

A Report Detailing Mental Health Services in
Australia in 2002 and Community Priorities for
National Mental Health Policy for 2003-2008



APRIL, 2003

'OUT OF HOSPITAL... OUT OF MIND!'

Dr Grace Groom, Mental Health Council of Australia, ACT

Professor Ian Hickie, *beyondblue: the national depression initiative*, Melbourne, VIC;
and, Brain & Mind Research Institute, University of Sydney, NSW

Ms Tracey Davenport, University of New South Wales, NSW

“Ask anyone with a serious mental illness and they will tell you of people they know who have committed suicide after having been neglected, rejected or turned away by services. Ask anyone with a serious mental illness and they will tell you of their struggle to make ends meet, they will tell you about how hard it all is and about the pressure experienced by their partners, friends and families in the absence of sufficient support.”

Ms Helen Connor
Consumer and Chairperson, Australian Mental Health Consumer Network

“We have to make services and support available to everybody in this country so that a ‘fair go’ will mean there will be a ‘fair go’ at life for the many Peters (consumers) ... the many Rosies (carers) ... and the many partners, families and friends around the country who experience depression.”

Mrs Sue Sidebottom
Carer, BlueVoices

“The report (‘OUT OF HOSPITAL, OUT OF MIND!’), in contrast to the draft Third National Mental Health Plan, provides a sound blueprint for tackling this serious public health issue (early intervention programs for young people with mental disorders). The Mental Health Council is to be congratulated for finally making these inconvenient facts public, not only on behalf of consumers, carers and families but also the wider public and most significantly – the electorate.”

Professor Patrick McGorry
Director, ORYGEN Youth Health (incorporating EPPIC) and ORYGEN Research Centre

“The Mental Health Council of Australia conducted a national survey and nationwide consultations ... One of their recommendations, based on their many consultations, will be the formation of a National Mental Health Commission or similar body.”

Associate Professor Allan Rosen
Secretary, Comprehensive Area Service Psychiatrists Special Interest Group

“What is clear from this study is that increased rates of illness, and a population more inclined to seek help for mental health problems, will result in increased demand for mental health services in the future.”

Dr Rob Walters, Chair, Australian Divisions of General Practice Ltd

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‘OUT OF HOSPITAL, OUT OF MIND!’

**A Report Detailing Mental Health Services in Australia in 2002 and
Community Priorities for National Mental Health Policy for 2003-2008**

APRIL, 2003

Dr Grace Groom, Mental Health Council of Australia, ACT
Professor Ian Hickie, *beyondblue: the national depression initiative*, Melbourne, VIC;
and, Brain & Mind Research Institute, University of Sydney, NSW
Ms Tracey Davenport, University of New South Wales, NSW

FOREWORD

While Australian mental health policy is often depicted as world-leading, for some time both those using and those providing services have claimed that the system is characterised by restricted access, variable quality, poor continuity of care, lack of support for recovery from illness and overt or covert human rights abuses. This report now documents the findings of a timely nationwide review by the Mental Health Council, the peak non-government association for consumer, carers, professional associations and health care providers in Australia.

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

This report highlights that too often the system repeatedly fails consumers, their families and carers right across the spectrum from early intervention to acute and ongoing care. There has been insufficient movement in mental health towards those universal principles of health care such as access, equity, quality, choice and participation which are recognised as fundamental in other parts of our national health system. This is an indictment not only of those responsible for our mental health but also of our community as a whole. Increased investment, accountability, leadership, review and sustained innovation are all urgently required if we are to address our national mental health needs.

With predicted increases in the rates of mental illness and the psychological impact of recent world events, new pressures on Australia's mental health system will emerge. Action is now required to combat the current crisis, improve the spectrum of available services and promote genuine recovery. Additionally, we must invest in the long-term sustainability of a mentally healthy community. Therefore, mental health promotion, prevention and early intervention strategies should be prioritised along with genuine community partnerships that increase illness awareness as well as our national capacity to respond to the needs of those millions of Australians whose lives are touched by the impacts of mental illness. The more that people who have never thought about mental health recognise these challenges, the more likely we are to reduce the stigma and the additional burden it places on consumers and their families.

This report adds further weight to other recent national and state-based reviews. In this report the community of consumers, families, carers, health professionals and health service providers has spoken with one voice. It has confirmed the key gaps in services, recognised opportunities for excellence and set priorities for the next five years. The time has now come for all levels of government to '*GET REAL*' - real money, real leadership, real accountability, real innovation and real ongoing review. We can no longer ignore the broad range of compelling evidence before us. We must act now for the improvement of mental health care for all Australians.



Mr Keith Wilson
Chairperson, Mental Health Council of Australia
April 2003

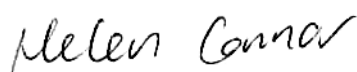
FOREWORD

The Australian Mental Health Consumer Network, a national consumer-run organisation, supports the findings of *'OUT OF HOSPITAL, OUT OF MIND!'*. This report, prepared by the Mental Health Council of Australia, details the findings of a review into mental health reform in Australia. The findings are stark and point to the need for Australian governments to press on with and resource adequately the national reform process.

The Australian Mental Health Consumer Network concurs with key findings that current community-based systems are failing to provide adequate services and support recovery from illness or protect against human rights abuses. Whilst current policies for community-based mental health care are appropriate, the implementation of these policies falls far short of need. The current failure of Australian governments to invest adequately in innovation and disease prevention will condemn many of the most disadvantaged and ill members of our Australian community to many more years of abuse, neglect and very poor mental and physical health. The current failure to resource community-based care puts at great risk the wellbeing of Australian families.

'OUT OF HOSPITAL, OUT OF MIND!' is an apt title for a report that reflects the lack of resources and support for people who have been consigned to yesterday's news. No longer in hospitals for lengthy periods, their needs are no longer seen or are as visible; funding has not kept pace with the level of need. Ask anyone with a serious mental illness and they will tell you of people they know who have committed suicide after having been neglected, rejected or turned away by services. Ask anyone with a serious mental illness and they will tell you of their struggle to make ends meet, they will tell you about how hard it all is and about the pressure experienced by their partners, friends and families in the absence of sufficient support.

Yes it is true that one in five Australians will experience a mental illness, but it also true that more than one in five Australians are affected by the experience of a loved one with mental illness. Services must be resourced adequately so they can respond to all Australians affected by the experience of mental illness.



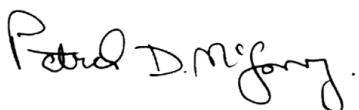
Ms Helen Connor
Consumer and Chairperson, Australian Mental Health Consumer Network
April 2003

FOREWORD

This report by the Mental Health Council on the current state of mental health services in Australia represents a timely reality check. It is a wake-up call to governments across Australia and to our society as a whole. The level of unmet need, the dangers of delayed and bargain-basement treatment and the preventable collateral damage to the lives of patients and their families is powerfully captured and burns through the pages of this report.

Despite its demonstrated capacity for innovation, Australia has not translated recent advances into better mental health care. The report demonstrates that this is primarily a matter of lack of political will and totally inadequate funding. The expertise and effective models of care are readily available but are not supported. Australia is still trying to deliver mental health services on the cheap. In the more visible post-institutional era, this is now having serious consequences for our community as a whole. Only the cosy bipartisan neglect of mental health by both sides of politics, and the lack of effective mobilisation of the population, enables this to persist. Other societies would not tolerate this.

Particularly welcome in the report is the ringing endorsement by the wider community of the need for uniform implementation of early intervention programs for young people with emerging and potentially serious mental disorders (such as psychosis, depression and substance abuse). Australia created and disseminated this model of care around the world yet it remains unavailable in most parts of our own country. This report, in contrast to the draft Third National Mental Health Plan, provides a sound blueprint for tackling this serious public health issue. The Mental Health Council is to be congratulated for finally making these inconvenient facts public, not only on behalf of consumers, carers and families but also the wider public and most significantly – the electorate.



Professor Patrick D. McGorry
Director, ORYGEN Youth Health (incorporating EPPIC) and ORYGEN Research Centre; and,
Professor, University of Melbourne, Department of Psychiatry
April 2003

SUE'S STORY

"My story ... involves complex family and personal relationships. My story concerns my late husband Peter, my three children, our grand-daughter (Rosie) and myself. Living in remote Australia has a lot of advantages for those of us who like the life. There are also some distinct disadvantages. We have floods, we have bushfires, we have drought. We also have mental illness in our community. Peter experienced a mental illness – and as a result of the system's failure to help him – he died of his mental illness.

Peter also had significant physical problems. He had diabetes, which was uncontrolled on occasions, and led to a foot ulcer and amputation of toes. He also had cardiac problems – and had had a heart attack in the past. There is no doubt that Peter's physical problems wore him down, but in the end it was his depression, and the inability of our system to help him, which led to his death. In dying, we not only lost a proud man, we lost a home with everything in it. Every physical possession that had meaning to us – lost in the fire.

The fire was deliberately lit by Peter. He was found several hours after the fire started. Peter had died by his own hand. He gassed himself while sitting in the family car and never regained consciousness.

Peter and I were married for 16 years. I'd have to say of those 16 years, 15 of them were good to very good, to outstanding. Over the last year of his life things began to change for him. Because of his physical debilitation, he wasn't able to do the work around our property, which was so important to him.

Peter was no different to many men who live in rural and remote communities. He liked to work, and in fact we were building a mud-brick house. Peter and I put a lot of energy into the mud-brick house, and he received a lot of his gratification as a man, by the work he did on our property. Peter was also a very compassionate man. Since our grand-daughter was 16 days old, she has lived with us. Rosie referred to Peter and I as 'Ma' and 'Pa'. There is no doubt that the bonds between us were as strong as if we were the biological parents of Rosie.

Peter was depressed ... there's no question of that. As his physical health began to deteriorate, so did his mental health – and in the last nine months of his life he created barriers. Those barriers were between those he loved, and I believe firmly that he was preparing us for when he was no longer here, to be part of our life. He was pushing me away The very person he needed to help him. Towards the end I believed Peter didn't love me ... but at the same time I knew he needed me.

In June of 2000, Peter attempted suicide. He took an overdose of insulin, cut his wrist and was found in an isolated area, unconscious, with a loaded rifle by his side. He was assessed by the local community health services who found that – under the terms of the Mental Health Act – he wasn't depressed. Five weeks later Peter completed suicide. The community team chose not to listen to me. I knew Peter – I lived with him, and even though our love had changed ... I loved him. I knew something wasn't right. Even after all of the physical problems of the diabetes and the heart attack, which he had had, nobody had ever talked to us about depression. Nobody had told us that depression was a reality for so many people with deteriorating physical health and someone who had just had a heart attack. I tried to talk to the community health services to tell them that I was concerned about Peter, and that he had tried to suicide some 30 years earlier, but they discharged him back into the care of the community – which unfortunately was lacking with respect to his mental health needs. Peter was never assessed by a psychiatrist!

Depression is an illness which I now know is manageable with very good results for people who receive treatment ... Depression is an illness which can push people apart. People who would not normally want to have distance between them due to the illness, can have this experience. Peter and I had this experience and it is the cause of great sadness to me that this happened in our relationship due to the illness of depression. Why wasn't Peter treated for his depression? We're told that there are a number of services all over the country which help people who experience depression. Why weren't Peter and I given information about depression? Even basic information – so that our lives would have been made so much more meaningful in trying to work together through this situation. I was his carer ... I wanted to care for him and I did the best that I could do. However without proper information and proper support, nobody is able to care for somebody with depression as well as they wish to ... and indeed want to. Peter, I believe, became a victim of the system. After his first suicide attempt, the helicopter service wouldn't airlift him to Traralgon as requested by his general practitioner. Due to the potential risk to aircraft and crew in transporting a psychiatric patient, he was admitted to the closest hospital. Peter was assessed by a Mental Health Care Team who told me that he wasn't mentally-ill ... according to the Mental Health Act. I'm not in any position to argue the legalities of the Mental Health Act. What I know is that Peter is dead and that, as a result of the lack of effective programs, systems, support and medication being offered to him – his chance for recovery was denied him. This is a situation which must stop. Every society will have people who commit suicide ... that is a tragic fact of life. However, in order to try and decrease the numbers of people committing suicide, services and education must be available everywhere in urban, rural and remote regions, so that other families won't experience the tragedy we have, which nearly destroyed us.

In Australia, we talk about having 'the fair go'. I believe that Peter didn't receive a 'fair go' at all. He deserved to have a proper psychiatric assessment, and to be started on antidepressant medication. We as a family, deserved to have the education to understand what was happening. I don't for one minute think that we might necessarily have saved his life to the point where he would have had a normal life span, because he had a lot of physical problems which were wearing him down. However, I do believe that with proper care and attention to his mental health problems, he would have had a much better chance of going forward ... and for the family to have had more years together. Peter's life was cut short by depression.

Earlier in this presentation I mentioned Rosie. Some weeks after Peter died, Rosie, who has a developmental disability, asked me if Pa loved her. I said *'yes of course Pa loved you'*. She then asked *'but why did he burn all my things?'* I said *'Pa was sick in the brain'* (which is how I described depression to her). Rosie then asked *'can the doctors fix you when you're sick in the brain?'* I said *'yes they can'*. She thought for a while and then said *'why didn't they fix Pa?'*

We have to make services and support available to everybody in this country so that a 'fair go' will mean there will be a 'fair go' at life for the many Peters ... the many Rosies ... and the many partners, families and friends around the country who experience depression."

Mrs Sue Sidebottom, Carer

BlueVoices: a national network of persons whose lives have been affected by depression

Extract from presentation at release of report *'OUT OF HOSPITAL, OUT OF MIND!'*

April 2003

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EXECUTIVE SUMMARY

A nationwide review of the experiences of those who use and provide mental health services has documented that current community-based systems fail to provide adequate services. Specifically, these services are characterised by: restricted access; variable quality; poor continuity; lack of support for recovery from illness; and, protection against human rights abuses. In the view of consumers, carers and health professionals who provide services, this does not represent a failure of policy. Instead, it is a failure of implementation through: poor administration; lack of accountability; lack of ongoing government commitment to genuine reform; and, failure to support the degree of community development required to achieve high quality mental health care outside institutional settings.

ACTIONS REQUIRED

While there is agreement that we must never return to institutional and other more abusive forms of care, before embarking on a third five-year National Mental Health Plan, this national review has identified the need for:

1. Real monetary investment

Action: Lift mental health expenditure to at least 12% of total health expenditure (i.e. increase by five percent) within five years.

2. Real intent, accountability and national leadership

Action: Development of an agreement between heads of Australian governments to support and review mental health reform, and prioritising an annual reporting system on progress against agreed service improvements.

3. Real and ongoing review

Action: Establishment of a permanent independent commission to report on progress of mental health reform in Australia and investigate ongoing abuse or neglect.

4. Real and sustained innovation

Action: Establishment of a national innovation system with a \$100 million initial investment and then supported at a level of five percent of recurrent mental health expenditure annually.

Currently, we do not devote sufficient resources to meet the existing demand for services. However, in the future, the costs of providing mental health care will increase substantially. This will be due to increased demand by those who do not currently use services and those who now receive grossly inadequate services. Changing population patterns of illness will also place greater pressure on demand. As the rates of illness continue to increase in younger persons (and if these young persons are not treated adequately), direct treatment, associated disability and unemployment costs will also increase. The costs of purchasing new pharmaceuticals (to be imported), and the need to establish broad population-based disease prevention strategies, will add new costs to the mental health budget.

New pressures on the mental health system will emerge. These are already evident as a consequence of the direct negative impact on Australian families, and particularly young children, of the ongoing threats of domestic and international terrorism, the stress of war and continued drought conditions. Due to our prior lack of investment in effective community-based care, service innovation, biomedical research and population-based psychological or social prevention strategies, we are not well placed to meet new demands.

Sadly, there has been a lack of national uptake of more effective service systems, particularly world-leading and Australian-developed prevention, early intervention and specialised treatment forms. For over a decade, we have failed to support initiatives designed to increase workforce professionalism or redistribute workforces to meet population needs. We have only just commenced investments aimed at changing community attitudes about the importance of mental health problems.

While Australian mental health policy is often depicted as world-leading, those using or providing the services continue to report widespread gaps in services and dissatisfaction with the quality of services provided. Our national policy has championed the appropriate move to non-institutional forms of ongoing care. Consumers, carers, local health service providers and national non-government organisations (NGOs) reported that the Commonwealth and States are unwilling to back widespread and systemic reforms and are ill-prepared to report on progress within any of the key service areas. Overwhelmingly, the perception of those who use or provide current services is that we have now arrived at a position of 'OUT OF HOSPITAL, OUT OF MIND!'

The community calls on the Australian Prime Minister and State Premiers to support:

- investment of financial and infrastructure resources;
- greater transparency and accountability;
- clear deadlines for key outcomes;
- a focus on quality service provision;
- reduction of human rights abuses and neglect; and,
- genuine investment in service innovation, evaluation, and associated aetiological and treatment research.

THE HISTORY OF MENTAL HEALTH REFORM

In 1992, the Australian Health Ministers committed their governments to correct decades of neglect in mental health. A national mental health policy was developed and mechanisms were described to: lift Commonwealth and State expenditures; reduce human rights abuses; move the locus of care from hospitals to the community; and, deliver quality mental health within the mainstream of Australian health and welfare services (1).

In 1993, the Human Rights Commissioner's Report ('Burdekin Report') brought the human rights issues of overt abuse within institutions, and covert neglect in the wider community, to the attention of the general public (2). For the next 10 years, Australian governments implemented two five-year plans aimed at: facilitating genuine participation for consumers and carers; developing high quality community-based mental health care; and, outlining a broader population-based health promotion and disease prevention approach.

This new national focus, on a long-neglected health area, assumed that all governments would invest additional dollars in the exercise. Those persons in need of mental health services, and their families, greeted these national commitments with great enthusiasm and expectation. Everyone assumed that real change required not only large increases in resources but also promotion of genuine national leadership and widespread professional and community support.

THE 2002 MENTAL HEALTH COUNCIL REVIEW

After 10 years of this national approach, the Mental Health Council of Australia (MHCA) conducted a nationwide review to ask those who used, or provided, mental health care whether substantial change had been achieved. This national consultation involved over 400 organisations and individuals and was conducted between August and December 2002. It utilised appropriate qualitative and quantitative methodologies. The face-to-face consultations and the three-stage mailed surveys engaged a wide range of national bodies representing consumers and carers, professional groups, NGOs and local service providers.

The major conclusion of the review is stark. Despite the efforts of many committed politicians, government officials, service providers and community advocates, we do not have a system of effective or accessible mental health care. At all levels of government, within some of the professions and out in the wider community, there is a perception of general apathy, lack of accountability and lack of commitment to real change. While public understanding of mental health has begun to improve, the wider community remains relatively ignorant of the service crisis. Only when a family member needs care are they made aware of the gross deficits in care.

People with mental disorders, and their families, feel frustrated and let down by the system. Their goodwill, patience and support for the protracted nature of genuine health care reform have been dissipated. People whose lives have been affected are willing to back another five years of government national planning only if it is supported by genuine national leadership and commitment.

While mental health reform is difficult, and needs to be seen as occurring over years rather than weeks or months, those in need of services today require an urgent and substantial improvement in our mental health care system. To simply continue with the current inadequate pace of reform, perpetuate the same inadequate resource base, utilise the same governance structures and fail to invest in innovation and disease prevention, is to condemn many of the most disadvantaged and ill members of our community to many more years of abuse, neglect and very poor mental and physical health. It also puts at great risk the wellbeing of many other Australian families who are likely to require such services for the first time in future years.

- *Community-based voices now favour a more proactive, more critical and more political approach. National and state governments have substantially underestimated this groundswell of disenchantment.*
- *Enquiries within several States over recent years have only scratched the surface of experiences of poor quality care. Further agreements between governments are now in danger of being perceived as hollow and without integrity.*
- *The current oversight of mental health care reform needs to be extended beyond the National Mental Health Working Group of the Australian Health Ministers' Advisory Council (AHMAC) to include heads of government.*

KEY ISSUES

A. Grossly unmet need for basic mental health services:

- Currently, 62% of persons with mental disorders do not utilise mental health services (3). Reported reasons include: stigma associated with mental disorders; fearfulness of medical treatments; poor distribution and costs associated with specialist services; and, inappropriate mix of medical and psychosocial services provided by government-financed systems.
- In 2001, 2,454 persons died by suicide constituting 4.4% of all deaths in those less than 75 years of age and 10.6% of potential years of life lost. The vast majority of suicides occur in persons with untreated mental disorders, particularly in those with depression and recent alcohol or drug abuse (4).
- Although 38% of persons with mental disorders access care, that care is largely provided by general practitioners (GPs) (3). The decline in bulk-billing is placing further pressure on even this most basic form of mental and physical health care for persons with mental disorders.
- GPs report that they are poorly supported by specialist care services and evidence from practice reviews indicates major deficits in the quality of care they provide (5).
- As a direct consequence of our lack of community understanding of current treatments available for mental disorders and our poorly resourced and poorly distributed service systems, the majority of people with mental disorders receive either no treatment or treatment that fails to meet current international standards for optimal care. For example, less than one in six persons with depression or anxiety are currently receiving evidence-based treatments (5).

B. Grossly inadequate growth in expenditure on basic services:

- Australia spends approximately seven percent (\$2.56 billion) of its health budget on mental health. While comparisons with other health areas are problematic, mental health accounts for 13% of total disease burden (death and disability) and nearly 30% of the non-fatal disease burden in Australia (6).
- Although international comparisons can only be approximate, other first-world countries report spending 10-14% of total health expenditure on mental health (7).
- The costs of all health areas continue to increase due to increased population size (17.6 to 19.0 million Australians over the last decade) and increased demand for new treatments, new technologies and more comprehensive services.
- Despite the increased expenditure in mental health over the last decade (\$778 million), there is no evidence that the *proportion* of total health expenditure devoted to mental health has increased. Increases in expenditure on mental health (46%) have simply mirrored increases in the costs of providing other forms of health care (42%) (1).
- The National Mental Health Strategy assumed that the proportion of health expenditure devoted to mental health would increase. While the Commonwealth did increase its contribution significantly (by 73% from \$26.80 to \$46.38 per capita), growth in State and Territory expenditure was only 19.8% per capita (from \$68.22 to \$81.76 per capita) (1). The larger States of New South Wales and Victoria recorded very low increases of 18% and 4.4% per capita, respectively. The largest State of New South Wales spends only \$77 per capita compared with \$85 in Victoria, \$86 in South Australia and \$96 in Western Australia.
- While growth in Commonwealth expenditure was significant, over two thirds of this was accounted for by the increase in pharmaceutical costs (402%) rather than planned or appropriate expansion of service systems, or support for non-pharmacological treatments.
- The expansion in pharmaceutical costs is a result of the rapid growth in new products to treat brain-related disease, as well as the decline in external purchasing power of the Australian dollar. Currently, there is no substantial investment in development of these products in Australia.
- The National Mental Health Strategy required all governments to broaden the mix of services they provided, and to actively promote notions of disease prevention, early intervention and prevention of relapse. Additionally, partnerships with other services (particularly primary and general health care) were supported. Essentially, such expanded roles had to be financed from within the same overall budget. Consequently, local clinicians and service providers report actual declines in the total number of direct clinical services provided.

C. Restricted access to existing services:

- The experience of current consumers of mental health care is that they have severely limited access to primary care (exacerbated by current declines in bulk-billing rates), emergency care, specialist care and rehabilitation services.
- Current care systems are perceived to be chaotic, under-resourced and overly focused on providing brief periods of medicalised care, largely within acute care settings.
- Private psychiatric services are grossly maldistributed (8) and involve large out-of-pocket costs, while access to specialist psychology and other allied health services has been restricted largely by lack of government or private insurance support.
- The demands on the carers and families of people with mental illness are increasing.

D. Ongoing human rights abuses and neglect:

- While the locus of care under the National Mental Health Strategy has moved from institutional to community-based care (1), no effective management system has evolved to provide either high quality care or the necessary supports for living productively within the wider community.
- Persons with mental illness report ongoing abuse within hospital forms of care and ongoing abuse and neglect in the wider community. Overt abuse is reported to occur within emergency departments and other acute care settings of general hospitals.
- Persons with mental illness report ongoing discrimination in key areas of employment and insurance, and restricted access to basic welfare services and support (9).

E. Increasing demand for mental health care:

- The future of mental health care will be one of increasing demand and increasing costs to health and welfare services.
- Increasing demand will be driven by the significant stress placed on Australian families from war, threat of terrorism, ongoing drought, more young people developing mental disorders, increasing numbers of persons with current disorders presenting for care (as public awareness of these conditions increases), and increasing expectations that services will provide optimal and evidence-based care for whole episodes of illness.
- In the 2001 *National Health Survey* (10), 10% of adults reported they had a long-term mental or behavioural problem, 9.5% of people had taken a pharmaceutical medication in the last two weeks and rates of severe psychological distress among adults in the community had increased from 8.2% in 1997 to 12.6% in 2001.
- Persons with disorders will expect treatments to be provided earlier in the course of their illness, in more specialised forms and for longer periods.
- Increased costs of care will occur when we import new pharmacological agents affecting the central nervous system.
- Increased public, business and professional awareness of the total societal burden and economic costs of untreated mental disorders (as described within the Global Burden of Disease framework; 11) will create increased expectations of a broad population-based approach.
- Governments will be expected to fund not just basic services but also support mental health promotion and disease prevention campaigns for the whole population.

The findings of this review resonate strongly with, and build on, the extensive nation-wide research undertaken by SANE Australia in 2002-03. SANE's *Mental Health Report 2002-03* (12) clearly showed that "... mental health services are in disarray around the country, (and) operating in crisis mode...". SANE also reported that "... effective treatments ... are not routinely available ...", and "... untreated mental illness is a leading contributor to Australia's suicide rate ..." (12).

"The weight of evidence presented to the Committee highlights that mental health services in NSW need revolutionary improvement. Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment." (13, p.xv)

Honourable Dr Brain Pezzutti
Chair, NSW Select Committee on Mental Health

A number of other independent State-based reports have also specifically highlighted the inadequacy of current mental health services. The *New South Wales Upper House Inquiry* (2002; 13) highlighted the inadequacy of community-based care systems while the report of the Victorian Auditor-General (2002; 14) placed particular emphasis on the poor performance on acute mental health services:

"This audit identifies a range of concerns about the timeliness of service provision, the completion of key service delivery processes in compliance with relevant standards and guidelines, and the burdens placed upon carers and families. In making these findings, I do not wish to impugn the many dedicated professionals providing mental health services. It is clear that the service system is under significant stress, due to demand pressure, work force shortages and the increasing complexity of mental disorder in our society." (14, pg. vii)

J. W. Cameron, Auditor-General

When the States and Territories most recently reported on their own performance (1), it was clear that some (notably South Australia, which had recently commissioned its own external review) had not made the substantial moves planned under the national strategy, while most had failed to implement the National Mental Health Standards or report significant increases in funding in the last five years.

We can no longer ignore the broad range of compelling evidence before us. Recent government and independent reviews, and the new systematic and representative data reported here, lead us inexorably to one conclusion. We must act now for the improvement of mental health care in Australia.

Each year for the next five years, each 'head' of government should be asked to respond to four simple questions:

Is there evidence in your State or Territory that:

1. *The proportion of total health expenditure on mental health has increased by one percent?*
2. *Access for people in need of primary care, emergency care, specialist care, or ongoing community support has improved?*
3. *Quality of mental health care has improved – as determined by a reduction in adverse incidents as well as increases in the rate of provision of effective forms of treatment and the consumers' experiences of care?*
4. *Reports of human rights abuses and neglect have diminished?*

PART ONE: INTRODUCTION

This report describes a review of mental health care in Australia undertaken by the MHCA. The findings of the International Mid-term Review of the Second National Mental Health Plan formed an important backdrop for this review. An overview of the findings of the International Mid-term Review is now discussed.

1.1 International Mid-term Review of the Second National Mental Health Plan

In 2001, two international academics, at the invitation of the then Minister for Health and Aged Care, The Honourable Dr Michael Wooldridge, conducted the International Mid-term Review of the Second National Mental Health Plan (15).

The International Mid-term Review provides an international perspective on the National Mental Health Strategy and outlines: major achievements to date; identifies obstacles in achieving the Strategy's objectives; and, suggests a number of 'ways forward' for mental health policy and services. The Review was a precursor to the final evaluation of the Second National Mental Health Plan and provides advice on possible future directions for mental health reform in Australia to the: Commonwealth Minister for Health and Ageing; Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group; and, AHMAC.

The Review methodology involved consultations being undertaken in seven of the eight States and Territories (no consultations undertaken in Northern Territory) and meeting with a range of individuals and services including consumers, carers, NGOs, mental health professionals and their representative organisations, State, Territory and Commonwealth officials, researchers and a range of service providers.

The International Mid-term Review outlines support throughout Australia for the directions and underlying principles of the National Mental Health Strategy. However, some respondents considered that the Second Plan was too ambitious and did not allow for the reforms of the First Plan to be fully implemented before expanding to a broader focus.

Overall, the International Mid-term Review concluded:

- The National Mental Health Strategy and its First and Second National Mental Health Plans are international exemplars;
- The main achievements are the integration of mental health assessment and intervention in mainstream health delivery and the inclusion of mental health consumers and carers in policy development; and,
- There is more to be done to implement the existing reform agenda. A Third National Mental Health Plan is supported by all stakeholders as needed to consolidate gains, maintain momentum and provides continuing national focus on mental health.

Key issues identified in the International Mid-term Review include:

- The need to focus on the comorbidity between substance abuse and mental health with poor coordination in terms of policy and practice in most States and Territories;
- A continuing lack of coordination between mental health services and other health and social support services (in particular housing, education and employment);
- The limited contribution of private psychiatric sources to mental health care, noting that there is limited accountability for funding and no monitoring of quality of practice;
- A serious mental health workforce shortage, particularly mental health nurses;
- The continuing stigma experienced by mental health consumers;
- The lack of child, adolescent and aged mental health services;
- The inadequate knowledge and understanding of the nature and extent of Indigenous mental health issues and effective and acceptable interventions;
- Forensic and prisoner mental health issues being a future priority, noting the high percentage of prisoners with mental health problems;
- The need to conduct mental health services research (including different models of primary mental health care); and,
- A need to expand primary prevention activities by the health promotion sector (not by the specialist mental health services) (15).

PART TWO: MENTAL HEALTH CARE REFORM IN AUSTRALIA – THE HISTORY AND THE SETTING

2.1 Introduction

Mental disorders contribute substantially to the burden of disease in Australia. The Australian Institute of Health and Welfare reports that mental disorders account for nearly 30% of non-fatal disease burden, and that mental health is third after heart disease and cancer in terms of disease burden (6). Despite considerable advances in the mental health reform process over the last decade (such as the movement towards community-based care), much remains to be done to address the burden of mental health as identified in this Australian study and the *1996 Global Burden of Disease Study* conducted by the World Health Organization/ World Bank (11).

The Australian *National Survey of Mental Health and Wellbeing* indicates that approximately 20% of the population experiences a mental health problem each year. Such mental health problems include affective, anxiety and substance abuse disorders (3). The prevalence of mental health problems in children and adolescents in Australia is 14% of the population (16). Three percent of Australian adults experience serious mental illness such as a psychotic disorder (17).

The stigma associated with mental illness is especially pervasive in the community, and society often deals with such fear and distress by alienating and segregating those with mental illness. The impact of stigma, discrimination and misunderstanding is often profound – becoming a part of the problem and affecting the life of the individual.

Services for people with mental illness are provided through a range of health and welfare programs funded by the Commonwealth, State and Territory governments, private health insurance and by individual co-payments.

In the public sector, the typical specialised mental health service delivery model involves services being provided for a defined catchment population, with the service integrated across hospital and community settings. Inpatient services are provided in general hospitals and in separate psychiatric hospitals. Community-based services comprise a range of service types, including clinic-based, mobile follow-up and treatment and mobile crisis response services. Case management is often used to coordinate services provided in different settings. Housing, disability, support, employment and income support services are funded under other government programs.

This report commences by outlining the national policy context for mental health reform and progress with the reform agenda to date.

2.2 National mental health policy context

The mental health of the Australian community has been a key policy area for Federal, State and Territory governments over the past decade. All governments have endorsed the National Mental Health Strategy.

2.2.1 National Mental Health Strategy (1993-2003)

The National Mental Health Strategy was agreed to by all Australian Health Ministers in 1992, initially for five years. The Strategy provided for the first time in Australia, a national agenda for mental health reform. The agreement defined a national direction and a framework for governments to work together to reform a system that was considered to be inadequate and neglected by policy makers.

The drive for reform had its origins in the convergent desire of mental health professionals, consumers and carers to see a better overall mental health service system in Australia and the release of the United Nations declaration *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (1992; 18). The 1993 *Report of the National Inquiry into the Human Rights of People with Mental Illness* ('Burdekin Report'; 2) recorded the extent of mental illness and its treatment in Australia at that time. Additionally, a number of inquiries in a number of States highlighted abuse and violation of human rights.

Broadly, the National Mental Health Strategy aims to:

- Promote the mental health of the Australian community and where possible, prevent the development of mental health problems and mental disorders;
- Reduce the impact of mental disorders on individuals, families and the community; and,
- Assure the rights of people with mental illness.

The National Mental Health Strategy is articulated in four major documents:

1. The *National Mental Health Policy* (19) – outlines the approach to mental health reform, promoting a shift from 'institutional care' to 'community care'. The policy was endorsed by all Australian Health Ministers in 1992 and defined the broad aims and objectives to guide service re-development.
2. The *Mental Health Statement of Rights and Responsibilities* (20) – articulates the principles of United Nations Resolution 98B (*Resolution on the Protection of Rights of People with Mental Illness*). This document was agreed to by all Health Ministers in 1991 and outlined the philosophical foundations of the Strategy in regard to civil and human rights.

3. The (*First*) National Mental Health Plan (21) provided priorities for reform for the period 1992/93 to 1997/98 and the Second National Mental Health Plan (22) builds on, and extends, these directions for the period 1998 to 2003. The plans describe how Commonwealth, State and Territory governments are to implement the aims of the National Mental Health Policy.
4. The Medicare Agreements (1992/93 to 1997/98) and the Australian Health Care Agreements (1998/99 to 2002/03).

The National Mental Health Strategy recognises the complementary but different roles of the Commonwealth, States and Territories. The Commonwealth coordinates the system reform on a national basis, monitors the reform process, and disseminates information in annual reports on national progress in achieving the agreed outcomes. As well as providing additional mental health funding for the States and national programs, the Commonwealth has gradually increased access to nursing homes, emergency relief and accommodation, vocational rehabilitation, disability services and income support for people with mental illness and psychiatric disability (23). Although, as documented in the body of this report, the findings of this evaluation suggest that much remains to be done in these areas. The States and Territories, which are responsible for service delivery in Australia's public mental health system, are responsible for the bulk of public sector reform.

The implementation of the National Mental Health Strategy is undertaken in collaboration between the Commonwealth Government, the governments of all States and Territories (i.e. jurisdictions), and consumers, carers and mental health sector representatives through the AHMAC National Mental Health Working Group.

The *National Mental Health Policy* (19), as one of the four major documents comprising the National Mental Health Strategy, articulates 12 priority areas. The remaining three documents support activity in these 12 priority areas of:

1. Consumer rights;
2. The relationship between mental health services and the general health sector;
3. Linking mental health services with other sectors;
4. Service mix;
5. Promotion and prevention;
6. Primary care services;
7. Carers and NGOs;
8. Mental health workforce;
9. Legislation;
10. Research and evaluation;
11. Standards; and,
12. Monitoring and accountability.

2.2.2 Second National Mental Health Plan (1998-2003)

The Second National Mental Health Plan was endorsed by all Australian Health Ministers in July 1998 and provides a five-year framework for activity at the national and State/ Territory levels building on the achievements of the First National Mental Health Plan. The essence of the Second Plan is to consolidate existing reforms and extend into additional areas of reform with a strong emphasis on population health issues and early interventions.

The three priority themes under the Second Plan are:

- a. Promotion and prevention;
- b. Partnerships in service reform and delivery; and,
- c. Quality and effectiveness.

Enhancements to the improvement of mental health care for the Australian population have been provided through initiatives such as:

- *beyondblue: the national depression initiative* (\$17.5 million from the Commonwealth);
- More Options Better Outcomes (*Better Outcomes in Mental Health Care* initiative – \$120.4 million which commenced July 2002; 24); and,
- MindMatters – national schools-based mental health promotion and prevention initiative currently being implemented in Australian high schools.

2.3 National Mental Health Strategy achievements

The main directions for reform to service delivery arrangements under the National Mental Health Strategy include the reduced reliance on stand-alone psychiatric hospitals and the expansion of community-based and primary mental health care. Whilst reasonable gains have been made, it has also been recognised that: improvements are uneven across, and within, jurisdictions; the structural reform agenda has not been finished; and, concerns about poor service quality and client outcomes have only begun to be addressed.

Some insight into how the National Mental Health Strategy is progressing is provided via a *National Mental Health Report*, prepared and published annually. The mandate for the report was provided by all Australian Health Ministers who agreed to monitor and report publicly on the progress of all jurisdictions.

Key achievements reported in the most recently published *National Mental Health Report* (1) include:

- A 30% increase in national spending on mental health (though, similar increases also occurred in other National Health Priority Areas);
- Shift to a community-based system of care;
- Reduction in the size of psychiatric institutions;
- Reduced isolation of mental health services from the mainstream health system;
- Increased consumer participation in decision-making;
- Expansion of psychiatric disability support services; and,
- Savings from the reduction in institutions redirected to new services.

It is also reported that all States and Territories have amended their mental health legislation to meet the National Mental Health Strategy requirements that all mental health legislation is consistent with the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (18) and the *Mental Health Statement of Rights and Responsibilities* (20). To facilitate this model, mental health legislation was developed and a 'Rights Analysis Instrument' was designed by the Federal Attorney-General's Department to evaluate the compliance of State and Territory mental health legislation.

Once again, however, there appears to be some inconsistency with the views of participants as documented in this report and the data reported in the National Mental Health Report. This tends to suggest that the National Mental Health Report may not fully capture the reality of stakeholder experience.

2.3.1 The impact of changes in psychiatric hospitalisation

The following information provides an overview nationally of the changes in psychiatric hospitalisation.

Central to the vision of the National Mental Health Strategy is the idea that an effective mental health service requires a core set of components, which place the locus of care in the community. The National Mental Health Strategy has therefore advocated a fundamental shift in the service balance, away from the historical reliance on separate psychiatric hospitals to the development of local, comprehensive mental health services. These should be linked to form a single, integrated service system that emphasises continuity of care, both over time and across service boundaries, mainstreamed with the health system as a whole.

Stand-alone psychiatric institutions were central to Australia's mental health system at the commencement of the Strategy, accounting for 49% of total mental health resources. By 1998 this reduced to 29% and total beds in institutions reduced by 42% (1). At the commencement of the Strategy, 55% of acute psychiatric beds were located in specialist mental health units in general hospitals. By June 1998, this had increased to 73% as a result of a reduction in stand-alone acute services and a 34% growth in general hospital-based beds through the commissioning of new or expanded units (1).

Protection of the resource base for mental health reform was imposed by the Federal Government. Federal mental health funding was quarantined from general health funding provided to States and Territories who subsequently agreed to maintain their previous level of mental health expenditure throughout the reform period. In addition, any savings arising from the downsizing of institutions was required to be directed back to new mental health service development.

New models of care, and the shift away from institutional care towards community care, have challenged the attitudes and skills of those working in mental health. Stigmatising attitudes to people with mental illness are still held by many clinicians and mental health professionals. It is important that practitioners acquire and maintain knowledge, skills and attitudes to provide quality services in this new service environment and ensure those with a mental illness play an active role in decisions regarding their treatment.

More people with mental illness are living in the community which means stigma from community members has a more direct impact on consumers. Consumer participation in community life, as well as in mental health service and policy development, is important for recovery and improved quality of life and citizenship. Ongoing efforts to reduce stigma and discrimination continue to be important.

2.3.2 Levels and methods of funding mental health services

The following information is an overview of mental health expenditure nationally. Australia spends approximately 7% (\$2.56 billion) of its health budget on mental health (1). Although international comparisons can only be approximate, other first-world countries report spending 10-14% of total health expenditure on mental health (7).

While comparisons with other health areas are problematic, mental health accounts for 13% of total disease burden due to death and disability (6). The costs of all health areas continue to increase due to increased population size (17.6 to 19.0 million Australians) and increased demand for new treatments, new technologies and more comprehensive services.

Despite the increased expenditure in mental health over the last decade (\$778 million), there is no evidence that the **proportion** of total health expenditure devoted to mental health has increased. Increases in expenditure on mental health (46%) have simply mirrored increases in the costs of providing other forms of health care (42%).

The National Mental Health Strategy assumed that the proportion of health expenditure devoted to mental health would increase. While the Commonwealth did increase its contribution significantly (by 73% from \$26.80 to \$46.38 per capita), growth in State and Territory expenditure was only 19.8% per capita (from \$68.22 to \$81.76 per capita) (1). The larger States of New South Wales and Victoria recorded very low increases of only 18% and 4.4% per capita respectively. While growth in Commonwealth expenditure was significant, over two thirds of this was accounted for by the increase in pharmaceutical costs (402%) rather than planned or appropriate expansion of service systems.

The expansion in pharmaceutical costs is a result of the rapid growth in new products to treat brain-related disease, as well as the decline in the external purchasing power of the Australian dollar. There is no substantial investment in development of these products in Australia.

2.3.3 Community participation in, and integration of, mental health services

Consumers and carers have been included in national planning since the National Mental Health Strategy began. By 1998, 61% of service delivery organisations reported the establishment of formal mechanisms for consumer participation in local service issues (1). However, both the International Mid-term Review (15) and this review concur that consumers and carers are still not satisfied with the rate of progress of service reform as their expectations of service responsiveness and quality still outstrip their direct experience.

Integration advocates the bringing together of various elements that make up a mental health service into a cohesive program that promotes continuity of care. These elements include acute and non-acute inpatient services, residential services and psychiatric disability support services. Achieving a balance between mainstreaming and integration has presented a challenge for States and Territories. This requires a balance between removing barriers separating mental health services from the general health system and maintaining the identity and cohesion of the mental health service network. Monitoring progress on the objectives of mainstreaming and integration is complex. Each State and Territory runs its health services differently and there is, as yet, no nationally agreed method for measuring progress.

2.3.4 Quality control of mental health services

It is an objective of the National Mental Health Policy that all mental health services have a quality assurance program. In December 1996, the AHMAC National Mental Health Working Group endorsed the *National Standards for Mental Health Services* (25) as an essential part of achieving high quality mental health services. Under the Australian Health Care Agreements all States and Territories agreed to full implementation of the National Standards in public sector mental health facilities by 2003.

There are three sections in the *National Standards for Mental Health Services*:

- Standards one to seven are related to universal issues including human rights, dignity, privacy and confidentiality and community acceptance;
- Standards eight to 10 address issues related to mental health service organisational structure, service integration and links between parts of the mental health sector; and,
- Standard 11 has sub-components which describe the process of delivering care on a continuum, commencing with access to mental health services, exit and types of treatment and support available.

The Commonwealth is working with States and Territories to support quality assurance through review and accreditation of services against the National Standards. States and Territories are currently at varying stages of this work. The private and non-government sectors are also working to implement National Standards.

Consumers and carers have consistently identified that many of their issues and concerns with mental health service delivery would be addressed through effective implementation of the National Standards for Mental Health Services.

2.4 Conclusion

This part of the report has provided the national context and a broad overview of the progress made in implementing the National Mental Health Strategy. It needs to be restated that the progress with mental health reform, as documented in the most recent National Mental Health Report, does not fit with the “felt reality” of those people who participated in this review (see data in latter half of this report). Whilst progress has been made, it seems that much remains to be done to complete the structural reform of mental health services and improve the quality of life of mental health consumers and their carers.

The following section outlines the methodology used to gather the data for this review. This is followed by the presentation and analysis of the review data.

PART THREE: METHODOLOGY OF NATIONAL REVIEW

3.1 Introduction

In this section of the report, the methodologies used to conduct this national review of consumers, carers and health care providers experiences of mental health services are described. The review was conducted in association with a community-based review of responses to the findings of the International Mid-term Review of the Second National Mental Health Plan (15). The MHCA's initial report describing its review of the community's perception of the International Mid-term Review was submitted to the Commonwealth in November 2002, and the specific data is not discussed further here. However, the general themes are presented to provide a context for interpreting the results of our third survey. Those results detail potential 'ways forward' for mental health reform in Australia.

Both internal and external government-sponsored reviews of the progress achieved under the first two National Mental Health Plans had, in the view of many consumers, families and carers, largely neglected their day-to-day experiences. In their view, the volume and nature of reports of inaccessible and inadequate care had been substantially glossed over. Additionally, a wider range of other key professional groups and non-government agencies that provided services at a local or regional level felt that they had not been adequately consulted. Many of these bodies also felt that the government rhetoric of reform had not been matched by genuine progress on the ground. While instances of excellence could be identified, there was a clear lack of confidence that the common experiences of restricted access, poor quality and continuity of care, insufficient respect for the concerns of consumers and their families and ongoing neglect of those residing in the community was being communicated at the highest level of national forward planning.

To collect and understand the breadth of experiences of these key stakeholders, the methodologies utilised in this review included systematic and comprehensive quantitative and qualitative strategies. As there was a clear need to organise the data to reflect experiences at both the macro (national and organisational) and micro (individual) levels, a number of different academic agencies were used to assist the Council to handle different aspects of the data collection and interpretation process.

3.2 Study design

The evaluation was conducted in several stages that are now explained.

Stage one of the review commenced in August 2002 and involved the dissemination of a detailed written survey (Appendix 1) to organisations and groups considered to be representative of key national stakeholders (eg. NGOs, consumers, carers, health managers and service providers). Stage two commenced in October 2002 and involved the dissemination of a briefer survey (Appendix 2) to organisations, groups and individuals that were more representative of regional and local levels of practice, as well as primary care providers. It was developed following response to the initial survey and sought to capitalise on apparent differences in the perception of reform between different stakeholder groups. Stage three involved a series of face-to-face consultations with community representatives and national professional groups (including GPs). A written workbook was provided to participants in the workshops to encourage further feedback (Appendix 3).

The rationale for conducting the first phase of this research in three stages reflected a need to: collect data relevant to the Commonwealth's desire to evaluate community and primary care service provider reactions to the International Mid-term Review; and, build on these responses to conduct a more extensive review of consumers, carers and local service provider experiences of health care.

The data collected by the MHCA to meet its contractual arrangements with the Commonwealth were then complemented by a fourth data set in 2003. It is the data from this later stage of the national consultative process that are reported in detail here. The data are based largely on the results from an extensive third survey that was designed to build on the earlier data. It sought to develop possible community-based priorities – 'future directions' or 'ways forward' – for national mental health planning. This final survey was undertaken in January and February 2003.

3.3 Research sample

3.3.1 Stage one (see Appendix 4)

The first survey was sent to a purposeful sample of 115 mental health sector stakeholders who were selected on the basis of:

- a. Being representative of a particular group of mental health stakeholders at either a State or national level; and,
- b. Having a reasonable understanding of, or experience with, the Second National Mental Health Plan.

Respondents completed the survey on behalf of their organisation rather than as individuals.

3.3.2 Stage two (see Appendix 5)

The second survey was sent to a purposeful sample of over 800 mental health sector stakeholders. These stakeholders were selected on the basis of:

- a. Being a mental health stakeholder (group or individual) at a regional or local level; and,
- b. Having a reasonable understanding of, or experience with, the Second National Mental Health Plan.

3.3.3 Stage three (see Appendices 6,7 and 8)

In the context of a national consultative process designed largely to answer key Commonwealth questions as to the validity of the findings of the Mid-term International Review, a series of face-to-face consultations (lasting between one and a half and two hours) were held with:

- Members of the 'Australian community' in each jurisdiction. In the five larger jurisdictions consultations were also held in a rural location. An open invitation was extended to community members through the placement of advertisements in local newspapers and the dissemination of information through various NGOs. Participants at the community forums included consumers, carers, service providers and NGOs.
- A range of mental health providers in each jurisdiction; and,
- A group of GPs in each jurisdiction. An open invitation was extended to GPs through their respective State-Based Offices of the Divisions of General Practice. A total of 60 GPs participated.

3.4 Triangulation of data

Whilst it would have been possible to utilise only one of these data sets to investigate participants' experiences of current mental health reforms, this prolonged process and use of multiple data sources reduced the chance that conclusions were based largely on a small group of policy makers, consumers, carers, specific professional groups or local service providers. This is in contrast to the methods typically employed by responsible governments where undue emphasis has been placed on the views of those who are responsible for developing and/or implementing national mental health policy, peak professional groups and/or a few key individuals.

PART FOUR: RESULTS OF NATIONAL REVIEW

4.1 Results from surveys one and two

For the first survey, there were 80 responses in total and, therefore, meaningful sub-categorisation into relevant subgroups (consumers and carers, GPs, specialists, NGOs and health management/ promotion/ research) could only be considered preliminary. There were 328 responses to the second survey. As expected, there were more consumers and carers, GPs and specialists. Together, the surveys provide more than 400 sets of responses.

The key findings from these surveys relevant to our general goal of reviewing consumers, carers and local service providers' experiences of mental health services are that:

- All respondents described current clinical services as generally poor, and that community-based services in particular are grossly inadequate;
- Restricted access to acute clinical services remains a major problem. Those services provided by key specialist groups such as psychiatrists and psychologists are inaccessible to many people as a consequence of either geography or financial status;
- All groups agree that little or no progress had been achieved in the area of changing community attitudes or reducing stigma;
- The legitimate roles of consumers and carers have not been well-established at the level of local policy or service implementation;
- Consumers and carers consider that there has been inadequate progress in reform of mental health legislation or protection of human rights; and,
- Two new aspects of policy, namely emphasis on prevention and early intervention and the increased medical and psychological care roles of GPs, have not been implemented nationally.

In general, health service managers expressed much more positive views of the progress of national mental health reform than consumers, carers, local service providers or GPs.

4.1.1 Conclusions from surveys one and two

- a. In general terms, all stakeholders believe that there is yet much work to be done to achieve most of the goals of the National Mental Health Strategy.
- b. From a consumer and carer perspective, there was no key policy area where the majority of respondents returned a positive rating.
- c. If the National Mental Health Strategy had been effectively implemented then one would have predicted much more positive affirmations of these key goals by at least some of the key stakeholders.
- d. Some areas such as persistent stigma and changes in community attitudes are seen by all as having achieved little, while in some service areas and in terms of consumer and carer participation, health service managers expressed a more optimistic view.

4.2 Themes from qualitative data

Qualitative data was collected through open sections in the first two surveys as well as from consultations with the community, GPs and other professional groups. For the purpose of this report, the qualitative data sets have been combined and are reported as one. Throughout the consultation phase, many individuals and organisations expressed strong support for the development of a Third National Mental Health Plan. It was regularly noted that mental health is a major health issue in Australia and that the first two Plans had been useful in providing a national framework for reform. However, there was a strong feeling from people in all areas of the mental health sector that much more needs to be done to achieve the goals of both the First and Second Plans, particularly in the area of partnerships.

Whilst most people agreed that a future Third National Mental Health Plan should focus on consolidating the work of the two previous plans, others felt it was important to identify additional areas, other than those in the first two Plans that also needed attention. It was in this context that respondents spoke of: the need to include new focus areas to stimulate innovation; and, the sustainability of innovations proven to be effective.

Following on from the idea that many elements of the First and Second Plans have not been fully implemented, there was general agreement that the development of a Third Plan needed to be supported with appropriate strategies for implementation activities. To encourage a focus on implementation, it was suggested that the mental health sector would need funding levels appropriate to the goals of the Plan, measures of implementation or impact, and funding models linked to deliverable items or outcomes from the plan.

4.2.1 Key themes

Systematic review of the qualitative data revealed 10 strong themes:

- National leadership and accountability;
- Community participation;
- Institutionalisation in the community;
- Spectrum of care settings (including housing);

- Human rights;
- Resources;
- Service integration;
- Workforce;
- Stigma; and,
- Innovation and sustainability.

Each of these themes are now discussed.

4.2.1.1 National leadership and accountability

“I want to know where all the money goes. It just seems to disappear. Who’s accountable? Who are they answerable to? Why can’t the system be more accountable so we can get the services we need? We don’t seem to have any say or any control.” (Carer)

“The ways forward are through the BIG PICTURE – national models of service, national standards, population-based funding and a national commission.” (State-based service provider)

“There are no clear answers from the state directors – the reporting is as dodgy as ever ...”
(State-based service provider)

“We need to fund the consumers and carers – until they get enough clout, we’ll never change the system of health funding!” (State-based service provider)

“There’s a huge degree of power in too few individuals.” (Mental health consumer representative)

“The national plan is too vague. No specific roles or responsibilities are assigned to specific players. At the end of the day, nobody is held accountable.” (Professional body representative)

“There’s so much inertia (in the government sector). If we don’t change who’s in charge, then I’ll be left wondering ‘is it really going to go anywhere?’” (Professional body representative)

“The relationship between the peak consumer and carer bodies and the health-service agencies is like the relationship between Bangladesh and West Germany! The central concerns of the health agencies should reflect those of consumers and carers. ... (currently) it’s a joke! The consumer and carer agencies are not central (to planning) and they’re not funded to play such a key role.”
(Professional body representative)

There was a strong perception that ‘leadership’ in mental health care and reform was limited to the Commonwealth Mental Health and Special Programs Branch and the AHMAC National Mental Health Working Group. This has resulted in a system that appears to lack a strong sense of leadership at an inter-governmental, professional and community level.

This lack of broad-based (true ownership) of mental health care and reform has resulted in problems associated with a perceived lack of accountability by States and Territories to the National Mental Health Policy and Plans. Most people felt this problem was clearly compounded by the Federated system of health care which results in the continual shifting of blame for inadequacies in the system to ‘other’ levels or ‘other’ areas of government. There were concerns raised regarding the lack of visibility of funding allocation of each State and Territory. Many respondents requested the need to be better informed about the distribution of funding from the Commonwealth to the local level, to enable better management of funds and to increase accountability:

“A reasonable level of funding is being skimmed off by large hospitals and it doesn’t seem to be going into mental health. Accountability of spending is a real issue that needs to be addressed urgently. There is a constant shifting of responsibility between sectors and service providers.” (Community respondent)

Stakeholders felt that even though there was a ‘National’ Mental Health Strategy, there was a lack of a national constituency and the lack of any strategic framework for the building of a national constituency. There was a sense that this lack of a national constituency has resulted in the fragmentation of care and a lack of accountability. It was noted that the consultation process conducted by the MHCA and *beyondblue* was one way to build a national constituency but this work would need to be ongoing rather than a one-off event conducted every five years. In a sense, what respondents were requesting was the opportunity to be meaningfully engaged in the reform process, and to provide ongoing feedback to Government on the implementation of the National Mental Health Strategy.

“ ... the plan is not very Australian-specific. It’s an international plan. Really – very soft!”
(Professional body representative)

“There’s a fundamental lack of priority settings. That leads to a lack of targeted funding and, in the end, no real accountability.” (Professional body representative)

“The (national) policy is monolithic – the implementation is chaotic. Most of the policy is isolated from the initiatives designed that eventually arise.” (GP representative)

“Historically, mental health believes that everything should come out of the mental health system. Actually, our most productive pathways are often outside of mental health.”
(Rural and remote GP representative)

“It’s been bits and pieces rather than any real system change. There’s a real lack of action and resources on the ground.” (Rural and remote non-government representative)

“After a bit of a fresh go, people have just settled back to what’s easy. We need real incentives to get (services) out of the comfort zone.” (Rural and remote consumer representative)

“The States are not interested in asking the end-users (of their services). They fund pilot projects but don’t go onto systematic change.” (Rural and remote consumer representative)

Community members generally hold the view that overarching structural and financing issues have produced a mental health system that is fragmented and extremely difficult to navigate by the average consumer. For example, cross border issues (i.e. the transportation of mental health consumers across jurisdictional borders) negatively impacts on timely access to care and effective outcomes. This is compounded by the fact that each jurisdiction has its own (different) mental health legislation. The fact that the responsibility for mental health care, even within jurisdictions, is scattered across levels of government and across multiple agencies compounds the perceived lack of accountability within the system.

“Why bother talking – we’ll just get more promises without solutions. It’s a system that’s just designed to wear you down.” (Rural and remote consumer representative)

“The problem with the Commonwealth is that it has good intentions but doesn’t really appreciate local situations.” (Rural and remote consumer representative)

“The national standards – are they a wish list or a serious requirement!” (Consumer representative)

“Without standardisation, there is no genuine reform movement – we must get the national standards implemented.” (State-based service provider)

“There’s no real access to the decision-making bodies.” (Professional body representative)

“The (state-based) mental health service – what do they know? How serious are they about engaging with the national agenda?” (Rural and remote consumer representative)

“There’s a general uselessness in reproduction and proliferation of state plans – just further replication of funding and resources – a national plan must be national!” (National professional body)

In this study, many research respondents support the move of a national framework of standardised legislation across States and Territories. However, many stated that models of care should be flexible to cater for the variety of consumers that need different types of care and/or present with comorbid disorders which include not just mental health issues:

“We need individualised care pathways – not a factory model of care.” (Ethnic community respondent)

Respondents commented that there is still a great emphasis on the medical model, and not community-based care, which: maintains clinician control over assessment and treatment; reduces consumer and carer involvement; and, overlooks the contribution of other mental health and community workers:

“The medical model is still dominating funding decisions and clinical care.” (Mental health nurse)

It was generally agreed that no one standard model can be used to assess accountability and effectiveness, and more research is required in assessing different types of models that are more holistic in approach.

“Core (state-based) services are so poorly funded that they undermine the credibility of national funding initiatives.” (National professional body)

“All this one-off project funding just takes good staff away from core clinical services.”
(National professional body)

“Core services just lurch from one crisis to another.” (National professional body)

“We need to start doing the things the community wants – not just what we want.”
(National professional body)

“Community consultation has become tiresome in the face of no real progress.”
(Community representative)

“There’s no need for a third new direction – the states are at least five years behind the national policy.”
(State-based service provider)

“Who leads this plan?” (Professional body representative)

4.2.1.2 Community participation

Participation remains token

“Consumer and carer participation is a joke! The service that I’m associated with thinks it’s enough to ask us (consumers) to fill in a satisfaction survey every six months. It’s such a humiliating experience.”
(Consumer)

“Carers are never included in the treatment plans. They’re just not consulted. The (doctors) just tell you that nothing is wrong. They tell you what you want and what you need!”
(Rural and remote consumer representative)

“We need a new model of services that has a hospitality (rather than hospital) focus! People should be treated with real courtesy and respect. Care needs to be appraised at the individual (not just system) level.” (National professional body)

“We just find institutional attitudes in non-institutional settings.” (Community representative)

“Carers feel totally disempowered ... There’s a complete lack of negotiation – they’re the place of last resort.” (Carer representative)

Whilst the principles of consumer and carer participation in the development, implementation and evaluation of the mental health system appear to be enshrined in National Mental Health Policy and Plans, there appears to be a lack of genuine consumer and carer involvement in mental health care or reform at the jurisdictional, regional and local levels.

Respondents from all areas of the mental health sector made comments about consumer and carer representation in mental health services, with consumers, carers and people from NGOs being most likely to comment on this issue. All of those who provided comment seemed to agree broadly on the value and importance of both consumer and carer representation in mental health services, although some suggested that the roles of consumers and carers needed to be clarified and formalised. It was broadly agreed that this could best be achieved through the development of a national consumer and/or carer participation strategy and policy.

A strong theme to emerge from the consultations was the need for consumers and carers to be more meaningfully involved in service planning, policy development and evaluation of services (including development of relevant measures and standards). This issue was raised by a range of groups, including consumers, carers, NGOs and those involved in prevention, policy or research. Many people expressed concern about the accreditation process, which is used to encourage compliance with the National Standards, because it often failed to involve genuine, long-term consumer or carer participation.

The community reports a real lack of ownership of the National Mental Health Strategy. Consumers commonly reported mental health care as being something that *“is being done to them”* as opposed to being developed and delivered in partnership with them. More importantly, many consumers reported strong feelings of disempowerment, frustration and neglect by the system. The concern is that many consumers may be afraid to voice their individual concerns about their treatment. Many of the respondents said that the role of consumer can be broadened considerably and could include roles as self-carers, evaluators, advisors or educators. It was suggested that consumers and carers be recognised by being employed in a supportive and/or consultative role and be given accreditation and training opportunities.

Consumers and carers reported that their representation on working/ planning groups and committees remains tokenistic and that the major planning and policy decisions have often been made prior to them being invited to participate. In particular, there is a feeling that carers receive less recognition than consumers in service planning. Parents (carers) of young consumers and children were highlighted as a special group that deserve a stronger role in policy and program planning for this group.

Some service providers suggested that while the intention of services may be to ensure representation and involvement of both consumers and carers, increasing pressures on clinical services may make meaningful participation difficult. There appears to be an additional difficulty with the inclusion of carers in treatment decisions who report that professionals are reluctant to disclose details because of concerns about confidentiality. Several respondents argued that carers ought to be incorporated into treatment as well as treatment decisions, as they spend more time with the client and may know more about their issues and progress. Recognition of the contribution of carers could also be improved through appropriate financial assistance.

Increasing demands on NGOs

"I don't know where the community would be without services like ours. But we can't keep going without an increase in funding. We're doing our best to support people but it isn't enough. It seems like the Government expects us to do more and more but with no more money! It's so hard!" (NGO worker)

"There's too much money in the hospitals – most people don't need to go there. I need to be out there in the community, no matter how hard it is." (Consumer representative)

"There's no services in the community and no funding to get quality services. We feel that the community is just becoming one big institution!" (Community representative)

"At the coalface, we're supposed to provide a high quality service on a shoe-string budget!" (Non-government service provider)

NGOs are increasingly being expected to take on broader and more demanding responsibilities of supporting mental health consumers and their carers. However, funding for NGOs has not been commensurate with the increasing demands being placed on them. Many consumers and carers expressed concern about consumer and carer organisations/ NGOs being under threat through funding cuts or through receiving inadequate funding in comparison with other areas and projects. Many felt that the survival of consumer and carer networks and NGOs were critical to community empowerment and to the success of the National Mental Health Strategy. Various respondents including GPs raised the importance of NGOs in delivering various services and providing a more holistic approach by being able to include counselling, advocacy, public education, workshops, referrals and social and support groups.

Consumers, carers and service providers raised the need to avoid fragmentation of advocacy groups, suggesting that State-based groups need to work more closely together and within a national framework. Whereas some respondents suggested that public and private consumer advisory mechanisms could be consolidated at State and national levels, others expressed concern that there is little representation for private sector consumers (and their carers) and that separate representation was necessary.

Lack of carer support

"I do all the caring for my boy. But nobody wants to help me. I'm tired, really tired and there's no end in sight – no help – nothing! Nobody tells me when he's being discharged from hospital either. He just turns up on the doorstep and we start all over again. Maybe it'd be better if we could have the asylums back – I don't know really. Who wants to listen to an old lady anyway – nobody!" (Carer)

A lack of support for carers was a common theme. The role of carers of people with a mental illness is considered by the community to be seriously disregarded by providers at local, regional and State levels. As is the case with the NGO sector, carers are increasingly being required to increase their role as providers of, and advocates for, care. Carers report that the imposition on their time is not only increasing, but the respect for the roles they play and their contributions to the system are frequently overlooked by providers such as their safety. One area of particular concern for carers is the lack of communication with them by the providers of care.

Many respondents felt that the rights of carers are less clear than those of consumers in legislation, especially under the new Privacy Act. Similarly, outcome measures developed by the Commonwealth Mental Health and Suicide Prevention Branch or local mental health services may include a carer perspective on consumer outcomes, but rarely focus on carer outcomes.

It was considered that many providers are unaware of carers' rights and responsibilities and are unfamiliar with relevant standards such as the 1991 *Health Ministers' Rights and Responsibilities Statement for Carers and Advocates* (18) and the

National Standards for Mental Health Services (25) involving carers. Others suggested that the standards for carers have only been partially implemented and that even this has required considerable pressure from advocates.

There was a strong feeling from respondents that there is a need for greater diversity in the type and duration of support offered for carers, and that the availability of support services varies from region to region. An increase in funding for respite care was called for, as was further research into appropriate models of respite care. It was also emphasised that carers need not only respite care but also other services such as: outreach and telephone support; counselling and debriefing; peer support; greater financial assistance; relaxation and health care activities; in-home specialised respite; clinical back-up; carer retreats; and, support for their own mental health and wellbeing.

Respondents emphasised the need for nationally consistent, but locally relevant, information and training for carers, stating that many carers were not informed about support systems in their area and, for example, how to access funds from Centrelink. Carers need greater information and education about: mental illness; specialist and generalist support systems; management strategies regarding the consumer; self-care; and, coping strategies for the carer. It was generally agreed that the NGO sector was best placed to develop and deliver this information but would need to be well-resourced to do so. It was also suggested that consumers should be involved in this process. Families, including children, should be better informed about a range of issues when someone is diagnosed with a mental illness. The needs of young carers and the children of those with a mental illness were a significant concern, raised by many respondents. It was suggested that their role is frequently overlooked and that they need greater assistance and support. Examples of the type of support recommended by respondents include the provision of family systems therapy and training in the management of 'at-risk' behaviour. Several respondents raised the importance of supporting funding of current successful programs such as the Early Psychosis Prevention and Intervention Centre (EPPIC) and the Association of Relatives and Friends of the Mentally Ill (ARAFMI) which provide helplines, seminars, workshops and teach coping and adjustment skills to family members of adults and children with mental health issues.

The needs of other carer groups were also raised, again by people from various roles within the mental health sector. The needs of carers from culturally and linguistically diverse (CALD) backgrounds were emphasised, with many being affected by family obligations and cultural expectations. It was suggested that all carer support and respite services should address cultural appropriateness.

In addition, there was concern about those who care for a person with a high prevalence disorder such as depression or anxiety. They are often caring for a person outside the specialist mental health system, so they may not be well-informed about support options. In addition, they may feel out of place in some support groups which cater mainly for those who care for a person with a psychotic or other serious mental illness.

4.2.1.3 Institutionalisation in the community

"My son sits alone in a unit with nothing to do, no motivation, no energy and doped up on a tranquiliser. I see other people like my son around where I live, who appear lost and lifeless, who roam aimlessly all day." (Carer)

Mental health consumers continue to experience poor quality of life and tend to remain isolated from the heart of their communities. In the rare situations where housing is provided, this is often located on the fringe of cities or regional centres, and the difficulties for consumers are compounded by the lack of accessibility to public transport. Several respondents reported that transport difficulties in rural areas greatly impact mental health teams accessing their clients and covering all of their areas.

A common view expressed by consumers and carers throughout the consultations, was that many mental health providers, particularly those working in the public sector, continue to function in an institutional framework. That is, their focus appears to be on 'containing' consumers in care rather than promoting quality of life and 'recovery'. Several respondents claimed that people are left in beds and not provided activities to do as there is not enough staff. The focus of inpatient mental health care appears to be one of fostering dependency rather than recovery.

Consumers and carers held the view that many providers appear to hold to a set of attitudes which are not reflective of the respect for dignity and human rights that mental health consumers deserve. For example, many consumers reported experiencing the worst stigmatising behaviour from providers of mental health care.

The need for consumers to be provided with nationally consistent, but locally relevant, information was also raised. It was in this context that people spoke about the lack of information provided to consumers on admission to, and discharge from, hospital. These were considered to be confusing times for consumers and they spoke about feeling uninformed about what was happening to them or why. Consumers and carers suggested that a simple education pack provided on admission and discharge could assist them in understanding these events and knowing what to do next. It was agreed that to ensure quality and consistency, this information was best developed at a national level and complemented with locally relevant information on support agencies and services. Once again, the NGO sector was considered best placed to develop this information.

Crisis response and hospital-based care

Respondents indicated that insufficient rehabilitation and relapse prevention is contributing to the re-admission of people with severe and recurrent mental illness. It was suggested that there are insufficient crisis response services to meet the needs of the community and that increasing service demands impact upon the timely availability of a response. Crisis response services may only partially address consumer needs. Several respondents commented that the process of hospital admission and discharge, prioritises only those who require acute care and has resulted in many falling between the gaps of services:

“Psychiatrists won’t take my son if he is not aggressive, yet the next day he is more than aggressive and gets admitted.” (Carer)

“We need to set priorities, get acute care right – while you’re fighting off crocodiles, its hard to think about draining the swamps.” (Community representative)

“Acute admissions are more complex, people are more unwell ... there are lots of drugs issues and criminal justice issues.” (Professional body representative)

“The promotion of the concept of ‘serious mental illness’ has had disastrous consequences in the public sector. It has just meant that we don’t take responsibility for large numbers of people in trouble.” (Professional body representative)

“You’ve got to throw a brick through a window to get admitted – but when you do that you end up being admitted to the wrong service!” (Consumer representative)

“The system needs a single point of entry. Its so fragmented. People just get lost. There are too many ‘dead-end’ and ‘no-care’ alternatives out there.” (Professional body representative)

Several respondents were concerned that the lack of communication between crisis assessment teams, hospitals and GPs, regarding notices of admissions and discharges impacts the number of assessments and admissions processed. Consumers and carers felt that if there were alternative services, some people with recurrent illness may not require re-admission.

There were also concerns that the quality of hospital care can be poor and that carers and families have problems with early and inappropriate discharge of patients, perhaps partially due to a lack of beds. It was frequently reported that patients are discharged with little or no support. It was suggested that ‘transition teams’ be funded to support patients after discharge to reduce re-admission as set up in various areas. Others recommended the establishment of ‘acute and sub-acute sections’ and ‘safe or transitional houses’, similar to domestic violence refuges, to service those who are not prioritised for hospitalisation but require support.

4.2.1.4 Spectrum of care settings (including housing)

“There are no recovery/ training/ employment facilities operating for the benefit/ empowerment of people who are ‘discharged’ from mental health organisations. Ex-patients are left to their own devices. Most are extremely vulnerable to DRUGS and other abuse and in time of ‘NEED’, there is no HELP available.” (Carer)

“There is a real lack of follow-up treatment, help, support etc. after people are discharged from mental health facilities. My son has been ‘deregulated’ from fortnightly Haldol injections on the ninth of September 2001. Since then we’ve had NO follow-ups, no visits, no phone calls, no contact, to this day (November 2002)! THERE’S NO SUPPORT!” (Carer)

“People have no idea where to go – where and how to get care. Who tells you? People don’t know what services to expect.” (Community representative)

“We end up with a self-rationing system – you feel you should let those who are worse off use the available resources – you just feel that you are not worthy of getting any more.” (Consumer representative)

“I just go back to the hospital when I run out of support (in the community).” (Consumer representative)

Whilst the provision of acute mental health beds in general hospitals settings is viewed more positively, there is a strong view that other critical levels of care are missing. In particular, consumers and carers report a significant lack of step-up or step-down care facilities.

There is an urgent need for recovery programs which span: mental health; housing; employment; drug and alcohol abuse; benefits and entitlements; and, medical treatment. Many mental health consumers reported being left in

settings not tailored to their needs. Others also commented on this issue, particularly with regard to a lack of adequate and appropriate housing for mental health consumers. It was generally felt that there is a distinct lack of stable and appropriate housing for mental health consumers. When consumers are discharged from hospital it is not uncommon for them to be left without any accommodation options and end up on the street; it was reported that many consumers lose their housing during their hospitalisation. There was the concern that many boarding houses are closing and the criteria for eligibility for housing is getting harder.

While deinstitutionalisation as a general policy thrust was viewed positively, responses generally indicated that there are not enough resources to adjust to the transition; staff were not trained or equipped to provide community care and responsibility has been left with family members.

Recovery and/or ongoing treatment also suffers due to the reported long waiting lists and the cost of specialist services. Many respondents suggested that access to psychological treatment would be more accessible to low income earners if psychologists were able to bulk-bill their clients using Medicare. To overcome this dilemma several GPs reported that their client access to specialist care improved when they were funded to provide their clients vouchers to visit other specialists.

Rehabilitation and relapse prevention

“There’s no care for us unless we’re in crisis. Nobody even mentions recovery anymore. I want to recover.” (Carer)

“We only pay lip service to relapse prevention. It gets little support and isn’t really disseminated as a philosophy throughout the services.” (Professional body representative)

“All the emphasis is on crisis services – there’s a complete lack of emphasis on recovery.” (Consumer representative)

Respondents called for improved rehabilitation and relapse prevention services. This was a particular focus for many of the consumer or carer representatives, however, it was also raised by those from NGOs and specialist services. The loss of dedicated psychiatric hospitals had also adversely affected the availability of rehabilitation programs and services.

It was suggested that a Third National Mental Health Plan should include rehabilitation and recovery as an important area which has not previously been adequately addressed. Psychosocial rehabilitation needs to be fostered and supported outside clinical frameworks, and requires dedicated funding. More services are needed to provide support for rehabilitation and one respondent suggested that NGOs could take a lead role. There was a feeling that community-based services work well together but that there are difficulties in the Commonwealth/ State interface of services.

Specific issues which related to rehabilitation and longer-term support were vocational rehabilitation and the availability of accommodation. Respondents felt that vocational rehabilitation and other supports need to be increased in all disability areas, including mental health. Generally, a more holistic service was suggested by respondents which include: consideration for their spiritual wellbeing; providing social and educational group activities to enhance skills and self-worth; and, options to alternative therapies. One respondent indicated that providing suitable employment for those able to work, assists mental health and wellbeing by: keeping people occupied; preventing isolation; and, encouraging recognition of their capabilities. Stigma against those with a mental illness was suggested as a barrier to access to employment opportunities.

Several respondents commented on the need for improved accommodation support for those with mental illness. There appears to be a need for more long-term supported accommodation options, particularly for those who are severely and chronically-ill. While in some areas people with mental illness are given priority access to public housing, the waiting list and lack of appropriate housing means that accommodation is not really readily available. Many respondents, including GPs, specialists, consumers and carers recommended the need to fund transitional or half-way housing with more aesthetic and less isolating environments similar to accommodation for the elderly. The needs of homeless people who have severe mental illness were noted as being neglected.

A number of people commented on the need for relapse prevention strategies and support for those who have a recurrent mental illness. Respondents pointed out that effective rehabilitation has benefits for consumers, carers and service providers. Rehabilitation and relapse prevention helps to: stabilise the illness; offers support for consumers and carers; and, reduces the probability of admission to hospital. It also helps to reduce disability and may reduce the impact or severity of recurrent episodes of illness. Overall, this can lead to both improved outcomes and better use of resources.

4.2.1.5 Human rights

“There is a terrible problem with accommodation and care of the chronically mentally-ill in the community with their exploitation by unscrupulous landlords. Most of the chronically mentally-ill patients now receive care in the community but we have seen an enormous growth of homelessness among this group of people who now represent a real underclass within our society.” (GP)

Human rights issues remain a fundamental problem, however, the issue appears to have moved from one of open human rights abuses to one of neglect. Where perceived cases of human rights abuses were reported these appeared to be limited to inpatient care. Many consumers reported feeling their most vulnerable when they are in hospital care and held the perception that there was no external monitoring of how consumers were treated whilst in care. Several respondents acknowledged that the legislation did include rights but implementing structures and processes to monitor and practice it still needs work. Several respondents expressed that consumers could be empowered if they are provided with an information pack of their rights when they are admitted to hospital, or distributed through community centres, medical centres, etc.

There was also a strong view that the discharge of seriously mentally-ill consumers from hospital into the community, without any real follow-up, was common and constituted serious human rights abuse (again through neglect). The general view was that there is a lack of attention and adherence to the principles of basic human rights for mental health consumers.

Consumers and carers generally felt that there has been a failure of the system to move to more customised models of care. Consumers felt they are treated as “groups of people with mental illnesses” rather than individuals with individual problems and individual needs. Individual care pathways were considered rare and this led to a lack of continuity of care.

4.2.1.6 Resources

“You know, I think the staff do want to do a good job. They are mostly good, caring people, but they don’t have the resources.” (Consumer)

“Funds are always being earmarked for special new purposes – the core services just keep contracting.” (State-based service provider)

“There’s just a total lack of capacity in the community – funds, people, support systems. We need primary care dollars into each community and then sufficient outreach of specialist services.” (Indigenous representative)

“Simply being told that there is not enough money makes you feel even worse – you end up taking the responsibility for it – you’re just made to feel that it is your fault!” (Consumer representative)

“We’ve had great demonstration projects. There’s just no further funding, no mechanism for, or commitment to, dissemination.” (Professional body representative)

Despite the strong evidence base, which indicates increasing prevalence rates and levels of disability for mental health problems and disorders in Australia, participants felt that resources for mental health care have not increased beyond those for other health areas. In fact, it appears that the relative resource base has remained static.

There was strong agreement between all groups (consumers, carer, NGOs and providers) that the current level of funding for mental health care in Australia is poor by international comparisons and insufficient for the level of need:

“We need to increase the proportion of health funding that goes to mental health care from its current level (6.5%) to that of comparable countries (10-11%).”

This was an important area of discussion that permeated all consultations. Comments related to the need for additional funding to support specific initiatives discussed in other areas of the review, such as: improved consumer and carer representation; respite care; workforce development and recruitment; GP support and partnerships; and, rehabilitation services.

Further comments included concerns about the lack of ongoing funding for pilot programs. A number of respondents noted that effective pilot programs were not continued, because no provision had been made for recurrent funding.

A commonly expressed view was that NGOs provide invaluable support to mental health consumers and their carers; however, their work continues to be hampered by low levels of resourcing and a lack of long-term resource commitments by governments.

4.2.1.7 Service integration

“We had grants to support our GPs with case conferencing and assessment, and that was great – we initially experienced trouble with the Acute Crisis Assessment Teams accepting the need for assessment. We met with them a lot and discussed the problems. The program involved GP clinical attachments to the service. This program helped us work together. We developed a great deal of respect for each other and each other’s roles. It was very helpful. Initially the funding came from the Commonwealth Government but then it became less and less and then nothing. The State won’t support it even though we can show that it works.” (GP)

“The communication difficulties (between GPs and specialists) are cultural – the communication needs to be bilateral – not simply telling us what we do wrong.” (GP representative)

“We only pay lip service to integration!” (National professional body)

“Its hard to find anything good about the current services. Doctors are the main problem. They gain the attention, work on their own and manipulate the system.” (Rural and remote consumer representative)

“Having more psychiatrists hasn’t resulted in better communication!” (Rural and remote GP representative)

“Money alone won’t change things – it’s a question of attitudes. Real partnerships are a key issue.”
(GP representative)

Inter-sectoral collaboration has not developed in a systemic or coordinated way. Collaboration appears to be sporadic and driven by key individuals rather than by systemic reform. Initiatives aimed at improving collaboration tend not to be sustained beyond the initial funding period.

Apart from the most recent introduction of the More Allied Health Services (MAHS) program and the Allied Health Pilots developed through the *Better Outcomes in Mental Health Care* initiative, inter-sectoral collaboration has not been facilitated through national service frameworks.

A general view was that there appears to be a lack of accountability or incentive for the different professions to work across their professional and service boundaries. There are various barriers to collaborations raised by respondents that impact communication between the different sectors/ groups. These include different values and approaches to working with clients and the need to maintain ownership of their area/ department. Other hindrances to collaboration include fear of competition for funds, protecting confidentiality of clients and the lack of standardisation of legislation and practices across States and Territories that negatively impact the transfer of information between sectors and States. Insurance also, for example, creates difficulties and keep services of people with physical and mental disabilities separated. Another barrier is the misunderstanding and attitudes towards, other professions and their roles. Recognition of each other’s multi-skills and roles were not acknowledged, or used optimally and consequently impacted communication between potential partners.

Whereas the issue of partnerships had been addressed in the Second Plan it was generally considered to be an area requiring much greater development. Broadly, stronger partnerships were recommended between GPs, psychiatrists and other mental health professionals. General practitioners need improved access to specialist advice regarding mental health issues and access to training and other forms of support. Several respondents said that having GPs, psychologists and/or mental health nurses under one roof has made access to these services more efficient and comprehensive as each can consult each other as to the progress of their mutual clients. The involvement of, and partnerships with, GPs is discussed in detail in the GP data.

“The mental health workforce discussion never refers to GPs at all.” (GP representative)

“The plan lacks an emphasis on quality and safety and it doesn’t link with other critical national initiatives (that promote) evidence-based practice or clinical effectiveness.” (Professional body representative)

“I’m amazed by the lack of recognition of the role of GPs (within the International Review and Plan). We are the largest providers of mental health care. We must address the issues of access, quality and better remuneration.” (National GP representative)

“Ninety percent of the plan is irrelevant to those people who use systems other than the (state-funded) public mental health system.” (Mental health consumer representative)

“I’m just stunned by the lack of formal consultation with GPs!” (GP representative)

“GPs have a totally different relationship to psychiatrists compared with other specialists – we just don’t get the professional support you’d expect.” (GP representative)

“I find it very hard to work with private psychiatrists – they just don’t want to share the care.” (GP representative)

More effective partnerships were also called for between the public and private mental health sectors. There were calls for greater recognition of the role of private hospital mental health services and for improved mechanisms for collaboration with the public sector. Exploration of this option would require the involvement of health funding bodies and the health insurance industry. A revised system could consider ways in which private hospital mental health service providers could consult to primary care practitioners and be more involved in crisis response and initial care. Additionally, it would be beneficial if private sector patients had improved access to public services such as allied health practitioners (eg. occupational therapy) and rehabilitation, for more inclusive and comprehensive care.

There was also a very strong expressed need for specialist mental health services to develop stronger partnerships with NGOs and government agencies which provide other forms of support for those with mental illness, particularly housing and employment. The current lack of inter-governmental collaboration in this area was a major concern. Stronger links between mental health services and other parts of the health care system were considered vital as many people with mental health disorders also experience physical health problems and/or substance abuse. Some suggested that stronger partnerships and improved care between health agencies could be facilitated by establishing a shared information system, with appropriate privacy protection mechanisms, which could be accessed by public, private and primary care practitioners. In addition, mental health services were encouraged to develop stronger links with organisations that support CALD communities, in order to facilitate access to services and programs and to develop mental health promotion strategies for these communities.

Partnerships with the education sector were also discussed by some respondents, particularly in regard to mental health promotion programs. Even though respondents felt that a national approach to mental health promotion was preferable, they acknowledged that under a federated system decisions to adopt particular programs rested with State-based education authorities and individual schools.

Several respondents provided examples of collaborations and partnerships. Collaborations were practiced in several ways which include regular inter-agency and inter-sectorial meetings to discuss mutual clients, case conferencing and the establishment of referral and feedback systems. The problem, however, is the time and resources required to coordinate such partnerships.

4.2.1.8 Workforce

“Attitudes of the workforce are problematic. I don’t think the real problem is with the skills of the workforce, it’s more about access and attitudes.”

“Many of the good staff leave because they become depressed with the system – they can’t tolerate the substandard level of care that’s dished out.” (NGO)

“We need different staff, non-patronising staff, skilled staff ... those who can make appropriate responses to difficult behaviours ... compassionate, professional staff!” (Rural and remote consumer representative)

“It’s a toxic workplace, the workers are affected by the workplace ... they just rely on rules, ward policies and procedures. We need people who treat other people with heart – we need people who can see the person as a person not just see the illness!” (Rural and remote consumer representative)

“Its time we had customised services, individualised services. We need to get rid of some sacred cows!”

“I hate being in hospital – I won’t go back again. They treat me like shit! You see the staff just sitting there reading books – how come they sit and read books? Shouldn’t they be providing care to us? One night I sat outside until 4am – no one knew because no one had checked to see if I was in bed! So what’s the point of being in there – no point!” (Consumer)

The attitudes of the mental health workforce are of major concern to the community. Participants strongly agreed with the need to address workforce issues, and specifically commented on the need for ongoing training and professional development, and clarification about the roles of particular professions. While mental health workforce planning, staffing and resource levels had been included in previous plans, they are areas considered to be relatively undeveloped and thus require further attention in any Third Plan.

Professional development and competency standards

In general, participants felt that insufficient attention has been paid to the extent to which continuous professional

development contributes to the improvement of staff attitudes and retention. Increased remuneration on its own does not appear to be a viable resolution to these issues.

Many participants including consumers, carers, prevention or promotion workers and NGOs, made recommendations about the training of the mental health workforce to ensure good standards of practice and care. Generally, it was suggested that employers should provide a general workplace standard whereby supervision, long-service and study leave be incorporated into budget to increase training options.

General practitioners voiced their concerns for the importance of accessing training in the area of mental health to recognise, for example, early symptoms, provide treatment and to manage their mental health care consultations with more effectiveness and efficiency. Other suggested methods were: to support collaborative projects to promote information exchange and sharing opportunities; and, debriefing and peer support to ensure a more comprehensive assessment and treatment strategy.

It was generally agreed that the training of psychiatrists and GPs should include a greater emphasis on the recognition and management of depressive and anxiety disorders, since changes in treatment practices have changed the nature of hospital-based training. However, the main issue regarding the training of psychiatrists was related to the need to train psychiatrists to work as consultants with other specialists, GPs and the community sector rather than purely as front-line therapists.

Some consumers felt that it would be beneficial to raise the standard required of those who wish to gain qualifications as psychologists and counsellors, since degrees for these professions were considered *“too easy to obtain”*. Other suggestions included a need: to focus on mental health training for child and adolescent practitioners; training the NGO workforce in psychosocial rehabilitation; and, reviewing the direction and content of training for social and community workers.

Nurses raised training as important for regularly updating their skills and credentials. One respondent stated that the Plan does not mention improving recruitment and retention of the nursing workforce, which makes up a large component of the health workforce:

“... the whole system would collapse without them”. (Mental health nurse)

Suggestions of improving recognition and retention included increasing supervision, training and positions for promotion. Several stated that psychiatric nursing training should be made separate but accessible to students at both undergraduate and postgraduate levels to ensure a highly skilled workforce.

Several respondents also proposed that training should be provided to police, ambulance and nurses on mental health first aid due to the traumatisation patients face during hospitalisation. Respondents further noted that generic workers involved in disability, supported accommodation and youth be provided training and/or information packs. Another common suggestion was that consumers and carers should be trained as well as be more involved in the education of mental health professionals, both in the development and delivery of training:

“There is a wealth of experience out there that can be used ... not taking advantage of people who have been right to the edge of the cliff and come back again.” (Consumer)

In addition to education from academics and clinical educators, mental health professionals would benefit from an understanding of the feelings and barriers encountered by consumers and carers. Respondents suggested involving consumers and carers at the undergraduate and postgraduate levels as well as in professional development.

There was broad support for the concept of core competencies across professions, although it was also suggested that as different regions and services have different service delivery options, some flexibility in training would still be necessary. Respondents also felt that it was important to ensure that the diverse skills and approaches of a multidisciplinary team would not be lost in such standardisation.

Specific issues were raised for inclusion in the core competencies. Carer competencies would include issues about understanding, recognition of carers, communication and support options. Cultural competencies would include cultural awareness, working cross-culturally and the development of culturally appropriate service models.

Distribution of workforce

“We should stop training them if they are going to end up on the North Shore of Sydney.” (NGO)

The maldistribution of the mental health workforce remains a serious issue. Consumers in urban fringe, rural and remote areas reported significant difficulties in accessing specialist care. Several respondents from more rural areas (such as Townsville and Bendigo) reported that there are only one or two psychiatrists in town and the waiting lists are too

long (up to two years in some instances).

Generally, it was viewed that there were less incentives for specialists to work in rural areas. It was reported that nurses move to rural areas as part of their scholarship for postgraduate studies then move to other States where they are able to obtain higher remuneration for their qualifications.

The other problem reported in relation to the distribution of the workforce, appeared to be associated with the lack of rural GPs willing to bulk-bill, rather than one of simple geographic access. There is also less financial incentive for GPs to treat patients with mental illnesses as they generally require more time than patients with physical illnesses. The suggestion by many was the need to provide better incentives for the workforce to remain in the rural areas and to treat patients with mental health issues.

The other concern raised in the study was that there is not enough use, support and focus on allied health professionals like occupational therapists, nurses, social workers, counsellors and psychologists to improve access and distribution of specialist care in needed areas. One respondent pointed out there are many people in the workforce that have experience and competently practice in the field of mental health but are ineligible for registration such as those with degrees in counselling or three years in psychology. With supervision and regular professional development the workforce could be expanded by utilising and equipping this group, thus improving recruitment (especially in rural areas where there are shortages).

Workforce attitudes

Mental health employees perceived their employers (the system) to be driven by economic rationalist notions of cost saving and “*more for less*” than quality of care. The mental health workforce acknowledges that their own lack of engagement in mental health reform in Australia has contributed to current problems with financing and resource distribution.

Some respondents expressed concern about ‘burnout’ of current members of the mental health workforce due to a lack of support and resources, and felt that there is a risk that without meaningful support mental health professionals could experience hopelessness and complacency. It was frequently suggested that the issues of workforce and workplace stresses and strategies to overcome these should be included in any Third National Mental Health Plan.

General comments were made regarding the need to balance the availability of specialist services and more general case management and to ensure that team members within multidisciplinary teams have opportunities to develop and use their specialist skills. It was suggested that the role of mental health caseworkers be refined and formalised to include a greater focus on forging inter-sectoral links. Some felt that the recruitment of bilingual and bicultural mental health workers should be encouraged, to better cater for the needs of people from CALD backgrounds.

The primary care workforce, particularly GPs, continue to report a lack of collaboration with, and support from, the specialist mental health sector. Where collaboration is enjoyed, GPs considered this to be based on the drive of key individuals rather than any systemic or structural frameworks.

It was apparent in the study that workforce attitudes were negatively impacted by several factors that impede inter-sectoral collaboration and overall morale. For example, different sectors and professions felt misunderstood and unrecognised for their contribution in mental health, resulting in negative attitudes between each other. In the study, a proportion of GPs, nurses, carers and consumers stated that they were not recognised for their skills, multiple roles and workload by other professionals and consumers. There was a strong sense by nurses that they are overlooked for their mix of roles as, for example, early intervention providers and in roles supporting GPs. Several GPs, for instance, viewed themselves as multi-faceted providers of both physical and mental health but non-GPs, consumers and carers voiced otherwise. Several GPs stated that the level of responsibility and stress was greater on those who did concern themselves with mental health issues, as many GPs were reported to avoid the added workload and focus on physical illnesses, thus further impacting morale. There were also many negative comments directed to psychiatrists. They were viewed, by several respondents, as prescribers of medication only without focus on the welfare of the consumer and alternative treatments. The Royal Australian and New Zealand College of Psychiatrists (RANZCP), however, did express concern about educating psychiatrists to work more effectively with consumers and carers and work with better models of integrated care.

The misrepresentation and different perceptions of each other’s roles indicated the need for joint education between sectors, professions and consumers both in the public and private sectors to improve recognition, workforce attitudes and prospective collaboration that should be addressed in the Third Plan.

Non-pharmacological treatments

There were several comments about the roles of psychologists in the mental health care system, offered by consumers and carers, providers of specialist services, NGOs and those involved in promotion or research.

Many respondents felt that improved access to a range of counselling services and psychological therapies (including

cognitive behaviour therapy and narrative therapy) would be beneficial, and that psychologists should primarily be employed in the role of providing therapies (rather than being case managers). Increased access to therapies was recommended in both the public and private sectors and could be enhanced by the inclusion of psychological therapies under the Medicare Benefits Schedule. It was also suggested that the public sector needs to fund additional positions for psychologists in both the public and community sectors. Respondents voiced the need for more holistic treatment, which included other health professionals as well as community workers to help provide non-pharmacological treatment such as support groups, counselling and advocacy. Voucher systems were supported by respondents to be successful in improving access to non-pharmacological treatment.

Furthermore, a number of specialist service providers suggested that the mental health workforce could be restructured to make greater use of specialist clinical psychologists. There is a perception that there is a small and diminishing number of psychiatrists available for work in the public health system, and that funding of more positions for specialist psychologists would help to address workforce issues, provide more treatment options and help to address the unmet demand for services.

General practice

Many of those representing general practice felt that GPs are valued by the community as important providers of mental health care and have an important role in early detection of mental health disorders and disease management, particularly of high prevalence disorders.

It was also suggested by GPs that since they see consumers more frequently and more holistically than many other health professionals, they are well-placed to assist in the recognition and management of psychosocial problems. Some consumers and carers, however, questioned whether GPs can provide adequate care and support for consumers and carers, given the increasing pressures and high workloads of general practice, particularly in rural and remote communities.

“We expect far too much from GPs, the average GP is unlikely to do a great deal. There’s a danger that all we are really doing is limiting access to real expertise.” (Professional body representative)

“Those with expertise in evidence-based treatments should be there to deliver those treatments to the customer in need.” (Professional body representative)

A number of respondents requested additional measures to support GPs in their role in mental health care provision. Suggestions included: education and skills development in the recognition and management of mental health problems; funding for educational programs; improved access to specialist support and psychological therapies; dedicated funding to build partnerships; administration costs associated with liaising; referral feedback relationships/agreements with hospitals, psychologists, psychiatrists and mental health and crisis teams; expansion of GP-item numbers which allow more time with patients; development of mental health outcome measures and assessment tools which are inclusive of general practice; and, a simpler and more streamlined approach to management of records.

General practitioners in this study were concerned with the increased paperwork and bureaucratic processes involved with assessing and treating patients and several suggested, for example, an IT-based system. To encompass these issues, some respondents suggested that a primary mental health care strategy with dedicated funding should be developed as a key area of any Third National Mental Health Plan.

Funding has been provided for one government initiative that has been reported by respondents to be successful in improving primary mental health care. The *Better Outcomes in Mental Health Care* initiative is designed to assist GPs to improve and review their assessments, mental health plans, remuneration and access to psychiatric and allied health professionals. GPs in the study have reported that the initiative has been favourable in, for example, uncovering GPs never before known to the Division, providing incentive and training in psychological strategies and assessment, access to other professionals as well as guidance in processing paperwork.

“An emphasis on quality in general practice through Federal incentives is critical!” (GP representative)

Private psychiatrists

“We need to be able to get on the phone and access specialist psychiatrist advice – we need advice around issues both medication and otherwise.” (GP)

“... (I) would use psychologists for more chronic problems, but psychiatrists are needed for acute cases.”
(GP)

Access to psychiatrists was reported to be difficult and especially restricted in rural and remote areas. This drew a number of comments, notably from consumers and carers but also from service providers, general practice representatives and NGOs. A respondent suggested that a community liaison psychiatrist be based in each GP Division

– their role could include assistance with: diagnosis (using DSM-IV; 26); treatment and management; and, options for evidence-based practice.

There is a perception that private psychiatrists have a limited focus on issues such as rehabilitation, social aspects of mental illness and support for carers. Education about these issues may be beneficial and there should also be some requirement for private psychiatrists to adhere to the mental health standards, including those relating to carers.

If private psychiatrists are to provide assistance with initial (and crisis) assessment, there must be mechanisms in place to ensure that consumers have access to appropriate follow-up by other mental health professionals. As previously discussed, some respondents also felt that improving access to specialist clinical psychologists and psychological therapies may help to address unmet need and reduce a reliance on psychiatrists.

Other comments included the need for incentives to keep effective psychiatrists in the public health system and also a feeling that the emphasis on offering incentives for private psychiatrists to consult more widely implied that other professionals had less to offer. Instead, some participants suggested that it would be preferable to:

“... encourage and provide incentives for inter-disciplinary consultancies ... and inter-professional support.”

Some respondents also suggested that in offering incentives for private psychiatrists to consult more widely, the capacity of private hospital mental health services to consult more widely should also be considered. This is related to issues previously discussed about stronger partnerships between public and private mental health services.

Other professions

Some representatives from NGOs and specialist mental health services also raised suggestions relating to the role of other professions in the mental health workforce. It was suggested that services look to greater involvement of occupational therapists, counsellors, social workers, community and housing workers and nurse practitioners to provide a more holistic service to consumers. For example, generalist telephone counselling services play a significant role in the community. They provide mental health consumers after hours contact and support and reach many members of the community who otherwise may not be able to access help (and wish to remain anonymous), especially in more rural areas.

Nurses, for instance, felt that their contribution to mental health care, although overlooked, can be optimally used in a variety of capacities, including working in consultation and support for primary care practitioners, as well increasing the involvement in crisis intervention. They also expressed interest in providing more services for early intervention in, for example, ante-natal, workplace and school-based screening. Some specific issues were raised in regard to occupational therapy, with concerns regarding recruitment and retention of occupational therapists in the area of mental health. It was suggested that at present, occupational therapists are not sufficiently available to support people with mental health problems or their families, or for consultation by other mental health professionals.

4.2.1.9 Stigma

“There is no such thing as a ‘schizophrenic’ and I urge researchers and the community to stop referring to people as an illness.” (Consumer)

“If the general public are given the choice between supporting a fundraiser for cancer or diabetes ... or the choice of supporting a fundraiser for the mentally-ill, we all know where the money and support will go.” (Consumer)

“Stigma reduction campaigns cost real money. They take time.” (Professional body representative)

“If you have a mental illness, you still have to hide it from the person next door. People are still scared. You don’t meet new people, they’re not your friends” (Consumer representative)

“We don’t talk about psychiatrists – we don’t tell people we go there.” (Consumer representative)

“Public advertising, education (about stigma) – it must be ongoing, it must be intelligent – not just one off, glossy – it needs to be grounded, local, community-owned.” (Consumer representative)

“If I was looking for a job, I certainly wouldn’t tell a future employer (about my illness).”
(Consumer representative)

“People need to be recognised as people. I don’t really care if people know I have a mental illness as long as they know what a mental illness is!” (Consumer representative)

The barriers to community understanding of mental illness remain profound. Structural reforms are urgently required

to address the discriminatory practices of the insurance industry, the employment and disability sectors. Respondents provided various examples of how stigma is perpetuated. Clients being transported by police van rather than an ambulance preserves the stereotype that people with mental health issues are 'violent'. Being on high doses of medication can also worsen stigma. One respondent pointed out that many who have been mentally-ill have prison and criminal records that they would not have otherwise acquired if they were not ill.

Many respondents from all parts of the mental health system felt that stigma remains a significant issue for people with mental illness. There is still a lack of understanding of mental illness in the community and even a fear of those with mental illness. In addition, respondents felt that stigma discourages help-seeking behaviour and has an adverse effect on access to paid and even voluntary employment opportunities. In the study, there were several reports of consumers losing their jobs and not being able to apply for education and training courses. It was stated that people do not disclose a history of mental illness when seeking employment for fear of stigma.

Stigma in the workplace was also raised as a concern. One respondent said, that if an employee has depression they must be very circumspect, as the possible financial and emotional cost is too high given the expected bad reaction from colleagues and employers. Several respondents argued the practice and policies of insurance industries may even be a broader problem than stigma. Insurance companies attach mental health item numbers to consumers that can limit access to both mental and physical health services; consumers may not be able to then claim both services on Medicare.

While all respondents who commented on this area agreed that it is an important issue, there was uncertainty about how it might best be addressed. Some people suggested that it is difficult to know which approach will change public opinion and that more research might be beneficial. Others recommended a coordinated media blitz to educate the community about stigma and mental illness, combined with some positive publicity. It was suggested that the best way to reduce stigma and to change attitudes and behaviour is through direct contact with consumers. It was recommended that funding and training be provided to consumer and carer organisations to create and take up educative roles and, for example, visit schools and tell their individual stories.

Of most concern was a commonly expressed view that the mental health workforce was perpetuating stigma due to the attitudes between staff and consumers. In some instances, respondents reported the attitudes of staff/ clinicians to be worse than those from the general community. Several consumers, for example, felt that the general attitude of nurses towards consumers needed improvement; this was highlighted by several respondents who perceived they are not always treated or referred to 'as people' by staff members.

A national campaign/ framework, with local implementation is needed to address the stigma of mental illness. The framework must incorporate comprehensive strategies for local community and school-based implementation, mental health literacy programs and mental health promotion programs. These programs should also include specific strategies for CALD communities that are culturally appropriate where stigma is also exacerbated by language and unfamiliar cultural differences.

4.2.1.10 Innovation and sustainability

"Prevention and promotion programs – often get grant monies and get good results but when the initial funding ceases there's no more funding. Good initiatives are simply left to die." (Mental health nurse)

"We need new systems that prioritise quality and safety. Systems that want to compare themselves with others, compare themselves with guidelines, compare themselves with the best available clinical services!" (National professional body)

"We must highlight the examples of outstanding practice, in both the public and private sectors. They just don't get the recognition or support they deserve." (Mental health consumer representative)

"We need to understand the developmental pathways to disorder. We must act at the real transition points in development." (Professional body representative)

There appears to have been a real lack of commitment to sustaining and adopting genuine systemic change to address gaps in service delivery and problems with access and equity.

Many of the innovative changes that have occurred at the national level have been welcomed. However, a common view is that these changes and innovations have been incremental in nature and have not been sustained beyond the initial implementation phase. Much of this appears to be due to reluctance on the part of the States and Territories to sustain programs that have grown out of national innovations/ initiatives.

It seems that public sector mental health providers have tended to continue with 'business as usual'. This has resulted in a lack of innovation or inter-sectoral collaboration or attention to early intervention programs, mental health promotion and prevention programs aimed at recovery. Respondents pointed out that there is a resistance to change

that threatens innovative strategies that are initially established. This appeared to be due to the threat to current staff positions and an increase in workload without the sustainability of increased resources or reward.

Evidence-based practice was generally supported but some respondents expressed concern about the limitations of too great an emphasis on this approach and felt that much more research is needed. Developing standard evaluation tools focused on evidence-based practice may not measure the many and varied therapies and projects that are being provided to consumers, carers and staff that are effective. Others supported evidence-based practice in areas where the evidence is available but called for a balanced approach which would also accord value to clinical and consumer preference, innovation and experience.

For many psychosocial interventions, there may have been insufficient research to provide conclusive evidence, perhaps owing to a lack of funding or professional support. Nonetheless, many practitioners and consumers may consider the intervention helpful and consumers should not be disadvantaged by the loss of these services.

Some participants called for a greater commitment to brain research in mental health, to develop a better understanding of illnesses, relieve the suffering associated with mental illness and maintain contact with the growing international knowledge base. The development of a national coalition of researchers with expertise in the combined areas of brain/ mind research should be a priority.

4.2.2 'Other' areas of interest

A large range of 'other' responses were gathered from the surveys or community consultations. These are now summarised under key themes.

4.2.2.1 Effectiveness and accountability

"Different models trialled ... but no evaluation of different models – we need to measure efficiencies. We need linkages between funding and outputs."

"Not enough hard information/ statistics on who accesses mental health services ... only get the crisis stories ... not transparent communication. We need to know size of problem, identify the needs, determine the number of hospital admissions etc."

Overall, there was support for the value of measures of effectiveness and accountability in the mental health services. Some respondents suggested linking funding to such measures (for example, adherence to standards, use of evidence-based practice or the completion of items in the National Mental Health Plan). Measuring 'wellbeing' of consumers and staff, for example, can prove difficult to do in tangible terms and thus easily ignored, but may be of great significance in measuring the quality of service delivery and accountability. The concern is that funding would be focused on measurable items and more dependent upon the organisation's ability and expertise in writing report and grant submissions to their funding or prospective funding bodies, rather than the success of their actual service delivery.

Considerations about data collection and outcome measurement were included in previous plans but the area needs further research and development, according to some respondents. Development of outcome measures and the evaluation of services should be inclusive of, and sensitive to, the needs of all stakeholders, including services in the non-government sector, people from CALD backgrounds and consumers and carers. Implementation of outcome measures also needs to be assessed and requires funding as staff need training and supervision in administering evaluation, and recording and reporting the results.

Research respondents provided examples and recommended several ways to improve evaluation of service delivery; the inclusion of compulsory exit interviews of staff to provide feedback to the organisation and to the public. Other suggestions were to examine the ratio of staff and skill sets, and implement a standard process by which professionals respond to consumer complaints, as practiced by physicians in Hobart to increase accountability.

4.2.2.2 High prevalence disorders

As previously mentioned, some respondents indicated that high prevalence disorders such as depression and anxiety are not being treated. However, respondents repeated a number of comments here in regard to supporting GPs, in the role of collaborating with other professionals and being able to access psychological services. Others recommended that mental health specialists should be more involved in treating high prevalence disorders.

4.2.2.3 Service 'silos'

Several respondents from various parts of the mental health sector felt that the concept of eliminating financial and service 'silos' (i.e. administratively and financially independent components of health and welfare services) across a huge range of services seems simplistic and unworkable. Instead, they proposed a stronger emphasis on a number of other strategies to enhance the integrated provision of care by these agencies. These included: better communication; shared planning; some coordinated policies; integration of services on the ground at the local level; coordinated care management; flexible funding models; and, a focus on relationships and consumer needs rather than structural barriers.

Other comments reflected concerns about the possible effects of eliminating 'silos' and suggested that there will always need to be some policy, funding and program divisions due to the differences in clientele, treatment philosophy and approaches and to ensure that specialist services are not devalued. There was some concern that areas which are traditionally under-funded or seen as lower in priority (such as services for children and adolescents) might find their funds diverted to other areas if they were simply incorporated within general services.

4.2.2.4 Services for children and adolescents

"We've got to improve the funding of services (eg. two workers in child and adolescent mental health services are on maternity leave and they have not been replaced) ... need to have access to psychiatrists!!!"

There appeared to be strong agreement with the need for an emphasis on services for children and adolescents, including both clinical services and mental health promotion programs. Comments were received from the full range of respondents, including consumers, carers, service providers and GPs, representatives from NGOs, people from other agencies and those involved in promotion and research.

Respondents were concerned about the perceived under funding of services for children and adolescents and the need to safeguard resources in this area from redirection to other services. Other respondents commented on the need to improve support for young carers and children whose parents or relatives have a mental illness.

Participants commented on the need to promote resilience for children and young people (eg. school-based programs), which have benefits in terms of substance abuse, suicide risk and youth homelessness. In addition, there were calls to introduce earlier interventions, given the research into the importance of the perinatal period and the zero-to-three age range.

Some participants called for an increase in specific programs, interventions and services for high risk children and young people. High risk groups included: children experiencing trauma and maltreatment; children in alternate care; Indigenous populations; young offenders; children of parents with a mental illness; children with chronic illness; and, young people with substance abuse problems. In addition, it was suggested that children and young people who have severe or disabling mental health problems are not well-supported.

The development of additional services and interventions for young people will require a commitment to research and development, education and training and policy support. It was suggested that mental health professionals and child psychiatrists could take a lead role in providing training across the child health and welfare sectors to improve approaches to complex problems.

Several respondents also called for the development of a module of the National Standards for Mental Health Services addressing issues for infants, children and young people. It was suggested that current Standards are strongly focussed on the needs of adults and that an additional module of Standards would help to support progress in this area.

4.2.2.5 Services for the elderly

"Mental health services for older adults are fragmented, and planning is too slow to meet the needs of the population, given the expected growth in numbers of people over 65."
(Health management and research respondent)

Some respondents commented on the need for more mental health services for the elderly. In particular, the elderly with mental illness need more equitable access to support, more support for their carers (such as respite and community services) and increased provision of residential care. However, there were several who viewed services more positively and considered the model of aged care homes to be a good environment for mental health care of the elderly. Respondents requested further advisory and consulting services for the management of services as well as advice on individual patients.

4.2.2.6 Dual diagnosis

"The substance abuse issues are just never addressed seriously within the public systems."
(National professional body)

Respondents felt that service provision for those with dual diagnosis needed significant improvement but did not necessarily see the integration of mental health and substance abuse agencies as the solution. Furthermore, respondents felt that attention should be given not only to those who have mental illness with a substance disorder but also to people with other comorbidities who are similarly disadvantaged. Dual diagnosis should be considered to include those who have mental illness in combination with a physical health problem or intellectual disability.

People with a co-occurring mental illness and substance disorder may experience stigmatisation in both service

settings, or their comorbidities may be neglected. It may not be uncommon that a person will have multiple issues and only be treated partly. For example, a drug and alcohol worker may have a client who: has a personality disorder; is suffering from a medical condition; has drug and alcohol issues; and, also be homeless. Many consumers do not fit one particular category and fall between the gap of residential housing and hospital admission. There is also the concern that certain groups of consumers would be more overlooked such as those concurrently suffering from comorbid high prevalence disorders.

Many who commented, suggested that substance abuse agencies should not be integrated with mental health services, but rather that strong partnerships and liaison would yield improved program development and care. Furthermore, there was concern about the effects of full service integration on those people who do not have this specific comorbidity. While it might be beneficial for those with combined mental illness and substance abuse disorder, other clients in both groups may be disadvantaged. People were also concerned about creating a public perception that mental illness and substance abuse are always closely associated; perhaps further stigmatising individuals who have one or both of these disorders.

Other suggestions made by respondents to improve dual diagnosis issues include: support for people with serious mental illness involved in family court issues relating to separation and child custody; training in comorbidity with better clarification of diagnostic guidelines; and, promotion of dual worker roles.

4.2.2.7 Forensic, prison and detention centre settings

Some service providers, consumer and carer representatives offered additional comments regarding the mental health needs of forensic, prison and detention centre settings. It was suggested that the draft forensic mental health principles be confirmed and adopted. Additionally, it was considered important to take into account the inter-relationships between offending, childhood abuse, substance abuse and mental illness. Furthermore, the needs of people from CALD backgrounds in these settings should be considered, as they are often further isolated by cultural differences or language barriers.

While people in detention centres should be included as an underserved population for the purposes of a Third Plan, one respondent pointed out that a larger number of refugees and families not in detention also suffer from mental health problems, some as a result of traumatic experiences.

4.2.2.8 CALD communities

“Non-use of interpreters is a problem for ethnic groups – there needs to be policy written for the consumer and the family ... there is horrendous confusion and trauma.” (Ethnic community respondent)

There was a strong feeling that people from CALD communities should be included as an underserved population in a Third National Mental Health Plan and also that they should be better represented in all the other initiatives and priority areas suggested. Respondents expressed concern over the omission of this group from the report despite the fact that their needs had been highlighted in previous plans.

Respondents from various parts of the mental health sector felt that services for people from CALD communities need further attention and that mental health services and programs should be more inclusive of cultural issues. Other comments related to specific gaps in the services available for people from CALD backgrounds, notably more interpretation services and long-term support services.

Ethnic communities suffer even greater stigma and access services only at crisis point. Several respondents reported that they mainly seek GPs rather than specialist services and do not discuss their issues openly or challenge the assessment and treatment provided. Respondents were concerned that CALD communities do not comprehend what is happening to them. There is the fear of being further ostracised and marginalised within their community as well as from professionals:

“... shame and secrecy abound in these communities ...”

“GPs are front line for ethnic communities – especially for mental illness related issues ... If a patient feels the GP is pressured for time, the patient won’t disclose or request an interpreter.” (CALD NGO)

It was suggested that cultural appropriateness and access should be included in the evaluation measures of both government and non-government services, including those not specifically targeting CALD communities. Service providers were encouraged to make greater use of the expertise available through State-based transcultural mental health services.

People from CALD backgrounds should be consulted and represented in all aspects of the mental health services, including: service planning; development of standards, guidelines and protocols; planning and implementation of service evaluation; and, development of promotion and prevention programs. Respondents in the study suggested

several strategies to improve mental health care for CALD communities. These include increasing employment of bilingual workers, educating health professionals how to ask the right questions that are culturally appropriate and treating persons quickly, to avoid deterioration of mental health. Respondents also recommended that more bilingual and overseas trained doctors, who are not recognised for their qualifications, be considered for community worker roles within their specific communities.

4.2.2.9 Indigenous communities

There was broad agreement regarding the identification of Indigenous mental health as a priority area, with some respondents reporting that rural, remote and Indigenous communities live under considerable stress and are seriously under-served and under-resourced in terms of mental health care. However, problems with workforce distribution were considered. Respondents stated that Indigenous workers are undervalued for their skills due to the continual application and emphasis on the medical model. It was suggested that there should be management position opportunities for Indigenous health workers in rural areas that are valued and considered for their traditional skills.

Some respondents felt that the baseline information for emotional and social wellbeing in Indigenous communities is, or may be, already available and that a higher priority now would be the development of appropriate pilot programs.

Participants conveyed the view that the most appropriate mental health care for Indigenous communities should be based on a holistic model of care where providers worked closely with families including the provision of family education. Early intervention through school-based programs and community education programs was also considered vital for Indigenous communities.

Those participants commenting on Indigenous mental health felt that more attention needed to be paid to the determinants of mental health. Most participants felt that governments and services were happy to treat illness but less willing to address the real determinants:

“... we need doctors to work within organisations that are resourced to address determinants.”
(Indigenous health worker)

4.2.2.10 Rural and remote communities

“Country areas need more psychiatrists desperately. Bendigo has only one full-time private psychiatrist – her books have been closed for three years!!!”

Respondents also agreed with the identification of rural and remote communities as an underserved population. People from all parts of the mental health sector commented on this issue and some called for a more comprehensive rural and remote mental health strategy as part of a Third National Mental Health Plan.

Such a strategy might include defining rural and remote sites, mapping the existing mental health networks against social and demographic information, defining the essential elements of rural mental health service delivery, developing a range of models of service, then implementing and evaluating these in selected communities.

Several respondents commented on workforce issues as a significant issue in regard to rural and remote mental health and felt that there was limited availability of skilled staff in some areas. Generally the shortage of skilled staff and geographical distances ensures that much greater effort in administration and time is required for mental health services to respond to consumers. For example, it was reported that there is only one mental health team that covers rural South Australia. Outreach teams cannot access many places by public transport and are only accessible via four-wheel drives and charter flights. Acute care is often managed from a distant location and is often the last resort.

To overcome this shortage, an integrated and collaborative approach would be needed to create effective workforce development strategies to recruit and maintain professionals in rural practice. There was broad agreement for the use of telehealth as an adjunct to rural and remote mental health but several pointed out that it is only one tool and should not be seen as a substitute for face-to-face service provision. While telehealth can provide valuable information and support, it would need to be considered as part of a much broader rural mental health strategy. Some people expressed concern that telehealth initiatives may be perceived negatively by some people due to delusions regarding electronic media and thus not helpful for some consumers.

4.2.2.11 Early intervention, promotion and prevention

“Teach kids about mental illness and drugs and alcohol – there are lots of youth here in Bendigo and they need education.”

Many comments about early intervention, promotion and prevention were made within the context of services for children and young people. Many respondents voiced the need to continue and develop programs to target schools and include them as part of the school curriculum to raise the awareness of mental health, as well as the effects of drugs

and alcohol. Programs such as MindMatters and *beyondblue* have been useful in educating the community. Respondents commented that teachers generally feel unsupported in dealing with child mental health issues, and there is little professional development available to assist in detecting early symptoms. It raises the question of who should take the responsibility of promoting, screening and educating children on mental health. Several respondents suggested that mental health nurses could play a significant role in early intervention providers. Other suggestions included employing consumers and carers in educative roles in schools.

It was also noted that promotion and prevention programs should target infants, young families and children who are carers, through pre-school screening, home visits, parenting programs and support groups:

“Results show that when support is provided to parents with a mental illness, this reduces the number of children going into care and notifications to the Department because children have no where to go. When people know there are alternatives and children know where to go for help – it assists getting help early.” (Community respondent)

However, other respondents pointed out that programs are needed for all age groups and population groups such as ethnic and rural communities, the general workplace and people with high prevalence disorders. Ethnic groups, for instance, need additional help in understanding the system and information packs in different languages.

Respondents from most areas of the mental health sector were supportive of a greater investment in promotion, prevention and early intervention. However, representatives of the consumers or carers were more likely to point out that there are still significant service gaps which need to be addressed and also made several comments more closely related to rehabilitation and relapse prevention.

The data showed that the vision of the National Mental Health Policy and the strategies outlined in the National Mental Health Plan did not always align with the reality of implementation. It will be recalled that the Commonwealth Government had to resort to ‘carrot and stick’ approaches to encourage the compliance of the States and Territories with National Mental Health Policy. The ‘sticks’ were not an option with the private sector and the ‘carrots’, in the form of multiple trials and initiatives, were readily consumed but rarely ‘replanted’.

4.3 Conclusions

The experiences of consumers, carers and providers of mental health services support the interpretation that the National Mental Health Strategy has not produced the enduring structural and systemic reform needed to meet the needs of the broad range of mental health consumers. The Strategy has given birth to many ‘initiatives’, ‘innovations’, ‘pilot programs’ and ‘trials’ but seems to have fallen short of producing strategic and sustainable mental health care reform for the broader community.

PART FIVE: DETERMINING COMMUNITY PRIORITIES

5.1 A survey of 'ways forward'

This final survey was designed to determine community priorities and possible mechanisms for future mental health reform. A lack of clear priority setting and associated detailed implementation strategies is a perceived weakness of the previous two mental health plans. The top priorities identified by this process should be at the centre of any Third Plan. Genuine community and consultation over such priorities, and preferred implementation strategies, has not previously been attempted in such a systematic fashion. The survey was sent to recipients of the previous two surveys as well as those (eg. community members, mental health providers and GPs) who attended national community consultations to identify and address key themes. Recipients were asked to complete the survey to reflect either their individual views or those of the organisation they represented.

Survey respondents were categorised into the following groups:

- Consumer of mental health services;
- Carer of a person with a mental illness;
- Consumer or carer advocacy group;
- Public provider of specialist treatment;
- Private provider of specialist treatment;
- Provider of early intervention services;
- General practitioner;
- Divisions of General Practice;
- Non-government community service provider;
- Mental health promotion or education;
- Mental health research or evaluation;
- Health policy maker or advisor; or,
- Human services agency other than health.

5.1.1 Survey development

The survey was divided into two sections (see Appendix 9):

1. The first identified a number of key themes or priorities. These were derived from the qualitative data linked to the previous surveys and the extended process of national community consultations. Recipients were asked to mark their top 10 preferences only, from within a list of 26 possible priorities.
2. The second outlined some suggested mechanisms for implementation of the priorities. Under a total of 25 headings, recipients were asked to mark only those methods that they felt were most appropriate.

There was also an opportunity for respondents to add other priorities and/or mechanisms and rank them along with the ones listed in the survey.

Four different versions of the first part of the survey were developed. Each version rotated the order of items (in section one) to avoid any response bias favouring items near the top of the survey.

5.2 Results from survey for community priorities

Responses were received from 270 organisations or individuals. The origins of these responses are shown in Table 1. The inputs from public providers of mental health services, GP organisations and consumer and carers (through organisations, as well as individually) were significant. Again, the number and breadth of responses is notable.

The various levels of community and stakeholder support for the priorities are detailed in Table 2. The top ten priorities listed provide major insights into the ways in which the respondents have considered the wide range of mental health needs of the Australian community. Strong priority was given to some key areas that have been promoted under national planning (i.e. early intervention, management of comorbid substance abuse, expansion of the range of acute care settings and expansion of services in rural and remote areas) but are perceived to have been poorly resourced, implemented or translated into action nationally. The high rating given to the implementation of national standards for mental health care services indicates the sectors frustration with State government failures to progress this item adequately over the last five years. National standards for care are seen as providing at least some baseline for expectations of reasonable quality care.

Although not the highest service priorities, the community and mental health stakeholders provided strong support for a range of priorities that emphasise the need to lead and refinance the battle against stigma and discrimination. The respective governments are seen as not having invested sufficient effort in these areas even though they continue to have major impacts on the quality of life for those with mental health problems. Within this broader context, the need to address the attitudes of mental health workers was seen as a very specific and urgent target for concerted action.

Consumer, carer and family participation were continually emphasised as key factors underpinning improvements in attitudes, quality of services and sustained improvements in the quality of life of those affected. Progress to date is

perceived to have been limited to national and State levels of participation rather than having achieved real progress in the process of day-to-day care.

A strong emphasis was placed on the need to support innovation, service evaluation, aetiological and treatment research, and national implementation of successful service improvements. There is an increased recognition that simply putting more resources into existing systems of care without promotion of innovation, excellence, accountability, staff education and development, and clinical biomedical and health systems research may only have marginal impacts on an already depleted health system.

As the full priority list was derived from the data collected from the initial surveys, and later community and professional consultations, all of the listed items should be seen as relevant to the development of effective national mental health policy. To ignore the top 10, or to not recognise the weights attached to progress in these areas in any Third National Plan, would risk even greater alienation of consumers, carers, families and local service providers. Those items should be recognised as key objectives for any proposed enhancements in service resourcing or development.

5.3 Proposed mechanisms for achieving system change

With regard to specific mechanisms for implementing each of these national priorities, the respondents indicated varying degrees of support for possible strategies (Table 3). The table has been organised to demonstrate those areas and mechanisms that were most frequently endorsed. Here, the lists of specific mechanisms were again developed from the earlier quantitative and qualitative data sources. However, the task of having stakeholders prioritise such mechanisms should assist national and local planning agencies to focus on processes that will attract considerable community support.

Some specific examples are notable. In the area of national leadership, strong emphasis is placed on the potential roles of national professional groups, consumers and carers rather than governmental agencies. With regard to mechanisms for accountability, there was strong support again for an independent national commission rather than current bureaucratic or more politically-acceptable alternatives. Consumer and carer participation is seen to be impeded largely due to lack of financial support at a local or regional level. Sixty-seven (67) percent affirmed at least one of the models for an independent commission that was proposed. Development of specific 'step-down' acute care facilities are seen to be a potential solution to the current perceived crisis in access to acute care. It has not been a feature of Australian developments in acute care but is seen as the potential bridge between acute hospital and ongoing acute care. The community and other stakeholders are NOT calling simply for more acute care hospital beds but rather a more appropriate spectrum of care settings. The provision of stable housing support is critical to ongoing quality of life within community settings.

Expansion of current community-based rehabilitation services is strongly supported along with other mechanisms for increasing the chances of meaningful recovery in community settings. The lack of inter-governmental agreements continues to impede the coordination of services across different levels of government.

The role of primary care groups in progress in managing comorbid substance abuse is given high priority. The needs of other important subgroups including those in forensic settings and those who are homeless also receive attention. National mental health law reform is perceived to be an important goal as is improvements in the methods for determining and implementing national mental health standards.

Within each of the other categories addressed a significant number of options are endorsed and should underpin future developments in these areas. The community and stakeholders emphasise the importance of a number of population-based (eg. stigma reduction, suicide prevention, a human rights focus and national disease prevention campaigns) as well as service enhancement strategies.

The significant place of NGOs in most areas of community engagement and services is emphasised throughout the mechanisms for change section. To date, governments are seen as not yet capitalising on the advantages of promoting genuine partnerships in this area (particularly at the level of State governments).

5.4 Conclusions

The recommendations of this report with regards to systematic improvement of mental health services in Australia over the next five years (see Executive Summary) are based largely on the results of this final survey. Priorities for specific service improvements are clear, as are the needs for national leadership, adequate resourcing and system-wide support for innovation in treatments and service development.

The priorities highlighted here could form the basis for a Third National Mental Health Plan, as well as providing a framework for implementation strategies and mechanisms for accountability. Such priorities and mechanisms are likely to be at variance with other national policy development processes. This is a consequence of both the experiences of the respondents surveyed as well as the fundamental task undertaken here. That is, stakeholders were required to set priorities and describe acceptable mechanisms for actual implementation and accountability rather than just propose general policy frameworks.

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Table 1: Origins of responses received from 270 organisations or individuals.

Survey completion:	Percentage (%)
Organisation	74
Individual	26
TOTAL	100
Position (or role) in mental health sector:	
Public provider of specialist treatment	29
Division of General Practice	18
Consumer or carer advocacy group	12
Non-government community service provider	9
Consumer of mental health services	7
Private provider of specialist treatment	6
Carer of a person with a mental illness	4
Health policy maker or advisor	3
Mental health promotion or education	2
Mental health research or evaluation	1
Provider of early intervention services	1
Human services agency other than health	0
Other*	8
TOTAL	100

*Others listed include: NGO peak body; private provider and early intervention; and, manager of mental health services.

Table 2: Various levels of community and stakeholder support for the national priorities.

Rank	Possible preferences:	Percentage (%)#
Top 5		
1	Implementation of early intervention strategies nationally	56
2	Development of innovative services for persons with mental health and alcohol or substance abuse disorders	54
3	Development of a wider spectrum of acute and community-based care settings	52
4	Support for service development in rural and regional areas	49
5	Implementation of national standards for mental health services	45
Next 5		
6	Support for service development in poorly resourced areas	44
7	Support for programs that promote attitudinal change among mental health workers	44
8	Increased support for stigma reduction campaigns	43
9	Development of specific inter-governmental service agreements (eg. between health, education, housing, employment and social security)	42
10	More genuine consumer participation at regional and local service levels	42
Next 10		
11	Direct support for 'innovation', 'research' and 'service evaluation' in mental health	39
12	Introduction of specific schemes to enhance access to mental health specialists	37
13	Support for specific disease prevention initiatives (eg. in anxiety, depression, alcohol or substance abuse)	35
14	More genuine carer participation at regional and local service levels	35
15	Support for general mental health promotion	34
16	Support for enhanced role of non-government organisations in all aspects of care	34
17	Clear accountability for expenditure of mental health strategy funds	30
18	Ongoing support for national suicide prevention campaigns	28
19	Development of standardised national mental health laws	27
20	Development of national data sets for monitoring the quality of local services	25
Next 7		
21	Service development for those in forensic (i.e. prison-based) services	23
22	Specification of clear primary care and specialist workforce roles	23
23	Service enhancement for persons from culturally and linguistically-diverse backgrounds	22
24	Support for national community leadership in mental health	14
25	Support for national professional leadership in mental health	14
26	Development of specific procedures for reporting Human Rights abuses or neglect	12
27	Other*	32

#All percentages calculated with the denominator equal to 270. *Others most commonly listed include: focus on carer/ consumer/ family education; and, specific housing programs for consumers.

Table 3: Various levels of community and stakeholder support for specific mechanisms for implementing each national priority.

Overall ranking	Specific question and order of appearance in section two	Percentage (%)
1	24. Support for changes in workforce attitudes:	
	Focus on changing attitudes among emergency care staff	62
	Focus on changing attitudes among general practitioners	58
	Focus on changing attitudes among mental health nurses	46
	Focus on changing attitudes among psychiatrists	43
	Focus on changing attitudes among other non-medical specialist staff	37
	Focus on changing attitudes among psychologists	27
	Other (eg. attitudes of general health workers)	8
2	16. Support for general mental health promotion and disease prevention initiatives:	
	Support for school-based promotion and prevention strategies	75
	Support for workplace-based promotion and prevention strategies	54
	Support for emphasis on social and economic determinants of illness	52
	Support for emphasis on childhood determinants of illness	46
	Support for national research and service consortia to improve the level of evidence	27
	Support for e-health and other technology-based approaches to health promotion and disease prevention	21
	Other (eg. assertive outreach for families/ children of parents with a mental illness)	3
3	13. Human rights focus:	
	Focus on discrimination in insurance, employment, disability assessment and housing support	49
	Focus on community neglect as a human rights issue	43
	Appoint a permanent Deputy Commissioner for Mental Health within the Human Rights Commission	40
	Prioritise reduction of human rights abuses in acute care settings	35
	Focus on human rights abuses in long-term care settings	29
	Initiate a national enquiry into human rights (i.e. a 10-year follow-up to the Burdekin Report)	28
	Introduce national, State and/or regional reporting of abuse or neglect	24
	Other (eg. guidelines for human rights and treatment)	3
4	7. Service development between mental health and alcohol or substance abuse:	
	Development of innovative approaches to primary care management of patients with both mental health and alcohol or substance abuse	65
	Development of staff education and professional training	56
	Development of clear agreements between national mental health and alcohol or substance abuse strategies	45
	Development of innovative approaches to provision of common specialist services	43
	Support for greater research into the changing patterns of comorbidity	33
	Other (eg. combine drug and alcohol with mental health services)	4
5	19. Specialist workforce distribution:	
	Incentives for psychologists and other non-medical mental health specialists to work in poorly resourced urban and rural areas	74
	Incentives for psychiatrists to work in poorly resourced urban and rural areas	74
	Support broadening of telemedicine strategies	33
	Limitation of new item numbers for psychiatrists in well-resourced urban areas	26
	Support e-health and other technology-based innovations in distribution of care	23
	Other (eg. Medicare item numbers for psychologists)	3

6	18. Development of community education and early intervention strategies:	
	Development of primary-care based education and early-identification strategies	62
	Development of initiatives focusing on earlier identification of persons with psychotic disorders	60
	Development of initiatives focusing on earlier identification of teenagers with any significant behavioural disturbance	54
	Development of initiatives focusing on earlier identification of persons with non-psychotic disorders	46
	Other (eg. identification must lead to early intervention)	4
7	4. Development of a wider spectrum of acute and community care settings:	
	Development of step-down acute care facilities (for use both prior to, and following, acute hospitalisation)	72
	General funding and agency support for community housing initiatives	51
	Improved specialised support in association with primary care settings	48
	Greater professional support within designated community housing	44
	Other (eg. greater resources for children and adolescents)	9
8	15. Innovation, research and evaluation:	
	Support for improved modelling of the impacts of different types of mental health services	44
	Support for national application of regionally-successful innovations in care	39
	Support for national mental health literacy and attitude initiatives	34
	Support for national health services research initiatives	29
	Support for development of national standards of service data collection	27
	Support for e-health and telephone-based innovations in care	24
	Support for national biomedical research initiatives	16
	Other (eg. support for local research and innovations in care)	4
9	22. Increase national and regional mental health literacy campaigns:	
	Support school-based mental health literacy campaigns	73
	Support workplace-based mental health literacy campaigns	59
	Support national advertising literacy campaigns	46
	Support Internet-based mental health literacy campaigns	33
	Other (eg. educate mental health volunteers)	2
=10	12. Stigma reduction campaigns:	
	Support for national stigma reduction campaigns	60
	Support for development of regional and local stigma reduction campaigns	53
	Prioritise stigma reduction amongst health care providers	43
	Support for stigma reduction focusing on psychotic disorders	27
	Support for stigma reduction focusing on non-psychotic disorders	25
	Other (eg. especially among children and adolescents)	3
=10	20. Development of clear primary care and specialist workforce roles:	
	Expand primary care incentive payments to improved assessment, education, medication, basic counselling and behavioural interventions and disease management roles	54
	Public mental health services to provide more consultancy and educational support to primary care services	51
	Incentives for psychiatrists and other specialists to increase their consultancy to primary care	50
	Use of specialist providers in public mental health services to provide specialised forms of treatments for a wide range of mental disorders	43
	Limit primary care incentive payments to improved assessment, education, medication, basic counselling and behavioural interventions and disease management roles	7
	Other (eg. develop sub-specialty of mental health within general practice)	5

12	25. Enhancement of services:	
	Enhanced services for people with personality disorders	57
	Enhanced services for people with comorbid mental and/or physical disorders	54
	Enhanced services for people with women with post-natal depression	36
	Enhanced services for people with anorexia nervosa	26
	Enhanced services for people with other eating disorders	24
	Other (eg. enhancement of services for depression and anxiety)	12
13	3. Genuine consumer and carer participation:	
	Funding of more extensive consumer participation at local and regional levels	67
	Funding of more extensive carer participation at local and regional levels	58
	Funding of more extensive participation at State and national levels	36
	Direct financial support for the National Consumer and Carer Forum	26
	Other (eg. Funding to States for consumer and carer research)	7
14	14. Development of genuine service pathways ('integrated care'):	
	Focus on integrating acute care (hospital-based) and longer-term (community-based) forms of care	59
	Focus on integrated primary and specialist care	48
	Focus on integrated medical and psychiatric care	39
	Focus on integrated medical treatments and disability support systems	31
	Other (eg. integration of more services)	3
15	5. Systematic approaches to reduce institutionalisation in the community:	
	Greater support for psychosocial rehabilitation strategies in the community	75
	Support for non-government organisations to provide high quality psychiatric disability services	56
	Reduction of structural barriers in insurance, employment and housing	43
	Other (eg. development of recovery guidelines)	2
=16	1. Promotion of national leadership:	
	Increased roles for key national professional groups (eg. medical colleges, professional associations of psychologists, mental health nurses, social workers, occupational therapists, general practitioners, etc)	46
	Independent and substantial funding for national groups of consumers and carers	41
	Development of national agencies focusing on specific illness categories (eg. depression, anxiety, schizophrenia)	29
	Development of independent and substantial funding for the Mental Health Council of Australia	27
	Broadening of representation within the National Mental Health Working Group of AHMAC	26
	Other (eg. consumers and carers need to be heard more clearly)	7
=16	2. Clear mechanisms for accountability:	
	Development of an independent national commission for review of mental health spending, critical incidents and national outcomes	46*
	Establish independent and permanent commission to report on national progress in mental health	40*
	Development of national data sets to track regional delivery of services	38
	Development of clear timelines for delivery of agreed outcomes by the States	27
	Development of more independent contracts by the Commonwealth to relevant non-government service providers (including universities and private service providers)	23
	Other (eg. consumer and carer evaluation of mental health spending)	3

* Sixty-seven (67) percent affirmed one of the models for an independent commission.

18	17. Support for the enhanced role of non-government organisations:	
	Support for increased provision of psychiatric disability and housing support services by non-government organisations	55
	Support for the enhanced role of the Mental Health Council of Australia	41
	Support for direct Commonwealth funding of national non-government organisations in mental health	36
	Delineation of clear educational and training roles for non-government organisations	32
	Other (eg. support for consumer-based community organisations)	4
19	6. Inter-governmental service agreements:	
	Specific service agreements between State-based departments of health, housing, education, corrective services and criminal justice	62
	Clear agreements between State and regional governments in key areas such as supported housing	50
	Specific service agreements between Federal departments of health, social security, employment and education	47
	Other (eg. agreement between State and Federal departments)	4
20	11. Suicide prevention campaigns:	
	Support ongoing national suicide prevention initiatives	61
	Support ongoing State-based suicide prevention initiatives	49
	Increase support for non-government organisations-based suicide prevention initiatives	43
	Other (eg. promote good mental health, not just focus on suicide statistics)	6
21	9. National mental health law reform:	
	Development of national laws for regulating psychiatric practice	52
	Development of national laws for providing compulsory treatments	52
	Development of national laws for dealing with forensic issues	46
	Other (eg. standardisation of legal frames and interpretation)	4
22	23. Engagement of corporate and community partners in mental health:	
	Development of corporate or community-led awareness campaigns (eg. Rotary forums)	60
	Development of workplace-based awareness and assisted employment programs	53
	Development of corporate support for community advertising campaigns	35
	Other (eg. awareness of carer issues in the workplace)	1
23	10. National Standards for Mental Health Services:	
	Support innovative approaches for increasing quality monitoring within current services	56
	Immediate implementation of current national mental health standards	52
	Development of new standards for determining quality of mental health services	33
	Other (eg. monitoring/ evaluation of current services)	5
24	21. Service enhancement for persons from culturally and linguistically-diverse backgrounds:	
	Increased funding support for the transcultural mental health network	45
	Development of more extensive specialised services	38
	Support for non-pharmacological treatments being delivered to persons who do not speak English	36
	Other (eg. interpreters)	3
25	8. Service development for special needs groups – notably those in forensic services and homeless populations:	
	Development of innovative approaches (eg. integrated financial or case management with other health and welfare agencies) to supporting persons with mental illness who are homeless	72
	Development of national standards for specialist forensic mental health services	43
	Other (eg. funding for housing)	4

APPENDIX 1: SURVEY ONE

Review of the Second National Mental Health Plan



Instructions for completing the survey

This survey presents several statements which describe either the ideal outcomes of the Strategy or the findings and recommendations from the International Mid-term Review. You will be asked to indicate your level of agreement with each statement using a ratings scale. There are also some sections which provide space for additional comment; if there is insufficient space provided here, please attach your comments on a separate sheet and indicate to which section they refer. At the end of the survey, you will also be invited to nominate which strategies you consider to be of the highest priority.

We suggest you consider each item from a national perspective and try not to be overly influenced by developments in any particular region. We realise some organisations will be representing a range of views, so we suggest you may like to arrange a time to consult with your members or constituents to determine the response which best describes your views.

Your details

As part of the survey, we would like to ask you some details about yourself and the area of the mental health sector you represent. Your name or organisation will not be reported in connection with your responses to the remainder of the questionnaire, so your opinions and comments remain confidential.

Name of person or organisation:

Please tick which ONE of the following descriptions BEST describes your position or role in the mental health sector, or the position or role of your organisation:

- | | |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Consumer of mental health services | <input type="checkbox"/> Non-government community service provider |
| <input type="checkbox"/> Carer of a person with a mental illness | <input type="checkbox"/> Mental health promotion or education |
| <input type="checkbox"/> Consumer or carer advocacy group | <input type="checkbox"/> Mental health research or evaluation |
| <input type="checkbox"/> Public provider of specialist treatment | <input type="checkbox"/> Health policy maker or advisor |
| <input type="checkbox"/> Private provider of specialist treatment | <input type="checkbox"/> Government human services agency other than Health |
| <input type="checkbox"/> Public provider of early intervention services | <input type="checkbox"/> Other: |
| <input type="checkbox"/> General practitioner | |
| <input type="checkbox"/> Divisions of General Practice | |

National Mental Health Strategy goals

This section presents a number of statements describing the outcomes that were intended as part of the National Mental Health Strategy. How closely do these statements describe the current situation? For each statement, please place one of the following numbers in the box, to indicate your organisation's opinions:

Rating scale:

- | | |
|----------------------------------------------------------|----------------------------------------------------------|
| 1 = very accurate description of the current situation | 4 = reasonably inaccurate description of the situation |
| 2 = reasonably accurate description of current situation | 5 = very inaccurate description of the current situation |
| 3 = accurate in some ways, inaccurate in others | 9 = don't know or unable to decide |

1. Consumers and carers participate in local mental health service planning and evaluation	
2. Service providers involve consumers and carers in individual treatment decisions	
3. Consumers and carers are recognised as legitimate stakeholders in national and State/ Territory level decisions about mental health services	
4. Effective mental health consumer groups have been established to represent opinions and views at national and State/ Territory levels	
5. The community understands mental illness and recognises that people affected by mental illness have the same rights as others	
6. Mental health legislation in Australia provides adequate protection of the rights of the consumer	
7. People affected by mental illness do not experience stigma as a result of their illness	
8. The quality of hospital care provided to people treated for a mental illness is equivalent to that provided to people affected by physical illnesses	
9. Mental health services for people who require care over an extended period are provided in a coordinated manner	
10. General community services are available to people affected by mental illness to the same extent as other members of the community	
11. Employment opportunities are available for people affected by mental illness who are able to work	
12. Publicly-funded housing is available for people affected by mental illness to the same extent as other people	
13. A full range of inpatient and community services is available to people affected by mental illness when they need them	
14. People are admitted to psychiatric hospitals because that is what they need rather than because there are no community treatment alternatives	
15. People affected by mental illness have access to mental health services in their local areas	
16. Prevention programs are an integral component of mental health services in Australia	
17. Mental health services in Australia are geared to provide early intervention for people who are experiencing a mental illness	
18. People affected by mental illness who live outside metropolitan areas are able to receive care appropriate to their needs	
19. Community support is available for the carers of people affected by mental illness	
20. General practitioners are able to recognise and provide appropriate care for people affected by mental illness	

Findings from the International Mid-term Review

This section presents a number of findings from the International Mid-term Review of the Second National Mental Health Plan. Does your organisation agree with these findings? For each statement, please place one of the following numbers in the box, to indicate your organisation's opinions:

Rating scale:

- 1 = strongly agree with this finding from the report 4 = disagree with this finding from the report
 2 = agree with this finding from the report 5 = strongly disagree with this finding from the report
 3 = agree with some aspects of this but not with others 9 = don't know or unable to decide

21. Consumers and carers are increasingly involved in mental health policy, systems of care and clinical decisions	
22. Partnerships between mental health services and other agencies have been increasing in number and becoming more effective	
23. Many areas are now developing shared care arrangements or increasing consultation between primary care practitioners and specialist mental health professionals	
24. There is a shortage of appropriately qualified specialist mental health workers	
25. There is poor distribution of specialist mental health workers, particularly psychiatrists, with most being situated in metropolitan areas	
26. There is a critical shortage of nurses; in some cases there are too few to fill current positions, and the situation is likely to become increasingly serious	
27. Underlying issues which may contribute to a shortage in the nursing workforce are not being addressed adequately at a systems level	
28. By international standards, there are relatively few psychologists in Australian mental health services and they often work as general case managers, rather than providing specialist psychological therapies	
29. People with a mental illness, including those experiencing a recurrence of an existing illness, often cannot access treatment and care until their illness is advanced or they are in crisis	
30. The crisis response from mental health services may be slow or unreliable	
31. Psychosocial rehabilitation – including employment, education, training and accommodation – has only been partially addressed, in some areas	
32. Psychosocial rehabilitation is made more difficult because of a lack of integration and cooperation between various services, including housing, employment, education, social security and transport	
33. Arrangements for supported accommodation and Commonwealth funding support for employment services appear to be less accessible to those with a mental illness, than to those with a physical illness	
34. There is a lack of funding for children and youth services, and there are insufficient services – including residential, respite, community options, acute mental health services and family interventions	
35. Mental health services for older adults are fragmented and planning is too slow to meet the needs of the population, given the expected growth in numbers of people over 65	
36. There are difficulties in providing services for people who have both mental health problems and substance abuse	
37. Australian mental health services are not required to distribute resources according to population needs, so the needs of rural, remote, lower socio-economic, Indigenous and other populations may be underserved	
38. Aboriginal and Torres Strait Islander communities are underserved by mental health services in Australia	
39. Mentally-ill prisoners and those in forensic and detention centres are underserved by mental health services	
40. Mental health services, including crisis response services, are less accessible in rural and remote areas than in metropolitan areas, and are affected by local challenges and difficulties in recruitment	
41. Opportunities for mental health service provision in rural and remote areas include telehealth facilities and enhancing the collaboration between mental health workers and primary health providers, police and media	
42. Outcome measures and service standards are well understood in mental health services but are often introduced in an ad hoc manner	

Ways forward

The recent International Mid-term Review of the Second National Mental Health Plan included a number of suggestions about future directions. Please indicate your level of agreement with these suggestions by placing a number in the box, using the scale below. If you wish, you may then add additional comments in the space provided. If you need additional space, please attach your comments on another sheet, making it clear to which section they refer.

Rating scale:

- | | |
|---------------------------------------------------------|------------------------------------------------|
| 1 = strongly agree with this recommendation | 4 = disagree with this recommendation |
| 2 = agree with this recommendation | 5 = strongly disagree with this recommendation |
| 3 = agree with some aspects of this but not with others | 9 = don't know or unable to decide |

Third National Mental Health Plan	
43. Develop a Third National Mental Health Plan to consolidate work to date	
44. Develop a Third National Mental Health Plan to encourage further progress on the existing goals of the National Mental Health Strategy	

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Consumers and carers: ways forward	
45. Expand and enhance the consumer and carer networks, ensuring their ongoing involvement in policy and program planning, and fund the necessary administrative capacity	
46. Rejoin the battle for stigma reduction in Australian society	
47. Organise and offer respite care and other practical support measures for carers of people with disabling mental health problems	
48. Fund training for consumers, carers and mental health advocates	

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Partnership development: ways forward	
49. Consolidate programming and funding for promotion and prevention across multiple targets and a variety of sectors and programs, placing the lead role in mental health promotion with mainstream, generic health promotion agencies	
50. Integrate universal and selected prevention across service sectors to attain economies of scale	
51. Integrate universal and selected prevention across sectors to achieve better utilisation of prevention specialists, utilising skilled mental health clinicians in indicated mental health prevention and treatment services	
52. Offer incentives (including new item numbers) to support psychiatrists to consult to primary care practitioners	
53. Nurture shared care resources	
54. Evaluate shared care's effectiveness, while innovating new models of primary mental health care with new partners	
55. Acknowledge and reward the contributions of providers, programs, services and non-government organisations through bringing innovative programs together to share successful ideas	
56. Adopt <i>beyondblue</i> in all areas	
57. Adopt <i>MindMatters</i> in all areas	
58. Encourage other innovative program development	
59. Introduce program-planning models that involve community choice and bottom-up recognition of community needs, resources available and successful programs	

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The mental health workforce: ways forward	
60. Address the immediate and serious workforce issues (in numbers, distribution, knowledge and training) at both the Commonwealth and State/ Territory levels	
61. Address education needs and the content of training for mental health professionals	
62. Standardise all new training models for mental health professionals, with a set standard for core competencies	
63. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to consult to primary care practitioners	
64. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to consult to rural and remote practitioners	
65. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to routinely conduct initial and crisis assessments (eg. by differential rebates favouring first assessments over follow-up appointments)	
66. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to collaborate with other components of the wider mental health service system	
67. Psychologists should increasingly focus their expertise upon the provision of psychological therapies, both directly to consumers, and indirectly through the supervision of other staff in providing talking treatments	
68. Consider imaginative and innovative options needed for the longer-term stability of viable mental health services	

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Specialist mental health services: ways forward	
69. Increase services to those with disorders of high prevalence focusing especially on early intervention opportunities in schools, the workplace and the community	
70. Eliminate the financial and service 'silos' that exist between mental health and housing, education, disability, geriatrics, child and family services	
71. Enhance services for children and adolescents including those that promote resilience and attachment, improve educational outcomes, expand intensive family and home visiting and promote use of other evidence-based practice models	
72. Assess the availability of 24-hour expert specialist services in emergency departments and in crisis/ home treatment teams to balance the capacity of community-based and hospital-based alternatives for people in crisis	
73. Provide mechanisms of bridge funding and recurrent long-term support to non-government organisations that provide advocacy and services for people with complex needs	
74. Increase the capacity for high support transitional and residential care	
75. Ensure that vocational rehabilitation and other disability support services leading to recovery are provided to people with mental health problems in parity with other disabled groups	

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Dual diagnosis: ways forward	
76. Eliminate barriers between mental health and substance abuse agencies and services at Commonwealth, State, Territory and local levels leading toward full integration	
77. Build upon integrated programming to build a seamless system for consumers, with elimination of ‘silos’ of care, financing and structure	
78. Build upon integrated programming for dual diagnosis to include care for a variety of comorbidities	
79. Establish a new national dual diagnosis evidence and training network to bring together understanding of effective interventions and to disseminate good practice	

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Underserved populations: ways forward	
80. Produce a national strategy for the improvement of mental health services in forensic, prison and detention centre settings	
81. Improve telehealth capacity for assuring mental health expertise to rural and remote regions	
82. Provide incentives (tax and other) for provision of expert services in rural and remote areas	
83. Provide incentives (tax and other) for provision of expert services to Indigenous populations	
84. Establish a baseline for the occurrence and nature of problems in emotional and social wellbeing among Aboriginal and Torres Strait Islander communities	
85. Increase establishment of centres for rural and remote mental health modelled on existing centres of excellence	

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Quality, effectiveness and accountability: ways forward	
86. Establish strong lines of accountability for the implementation of service standards and routine use of outcome measures	
87. Fund service providers based on addressing population needs and using evidence-based practice and measurable outcomes for financial, system and clinical accountability	
88. Establish co-ordinated centres and networks to teach and evaluate the routine use of clinical guidelines and protocols	
89. Establish a national network for mental health services research to evaluate cost-effective treatments and service models	

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Other issues

This section gives you the opportunity to raise other issues which have not been discussed in the survey so far. For example, the first part provides two statements which are not derived from the report of the International Mid-term Review, but arose during a recent consultation. Please indicate your level of agreement with these. Below these statements, you may wish to list other suggestions which should be considered in the development of a Third National Mental Health Plan. If you have insufficient room here, please attach an extra page.

Rating scale:

1 = strongly agree with this statement

4 = disagree with this statement

2 = agree with this statement

5 = strongly disagree with this statement

3 = agree with some aspects of this but not with others

9 = don't know or unable to decide

Additional statements	
90. There is a need to improve the provision of mental health care to people from non-English speaking backgrounds	
91. Most mental health services have fully implemented the National Standards for Mental Health Services	

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What are the highest priorities?

Which five of the statements and actions suggested in this survey do you consider to be the highest priority? Each of the items is numbered. Beginning with your highest priority, please write down the number and a brief description of the action suggested. You can also nominate your own suggestions from the 'Other issues' section above.

1.
2.
3.
4.
5.

Thank you for your assistance in completing this survey. Please return the survey in the reply-paid envelope provided to: The Hunter Institute of Mental Health, P.O. Box 833, Newcastle NSW 2300. Completed surveys must be received by Friday 23 August 2002.

APPENDIX 2: SURVEY TWO

Review of the Second National Mental Health Plan



Instructions for completing the survey

This survey concerns your views on the International Mid-term Review of the Second National Mental Health Plan. The survey consists of three sections. In the first section there are several statements which describe the findings from the International Mid-term Review. The second section called 'Ways forward' consists of the recommendations from the International Mid-term Review. You will be asked to indicate your level of agreement with each finding and recommendation using a ratings scale. The final section provides an opportunity for you to provide additional comments.

Please return the completed survey by **Friday 1 November 2002** to:

Hunter Institute for Mental Health Phone: (02) 4924 6722
P.O. Box 833 Fax: (02) 4924 6724
NEWCASTLE NSW 2300

Further information is available by contacting the Mental Health Council of Australia on (02) 6285 3100. Additional copies of this survey are available at www.mhca.com.au and www.beyondblue.org.au

Your details

As part of the survey, we would like to ask you some details about yourself and the area of the mental health sector you represent. Your name or organisation will not be reported in connection with your responses to the remainder of the questionnaire, so your opinions and comments remain confidential.

Name of person or organisation:

Please tick which ONE of the following descriptions BEST describes your position or role in the mental health sector, or the position or role of your organisation:

- | | |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Consumer of mental health services | <input type="checkbox"/> Non-government community service provider |
| <input type="checkbox"/> Carer of a person with a mental illness | <input type="checkbox"/> Mental health promotion or education |
| <input type="checkbox"/> Consumer or carer advocacy group | <input type="checkbox"/> Mental health research or evaluation |
| <input type="checkbox"/> Public provider of specialist treatment | <input type="checkbox"/> Health policy maker or advisor |
| <input type="checkbox"/> Private provider of specialist treatment | <input type="checkbox"/> Government human services agency other than Health |
| <input type="checkbox"/> Public provider of early intervention services | <input type="checkbox"/> Other: |
| <input type="checkbox"/> General practitioner | |
| <input type="checkbox"/> Divisions of General Practice | |

Findings from the International Mid-term Review

This section presents a number of findings from the International Mid-term Review of the Second National Mental Health Plan for Australia. Do you or your organisation agree with these findings? For each statement, please place one of the following numbers in the box, to indicate your opinions:

Rating scale:

- | | |
|---------------------------------------------------------|---------------------------------------------------------|
| 1 = strongly agree with this finding from the report | 4 = disagree with this finding from the report |
| 2 = agree with this finding from the report | 5 = strongly disagree with this finding from the report |
| 3 = agree with some aspects of this but not with others | 9 = don't know or unable to decide |

1. Consumers and carers are increasingly involved in mental health policy, systems of care and clinical decisions	
2. Partnerships between mental health services and other agencies have been increasing in number and becoming more effective	
3. Many areas are now developing shared care arrangements or increasing consultation between primary care practitioners and specialist mental health professionals	
4. Underlying issues which may contribute to a shortage in the nursing workforce are not being addressed adequately at a systems level	
5. By international standards, there are relatively few psychologists in Australian mental health services and they often work as general case managers, rather than providing specialist psychological therapies	
6. People with a mental illness, including those experiencing a recurrence of an existing illness, often cannot access treatment and care until their illness is advanced or they are in crisis	
7. The crisis response from mental health services may be slow or unreliable	
8. Psychosocial rehabilitation – including employment, education, training and accommodation – has only been partially addressed, in some areas	
9. Psychosocial rehabilitation is made more difficult because of a lack of integration and cooperation between various services, including housing, employment, education, social security and transport	
10. Arrangements for supported accommodation and Commonwealth funding support for employment services appear to be less accessible to those with a mental illness, than to those with a physical illness	
11. There is a lack of funding for children and youth services, and there are insufficient services – including residential, respite, community options, acute mental health services and family interventions	
12. Mental health services for older adults are fragmented and planning is too slow to meet the needs of the population, given the expected growth in numbers of people over 65	
13. There are difficulties in providing services for people who have both mental health problems and substance abuse	
14. Australian mental health services are not required to distribute resources according to population needs, so the needs of rural, remote, lower socio-economic, Indigenous and other populations may be underserved	
15. Aboriginal and Torres Strait Islander communities are underserved by mental health services in Australia	
16. Mentally-ill prisoners and those in forensic and detention centres are underserved by mental health services	
17. Opportunities for mental health service provision in rural and remote areas include telehealth providers, police and media	
18. Outcome measures and service standards are well understood in mental health services	
19. Outcome measures and service standards are often introduced in an ad hoc manner	

Ways forward

The recent International Mid-term Review of the Second National Mental Health Plan included a number of suggestions about future directions. Please indicate your level of agreement with these suggestions by placing a number in the box, using the scale below. If you wish, you may attach any additional comments on another sheet, making it clear to which section they refer.

Rating scale:

1 = strongly agree with this recommendation

2 = agree with this recommendation

3 = agree with some aspects of this but not with others

4 = disagree with this recommendation

5 = strongly disagree with this recommendation

9 = don't know or unable to decide

Third National Mental Health Plan	
20. Develop a Third National Mental Health Plan to consolidate work to date and to encourage further progress on the existing goals of the National Mental Health Strategy	

Partnership development: ways forward	
21. Consolidate programming and funding for promotion and prevention across multiple targets and a variety of sectors and programs, placing the lead role in mental health promotion with mainstream, generic health promotion agencies	
22. Integrate universal and selected prevention across service sectors to attain economies of scale	
23. Integrate universal and selected prevention across sectors to achieve better utilisation of prevention specialists, utilising skilled mental health clinicians in indicated mental health prevention and treatment services	
24. Offer incentives (including new item numbers) to support psychiatrists to consult to primary care practitioners	
25. Nurture shared care resources	
26. Evaluate shared care's effectiveness, while innovating new models of primary mental health care with new partners	
27. Adopt <i>beyondblue</i> in all areas	
28. Adopt <i>MindMatters</i> in all areas	
29. Encourage other innovative program development	
30. Introduce program planning models that involve community choice and bottom-up recognition of community needs, resources available and successful programs	

The mental health workforce: ways forward	
31. Standardise all new training models for mental health professionals, with a set standard for core competencies	
32. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to consult to primary care practitioners	
33. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to consult to rural and remote practitioners	
34. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to routinely conduct initial and crisis assessments (for example, by differential rebates favouring first assessments over follow-up appointments)	
35. Introduce item numbers and other financial measures to act as incentives for private psychiatrists to collaborate with other components of the wider mental health service system	
36. Psychologists should increasingly focus their expertise upon the provision of psychological therapies, both directly to consumers, and indirectly through the supervision of other staff in providing talking treatments	

Rating scale:

1 = strongly agree with this recommendation

4 = disagree with this recommendation

2 = agree with this recommendation

5 = strongly disagree with this recommendation

3 = agree with some aspects of this but not with others

9 = don't know or unable to decide

Specialist mental health services: ways forward	
37. Increase services to those with disorders of high prevalence focusing especially on early intervention opportunities in schools, the workplace and the community	
38. Eliminate the financial and service 'silos' that exist between mental health and housing, education, disability, geriatrics, child and family services	
39. Enhance services for children and adolescents including those that promote resilience and attachment, improve educational outcomes, expand intensive family and home visiting and promote use of other evidence-based practice models	

Dual diagnosis: ways forward	
40. Eliminate barriers between mental health and substance abuse agencies and services at Commonwealth, State, Territory and local levels leading toward full integration	
41. Build upon integrated programming to build a seamless system for consumers, with elimination of 'silos' of care, financing and structure	
42. Establish a new national dual diagnosis evidence and training network to bring together understanding of effective interventions and to disseminate good practice	

Underserved populations: ways forward	
43. Produce a national strategy for the improvement of mental health services in forensic, prison and detention centre settings	
44. Improve telehealth capacity for assuring mental health expertise to rural and remote regions	
45. Establish a baseline for the occurrence and nature of problems in emotional and social wellbeing among Aboriginal and Torres Strait Islander communities	
46. Increase establishment of centres for rural and remote mental health modelled on existing centres of excellence	

Quality, effectiveness and accountability: ways forward	
47. Establish strong lines of accountability for the implementation of service standards and routine use of outcome measures	
48. Fund service providers based on addressing population needs and using evidence-based practice and measurable outcomes for financial, system and clinical accountability	
49. Establish co-ordinated centres and networks to teach and evaluate the routine use of clinical guidelines and protocols	
50. Establish a national network for mental health services research to evaluate cost-effective treatments and service models	

APPENDIX 3: CONSULTATION WORKBOOK

Review of the Second National Mental Health Plan



Instructions for completing the survey

This workbook allows you to express your views on the International Mid-term Review of the Second National Mental Health Plan. The workbook consists of 2 sections:

1. Section one: ('Ways forward') contains a series of recommendations from the International Mid-term Review. You will be asked to indicate your level of agreement with each finding and recommendation using a ratings scale.; and,
2. Section two: Provides an opportunity for you to make additional comments.

Please return the completed workbook by **placing it in the boxes provided at the meeting** or send to the Mental Health Council of Australia (MHCA) at **P.O. Box 174, DEAKIN WEST ACT 2600**.

Further information is available by contacting the MHCA on (02) 6285 3100. Additional copies of this survey are available at www.mhca.com.au and www.beyondblue.org.au

Your details

As part of the survey, we would like to ask you for some details about yourself. Please tick which ONE of the following descriptions BEST describes you.

Gender: Male Female **Location:** Rural Urban Year of birth:(please insert)

Language spoken at home: English Other: (please insert)

- | | |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Consumer of mental health services | <input type="checkbox"/> Non-government community service provider |
| <input type="checkbox"/> Carer of a person with a mental illness | <input type="checkbox"/> Mental health promotion or education |
| <input type="checkbox"/> Consumer or carer advocacy group | <input type="checkbox"/> Mental health research or evaluation |
| <input type="checkbox"/> Public provider of specialist treatment | <input type="checkbox"/> Health policy maker or advisor |
| <input type="checkbox"/> Private provider of specialist treatment | <input type="checkbox"/> Government human services agency other than Health |
| <input type="checkbox"/> Public provider of early intervention services | <input type="checkbox"/> Other: |
| <input type="checkbox"/> General practitioner | |
| <input type="checkbox"/> Divisions of General Practice | |

Section one: ways forward

The recent International Mid-term Review of the Second National Mental Health Plan included a number of suggestions about future directions. Please indicate your level of agreement with these suggestions by placing a number in the box, using the scale below. If you wish, you may attach any additional comments on another sheet, making it clear to which section they refer.

Rating scale:

1 = strongly agree with this recommendation

2 = agree with this recommendation

3 = agree with some aspects of this but not with others

4 = disagree with this recommendation

5 = strongly disagree with this recommendation

DK = don't know or unable to decide

Third National Mental Health Plan. There is a need to ...	
1. Develop a Third National Mental Health Plan (2003-2008) to consolidate the work undertaken over the past decade through the National Mental Health Strategy	

Partnership development: ways forward. There is a need to ...	
2. Consolidate mental health promotion and prevention across a variety of sectors and emphasise partnerships with other health promotion agencies	
3. Apply broad prevention strategies to maximise their impact and cost effectiveness	
4. Promote better use of both prevention specialists and skilled mental health clinicians	
5. Offer incentives (including new item numbers) to support psychiatrists to consult with primary care practitioners	
6. Support shared care resources	
7. Evaluate the effectiveness of new models of primary mental health care	
8. Integrate beyondblue (the National depression initiative) philosophy and activity in all areas	
9. Integrate MindMatters (school mental health program) philosophy and activity in all areas	
10. Encourage other innovative program development across all areas of mental health	
11. Introduce program planning models that embrace community choice and recognise community needs, available resources and successful programs	

The mental health workforce: ways forward. There is a need to ...	
12. Standardise all new training models for mental health professionals, with a set standard for core competencies	
13. Introduce incentives to encourage private psychiatrists to consult to primary care practitioners	
14. Introduce incentives to encourage private psychiatrists to consult to rural and remote practitioners	
15. Introduce incentives to encourage private psychiatrists to routinely conduct initial and crisis assessments	
16. Introduce incentives to encourage private psychiatrists to collaborate with the wider mental health service system	
17. Psychologists to increasingly focus their expertise upon the provision of psychological therapies, directly to consumers, and indirectly through the supervision of other staff in providing talking treatments	

Rating scale:

1 = strongly agree with this recommendation

4 = disagree with this recommendation

2 = agree with this recommendation

5 = strongly disagree with this recommendation

3 = agree with some aspects of this but not with others

DK = don't know or unable to decide

Specialist mental health services: ways forward. There is a need to ...	
18. Increase services to people with disorders of high prevalence (eg. depression, anxiety) focusing especially on early intervention in schools, the workplace and the community	
19. Encourage collaboration between service providers in mental health, housing, education, disability, geriatrics, child and family services	
20. Enhance services for children and adolescents. This includes promoting resilience (coping skills) and attachment (bonding), improving educational outcomes and expanding intensive family and parenting support programs	

Dual diagnosis: ways forward. There is a need to ...	
21. Eliminate barriers between mental health and substance abuse (eg. drug and alcohol) agencies and services at Commonwealth, State, Territory and local levels	
22. Develop an integrated approach across all services including direct care, financing and structure	
23. Establish a new national training network in the area of dual diagnosis (mental health and drug and alcohol), to improve understanding of effective interventions and disseminate good practice	

Underserved populations: ways forward. There is a need to ...	
24. Produce a national strategy for the improvement of mental health services in forensic, prison and detention centre settings	
25. Improve teleconferencing to provide mental health expertise to rural and remote regions	
26. Establish the incidence and nature of problems in emotional and social wellbeing among Aboriginal and Torres Strait Islander communities	
27. Establish more centres of excellence for rural and remote mental health	

Quality, effectiveness and accountability: ways forward. There is a need to ...	
28. Establish strong lines of accountability for the implementation of mental health service standards and routine use of outcome measures	
29. Fund service providers based on their ability to address population needs and use evidence-based practice and measurable outcomes for financial, system and clinical accountability	
30. Establish co-ordinated centres and networks to teach and evaluate the routine use of clinical guidelines and protocols	
31. Establish a national network for mental health service research to evaluate cost-effective treatments and service models	

Additional statements. There is a need to ...	
32. Improve the provision of mental health care to people from non-English speaking backgrounds	

APPENDIX 4: SURVEY ONE RECIPIENT LIST

TITLE	FIRST NAME	SURNAME	POSITION	COMPANY/ ORGANISATION
Ms	Helen	Connor	Chairperson	Australian Mental Health Consumer Network
Ms	Judy	Hardy		Network of Australian Community Advisory Groups
Ms	Janne	McMahon		Network of Australian Community Advisory Groups
Ms	Jodie	Brown		Network of Australian Community Advisory Groups
Mr	Patrick	Hardwick	President	Association of Relatives and Friends of the Mentally Ill (ARAFMI)
Mr	John	McGrath	Chair	Carers Australia
Ms	Irene	Gibbons	Chief Executive Officer	Carers Australia
Associate Professor	Harry	Minas		Australian Transcultural Mental Health Network
Mr	Abd-Elmasih	Malak	Director	Australian Transcultural Mental Health Network
Mr	John	Lawrence		National Rural Health Alliance
Mr	Gordon	Gregory	Executive Officer	National Rural Health Alliance
Professor	Robert	Bland		Australian Association of Social Workers
Mr	Stephen	Elsom	President	Australian and New Zealand College of Mental Health Nurses
Associate Professor	Dimity	Pond		Royal Australian College of General Practitioners (RACGP)
Adjunct Professor	Joan	Lawrence		Royal Australian and New Zealand College of Psychiatrists (RANZCP)
Mr	Craig	Patterson	Executive Officer	Royal Australian and New Zealand College of Psychiatrists (RANZCP)
Professor	Jeff	Richards		Australian Psychological Society
Ms	Joy	Pennock		Australian Association of Occupational Therapists
Ms	Sue	Feeney		Ramsay Health Care
Professor	Graham	Burrows		Mental Health Foundation of Australia
Mr	Bernard	McNair		Mental Illness Fellowship Council of Australia
Ms	Dawn	Smith	Chief Executive Officer	Lifeline Australia
Ms	Barbara	Hocking		SANE Australia
Dr	Nick	Kowalenko		Australian Infant, Child, Adolescent and Family Mental Health Association
Mr	Phillip	Robinson	Chair	Australian Infant, Child, Adolescent and Family Mental Health Association
Mr	Craig	Ritchie	Chief Executive Officer	National Aboriginal Controlled Health Organisation
Ms	Joy	Said		Mental Health Co-ordinating Council
Ms	Jenna	Bateman	Chief Executive Officer	Mental Health Co-ordinating Council
Mr	Keith	Wilson		Western Australian Association for Mental Health
Ms	Ann	White	Executive Officer	Western Australian Association for Mental Health
Ms	Narelle	Oliver		The Queensland Alliance of Mental Illness and Psychiatric Disability Groups
Dr	Joan	Clarke		Psychiatric Disability Services of Victoria (VICSERV)
Mr	David	Clarke	Chief Executive Officer	Psychiatric Disability Services of Victoria (VICSERV)
Professor	Maxwell	Bennett		Australian Neuroscience Society
Ms	Angela	MaGarry	Director Policy	Catholic Health Australia
Professor	Phillip	Mitchell		Australasian Society Psychiatric Research
Ms	Joy	Gillet		Australian Rotary Health Research Fund
Ms	Barbara	Ryan-Thomas		Royal Flying Doctors Service of Australia
Mr	John	Barletta	Chair	Australian Board of Certified Counsellors
Mr	James	MaGuire	President	Institute of Australasian Psychiatrists
Ms	Colleen	Mullavey-O'Byrne		Mental Illness Education Australia
Dr	Bill	Pring		Australian Medical Association
Dr	Jan	Orman	President	Australian College of Psychological Medicine
Professor	Beverley	Raphael	Director	Centre for Mental Health
Dr	Peggy	Brown	Director	Mental Health Unit
Ms	Wendy	Quinn	State Manager	Mental Health Program
Mr	Simon	Rosenberg	Manager	Mental Health Unit
Dr	Margaret	Tobin	Director of Mental Health	Department of Human Services
Ms	Cheryl	Furner	Director	Social and Emotional Wellness (SOEWELL) Branch, Department of Health and Community Services
Ms	Angela	Jurjevic	Director of Aged Care	Mental Health Branch, Department of Human Services
Dr	Aaron	Groves	Acting General Manager	Mental Health Division, Department of Health

TITLE	FIRST NAME	SURNAME	POSITION	COMPANY/ ORGANISATION
Professor	Ian	Hickie	Chief Executive Officer	<i>beyondblue: the national depression initiative</i>
Mr	Phillip	Taylor	Chief Executive Officer	Strategic Planning Group for Private Psychiatric Services
Ms	Margaret	Bunker		Australian Council of Healthcare Standards
Mr	Stephen	Einfield		Quality Improvement Council
Ms	Vivienne	Miller		TheMHS Conference (Mental Health Services)
Ms	Cheryl	Wilson	Chief Executive Officer	Alcohol and Other Drugs Council of Australia
Mr	Matthew	Blackmore	Chief Executive Officer	Consumer Health Forum of Australia
Mr	Allan	Evans	Chief Executive Officer	Medicines Australia
Mr	Nicholas	Bolto		Ostara Australia
Mr	Simon	Champ		
Mr	David	Copolov	Director	Mental Health Research Unit
Mr	Mark	Cormack	National Director	Australian Healthcare Association
Professor	Tony	Jorm	Director	Centre for Mental Health Research
Mr	Michael	Roff	Executive Director	Australian Private Hospitals Association
Mr	Ben	Carey	Chief Executive Officer	Suicide Prevention Australia
Ms	Kellie	Howe	Acting National Coordinator	Australian Divisions of General Practice
Ms	Elvessa	Marshall	Development and Liaison Officer	Alliance of NSW Divisions Limited
Ms	Anne	Diamond	Development and Liaison Officer	General Practice Divisions – Victoria
Ms	Shirley	Anastasi	Development and Liaison Officer	Queensland Divisions of General Practice
Ms	Patricia	Smith	Development and Liaison Officer	South Australia Divisions Incorporated
Ms	Anna	Roberts	Development and Liaison Officer	General Practice Divisions of Western Australia
Ms	Jill	Currey	Development and Liaison Officer	Tasmanian General Practice Divisions
Ms	Sophia	Boutsis	Development and Liaison Officer	ACT Division of General Practice
Ms	Bronwyn	Russell	Development and Liaison Officer	General Practice Divisions Northern Territory
Dr	David	Monash	GP Advisor	Australian Divisions of General Practice
Ms	Eleanor	Jackson-Bowers		Primary Mental Health Care Australian Resource Centre
Dr	Kathryn	Woodhead	GP Mental Health Advisor	Alliance of NSW Divisions Limited
Dr	Tori	Wade	Director	Primary Mental Health Care Australian Resource Centre
Professor	Harvey	Whiteford	Kratzmann Chair in Psychiatry	University of Queensland
Ms	Mary-Anne	Lucas		National Consumer and Carer Forum
Ms	Janet	Meagher	Co-chair	National Consumer and Carer Forum
Ms	Fay	Jackson		National Consumer and Carer Forum
Ms	Sue	Sidebottom		National Consumer and Carer Forum
Ms	Ruth	Carson		National Consumer and Carer Forum
Ms	Alvina	Hill		National Consumer and Carer Forum
Mr	Matthew	Fowler		National Consumer and Carer Forum
Mr	Gregory	Johnson		National Consumer and Carer Forum
Dr	Subhash	Chandra		National Consumer and Carer Forum
Ms	Helen	Glover		National Consumer and Carer Forum
Ms	Jean	Platts		National Consumer and Carer Forum
Ms	Nadine	Britton		National Consumer and Carer Forum
Ms	Linda	Rosie	Dep Co-chair	National Consumer and Carer Forum
Ms	Jodie	Brown	Dep Co-chair	National Consumer and Carer Forum
Ms	Lorraine	Toms		National Consumer and Carer Forum
Ms	Ann	Smith		National Consumer and Carer Forum
Ms	Paola	Mason		National Consumer and Carer Forum
Mr	Justin	Habner		National Consumer and Carer Forum

TITLE	FIRST NAME	SURNAME	POSITION	COMPANY/ ORGANISATION
Ms	Lynette	Pearce		National Consumer and Carer Forum
Mr	Tony	Fowke	Co-chair	National Consumer and Carer Forum
Mr	Lloyd	Marsh		National Consumer and Carer Forum
Ms	Isabella	Collins		National Consumer and Carer Forum
Ms	Beth	Bailey		National Consumer and Carer Forum
Ms	Jackie	Wilson	Ass Sec	Commonwealth Department of Family and Community Services
Ms	Helen	Evans	1st Ass Sec	Office for Aboriginal and Torres Strait Islander Health
Mr	Wayne	Gibbons	Dep Sec	Department of Employment and Workplace Relations
Mr	John	Lloyd	Dep Sec	Department of Employment and Workplace Relations
Mr	Tony	Greer	Group Manager – Schools	Department of Education, Science and Training
Mr	Collin	Walters	Manager	Department of Education, Science and Training
Ms	Julie	McCormack		Royal Australian College of General Practitioners (RACGP)
The	Chairperson			Western Australian Community Advisory Group on Mental Health
The	Chairperson			Victorian Community Advisory Group on Mental Health
The	Chairperson			ACT Community Advisory Group on Mental Health
The	Chairperson			Tasmanian Community Advisory Group on Mental Health
Ms	Jodie	Brown	Chairperson	NSW Consumer Advisory Group Mental Health Inc.

APPENDIX 5: SURVEY TWO RECIPIENT LIST

TYPE OF ORGANISATION	NUMBER OF RECIPIENTS
Area mental health services	210
Consumer groups	245
Carer groups	97
Divisions of General Practice	137
Private hospitals	45
MHCA member organisations	40
TOTAL	774

Notes: A detailed list of survey two recipients is available on request from the MHCA. Approximately 50 were also sent to other recipients who requested the survey.

APPENDIX 6: COMMUNITY CONSULTATIONS

DATE	LOCATION	FACILITATOR	VENUE
Monday 21 October, 2002	Townsville	Dr Nicole Highet Ms Carmen Hinkley	QCWA DENHAM STREET FUNCTION ROOM 134 Denham Street (Cnr Walker Street) TOWNSVILLE QLD
Tuesday 22 October, 2002	Brisbane	Dr Nicole Highet Ms Carmen Hinkley	CHRISTIE CORPORATE OFFICES Bowman Room, Level 6, 320 Adelaide Street (Cnr Wharf Street) BRISBANE CBD QLD
Wednesday 23 October, 2002	Darwin	Professor Ian Hickie Dr Grace Groom	THE MIRAMBEENA RESORT 64 Cavenagh Street DARWIN NT
Wednesday 23 October, 2002	Bathurst	Dr Nicole Highet Ms Carmen Hinkley	THE BATHURST MEMORIAL ENTERTAINMENT CENTRE 105 William Street BATHURST NSW
Thursday 24 October, 2002	Sydney	Dr Nicole Highet Ms Carmen Hinkley	LEICHHARDT TOWN HALL Cnr Marion and Norton Streets LEICHHARDT NSW
Monday 28 October, 2002	Melbourne	Professor Ian Hickie Dr Grace Groom	AUSTRALIAN EDUCATION UNION Victorian Branch, 112 Trenerry Crescent ABBOTSFORD VIC
Tuesday 29 October, 2002	Bendigo	Dr Nicole Highet Ms Carmen Hinkley	RL CAMPBELL THEATRE North Central Goldfield Regional Library Complex 251-259 Hargreaves Street BENDIGO VIC
Wednesday 30 October, 2002	Hobart	Dr Nicole Highet Ms Carmen Hinkley	LENNA OF HOBART 20 Runnymede Street BATTERY POINT TAS
Thursday 31 October, 2002	Canberra	Dr Grace Groom Ms Carmen Hinkley Mr Hedley Middlebrook	THE WALDORF APARTMENTS The Chatham Room Street floor CANBERRA CITY ACT
Thursday 31 October, 2002	Canberra	Dr Grace Groom Ms Carmen Hinkley Mr Hedley Middlebrook	ACT STATE-BASED ORGANISATION (ACTDGP) Unit 4, 19 Trenerry Street WESTON ACT
Thursday 14 November, 2002	Northam, WA	Dr Grace Groom	PRINCE HOUSE 4 Prince Road NORTHAM WA
Thursday 14 November, 2002	Perth	Dr Grace Groom	ST JOHN OF GOD HOSPITAL – CONFERENCE CENTRE Level 3, 25 McCourt Street SUBIACO WA
Friday 22 November, 2002	Adelaide	Professor Ian Hickie Dr Grace Groom	South Australian Postgraduate Medical Education Association (SAPMEA) 68 Greenhill Road WAYVILLE SA

APPENDIX 7: SPECIAL GROUPS CONSULTATIONS

DATE	LOCATION	GROUP	FACILITATOR	VENUE
Friday 27 September, 2002	Perth	STRATEGIC PLANNING GROUP FOR PRIVATE PSYCHIATRIC SERVICES (SPGPPS)	Professor Ian Hickie Dr Grace Groom	WEST PERTH
Monday 14 October, 2002	Sydney	AUSTRALIAN AND NEW ZEALAND COLLEGE OF MENTAL HEALTH NURSES	Professor Ian Hickie Dr Grace Groom	CARLTON CREST HOTEL 169-179 Thomas Street SYDNEY NSW
Wednesday 16 October, 2002	Melbourne	NATIONAL CONSUMER AND CARER FORUM	Professor Ian Hickie Dr Grace Groom Dr Nicole Highet Ms Carmen Hinkley	HILTON MELBOURNE AIRPORT Daylesford/ Ballarat Room Arrivals Drive Melbourne Airport MELBOURNE VIC
Wednesday 16 October, 2002	Melbourne	AUSTRALIAN PSYCHOLOGICAL SOCIETY (APS)	Professor Ian Hickie Dr Nicole Highet	AUSTRALIAN PSYCHOLOGICAL SOCIETY National Office Level 11, 257 Collins Street MELBOURNE VIC
Sunday 27 October, 2002	Melbourne	ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS (RANZCP)	Professor Ian Hickie Dr Grace Groom Dr Nicole Highet	RANZCP NATIONAL OFFICE 309 La Trobe Street MELBOURNE VIC
Friday 1 November, 2002	Sydney	COMPREHENSIVE AREA HEALTH SERVICE PSYCHIATRIC GROUP	Professor Ian Hickie Dr Nicole Highet	ROZELLE HOSPITAL Tribunal Room (Off Wharf Road) LILYFIELD NSW
Monday 25 November, 2002	Alice Springs	CENTRAL AUSTRALIAN ABORIGINAL CONGRESS	Dr Grace Groom	TELECONFERENCE

APPENDIX 8: GP FOCUS GROUP CONSULTATIONS

DATE	LOCATION	FACILITATOR	VENUE
Tuesday 22 October, 2002	Brisbane	Dr Nicole Highet Ms Carmen Hinkley	QUEENSLAND DIVISIONS OF GENERAL PRACTICE 467 Enoggera Road ALDERLEY QLD
Wednesday 23 October, 2002	Darwin	Professor Ian Hickie Dr Grace Groom	TOP END DIVISIONS OF GENERAL PRACTICE Centre for General Practice 1st Floor, Stuart House, 5 Shepherd Street DARWIN NT
Thursday 24 October, 2002	Sydney	Dr Nicole Highet Ms Carmen Hinkley	WESLEY PRIVATE HOSPITAL 91 Milton Street ASHFIELD NSW
Monday 28 October, 2002	Melbourne	Professor Ian Hickie Dr Grace Groom	GENERAL PRACTICE DIVISIONS VICTORIA Level 1, 458 Swanston Street CARLTON VIC
Wednesday 30 October, 2002	Hobart	Dr Nicole Highet Ms Carmen Hinkley	TASMANIAN GENERAL PRACTICE DIVISIONS 3/33 Salamanca Place HOBART TAS
Thursday 31 October, 2002	Canberra	Dr Grace Groom Ms Carmen Hinkley Mr Hedley Middlebrook	ACT STATE-BASED ORGANISATION (ACTDGP) Unit 4, 19 Trenerry Street WESTON ACT
Wednesday 13 November, 2002	Perth	Dr Grace Groom	GP DIVISIONS OF WESTERN AUSTRALIA Level 3, 130 Royal Street EAST PERTH WA
Friday 22 November, 2002	Adelaide	Professor Ian Hickie Dr Grace Groom	TIFFINS ON THE PARK 176 Greenhill Road PARKSIDE SA

APPENDIX 9: SURVEY THREE

Community Priorities for the Third National Mental Health Plan



Introduction: Community priorities for 'ways forward'

After completing a series of surveys, and community and professional consultations, the next step in our response to review the *Second National Mental Health Plan* is to carry out this final survey.

We greatly appreciate the efforts of all involved and beg your indulgence for the last stage in this process. Unfortunately, the turn-around time is again very short. While we will continue to receive replies and process them until the 28th February 2003, we do need to make public statements about the nature of the responses by mid-February 2003.

PLEASE COMPLETE THIS SURVEY AS SOON AS YOU RECEIVE IT! IF YOU FEEL OVERWHELMED BY THE PROCESS – PLEASE COMPLETE AT LEAST SECTION ONE AND RETURN AS SOON AS POSSIBLE.

Instructions for completing the survey

Our intention is to develop a community-based priority list for key themes and possible mechanisms for 'ways forward'. This method is in stark contrast to previous approaches to community consultation. While we are somewhat constrained by the ways in which we collected the previous data (remember, we are only making recommendations), we believe that this is a unique opportunity for genuine and broad mental health sector input to priorities for the next five years.

This survey is divided into two sections:

- The first identifies a number of key themes that we have distilled so far. Here, a simple ranking is required. There is also the opportunity to add other priorities and rank them along with the ones we have distilled.
- The second outlines some possible mechanisms for going forward. Here again, there is the opportunity to add your own preferred mechanisms and rank them as you see fit.

Please return the completed survey in the reply paid envelope enclosed. For any further queries, our contact details are: Psychiatry Research Unit, Top Floor, Broughton Hall, PO Box 1, ROZELLE NSW 2039, Phone: (02) 9556 9113, Fax: (02) 9556 9171.

Your details

As part of the survey, we would like to ask you some details about yourself and the area of the mental health sector you represent. Your name (or organisation) will not be reported in connection with your responses to the remainder of the survey, so your opinions and comments remain confidential.

Are you completing this survey as an individual or on behalf of an organisation?

- Individual Organisation

Name of organisation:

Please tick ONE of the following descriptions which BEST describes your position or role in the mental health sector, or the position or role of your organisation:

- | | |
|-------------------------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Consumer of mental health services | <input type="checkbox"/> Non-government community service provider |
| <input type="checkbox"/> Carer of a person with a mental illness | <input type="checkbox"/> Mental health promotion or education |
| <input type="checkbox"/> Consumer or carer advocacy group | <input type="checkbox"/> Mental health research or evaluation |
| <input type="checkbox"/> Public provider of specialist treatment | <input type="checkbox"/> Health policy maker or advisor |
| <input type="checkbox"/> Private provider of specialist treatment | <input type="checkbox"/> Human services agency other than Health |
| <input type="checkbox"/> Public provider of early intervention services | <input type="checkbox"/> Other: |
| <input type="checkbox"/> General practitioner | |
| <input type="checkbox"/> Divisions of General Practice | |

SECTION ONE: Key themes

This section relates to the following list which details a number of possible preferences for focusing activity over the next five years in mental health planning. Please mark up to 10 preferences with a cross. Feel free to propose (and mark) other options we have not yet considered.

For example:

Support for national training programs in mental health

- Support for national community leadership in mental health
- Support for national professional leadership in mental health
- Clear accountability for expenditure of mental health strategy funds
- More genuine consumer participation at regional and local service levels
- More genuine carer participation at regional and local service levels
- Development of a wider spectrum of acute and community-based care settings
- Development of specific inter-governmental service agreements (eg. between health, education, housing, employment and social security)
- Development of innovative services for persons with mental health and alcohol or substance abuse disorders
- Service development for those in forensic (i.e. prison-based) services
- Development of standardised national mental health laws
- Implementation of national standards for mental health services
- Ongoing support for national suicide prevention campaigns
- Increased support for stigma reduction campaigns
- Development of specific procedures for reporting Human Rights abuses or neglect
- Direct support for 'innovation', 'research' and 'service evaluation' in mental health
- Development of national data sets for monitoring the quality of local services
- Support for general mental health promotion
- Support for specific disease prevention initiatives (eg. in anxiety, depression, alcohol or substance abuse)
- Support for enhanced role of non-government organisations in all aspects of care
- Implementation of early intervention strategies nationally
- Introduction of specific schemes to enhance access to mental health specialists
- Support for service development in poorly resourced areas
- Support for service development in rural and regional areas
- Specification of clear primary care and specialist workforce roles
- Service enhancement for persons from culturally and linguistically-diverse backgrounds
- Support for programs that promote attitudinal change among mental health workers
- Others 1 (please specify)
- Others 2 (please specify)

SECTION TWO: Possible 'ways forward'

This section relates to the following lists which detail proposed methods for 'ways forward'. Within each section please mark those methods you support most with a cross. Feel free to propose (and mark) other options we have not yet considered.

For example:

- Promotion of national leadership*
- Service development between mental health and alcohol or substance abuse*
- Support for general mental health promotion and disease prevention initiatives*
- Support for changes in workforce attitudes*

1. Promotion of national leadership:

- Increased roles for key national professional groups (eg. Medical Colleges, Professional Associations of Psychologists, Mental Health Nurses, Social Workers, Occupational Therapists, General Practitioners etc)
- Broadening of representation within the National Mental Health Working Group of AHMAC
- Independent and substantial funding for national groups of consumers and carers
- Development of independent and substantial funding for the Mental Health Council of Australia
- Development of national agencies focusing on specific illness categories (eg. depression, anxiety, schizophrenia)
- Other (please specify)

2. Clear mechanisms for accountability:

- Development of an independent national commission for review of mental health spending, critical incidents and national outcomes
- Development of national data sets to track regional delivery of services
- Development of clear timelines for delivery of agreed outcomes by the states
- Development of more independent contracts by the Commonwealth to relevant non-government service providers (including universities and private service providers)
- Establish an independent and permanent commission to report on national progress in mental health
- Other (please specify)

3. Genuine consumer and carer participation:

- Funding of more extensive consumer participation at local and regional levels
- Funding of more extensive carer participation at local and regional levels
- Funding of more extensive participation at state and national levels
- Direct financial support for the National Consumer and Carer Forum
- Other (please specify)

4. Development of a wider spectrum of acute and community care settings:

- Development of step-down acute care facilities (for use both prior to, and following, acute hospitalisation)
- Greater professional support within designated community housing
- Improved specialised support in association with primary care settings
- General funding and agency support for community housing initiatives
- Other (please specify)

5. Systematic approaches to reduce institutionalisation in the community:

- Greater support for psychosocial rehabilitation strategies in the community
- Support for non-government organisations to provide high quality psychiatric disability services
- Reduction of structural barriers in insurance, employment and housing
- Other (please specify)

6. Inter-governmental service agreements:

- Specific service agreements between Federal departments of health, social security, employment and education
- Specific service agreements between State-based departments of health, housing, education, corrective services and criminal justice
- Clear agreements between state and regional governments in key areas such as supported housing
- Other (please specify)

7. Service development between mental health and alcohol or substance abuse:

- Development of clear agreements between national mental health and alcohol or substance abuse strategies
- Development of innovative approaches to provision of common specialist services
- Development of innovative approaches to primary care management of patients with both mental health and alcohol or substance abuse
- Support for greater research into the changing patterns of comorbidity
- Development of staff education and professional training
- Other (please specify)

8. Service development for special needs groups – notably those in forensic services and homeless populations:

- Development of national standards for specialist forensic mental health services
- Development of innovative approaches (eg. integrated financial or case management with other health and welfare agencies) to supporting persons with mental illness who are homeless
- Other (please specify)

9. National mental health law reform:

- Development of national laws for dealing with forensic issues
- Development of national laws for providing compulsory treatments
- Development of national laws for regulating psychiatric practice
- Other (please specify)

10. National standards for mental health services:

- Immediate implementation of current national mental health standards
- Development of new standards for determining quality of mental health services
- Support innovative approaches for increasing quality monitoring within current services
- Other (please specify)

11. Suicide prevention campaigns:

- Support ongoing national suicide prevention initiatives
- Support ongoing state-based suicide prevention initiatives
- Increase support for non-government organisations-based suicide prevention initiatives
- Other (please specify)

12. Stigma reduction campaigns:

- Support for national stigma reduction campaigns
- Support for development of regional and local stigma reduction campaigns
- Support for stigma reduction focusing on psychotic disorders
- Support for stigma reduction focusing on non-psychotic disorders
- Prioritise stigma reduction amongst health care providers
- Other (please specify)

13. Human rights focus:

- Prioritise reduction of human rights abuses in acute care settings
- Focus on human rights abuses in long-term care settings
- Focus on community neglect as a human rights issue
- Focus on discrimination in insurance, employment, disability assessment and housing support
- Introduce national, state and/or regional reporting of abuse or neglect
- Initiate a national enquiry into human rights (i.e. a 10-year follow-up to the Burdekin Report)
- Appoint a permanent Deputy Commissioner for Mental Health within the Human Rights Commission
- Other (please specify)

14. Development of genuine service pathways ('integrated care'):

- Focus on integrated primary and specialist care
- Focus on integrated medical and psychiatric care
- Focus on integrated medical treatments and disability support systems
- Focus on integrating acute care (hospital-based) and longer-term (community-based) forms of care
- Other (please specify)

15. Innovation, research and evaluation:

- Support for national biomedical research initiatives
- Support for national health services research initiatives
- Support for national mental health literacy and attitude initiatives
- Support for national application of regionally-successful innovations in care
- Support for development of national standards of service data collection
- Support for e-health and telephone-based innovations in care
- Support for improved modelling of the impacts of different types of mental health services
- Other (please specify)

16. Support for general mental health promotion and disease prevention initiatives:

- Support for school-based promotion and prevention strategies
- Support for workplace-based promotion and prevention strategies
- Support for national research and service consortia to improve the level of evidence
- Support for e-health and other technology-based approaches to health promotion and disease prevention
- Support for emphasis on childhood determinants of illness
- Support for emphasis on social and economic determinants of illness
- Other (please specify)

17. Support for the enhanced role of non-government organisations:

- Support for the enhanced role of the Mental Health Council of Australia
- Support for increased provision of psychiatric disability and housing support services by non-government organisations
- Support for direct Commonwealth funding of national non-government organisations in mental health
- Delineation of clear educational and training roles for non-government organisations
- Other (please specify)

18. Development of community education and early intervention strategies:

- Development of initiatives focusing on earlier identification of persons with psychotic disorders
- Development of initiatives focusing on earlier identification of persons with non-psychotic disorders
- Development of initiatives focusing on earlier identification of teenagers with any significant behavioural disturbance
- Development of primary-care based education and early-identification strategies
- Other (please specify)

19. Specialist workforce distribution

- Limitation of new item numbers for psychiatrists in well-resourced urban areas
- Incentives for psychiatrists to work in poorly resourced urban and rural areas
- Incentives for psychologists and other non-medical mental health specialists to work in poorly resourced urban and rural areas
- Support broadening of telemedicine strategies
- Support e-health and other technology-based innovations in distribution of care
- Other (please specify)

20. Development of clear primary care and specialist workforce roles:

- Limit* primary care incentive payments to improved assessment, education, medication, basic counselling and behavioural interventions and disease management roles
- Expand* primary care incentive payments to improved assessment, education, medication, basic counselling and behavioural interventions and disease management roles
- Incentives for psychiatrists and other specialists to increase their consultancy to primary care
- Public mental health services to provide more consultancy and educational support to primary care services
- Use of specialist providers in public mental health services to provide specialised forms of treatments for a wide range of mental disorders
- Other (please specify)

21. Service enhancement for persons from culturally and linguistically-diverse backgrounds:

- Development of more extensive specialised services
- Increased funding support for the transcultural mental health network
- Support for non-pharmacological treatments being delivered to persons who do not speak English
- Other (please specify)

22. Increase national and regional mental health literacy campaigns:

- Support school-based mental health literacy campaigns
- Support workplace-based mental health literacy campaigns
- Support internet-based mental health literacy campaigns
- Support national advertising literacy campaigns
- Other (please specify)

23. Engagement of corporate and community partners in mental health

- Development of corporate or community-led awareness campaigns (eg. Rotary forums)
- Development of workplace-based awareness and assisted employment programs
- Development of corporate support for community advertising campaigns
- Other (please specify)

24. Support for changes in workforce attitudes

- Focus on changing attitudes among general practitioners
- Focus on changing attitudes among psychiatrists
- Focus on changing attitudes among mental health nurses
- Focus on changing attitudes among psychologists
- Focus on changing attitudes among other non-medical specialist staff
- Focus on changing attitudes among emergency care staff
- Other (please specify)

25. Enhancement of services

- Enhanced services for people with personality disorders
- Enhanced services for people with women with post-natal depression
- Enhanced services for people with comorbid mental and/or physical disorders
- Enhanced services for people with anorexia nervosa
- Enhanced services for people with other eating disorders
- Other (please specify)

26. Any other key areas and mechanisms

-
-
-
-
-

Thank you for completing this survey!

“I commend the Mental Health Council for its consultations on the Mental Health Strategy. I urge Australia’s governments to treat the Council’s call for action with the seriousness that these fundamental human rights issues deserve.”

Dr Sev Ozdowski OAM
Human Rights Commissioner; and,
Acting Disability Discrimination Commissioner

“Titled ‘OUT OF HOSPITAL, OUT OF MIND!’, the Council’s report finally gives a national voice to our experiences. Although it demands a response ... from the Heads of Government, I am not confident that its recommendations will be taken seriously.”

Professor Allan Fels AO, Chair,
Australian Competition and Consumer Commission

“The Council’s report makes very worrying reading, particularly about the rising incidence and shortfalls in treatment of mental health problems in our community.”

Professor Fiona Stanley AC, Australian of the Year, 2003

“The deterioration in mental health, fast becoming the major disability in the nation, requires immediate attention. The conditions that lead to enhanced likelihood of depression and psychosis need to be identified in the community and alleviated. Importantly, the capacity to carry out research required to identify and ameliorate those conditions... requires urgent support.”

Professor Max Bennett AO, Professor; and, University Chair
Neurobiology Laboratory, Department of Physiology, Institute for
Biomedical Research, University of Sydney

“Even after a decade of effort, we still find the shameful fact that over 60 percent of people with a mental disorder go without a proper service.”

Francis Sullivan, Chief Executive Officer, Catholic Health Australia

“A nationwide review of the experiences of those who use and provide mental health services has documented that current community-based systems fail to provide adequate services. Specifically, these services are characterised by: restricted access; variable quality; poor continuity; lack of support for recovery from illness; and, protection against human rights abuses.”

“The priorities highlighted here could form the basis for a Third National Mental Health Plan, as well as providing a framework for implementation strategies and mechanisms for accountability. Such priorities and mechanisms are likely to be at variance with other national policy development processes. This is a consequence of both the experiences of the respondents surveyed as well as the fundamental task undertaken here. That is, stakeholders were required to set priorities and describe acceptable mechanisms for actual implementation and accountability rather than just propose general policy frameworks.”

Groom, Hickie and Davenport, ‘OUT OF HOSPITAL, OUT OF MIND!’, 2003

“In this report the community of consumers, families, carers, health professionals and health service providers has spoken with one voice. It has confirmed the key gaps in services, recognised opportunities for excellence and set priorities for the next five years. The time has now come for all levels of government to ‘GET REAL’ – real money, real leadership, real accountability, real innovation, and real ongoing review. We can no longer ignore the broad range of compelling evidence before us. We must act now for the improvement of mental health care for all Australians.”

Keith Wilson, Chairperson, Mental Health Council of Australia



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Facsimile: +61 3 9810 6111
Email: bb@beyondblue.org.au

www.beyondblue.org.au