a consequence, investment is skewed to a particular service, cause or condition.

Furthermore, saying there are lots of stakeholders with different agendas makes it easy to ignore an advocate or group as being merely one of many voices. The other approach is actually a lot harder and involves government and its agencies building an intimate understanding of the players, the issues and the competing ideas.

The level of expertise needed to establish this level of understanding is sometimes lacking. The Ten Year Roadmap for National Mental Health Reform is a good example. It sets no real targets, benchmarks no goals, established no funding parameters and doesn’t articulate what Australia’s mental health system will look like in 2022. This is not to denigrate or downplay the hard work and commitment of many in government bureaucracies, however there is a culture that does not engender innovation or ingenuity.

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.

The MHCA, SANE, beyondblue and others have initiated limited mental health awareness campaigns; however these are no substitute for a nationally funded, vertically integrated campaign like they have in New Zealand or the UK.

The best campaigns, the ones that work, are those targeted at specific conditions or groups.

Yet governments and NGOs don’t fund awareness campaigns/programs under the overarching banner of ‘cancer’ – they recognise that different forms of cancer affect and impact on different people and communities; so they initiate targeted campaigns/policies for breast cancer, lung cancer, prostate cancer, skin cancer and so on.

Importantly, public awareness and information relates specifically to the factors affecting each cohort, such as early detection, smoking, protection from the sun, men over 50, et cetera.

The public is now well aware that someone with breast cancer has vastly different needs than someone with skin cancer, but I’m not so sure they fully understand that a student experiencing stress and anxiety may not necessarily think of themselves as being in the same category as someone with bi-polar disorder or schizophrenia. They both have a mental illness but the information and services needed are different.

Frustratingly, the evidence to date suggests that too many agencies and departments approach ‘mental health’ as an amorphous problem, rather than recognise that policies, practices and messages need to be tailored and delivered with consumers, carers and communities at the centre and with specific groups and even conditions not lumped into one basket.

With the creation of the National Mental Health Commission and an abundance of Senate inquiries, Plans, Reports and consultations, state, territory and federal governments are now ideally placed to capitalise on the very strong agreement about priorities that now exists in the mental health sector and together with the sector build a more intelligent approach to mental health care in Australia.

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.
74. The emergence of postvention

United Synergies

The StandBy Response Service

‘As Shneidman has written, “a benign community ought routinely to provide immediate postvention mental health care for the survivor-victims of suicidal deaths” and indeed, during the past decades a number of countries, including US, UK, Ireland, New Zealand, Australia, Sweden, Norway, and the Flemish Region in Belgium, have developed comprehensive suicide prevention programs and policies which encompass postvention strategies’. 198

At the first American Association of Suicidology Conference in 1968, Schneidman coined the phrase ‘postvention’ to describe those activities that occur after a dangerous or stressful situation and which are now accepted as the response provided to those affected after suicide.

Over the past decade emerging postvention initiatives have included support-related activities (e.g., support groups, online resources, national suicide survivor days), awareness raising activities via dissemination of brochures, books as well as public walks and art exhibitions, and fundraising activities (ibid). Countries that have developed National Suicide Prevention Strategies, e.g. England, New Zealand, USA and the Australian Living Is For Everyone (LIFE) Framework have included initiatives aimed at supporting individuals bereaved by suicide. The increased understanding of suicide bereavement as a public health issue has been a key driver in these changes as the populations statistics become more significant with increased understanding of the long-term impact of suicide loss on productivity and demands on services and the sheer number of those exposed to suicide loss. A recent as yet unpublished research study in the USA has indicated that 47% of the population surveyed had been exposed to suicide loss in a meaningful and impactful way. Efforts to collect postvention data have increased although the deficits in data collections systems particularly in relation to coronial issues remain challenges for reliable data systems. Finally, issues about the social taboo relating to suicide and stigmatisation of those bereaved appear to be changing in some areas and may have constricted the development of postvention as a recognised health practice.

The lack of a coherent and coordinated sector approach also has been identified as a challenge to the recognition of postvention as well as the severe limitation of evidence and research in an area that already experienced competing priorities for scant mental health funds and resources. The focus on understanding and treating suicidal individuals has also meant that until recently postvention received little focus. 199 In addition the postvention field covers several domains including crisis and disaster, thanatology, loss and grief and mental health, and is only recently recognised as an effective suicide prevention approach. In many countries no coherent approach to postvention occurs with additional impacts where suicide is still under judicial consideration and deemed a criminal activity.

The StandBy Response Service is unique in Australia, and throughout the world, in that it is an active postvention service that provides support that is both locally-based and community-appropriate. First implemented in 2002, StandBy operates on the principle of community respect, understanding, and support for the health and wellbeing of people bereaved by suicide. The program differs from other postvention response programs, such as the Baton Rouge LOSS program, due to the strong focus on a

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community based integrated response. The LOSS model has been adapted, or built on in other areas of the world including Singapore, Northern Ireland and Australia. Very few specific suicide postvention programs exist internationally that actively seek out the bereaved in the immediate aftermath of a death, especially in terms of both practical support as well as counselling.

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.

The impact of World Suicide Prevention Day efforts is yet to be systemically measured, however this awareness raising which coincided with greater internet access may also be a contributing factor to the rise in awareness of suicide bereavement and the efforts of governments, statutory bodies, health sectors and communities themselves to recognise and address this issue in a caring and compassionate way.
75. Do we need a crisis to initiate reform?

Harvey Whiteford

Most health reform is incremental and cyclical. Windows of opportunity open from time to time which allows change to occur. This has been true in mental health services in Australia over the past thirty years at the state, territory and Commonwealth levels. Prior to 1990 the Commonwealth Government had little involvement in national mental health reform. In addition to incremental changes over the years, there have been four occasions, 1992/93, 1998, 2006 and 2011, when significant national reform was announced and funded by the Commonwealth Government, usually along with complementary reform by state and territory Governments.

In 1992 the Commonwealth Government endorsed the National Mental Health Policy and first National Mental Health Plan and in the 1993 budget allocated funding, incorporating for the first time mental health specific funding into the Commonwealth/State healthcare agreements. In 1998 the Commonwealth Government endorsed the Second National Mental Health Plan and in that year’s budget provided funding which shifted its focus toward primary care while continuing to provide the state and territories governments with funding in the healthcare agreements. In 2006 the Commonwealth Government supported the Council of Australian Governments (COAG) National Action Plan for Mental Health with an emphasis on a whole of Government approach to mental health reform. In 2011 the Commonwealth budget announced funding for a range of new initiatives and the establishment of a National Mental Health Commission.

There is no doubt that services are better resourced, distributed and serving more consumers than in 1980s, when for example nearly 80% of all state mental health spending was in stand-alone psychiatric hospitals. Spending on these hospitals is now less than 30%, over 90% of acute beds are now in general hospitals and staff numbers in community based services have tripled. However, that there continue to be deficiencies is self-evident to consumers, carers and those working in the sector. The quality of care has not improved as much as the quantity of care and in some areas has actually declined. Ongoing reform is essential. The challenge is how to make this happen.

There are always many issues competing for government attention and funding. Governments often take action in a particular area (what political scientists refer to as a policy window opening) when there is a coalescence of three things – a significant problem, a policy solution to that problem and an environment where action is politically expedient. The latter, the political imperative to do something, can be driven by a sense of crisis and an urgency to address the problem, especially when the problem and its consequences are being repeatedly highlighted in the media. That there was a real or perceived crisis in mental health needing urgent attention has underpinned many government decisions in mental health.

In the lead up to the 1992 launch of the National Mental Health Policy and the 1993 Commonwealth budget, the Human Rights and Equal Opportunities Commission inquiry (the Burdekin inquiry) was relentlessly identifying and publicising major shortcomings in services. The 1998 reforms were preceded by the Port Arthur shootings and, although not found to be a result of a deficiency in mental health services, the tragedy focused attention on mental health issues in political circles and a need for services in the community. Prior to the COAG National Mental Health Action Plan in 2006, the findings of the Not for Service report by the Mental Health Council of Australia, Senate inquiries and the failures that occurred in the treatment of Cornelia Rau were all very prominent. There have been similar, well publicised examples of service failure and personal tragedy, forcing a response from government at state and territory levels.

All health services have failures and personal tragedies. Mental health might well have more than its share due to its legacy of marginalisation and neglect. However other areas of health seem to be able to garner support with more of a balance between highlighting what has worked, what needs fixing and what more can be achieved. How do we balance the two realities in mental health – that cycles of reform have, in aggregate, produced an improvement in the ‘problem’ of suboptimal mental health care but that this
‘problem’ has not been fixed and much more needs to be done. Is it possible to escalate mental health to the threshold where governments will take action without having to rely disproportionately on presenting the system as being in crisis and its services as failing? While the ‘crisis’ approach might obligate governments to do something (reluctantly), it devalues achievements and damages the morale of those working in services, worsens public (and political) scepticism about mental health and impacts adversely on the recruitment and retention of good staff.

However, the way the mental health sector advocates is changing. The 2006 reforms saw the most sophisticated political advocacy campaign (much of it working behind the scenes) that mental health has ever had. The 2011 reforms required sustained advocacy but with less of an emphasis on crisis, failure and personal tragedy. There continue to be service failures and tragedies and these get aired, but the advocacy is starting to more selectively target those individuals and groups who can open the policy window, and is emphasising the solutions as well as the problems. What remains rare is to highlight the successes as part of this package. It is almost as if we fear that this will take the pressure off government to act. But if the cost of getting more funding is damage to the morale and reputation of the sector, and the staff and services we rely on to deliver treatment and care, what do we really gain for the consumer? There are too many examples of funding going up and quality of care stagnant or going down. The reasons for this are complex to be sure, but a barrage of unconstructive criticism doesn’t help. Cancer and cardiovascular services, for example, seem to get resourced with a better balance in their advocacy.

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.

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76. It’s the economics stupid!
Ruth Williams and Darrell Doessel

Economics and ending the crisis in mental health services

Australia’s mental health services sector is subject to several long-standing economic problems. The resource shortages are a well-known economic problem. This problem attracts media attention and the case is often made that more resources could be committed to this sector. Other problems of this sector are not solved by ‘throwing dollars’ as those types of problems are not about resource shortages. For example, we have some empirical evidence of a tendency for resources in this sector to be misaligned with need. Hence, the provision of more resources will not fix this specific type of misallocations of resources and may contribute to the persistent reluctance by governments to provide adequate budgets for people with a mental illness.

The term that we apply here to this misallocation problem is ‘structural imbalance’. Structural imbalance in mental health services can be mistaken for the sector’s resource shortages, even though quite different economic problems are at work, because the impact on the public is the same. That is, both problems result in some of the people in need of services not being served adequately by the system; however, structural imbalance is different from resource shortages 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). Met non-need is anecdotally discussed but seldom analysed in the literatures of service providers.

Unmet need and met non-need are co-existing sides of the same problem of structural imbalance, and under Medicare insurance the mental health sector seems particularly prone to this resource misalignment. The problem has also been noted internationally, including in the United States, Ontario (Canada) and New Zealand, as well as in our Australian studies. Despite the available evidence, any detection of this problem is clearly not to suggest that the correspondence between current illness and service use is completely misaligned.

Our analysis of relevant Australian data-sets provides some quantification of resource shortage, as well as unmet need and met non-need. In our first Australian study we examined the available cross-sectional data200, and we then undertook a study of time-series data 201 and found further evidence of structural imbalance. A book chapter by Williams and Doessel202, entitled “Mental Health Services are Different: Economic and Policy Effects”, summarises those studies and discusses further the sources and implications for Australian mental health policy.

Structural imbalance in the funding and administration of Australian mental health services is not fixed by political pressure to yield to more resources. Mental health services under Medicare insurance are subject to this specific mismatching of need and service utilisation, and throwing ‘political dollars’ to this resource misallocation means the problem is unlikely go away, that governmental relations in this sector become jaded and weary and that people in general also may lose confidence that this sector can ever be different.

The economic development of Australia’s mental health sector is long overdue. It is attainable but many of the sector’s problems remain unaddressed. We have undertaken studies of the various other problems in the sector, reported in 29 journal articles; some headway was made on all fronts regarding the sector’s economic problems. The key message in conclusion is to emphasise that the sector does not have to

trapped in its ‘less developed’ economic state and that a step towards the sector’s development requires an appropriate stance towards the problems and for economic policy to be developed that is informed appropriately by evidence. For example, there are economic reasons behind why structural imbalance and poor resource management are happening. That economics is a critical aspect of the ‘crisis wheel’ of the mental health sector. Whether, or not, the sector gets off its treadmill requires diligent, evidence-based planning and deployment of such plans. Until such a stance is accepted, little will change. This matter is actually quantified in a study of the economic structure of the sector since 1992-93 by Doessel, Tonk and Williams\textsuperscript{203}. The implications are for the future welfare of people in need of mental health services and a political choice towards this stance is the crucial step.

\textit{Dr Ruth 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 \textit{The Economics of Mental Health Care…} She has nearly forty refereed publications and several books chapters.

\textit{Dr Darrel 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.

77. I get knocked down...

WISE Employment

Employment and persistent barriers for people with mental illness

This paper briefly discusses the need for greater employer focused education, the use of employment service specialists integrated with mental health services, and the role of social enterprises for people with mental illness to develop work histories and career progression.

As reaffirmed in the June 2012 House of Representatives’ Work Wanted: Mental Health & Workforce Participation, mental illness is the single largest cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (Department of Health and Ageing, 2010).

Work is meaningful for people with mental illness, providing opportunities to socialise, develop skills and to engage occupations that give meaning to their life (Stewart & Craik, 2007). People with mental illness want work and see employment as feasible and important to their recovery (Bond, 2004; Waghorn & Lloyd, 2005).

Not surprisingly, people with mental illness are the largest group accessing disability employment services, (VICSERV, 2008). Of the 30,000 job seekers WISE supports annually through programs such as Disability Employment Services and Job Services Australia, up to 40% experience mental illness.

One of the initiatives outlined in the Australian Government’s 2011 Building Australia’s Future Workforce is aimed at encouraging and supporting employers to recruit people with disability. 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.

People with mental illness accessing disability employment services have the poorest outcomes for gaining and maintaining employment (VICSERV, 2008). In fact, Australia ranks among the lowest of OECD countries for workforce participation by people with disabilities (Disability Investment Group, 2009) and only 44% of working age adults with a mental illness are in employment.

Unemployment of people with mental illness jeopardises Australia’s economic potential. Estimates of the annual cost of the productivity losses attributable to joblessness among people with a mental illness ranges from $10 to $15 billion. Poor vocational outcomes can compound the clinical condition of a person with mental illness leading to increased hospitalisation. Outlays in 2007–2008 by governments and health insurers for the cost of operating mental health services totalled $5.32 billion, representing 7.5% of all government health spending (Commonwealth of Australia, Fourth National Mental Health Plan 2009).

Stigma, and community and employer attitudes

Pervasive stereotypes of people with mental illness contribute to barriers in being able to make valuable contributions to the workplace (Pruett & Chan, 2006). Employers are often reluctant to employ someone with a mental illness due to perceived risk to the organisation. McNair Ingenuity Research commissioned by WISE in 2012 surveyed 253 small to medium sized employers, charting their readiness to employ a person with a mental illness. The results indicated that only one in three would consider employing a person with a mental illness, compared to one in two for people with a physical disability.
Symptoms of mental illness are often misread as signs of laziness or incompetence (Mental Health Council of Australia, 2007). This stigma of mental illness can discourage people from disclosing due to concern about how the disclosure would impact on employment opportunities (Mental Health Council of Australia, 2007).

**Government investment in employer focused education**

Employers have an important role in helping people with mental illness to overcome barriers to workforce participation. Therefore it is critical that awareness and education campaigns targeting employers’ misconceptions surrounding employing people with a mental illness continue. To advance these aims government may also consider its own role in employing people with a mental illness.

Education campaigns may take the form of WISE’s own Empowermental campaign, a three year campaign to help reduce the stigma associated with employing a person with a mental illness. The campaign began in October 2012, grounded in a national television commercial on Foxtel featuring well known actor and mental illness advocate Garry McDonald.

The central message of the campaign and the commercial was that a person with a mental illness can and does work, and might be “the best person for the job”. The release of the McNair Ingenuity research to national and community media outlets highlighted misconceptions about mental illness in the workplace and told some real stories about the abilities of people with mental illness. For example, the research revealed that 74% of employers who had employed someone with a mental illness described their experience as positive or very positive, which was an important message for the campaign.

A social media strategy was also in place to spread these messages, a dedicated landing page on the website was created and WISE produced brochures and tips to help educate employers. The Empowermental commercial ran 825 times and coverage in over 250 media outlets including ABC Radio, Channel 10, The Age, Sydney Morning Herald, BRW and The Financial Review, meant that WISE had a strong platform from which to challenge misconceptions.

**Weaknesses in current key labour market programs for people with mental illness**

Over the last decade Australia’s key labour market programs have expanded their range and scope of service to ensure that highly disadvantaged job seekers have the opportunity to access employment assistance. The current key programs are Job Services Australia (JSA) and Disability Employment Services (DES).

Broadly these programs work to a principle that the most amount of support goes to assist the person furthest from employment. Competitive employment is considered the preferred outcome for people with mental illness through these models.

One performance measure of JSA and DES is efficiency – the average time taken comparative to other employment service providers to place job seekers into work and keep them employed for 13 and/or 26 weeks.

However, current research indicates that such “work first” principles puts undue pressure on employment service providers to fast track job seekers into any job. Vulnerable, highly disadvantaged job seekers with mental illness are at risk of being placed into short term lower paid employment that does not match their interests or career ambition. These jobs often last only as long as the government-paid employer wage subsidies.

Poor quality work may be worse than no work at all. Often for those with mental illness having a job can also mean the loss of a health care card resulting in ongoing cost of medical expenses, and a struggle day to day to meet essential living costs (Davidson 2008). An analysis of 2005 surveys from the Household, Income and Labour Dynamics in Australia (HILDA) showed that those who moved into poor quality jobs showed a significant worsening in their mental health compared to those who remained unemployed (Bevan 2012). With unsustainable and unfulfilling jobs, job seekers ultimately experience job loss.
**Employment service specialists integrated with mental health services**

People with mental illness move in and out of "work readiness", and they often require specialised support and assistance beyond the workplace which requires a cooperative effort from multiple services. New models are emerging to achieve this, such as the Individual Placement and Support (IPS) model. IPS uses team-based employment assistance, offering individualised, client-led and collaborative assistance for people with mental illness, via community mental health centres or case management services.

According to Bond 2004, IPS services are based on seven key principles:

- a goal of competitive employment
- zero-exclusion policy – eligibility based on consumer choice
- rapid job search
- integration of vocational and clinical services
- attention to consumer preferences
- time-unlimited and individualised support
- personalised benefits counselling.

LEAP and HOPE are examples of other emerging programs that promote service integration between local disability employment support providers, clinical mental health teams and rehabilitation services. Developed by Social Firms Australia (SoFA) a key aim of LEAP is to enhance the skills and capacity of disability employment staff and employers to assist job seekers with mental illness.

HOPE is a peer inclusive service model to job seekers with a mental illness to manage anxiety and other symptoms and improve job readiness skills to secure and sustain employment. The HOPE program is delivered jointly by mental health peer educators and mental health facilitators. It has been adapted by SoFA and Frameworks for Health from an existing evidence-based clinical training program developed by Professor David Castle.

**The important role of social enterprises for people with mental illness**

To be unemployed is to be cut off from a valued social role (Johnsen, McKay, Henry and Manning 2004). Many people with severe mental illness consider Australian Disability Enterprises (ADE) as a suitable starting point and for some working in an ADE represents the only form of work they can obtain. WISE cleaning company Clean Force is one example of an Australian Disability Enterprise that operates as a social enterprise and replicates mainstream workforce conditions in a supported environment.

Clean Force provides quality commercial cleaning services for offices, apartment complexes, entertainment venues and vacated residences. It was one of the first social enterprises in Victoria to exclusively focus on people with a mental illness who have been unable to find or maintain employment in the competitive labour market.

Clean Force offers award-based wages encompassing industry conditions, and flexible hours depending on health and capability. Its operating model incorporates significant on-the-job support for its supported employees, as well as holistic support provided by a dedicated Employment Support Officer who can assist with other issues such as physical and mental illness, limited education, substance misuse, criminal records, inadequate transport, poverty and homelessness.

While there is an assumption that jobs through social enterprises are less competitive and in some way inferior, WISE believes it is an effective way of supporting people with mental illness to achieve long term change. In the 2012 financial year, 50 vulnerable Clean Force workers completed 74,552 hours of vital work; 54% had diagnosed psychotic conditions such as schizophrenia.

Individuals are more likely to recover if they are empowered to optimise their own wellbeing and self-direction (Gould, 2010). To illustrate this point consider the statements below from a Clean Force worker and a family member about changes in their quality of life since before and during their employment.
I was quite isolated and lonely at the time of joining Clean Force...The relationships in my life have improved one hundred fold. And one of the reasons is meaningful employment Supported Employee 3, September 2012

...When my son got sick it put huge pressure on the marriage and I had a lot less contact with my other kids... In fact every friend and relative just ran away... It is all a lot better now. We [my husband and I] are now able to talk about things that are about us as a couple, including planning for our retirement, and we have more social contact with our friends... Parent, September 2012

Like other social enterprises, Clean Force has significant economic and social flow-on benefits to the whole community.

The application of the Social Return on Investment (SROI) methodology was able to illustrate the social and economic benefits created by Clean Force. An investment of $2.9m created $17.8m of present value, resulting in an SROI ratio of 6.1:1. This means that for every $1 invested in Clean Force, $6.10 is returned in social and economic value.

Despite these proven outcomes for people with mental illness, limited funding and recognition are a threat to the development and growth of social enterprises. This minimises the opportunity to employ more people with a mental illness in meaningful employment for improved quality of life.

**Conclusion**

It is evident that people with mental illness experience positive impact from long-term, sustainable employment. Further investment particularly in education for employers, and articulated government policy around accommodating people with mental illness in the work place, including their own, is needed.

Furthermore, there is a recognised need to provide specialised long-term in-work support. Models such as IPS, LEAP and HOPE help focus on job placement and in-work support to meet an individual's career ambition and advancement.

Additionally, for people with mental illness, social enterprises can offer inclusive individually tailored supports to assist them in this goal. However, future investment commitments for social enterprises are needed.

Looking beyond quantitative outcomes, such as 13 or 26 week employment outcomes, the application of a Social Return on Investment is one method that can assess and demonstrate the impact of long-term, sustainable employment on economic and social participation, and quality of life.

WISE hopes these comments will continue to motivate an Australia-wide endeavour to support people with mental illness who still face significant barriers to job entry, retention and career advancement and can make a positive contribution to our community.

WISE Employment http://www.wiseemployment.com.au is a not-for-profit organisation. We empower jobseekers to find meaningful work and become self-sufficient and we help employers to find the right staff by understanding their needs and providing them with workers from diverse backgrounds.

Each year, our passionate and skilled staff assist over 10,000 people into jobs. Our services are cost-free to eligible jobseekers and employers.

Since 2001, we have invested $3.5 million of our funds into innovative projects to support the most disadvantaged in our community including people with disability, mental illness, youth, ex-offenders, refugees and Indigenous communities. WISE Employment also operates four socially-inclusive social enterprises http://www.wiseemployment.com.au/en/community/social-enterprises/, employing 200 people.

Since 1992, we have been empowering jobseekers and employers. We believe the entire community is enriched when everyone is supported to achieve their potential.
78. Creating employment through social enterprise

Wise Employment

Clean Force Property Services (Clean Force) http://www.cleanforce.com.au, operating since 2001, is a commercial contract cleaning social enterprise of WISE Employment Ltd http://www.wiseemployment.com.au. Clean Force employs 84 people with and without disabilities. Of these people, 50% have diagnosed persistent and/or severe mental illness of which 54% have psychotic conditions such as schizophrenia. Additionally, 19% of the workforce is from Culturally and Linguistically Diverse (CALD) backgrounds.

As a not-for-profit social enterprise, Clean Force’s approach is guided by its vision of “enriching the community – empowerment through employment” and mission in guiding and inspiring people to realise their potential and achieve fulfilling vocational goals. These underpin Clean Force’s devotion to its workforce to optimise their self-determination, and career progression for an improved quality of life towards self-sufficiency.

Clean Force managers Jim Dinuccio and Paul Fraser started Clean Force in 2001, and, from humble beginnings that included a mop, a bucket and one cleaner, have built a successful social enterprise.

An enduring commercially successful social enterprise that delivers significant employment benefits for people with mental illness and other disadvantaged members of society, Clean Force has a current workforce of 84 people. The social enterprise has delivered over $6.6 million in commercial cleaning contracts since inception, and has empowered over 200 workers towards independent living, inclusion and integration into all aspects of community.

For the last 3.5 years, Clean Force has delivered a monthly average of $149,000 in commercial cleaning contracts, with only 2 of the last 42 months unprofitable. “We don’t want charity – just an opportunity to provide a high quality cleaning service to you” is Clean Force’s motto.

Year to date over 86% of Clean Force’s revenue is generated through commercial sales from a customer base of 60 including not-for-profit organisations such as AMES, Lort Smith Animal Hospital, Dallas Brooks Hall, Berry Street, Active Housing, and corporate customers such as Telstra.

Clean Force operates as a stand-alone business from its parent company, WISE Employment, a stable and growing not-for-profit employment services organisation established in 1992 with operations spanning four states in Australia and the UK.
Employment as transformative factor for people who have a mental illness

Clean Force plays an important role in helping to transform the lives of people with a mental illness and other disadvantaged members of the community who have high practical and emotional in-work support requirements.

The social enterprise’s vulnerable employees require a significant amount of ongoing support to remain stable and competitive. Around 620,000 hours of valuable learning and social contact is gained through employment during an average workforce life span. Being employed has a profound effect on more life domains than almost any other social intervention.

Throughout the design and delivery of Clean Force, WISE Employment has developed specialist capabilities to help clients remove physical, perceptual, attitudinal, psychological, social or infrastructural barriers which contribute to disadvantage and unemployment.

Clean force offers two pathways to employment:

1) A supported employment program* for people on a Disability Support Pension with major vocational barriers finding it hard to gain meaningful employment.

2) An open employment stream for disadvantaged people wanting to enter into the general work force.

The supported employment program assists people with severe mental illness who are often on the fringes of society and, move in and out of work-readiness, be it as a result of an employment-related problem or personal or medical situation. Many Clean Force employees present with severe and persistent mental illness, limited education, substance misuse, criminal records, physical health problems, inadequate transport, poverty and homelessness that further impede movement into competitive employment.

Clean Force’s operating model incorporates significant on-the-job support for its supported employees, as well as holistic support provided by a dedicated Employment Support Officer who understands the unique support needs of employees. The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) http://www.fahcsia.gov.au provides funding for direct case management support through an Australian Disability Enterprise (ADE) agreement. The Employment Support Officer and management need to be able to respond to supported employees needs and as Clean Force employees move in and out of work-readiness they often require assistance beyond the workplace which takes a cooperative effort from multiple service providers.

Training, mentoring and coaching

When barriers are addressed and stabilised, employees engage in a range of interventions (e.g. training, and paid work trials). In this phase, supported workers undertake Clean Force’s successful training program where they complete Certificate II and III in Asset Maintenance. For many supported employees, completing training in itself is a huge achievement.

All new starters at Clean Force receive mentoring and coaching provided by experienced co-workers who work alongside the supported employees.

Clean Force employees work in teams of up to eight in a team, and supported staff are offered the flexibility to perform assigned cleaning tasks or modification of duties to suit an individual’s ability. Each team has a Team Leader who provides significant role modelling behaviour to employees. Often, Team Leaders, have also lived experience of mental illness, and can transfer their successful workforce participation strategies. Working as a team of employees builds social networks and strengthen their sense of connection with the community, which helps to facilitate recovery and wellbeing.

WISE believe that Clean Force is an effective way of supporting people with mental illness achieving more long-term change.
WISE management continually encourages, and empowers Clean Force staff to ultimately work at full productivity and have enduring rewarding employment. With support, in the 2012 financial year, 80 vulnerable Clean Force workers completed 55,445 hours of vital work, earning a combined $890,056 in wages, at an average hourly rate of $14.71, significantly higher than comparative supported employees with high support needs of other ADEs who recorded a national average gross hourly wage of $4.27. This contributed taxes, and reducing their dependence on Australian government benefits, and health services and helping them to achieve inclusion into all aspects of community.

**Changing perceptions and helping bring an end to stigma**

The quality of Clean Force's work has changed perceptions amongst customers regarding the abilities of people with mental illness and generated more contracts. Through continuous quality activities, Clean Force has enhanced its knowledge of pricing, and customer and staff support and development.

Clean Force Manager Paul Fraser points out that due to the impact of stigma on employment opportunities for people with mental disorder, Clean Force also seeks to educate employers and their staff on mental disorder and show case how to support someone with mental disorder in the workplace.

Every day, Clean Force contributes towards more fulfilling and self-determined lives for its workers and the community, which has a significant economic and social flow-on benefit.

**Clean Force Social Return on Investment (SROI) study**

To help measure the amount of change created by Clean Force for its stakeholders and compare it to the costs of creating them, WISE Employment engaged Social Ventures Australia to complete a Social Return on Investment (SROI) study on Clean Force. The Social Return on Investment model uses method for understanding, measuring, and reporting on the value that is created by an organisation/activity/service. SROI examines an organisation's work and impact across three areas: Social, Economic, and Environmental. It attributes a value to each outcome using stakeholder engagement, research and common accounting and investment appraisal methods.

Eight Clean Force supported workers were interviewed for the SROI study and some key themes about the changes (i.e. skills and capabilities, housing status, physical and mental health, and relationships) they have experienced since starting with Clean Force. This feedback, along with the feedback of other Clean Force stakeholders, e.g. suppliers, customers, other Clean Force staff and WISE Employment staff was used to measure and estimate the social value Clean Force creates for its stakeholders.

The application of SROI helps WISE Employment assess whether Clean Force is accomplishing its mission.

Some of the key findings of the SROI study include:

- Employees and their families experiencing profound changes in their lives because of the opportunities and the support provided by Clean Force.
- Supported employees reported that having a job at Clean Force and earning their own money had a strong impact on how they felt about themselves and what they thought they were capable of. Assessors heard numerous counts about the changes experienced by supported workers such as: “...My mother is really proud of me and happy that I have a job. I now have a phone so I can call her and I will be able to buy her a present when I go see her for Christmas …” – Supported Employee, September 2012
- “I used to be admitted to the hospital at least every three months for a week. Now I only see my GP.” – Supported Employee, September 2012
As a provisional figure the investment into Clean Force was estimated at $2.9mil and created $17.8mil of present value, resulting in an SROI ratio of 6.2:1. This means that for every $1 invested in Clean Force, $6.20 of social and economic value is created for stakeholders, including supported program and open program employees, family and case managers of the supported employees, the government and WISE Employment.

As acknowledgment of Clean Force’s consistent performance, it has been announced as a finalist in the inaugural Social Enterprise Awards http://socialenterpriseawards.com.au/2013-awards/ in the Medium/Large category.

Please have a look at the Telstra video https://www.youtube.com/watch?v=D0cTKM9UyQA and the Dallas Brooks Hall video https://www.youtube.com/watch?v=3yWgUq9Mpdg that showcase Clean Force’s work as social enterprise.
79. The experience of helplines in Australia

Alan Woodward

In 1963, when Lifeline first operated its telephone helpline, the idea of using the telephone to provide easily accessible responses to people experiencing difficulties in their lives was novel.

Like many great social action movements, Lifeline was born out of need.

The founder of Lifeline Rev Dr Sir Alan Walker was receiving so many calls from people, including calls at all times to his home, that he could not personally respond to everyone and he looked for ways to answer those calls for help. A 24 hour seven days a week telephone helpline was the answer.

Lifeline is now part of Australia’s social fabric. When asked in a News Poll survey which services adult Australians thought were available for suicidal persons, Lifeline was nominated by more than 29% of respondents unprompted, and 87% of respondents when prompted – far higher than GPs, psychologists and other professional services.

Yet, there is no policy recognition for helplines and crisis support services such as Lifeline in the national Mental Health Plan, or the 10 Year Road Map for Mental Health Reform, no mandated protocols or partnership arrangements with other components of the mental health system, such as state mental health services, primary health care and specialist psychiatric treatments.

This month, exactly 50 years after the first calls were taken, Lifeline takes more than 50,000 telephone calls a month and about 2,100 contacts a month through its online crisis chat service. A special telephone service, which is promoted at suicide ‘hot spots’, is taking more than 100 calls a month. And demand for these services is increasing.

That there is no shortage of demand from Australians in crisis seeking help and referrals from the Lifeline services should be no surprise; in our society at any point in time thousands of individuals and families are going through tough times and we encourage them to reach out to trusted services such as Lifeline.

Moreover, the ABS National Survey on Mental Health and Wellbeing has established that one in four adult Australians will experience a mental health issue in a 12 month period; this amounts to several million Australians finding their mental health difficulties flowing into their lives: workplace performance, family relationships, sporting and leisure activity, alcohol and drug use, social participation are all affected potentially by on the onset of mental health issues.

Lifeline has identified that more than 35% of the callers to the telephone helpline self-report mental health issues. Closer studies of the callers have established that about 80% are experiencing high levels of psychological distress at the time of the call: sufficient distress to warrant clinical diagnosis if they were to visit a mental health specialist at the time. The difference between these statistics suggests many of the people with undiagnosed mental ill health are calling the Lifeline telephone help line.

With stigma surrounding mental health issues still prevailing in Australian society, the ‘no names’ confidential access to service and the ease of the phone communication is attractive to many people when they are exploring the supports available to them. In the case of the online crisis chat, 30% of the contacts report when surveyed that they have not and do not intend to seek help from other services, preferring the online medium and the confidential access to support available from this Lifeline service; they do not want to talk to anyone, just now.
Research evidence on helplines suggests that they can be effective in attracting people seeking help, and especially those with mental health issues and suicidal ideation.

Emerging research evidence also suggests that telephone helplines can be very effective in putting people in touch with other services that can offer a longer term benefit: mental health treatment programs and clinical services. A recent study of the US National Suicide Prevention Lifeline showed that of those callers who were offered referrals, more than 50% took action post-call to access these referrals.

Some international research has considered the mere existence of crisis centres offering crisis support services in a community has a beneficial impact on suicide rates and mental health – possibly because of the creation of a compassionate outlet for people to seek help.

There would seem to be a vital place in the mental health system for helplines and crisis support services, both as supports to individual help seeking, and as mechanisms for creating pathways to access professional mental health services. They are surely part of solution to the policy problem in Australia where it is estimated that two-thirds of those adults experiencing mental health issues do not access services.

And what do the consumers – the callers and contacts – to the telephone helpline and crisis chat have to say about the services?

“I wanted you to know that Lifeline has been like gold to me, where no one else has been, and I want to say thank you from the bottom of my heart.”

“Thank you very much for helping me. I was in a really agitated crisis situation and female TCS helped calmed me down. Thank you from the bottom of my heart.”

“I would not be alive today if not for the TCS I spoke with the other night.”

A consumer-oriented mental health system in Australia must give recognition of and integration for telephone helplines and crisis support services; this is what those Australians in crisis and struggling with difficulties – often related to the onset of mental ill health – actually want. Furthermore, a gateway for many people rests in the non-professional helping services which can form the bridge for the individual between the issue they are facing right now and the longer term need for professional services.

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).
80. Working for better mental health

WorkFocus Group

How do you get a job when you have a criminal past, a drug problem, no work experience and mental health issues?

What do you do when your job makes your mental health condition worse?

How do you find work again after your life falls apart and depression takes over?

Questions like these are important. Not just for mental health practitioners and employment services, but for our economy and for Australian society in general. In this essay we describe three real-life cases that show how the questions above can be answered.

These cases are from our employment services business, a considerable part of which involves helping job seekers with mental health issues to find work and stay in work. In our experience, on the ground, we have seen over and over that employment can be of considerable benefit to people with mental health issues. Employment may contribute to financial security, stronger social support and improved self-esteem. However, we have also seen first-hand, that for these benefits to eventuate, a specialist support approach is required.

Specialist support means that employment services are delivered in ways that are sensitive, tailored and appropriate to the job seeker, while also being seamlessly integrated with clinical mental health services and holistic non-vocational support. With informed, multi-disciplinary and collaborative efforts, specialised employment service providers can create lasting, beneficial work and life outcomes for people with mental illness.

No one is intrinsically unemployable

Contrary to the prevailing consensus 20 or 30 years ago, work is a realistic option for the vast majority of jobseekers with mental health conditions. The challenge we observe is that the right levels and types of specialist support are often missing. In addition, employment involves a relationship between employee and employer – both have responsibilities and both require specialist mental health support. Whether they admit it or not, many employers are reluctant to employ people with mental health conditions. We work with employers to increase their mental health awareness, confidence and capabilities, while also offering tailored post placement support to help both the job seeker and employer form a lasting relationship.

To best illustrate the impact specialist mental health employment services can have, we now turn to three examples of real-life case studies from our business that have benefited from such an approach. These cases serve as examples of what is possible for many more Australians with mental health issues.204

204 All personal and company names have been changed in the cases described in this essay.
**Specialist employment services can transform lives**

Our first case is that of 'Jane' who was unfortunate to become mixed up with the wrong crowd as a teenager and entered a life of drugs and crime. For over 10 years, heroin and speed addiction kept her bouncing between the streets and prison. She accumulated more than 200 convictions, including breaking-and-entering and theft. Jane’s case was further complicated by a challenging, yet undiagnosed mental illness. Remarkably though, today Jane has overcome her hardships, disadvantages and barriers to employment and now has a bright future ahead of her.

Back in 2007, during her last prison sentence, Jane decided enough was enough. She decided to turn her life around by dissociating herself from bad influences and working hard to get a decent job. This bold decision would prove to be a massive challenge. As an indigenous woman with no employment history (at 28 years of age), a psychiatric disorder and a past littered with criminal convictions and drug abuse, Jane struggled for years to get into the workforce. On 15 occasions, Jane negotiated interviews successfully but was rejected after failing police clearances.

When Jane commenced with us she was very introverted but clearly committed to trying anything to create a better life for herself. After beginning treatment with a psychiatrist and working well at a plant nursery Jane showed significant progress and she was promoted to team leader. We then supported her through a transition into a more long-term job in warehouse administration with a major logistics group. In both cases we made sure the employers were educated and supported so that Jane had the best possible chance of success.

With psychological supports, counselling and mentoring built into her employment journey, Jane made incredible process throughout her program. For example, her level of confidence, responsibility and motivation increased dramatically. This became evident in her behaviour. She was always on time and didn’t miss any appointments or phone calls. She is always neatly dressed and expressed a positive attitude. She was without a driving licence, so arranged lifts from family members or caught the bus to work and to all her appointments. Though these behaviours seem commonplace, they represent an incredible life turn-around for Jane. To move forward from her reckless past of crime and drug addiction, to become a responsible, positive and engaged employee is extremely difficult. We believe it is also near impossible without psychiatric intervention and the right level of specialist employment services support.

Jane’s case shows what can be achieved through strong collaborative working relationships between employment services and mental health providers, as well as targeted initiatives to address misunderstandings and fears among employers, employees and the services that support them. We believe that integrated, personalised and flexible support helps people with mental health disability gain and sustain work. Part of this involves collaborating and co-locating with mental health and other support services. In Jane's case this involved coordinating psychiatric care, drug rehabilitation services, indigenous mentoring and counselling services from the community, with our own internal supports and employment services.

**The right job for the right person**

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. When mental health issues are significant, some jobs can act as 'triggers' for more severe symptoms, while other jobs can help improve symptoms dramatically. For these reasons, our company catch-phrase – 'the right job for the right person' – is especially relevant to those with mental health issues.

Our second case, 'Margaret', is an excellent example of this. Margaret is a 54 year old woman diagnosed with bi-polar and anxiety disorders. Margaret came to us as an employed DES-DMS client but the job she had, at a bakery, was making her very distressed. The people and the environment of the bakery disagreed with her. She was part of a large team, which she found intimidating and stressful, and in order to cope she had already been forced to reduce her hours to two days per week. She desperately wanted to work more of the week but was overwhelmed by her current place of work.
After we met, assessed and got to know Margaret we began to work hard on identifying a better occupational match for her strengths and temperament. At the time Margaret was very depressed. She was not sleeping because she was so anxious and was barely coping from day to day. In addition to evaluating Margaret for an improved job match, we also uncovered the fact that her medication was not working as it should and arranged for medical appointments to assess Margaret's suitability for alternatives. A new pharmacological treatment was determined and Margaret began her new medication while her case manager continued to reassure her and involve her in the job seeking process.

The breakthrough came in the form of a retail position with a shoe shop. The new role allowed for more hours in a much smaller team and soon after starting, the impact on Margaret was clear to see. She now felt positive about going to work. She worked mainly on her own looking after a store, and though this would not suit everyone, it was perfect for Margaret. She felt much more relaxed and in control at work and also enjoyed the more personal process of helping people with their shoes. She has moved from working just two days a week to now working nine days every fortnight – all while self-managing her mental health conditions very positively.

The case of Margaret demonstrates the need for specialist mental health providers in employment services. Our psychologists were able to help understand the kind of work that Margaret would thrive in. Without this deeper understanding of Margaret's barriers, strengths and triggers a negative employment situation may have continued to exacerbate her symptoms. Additionally, our understanding of the role of pharmacological supports helped us refer Margaret to her doctor for a discussion about her medication. We believe generalist providers often ignore the clinical and personal lives of job seekers with mental health problems and this leads to poor outcomes.

**Battling through barriers requires sustained support**

Our last case is that of 'Peter' who faced a daunting combination of barriers to employment including his age (49), a physical disability and a mental health condition. Only with the right support, dedication and determination – from job seeker, employer and service provider – can multiple barriers like Peter's be overcome to create quality, sustainable and life-changing employment opportunities.

Back in the year 2000, Peter had a promising career ahead of him. He was a management trainee at a major supermarket chain where he planned to work his way up the ladder. He was also in a strong relationship and had two young sons. But when back pain progressed into degenerative disc disease, Peter's downward spiral began. He was forced to give up his job, spent most of his days in agony and gradually became completely housebound. This was just the beginning of a snowball effect that was taking Peter's life on a negative trajectory. Now unemployed, Peter was anxious about his finances and began to feel both hopeless and helpless. His relationship began to suffer and eventually failed completely. Peter gained over 40kg, putting more strain on his spine, and ultimately developed major depression.

When Peter first came to us he had hit rock bottom. He was nearly 50 years old, living in transient housing and he felt like he was of no use to the world anymore. Without a proper home he could not even have his boys over to stay with him, something he found extremely difficult to deal with. We matched Peter to a case manager, John, of similar age who has first-hand experience with depression. This gave Peter someone he could be honest with and someone he trusted enough to take help from.

Over many months, John gradually built Peter's confidence and got down to the business of improving his employability. He was repeatedly rejected from job applications, which required careful management from John, but eventually got a breakthrough as a floor supervisor with a property management company. We provided guidance and support for the employer and the relationship has worked very well with Peter now in a higher position within the company. Employment has played a key role in lifting Peter out of depression. His job has led to a house of his own where he can see his sons, greater self-esteem and the financial means to live a healthy, happy life.
Obsessive Hope Disorder

John’s mental health experience was a critical factor in Peter’s success. John understood how to engage with people who are suffering from major depression, he knew how the rejected job applications could lead to serious consequences for Peter’s condition and he was able to keep Peter sufficiently motivated to keep going, despite the enormous challenges he faced.

**Appropriate work is good for you: It improves mental health**

Peter, Margaret and Jane have all overcome serious barriers to employment. These same barriers are keeping many other Australians out of the workforce. Worse than this, a lack of employment is potentially worsening the symptoms of those with mental illness. In some cases (such as Peter’s above) unemployment is a major contributing factor to his mental health problem. Much of this is preventable or remediable with the right kind of specialist mental health employment services.

The people and their employers featured here have all benefited from a specialist approach that is sensitive to the patterns of many psychological illnesses, equipped to properly support affected job seekers into work, while also empowering employers to open their doors more actively to those with mental health conditions. This approach involves specialist in-depth assessments, counselling, mentoring, dedicated clinical psychologists on staff, case managers with mental health experience as well as open collaborations with mental health and other support services in the community.

By doing all these things we can help employers to access one of the most underutilised sectors of Australia’s workforce and help thousands of job seekers – just like Peter, Margaret and Jane – to rebuild their lives through the many benefits of a fair go in a good job.

*The WorkFocus Group (the Group) is a synergistic group of companies which operate in disability employment services, advisory services and workplace rehabilitation. They have particular expertise in assisting those with mental health conditions. The Group has a national footprint and employs more than 300 people across 27 locations. The Group operates mental health employment services contracts for the Department of Education, Employment and Workplace Relations (DEEWR) under both Job Services Australia (JSA) and Disability Employment Services (DES-DMS and DES-ESS). The Group also administer a range of innovative advisory services on behalf of the Federal Government including JobAccess (DEEWR); National Disability Recruitment Coordinator (DEEWR); Complaints Resolution and Referral Service (FaHCSIA); National Disability Abuse and Neglect...*
81. My mental health “journey”

Senator Penny Wright

Before 1996 I knew very little about mental illness. I found it mysterious and slightly frightening, and I had no idea just how many Australians are affected on a daily basis – or how debilitating it can be.

I now have a very personal perspective, shaped by what I learned over thirteen years as a Deputy President of the South Australian Guardianship Board, and my more recent work as a Senator, with responsibility for Mental Health policy for the Australian Greens. In the last year, I have met with many people throughout Australia whose lives are touched by poor mental health – either personally or as a result of their relationships or the work they do, and I just keep learning.

As challenging as it was to make legal decisions affecting people’s lives, I absolutely loved my work on the Board. Week after week I was privileged to hear the very private accounts of people who were detained in hospital for treatment because it was thought their illness posed an unacceptable risk to themselves or other people. In deciding whether they should stay or leave, I regularly came face to face with what it means for someone to have an arbitrary illness, like schizophrenia or bipolar disorder. Unasked for and undeserved, they are conditions that can tear a life apart.

I heard hundreds of cases and was constantly moved by the courage, humanity, and spirit I saw in the people before me. Facing up to a legal tribunal of people they didn’t know, they would tenaciously defend their sense of who they were. Irrespective of the outcome, and it was often not what they wanted, I always sought to make those hearings as affirming as possible. Being “heard” and being respected are powerful experiences for all of us, and especially for people who are used to being marginalized and devalued.

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. Labelled “mentally ill,” it often takes great courage to get up each day and face the world. Most do, but others find they just can’t keep going. Life expectancy is around two decades shorter than it is for those without mental illness. Smoking, suicide and poor healthcare take their toll.

There is one man I will never forget. Towards the end of a long hearing, he broke down and told me, “I just want to retire now. I don’t want to have schizophrenia any more. I just want to get married and have a family like other people.” Years of living with a severe mental illness and many hospitalisations had left this man isolated and yearning for something that many of us take for granted – a loving relationship and a family. In between hospital admissions, at the age of 55, he shared a small dormitory in a hostel with three other men, the walls stained by nicotine.

I am convinced that public money is extremely well spent on providing strong social supports and secure accommodation in order to assist people with mental illness to participate in work and the community, to ameliorate loneliness, reduce stigma and promote resilience and wellbeing. It contributes to a stronger, healthier, more inclusive society and that benefits all of us.

I also understand the value of peer workers, who validate the experience of the people they work with, modelling achievement and offering hope and inspiration. I am grateful for the lessons I learned from colleagues on the Board who had experience as consumers or carers.

Over the last 17 years, there have been some significant changes. There is now more discussion about the prevalence of poor mental health in Australia and its costs – human and economic. However, there is still a very long way to go before it attracts funding and attention commensurate with the burden of disease mental ill-health poses.
Attitudes toward treatment and “recovery” are also undergoing great change, with the recognition that people who have an illness are people, not a condition, and should be at the centre of treatment and planning that affects them. It has been said that an important element of recovery is the regaining of one’s belief in oneself. Having a system that respects people as unique and whole individuals, from the outset, can only make that goal easier.

Life in the 21st Century presents many challenges to resilience and equanimity. As we go through the life cycle we will be buffeted by events and experiences that will test us, sometimes beyond our limits. As the mother of three young adults, I am particularly conscious of the pressures stalking young people in these modern times.

The most powerful aspect of my own “mental health” journey has been to stop thinking in terms of “us” and “them”. I have come to believe that we are all, as human beings, on a shifting spectrum of mental health throughout our lives. Many of us will move back and forth on this spectrum to varying extents, depending on what life is throwing at us, and our capacity to manage it from time to time.

By accepting that mental health and mental ill-health affects us all, we will increase empathy and reduce fear and stigma, making it easier for any of us to seek help. If we can acknowledge our shared humanity and vulnerability, we are more likely, as a society, to make the investment necessary to ensure that the most effective treatment and support is available to all of those who need it – our colleagues, our loved ones or, indeed, ourselves.

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.