Introduction

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The Commonwealth Government has already committed $1.8bn over five years towards mental health reform. The Prime Minister's involvement, and that of the Council of Australian Governments (COAG) more generally, represent an unprecedented opportunity for the advancement of mental health in Australia – the issue is centre stage. This opportunity must not be missed but new investments must be properly targeted.

Time for Service is the first of a series of MHCA papers presenting solutions to Australia's mental health crisis. It presents practical solutions that governments should fund and implement now through the Council of Australian Governments (CoAG). The solutions proposed aim to deliver new pathways to new services, offer flexibility and choice, and make a real difference to people with a mental illness and their carers.

The state of mental health services in Australia has been well documented, including in the Mental Health Council of Australia's own *Not for Service Report* and most recently by the report of a Senate Committee of Inquiry entitled *From Crisis to Community*. It is commonly agreed that a lack of investment and accountability following deinstitutionalisation has led to a crisis in public confidence because people cannot access the mental health services they need when they need them.

There is a massive under-investment in mental health services – mental health is responsible for 13% of the burden of disease but attracts only 7% of the health budget[1].

Indicators of the crisis are that:

- 20% of the Australian population will experience mental illness[2]. This has a profound affect on the whole community;
- two-thirds of people with a mental illness do not receive any treatment in any twelve month period[3];
- there is unprecedented pressure on all parts of the mental health system, particularly access to acute care beds and access block in hospital emergency departments;
- there is increasing homelessness among people with a mental illness with reports indicating that up to 85% of homeless people have a mental illness;
- rates of suicide for men aged <75 years tripled in the thirty years from 1960-1990[4];
- seclusion and restraint still feature in our mental health system;
- people with mental illness are grossly over-represented in our prisons;
- depression alone accounts for six million full work days lost per year[5];
- less than 30% of people with a disability due to mental illness participate in the workforce[6]. This is less than half the rate of comparable OECD countries.

It is not time for another report. Australia needs a clear and immediate response to this mental health crisis. It is ***Time for Service***.

1 Mathers C, Vos T, Stevenson C, The Burden of Disease and Injury in Australia, Australian Institute of Health and Welfare, Canberra 1999.
2 McLennan W, Mental Health and Wellbeing: profile of adults, Australia 1997, Australian Bureau of Statistics, 1998.
3 McLennan W, Mental Health and Wellbeing: profile of adults, Australia 1997, Australian Bureau of Statistics, 1998.
4 Commonwealth Department of Health Fact Sheet: http://www.aifs.gov.au/ysp/factsheets/factsheet04.pdf
5 Hickie I et al, Investing in Australia's Future, Mental Health Council of Australia, Canberra, 2004
6 Trewin D, Year Book Australia 2003, Australian Bureau of Statistics, Canberra, 2003

Mental illness is a key factor in social exclusion, leading to unemployment, poor housing, poor health and family breakdown. New investment in specific strategies designed to prevent this social exclusion is urgently required to re-integrate people with a mental illness who may otherwise fall through the net.

The priorities for the future mental health system are clear. Australia needs a system which focuses on recovery by providing:

- services designed to prevent mental illness and provide for early intervention once mental illness appears. Current investment is too focused on services for people once they are already acutely unwell;
- services designed to help people live independently in their homes – if this means living with family then there must be support for families and carers as well as support for consumers;
- services to help people with a mental illness so they can complete their education, take up or go back to work and participate in the social life of their community; and
- proper funding for the community services needed to make deinstitutionalisation really work for people with mental illness. This involves a full spectrum of health care services, accommodation options from short to longer term, and rehabilitation, vocational training and education services.

The vast bulk of mental health investment is currently aimed at clinical care, medical improvement and remission of symptoms. While important, this is only part of the picture of an improved mental health system.

The traditional and completely inadequate response of governments to the mental health crisis has been further investment in hospital beds. However, according to a number of unpublished data up to 40% of patients in acute mental health inpatient facilities could be discharged from these facilities if suitable services and supports were available.

A response which focuses on mental health beds, particularly acute care beds, will do nothing to alleviate the crisis. ***Time for Service*** instead calls for a fundamental rebalancing of our mental health system towards services historically and critically underfunded.

Currently, it is common for people to be discharged from hospital having not received adequate clinical care. They are then discharged into the community with little or no support. ***Time for Service*** calls for a massive investment in a range of community-based recovery support services, both clinical and non-clinical, designed to maintain hope in, and a focus on, the person's recovery. The types of services required include sub-acute clinical care, counselling, living skills training, employment assistance, supported accommodation and community inclusion. Investment in these services is a cornerstone of mental health system reform which will promote recovery, and reduce people's dependence on expensive treatment services.

Early intervention is vital, particularly among the young 75% of mental health problems start before the age of 25. It is critical that services are provided early to prevent the problems developing.

If a woman has a breast lump, the person is encouraged to get advice as soon as possible from a doctor to find out if it is cancer. If it's serious, treatment is provided early to get the best result.

In mental health, people are sent away and told to come back only when the lump has spread and when the problem is worse if not overwhelming. Then some services might be provided. This is a dysfunctional system, known to fail in cancer and in heart disease. The whole mindset in mental health must change to early intervention, particularly for young people and those with alcohol and drug problems.

A New Mental Health System for Australia

Progress in mental health cannot be achieved by any one government but depends on a co-operative approach in which quality mental health care relies on a new social coalition of partners; Commonwealth, state and territory governments, the non-government community sector and the private sector (as seen in Figure 1). Quality mental health care is not possible if this interaction is not working well.

This joined-up approach does not mean mental health services must be set up and managed in exactly the same way in each state and territory. Differences and variations must be acknowledged.

It is ***Time for Service*** that meets nationally accepted and consistent standards so that no matter which state you live in, in the country or the city, you can access high quality mental health care.

In this context, who provides the service is far less important than ensuring that high quality services are available. A new mental health system for Australia will be based on more flexibility and the greater involvement of non-government and private sector service providers.

Figure 1

Figure 2 below presents the Mental Health Council's overall conception of the mental health system Australia must build to meet the needs of the future. A central tenet of this new system is that home is the place where most people would prefer to live and receive care.

As the mental health system is currently constructed it is not possible to receive acute care at home and extremely difficult to access any other care.

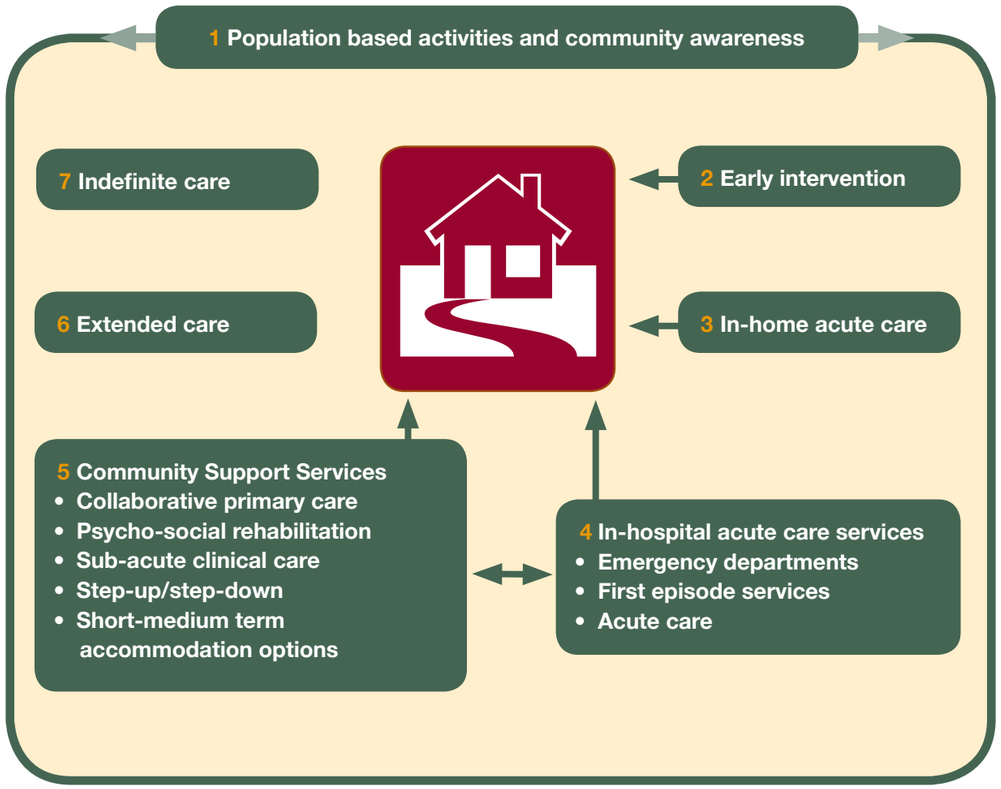
For people with a mental illness to achieve recovery and live successfully at home, independently or with their families (families being broadly defined), they and their families need access to clinical and community support.

Without this support, the burden on parents, spouses, partners and children is great and, in our view, becoming unsustainable. Without this support, independent living for people with mental illness is unrealistic and recovery considerably less likely.

It is ***Time for Service*** which focuses on recovery and makes it easier for consumers and their families to manage mental illness at home.

Figure 2 A New Mental Health System for Australia

Key components to enable independent living at home



Funding Priorities for the New Mental Health System

The Senate Report *Crisis to Community* recommended a massive increase in funding for mental health in Australia of between 50-100% or $1.5-3 billion per annum. To put this in perspective, the Federal Government's recent announcement will see an increase in mental health expenditure of between $200-500 million per annum.

Reform of the mental health system in Australia depends on this investment being properly targeted and properly accounted for across nine key areas:

Prevention and Promotion	**Private Health Sector Initiatives**
Detection and Early Intervention	**Research**
Primary Care	**Workforce**
A Spectrum of Acute and Community Care	**Accountability**
Vocational Rehabilitation and Employment Support	

Within these nine areas are several critical priorities where it is ***Time for Service***:

Priority Service Areas	Estimated Cost p.a.
1. Early Intervention Youth Mental Health Service Program	Yr 1 $300m
	Ongoing $150m
2. First Episode Services	Yr 1 $500m
	Ongoing $300m
3. Initiatives to Promote Collaborative Primary Care	$300m
4.1 Acute Care Outside Hospital	$200m
4.2 Community Supported Recovery Services	$400m
5. Vocational Rehabilitation and Employment Support	$370m
6. Addressing Stigma in the Community	$10m

It is ***Time For Service*** investment in the order of $1.7 – 2 billion per annum[7] for the next five years to meet these priorities, until mental health constitutes 12% of Australia's total health expenditure.

7 In 2006 dollar terms.

Priority 1

Early Intervention Youth Mental Health Service Program

Youth mental health services…at the moment there's no access to services at all – previously there was a six month waiting list – so the notion of early intervention or prevention doesn't exist for this community. *Bunbury Forum, Western Australia, Submission #8, Not For Service, p. 165*

Despite the seriousness of the disorders, there is no philosophical or legal framework supporting a more assertive or early intervention approach, nor the funding capacity to support such a model. Indeed, such an endeavour is still impeded by a residual moral dimension to understanding these disorders. The clinical focus is typically on advanced phases of disorder (even in young people) where treatment can no longer be withheld, yet when it may be much less effective. *Professor Pat McGorry, Victoria, Submission #180, Not For Service, p. 164*

It is ***Time for Service*** for young people with a mental illness.

Mental illness is a problem which affects you when you are young. Around 14% of 12-17 year olds and 27% of 18-25 year olds experience mental illness in any given year. At least one third of young people have had an episode of mental illness by the age of 25 years[8].

This generation is the future of our country – the students, the workforce, the taxpayers and the parents, yet there is almost no investment in services for them. The odds on this group becoming full participants in our society are heavily stacked against them.

The Commonwealth has invested approximately $50m in establishing the National Youth Mental Health Foundation, not to provide services but to establish links between service organisations. These organisations now require funds in order to address this critical service gap.

Time for Service calls for the establishment of 30 Youth Mental Health Services across Australia designed specifically to provide early intervention services for people aged between 12 and 25 years.

These services would link with the Foundation and be located in metropolitan, rural and remote areas. The services offered will have a particular emphasis on the early stages of mental disorder, particularly when problems co-exist with the early stages of substance abuse.

These services could be run by government or non-government providers and would be resourced to engage health professionals and apply the type of service methodology being developed by the Foundation.

A significant issue in mental health, particularly for young people, is poor coordination between drug and alcohol services and mental health services, and that both types of services are poorly funded. Australia needs a new model of drug and alcohol and mental health service that ensures people with complex needs receive proper care from a well resourced cross-disciplinary care team.

Expenditure Required: Yr 1 $300m, then $150m per annum.

8 Making Sense of Orygen Youth Health - http://www.orygen.org.au/docs/INFO/MS%20OYH2(1).pdf

Priority 2

First Episode Services

What is acceptable about refusing to carry out early intervention until the person is 'acutely' unwell, which leads to a very distressing forceful intervention, then having to administer extremely strong dosages of medication which induce obvious physical side effects which take months to subside?... What is acceptable about not keeping people with a mental illness as well as they can possibly be, thus reaching and maintaining their full potential within the illness? *Carer. Mother, Victoria, submission #178, Not For Service p. 47.*

It is ***Time for Service*** for people experiencing their first episode of mental illness.

There is an urgent requirement for services to be re-organised to better meet clinical need. Currently, the services provided to people when they are first admitted are only divided by age (under 18, 18-65 and over 65 years) and are not differentiated from acute admission services provided to people with chronic or recurrent illnesses.

Clear evidence[9] shows that the first episode is the best point at which to provide maximum health, family and vocational interventions to achieve full recovery.

Despite this area of the mental health system being critical, not only are existing services poorly targeted, admissions are rare and far too brief. For people experiencing their first episode, the interaction with the system needs to be thorough and profound. First episode services must offer ongoing interventions lasting up to a year if required.

First episode services can be differentiated by clinical need, including:

- adolescent onset depression and substance abuse;
- first onset psychosis;
- post natal depression;
- impulsive and conduct disorders;
- eating disorders; and
- late onset depression or cognitive impairment.

Each state and territory must commit to reorganising their services to ensure that an adequate number of clinical beds and linked community services are available to meet each of these clinical needs.

The goals of treatment are returning to good health and then returning to school, education and training and/or work. For this group in particular, the mix of clinical and vocational elements is critical. Services for eating disorders are best organised at a regional, rather than local health service area basis.

For first episode services, consideration should be given to purchasing services from the private sector as well as the public sector.

Expenditure Required: Yr 1 $500m, then $300m per annum.

9 P McGorry, Guest Editorial, ***Australian Family Physician***, May 2006

Priority 3

Initiatives to Promote Collaborative Primary Health Care

Another factor in mental health consumers 'missing out' on appropriate services and timely treatment is the user pays system. Many simply cannot afford the cost of luxury 'private' services and many cannot afford the cost of private health insurance. Health insurance is becoming more and more out of reach for the 'average' Australian, let alone someone who tries to exist on a disability support pension. *Clinician, Queensland, Submission #105, Not For Service, p.190*

It is ***Time for Service*** for people needing access to primary mental health care.

Time for Service strongly supports a massive expansion in the role of allied health professionals, particularly psychologists, in providing quality mental health services. However, we must ensure that we don't create a system in which people needing mental health care face large out of pocket expenses for services. This is a real and growing problem with existing fee for service funding models.

Instead, ***Time for Service*** proposes a system where people living right across Australia, from metropolitan, regional, rural and remote areas can access the services they need when they need them.

New and innovative models of funding are required to enable better access to psychology services, and we need this access to be part of a collaborative package of care with GPs, nurses, other allied health professionals, plus non-clinical community support.

One key initiative already in place is the Commonwealth's 'Better Outcomes in Mental Health Care' (BOiMHC) program. But with only 20% of GPs registered to make referrals to psychologists under this initiative, there are severe restrictions on public access to these services.

The Commonwealth must provide funds to facilitate more widespread access to psychology services while maintaining the vital collaborative aspects of the Better Outcomes Program. Better access to services would be achieved by:

- geographically-based multidisciplinary primary mental healthcare teams that could be led by a 'community coordinator' – these could be registered psychologists or other allied health professionals employed through the Divisions of General Practice Network or NGOs;
- funding to enable the employment of psychologists within, or across, GP practices;
- implementation of multidisciplinary education, training and support for GPs, allied health professionals and other relevant community workers;
- the development of enhanced systems of integration between primary care and public mental health systems to improve referral and discharge protocols, shared care arrangements and improved communication flows;
- incentives for practice change by GPs to accommodate new ways of delivering mental health care; and
- real investment in building a better-trained and larger workforce.

Enhanced access to collaborative primary mental health care is particularly important for the at risk groups currently poorly serviced; people living outside metropolitan areas, youth, indigenous people and those with co-existing alcohol or drug problems.

Expenditure Required: $300m per annum.

Priority 4

A Spectrum of Acute and Community Care

There's a real revolving door syndrome – people get admitted, they get treatment and then they get discharged but because there's no supported accommodation for them they keep coming back into the hospital. *Clinician, South Australia, Murray Bridge Forum #5, Not For Service, p. 179*

Time for Service is primarily concerned to move to a more community-based system of mental health because, with appropriate support, the best place for people to receive care is at home.

Initiatives which focus solely on expanding beds, especially acute care beds, will fail to deliver fundamental reform and good outcomes for the community.

Time for Service calls for 40% of spending on the acute care sector to be devoted to acute mental health services provided in the home, not hospitals. New and innovative pathways are needed to provide a choice of effective services to consumers.

If somebody is becoming acutely unwell, the system should deliver acute care first at home. If a person attends the emergency department of a hospital, it should be possible with appropriate support, for the person to return home, avoiding a hospital admission. If admission to an acute ward is unavoidable, again it should be possible to be discharged directly to home to receive ongoing community supported recovery services.

If going home isn't possible straight away, the system should offer this same suite of clinical and non-clinical services plus access to short to medium term accommodation options (step-down care). These same options should be available for people if they become unwell at home but before they become acutely unwell and require hospitalisation (step up care).These community-based clinical and non-clinical services and these pathways do not exist now or are seriously underfunded.

Most acute care services are currently in crisis and often fail to provide good quality care. Most state and territory governments have already committed to further investment in acute hospital beds — ***Time for Service*** does not call for additional funds specifically for acute beds located in hospitals.

It is ***Time for Service*** designed to enable a successful return to home, study and work following an acute episode of mental illness.

This means funding a new spectrum of acute care with the best balance of services, from home-based acute care, through to hospital care, step-up/step down care in the community and longer term care options.

Initiatives which focus solely on expanding beds, especially acute care beds, will fail to deliver fundamental reform and good outcomes for the community.

The cornerstone of ***Time for Service*** is a call for concerted investment in clinical and non-clinical community-based services, particularly services accessible from home. This type of investment is designed to avoid a bed-based mental health system. However, in any mental health system, one part of the spectrum of care required will be mental health beds in health services. As a guide to planning, these beds should be allocated in the following proportions:

Emergency Department Beds	5% of all beds
Intensive Care Hospital Beds	10% of all beds
Acute Care Beds in Hospital (<28 day stay)	30% of all beds
Community Supported Recovery Service Places (up to six months stay, provided as step up/step down care)	30% of all beds
Extended Care Beds (1-2 year stay)	10% of all beds
Indefinite Care Beds	15% of all beds

The CSRS places, as explained later, will only be required where it is not possible to provide the suite of clinical and non-clinical support services at home.

Extended and Indefinite Care

It must be acknowledged that for a group of people with mental illness, the goal of return to home is unlikely to ever be achieved. For a range of reasons and particularly because they have not had access to the type of services called for in ***Time for Service***, these people have lost connection with their families, are homeless or are unlikely to ever be able to live successfully in the community. These people are a critical but small group, often with very high support needs, who must be provided with appropriate services and accommodation.

The mental health system described in Figure 2 indicates the importance of catering for this group. In such cases, extended care and indefinite care options must be available (about 25% of total system beds). There are already successful models and investment in Australia where stable public housing is mixed with clinical and non-clinical support services to substantially improve the quality of life for people with a mental illness.[10]

But the focus of ***Time For Service*** is different and quite clear – it is to put in place services specifically designed so that people stay connected to their home, their job and the people who love and support them. Maintaining and strengthening these crucial social connections should underpin the objectives of all mental health services.

Across the spectrum of acute and community care services, consideration needs to be given to engagement of the private sector in building and servicing appropriate facilities, particularly for certain groups such as mood disorders, eating disorders, post natal depression and psycho-geriatric services. The nature of these disorders increases their suitability for management within voluntary care settings.

4.1 Acute Care Outside Hospital

Clinical services leave clients till they are so unwell that they have to be hospitalised. *Anonymous, Northern Territory, Submission #188, Not For Service, p. 748*

It is ***Time for Service*** for people so they can receive acute mental health care without needing to be admitted to hospital.

Preventing admission to acute hospital care relieves pressure on the emergency care system which is choking.

10 Housing and Accommodation Support Initiative Report 1: Summary http://www.health.nsw.gov.aau/pubs/2005/house_accom.html

It is also associated with better social and vocational outcomes and removes the concern about secondary morbidities and additional trauma that are often a consequence of acute hospitalisation.

Each area health service would need to develop a designated team to provide in-home acute care. Each team would not only provide intensive and multi-disciplinary clinical services such as nurses, doctors, psychology services but also strongly emphasise practical family support services, counselling, interventions and employment support services to enable successful return to work or study. Note that this is not an acute care service for those who are homeless or in poorly supported accommodation, such as hostels.

This style of service has never been routinely provided in Australia despite two decades of evidence of its efficacy[11]. When provided appropriately and properly integrated with other services, this service would not be cheaper than the current cost of hospitalisation but would serve to prevent hospitalisation.

This service will fail unless there is a network of community supported recovery services available to assist both the consumer and their family during and following the acute illness.

Expenditure Required: $200m per annum.

4.2 Community Supported Recovery Services (CSRS)

After exhibiting psychotic behaviour my son spent 21 days (detained) in Glenside Hospital in March 2002. He was counseled and medicated then turned out into the community with some medication but no follow up care. Shortly afterwards he stopped his medication, reverted to his anti-social, aggressive and irrational behaviour, a state he has been in unchecked for two years. *Carer, Mother, South Australia, Submission #11, Not For Service, p. 21*

There is a need for appropriate transitional models of care between hospital and community.

Anonymous, Tasmania, Submission #254, Not For Service, p. 800

It is ***Time for Service*** to give people the care they need to continue their recovery following discharge from an acute hospital. We need a new model of care - the Community Supported Recovery Services (CSRS).

The CSRS model is designed to realise the goal of enabling independent living at home. This goal will fail unless a full range of community services is developed, including primary care, vocational rehabilitation and a range of psycho-social support services designed to help people recover and stay well.

As many as 40% of people currently occupying acute mental health inpatient facilities could be discharged from these facilities if suitable services and supports were available.

The CSRS model of care is about getting the mix right between clinical and non-clinical care. It is sometimes called ‘stepped care’, ‘step-up/step down care’ or ‘transitional care’ – this is a model of care designed to provide additional support following discharge from an acute hospital. All care should be provided at home wherever possible. Where this isn’t possible, accommodation options must be part of the CSRS model of care. The CSRS model should work to prevent hospital admissions

Community Supported Recovery Services work alongside people with a mental illness. These programs are predominantly delivered by the NGO sector to provide essential support to assist people with housing, activities of daily living, social skills, community access, social and recreational activities, counselling and advocacy, financial skills and management, vocational and employment support as well as general and specialist information sharing.

11 G Thornicroft and M Tansella, ***What are the Arguments for Community-based Mental Health Care?***, World Health Organisation, August 2003

Services can be delivered through individually tailored programs or group activities that assist people gain or develop new skills to manage and maintain their mental health and deal with the impact their mental illness has had on their lives. These non-clinical services must work alongside clinical treatment services with the goal of assisting people to live successfully in the community. Some bed based rehabilitation services are essential and useful as part of a rehabilitation continuum, but the prime focus must be on assisting people to develop/ redevelop their skills in as normalised an environment as possible and in a way that assists people to integrate with and reconnect with their community.

Australia's mental health system is not designed to keep people well now. The average length of hospital stay for acute mental illnesses such as schizophrenia is far too brief to initiate real recovery in the course of an acute hospital stay.

At the same time it is estimated that 30% of patients currently on acute care wards in public hospitals are no longer acute and could be cared for at home or elsewhere with appropriate support. Readmission rates to acute hospital care are unacceptably high.

Because the necessary support is not available in the community, acute care beds are blocked and people are commonly discharged from hospital having received insufficient clinical or non-clinical mental health service. Without the necessary follow-up care or support, people can become quickly unwell enough to require further admission to hospital. This is both unacceptable and inefficient - the so-called 'revolving door' in our acute care system.

The CSRS are a critical piece of service infrastructure never systematically funded following deinstitutionalisation. With proper investment in CSRS, it should be possible to receive ongoing step-down clinical and non-clinical services at home following discharge.

Similarly, if an episode of mental illness is commencing, it should be possible to 'step-up' the level of clinical and non-clinical care available minimising the escalation of problems and avoiding hospital admissions.

CSRS are not holding bays or merely supported housing but have a clear focus on recovery, delivering a mix of clinical and non-clinical services to achieve this, including accommodation if necessary.

If care at home isn't possible, the CSRS model of care should also offer stable, short to medium term accommodation options (<6 months) in which this same suite of transitional care, clinical and non-clinical services can be provided. Accommodation options as part of CSRS should also act to increase the availability of acute care beds and thus reduce time spent in emergency departments by patients requiring acute admission.

This type of transitional accommodation option is not a significant feature of Australia's mental health system currently but must become a real option for those still requiring clinical and non-clinical services on discharge from an acute hospital, and where these services cannot be provided at home.

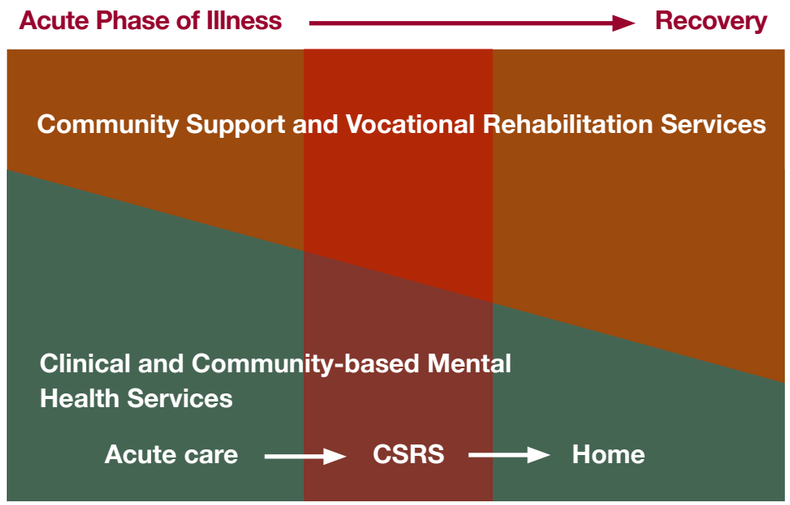
While the CSRS are focused on home-based support, step-up/step-down accommodation options should constitution about 30% of all mental health system beds .

Vocational rehabilitation needs to feature as early as possible in the course of a person's recovery from mental illness. As a person recovers from an acute illness, their requirement for clinical and community mental health services declines while the importance of vocational rehabilitation and community support increases (see Figure 3). The CSRS are designed so that 50% of the budget for each CSRS will be spent on vocational services. CSRS will provide a stable clinical environment in which detailed vocational assessment and relevant education and training can be provided for a period of around six months. CSRS are not designed to provide extended or indefinite care.

CSRS are the crutches you need until the plaster comes off and you can stand on your own two feet.

Figure 3 From acute-care to home care

The role of community supported recovery services (CSRSs)



CSRS can usefully be differentiated to meet the needs of specific groups: those still at school; those with comorbidities; those with children; the elderly etc. This targeting will not only benefit those groups who currently find it difficult to access the services they need, it will also encourage the maximum number of private and NGO providers to be involved in running and managing the CSRS.

A small number of step-up/step-down services already exist in Australia but these have most often become mere extensions of acute care wards providing cheaper care to people with established illnesses.

By contrast, CSRS must have a true recovery focus based on close interaction between clinical and non-clinical services and a range of psycho-social support services. Community services and consumer-operated services can often provide effective peer support and assistance.

Investment in CSRS needs to occur in each state and territory. WA and Victoria have already commenced.

While the bulk of community supported recovery services should be available in the home, in order to facilitate accommodation options, there is a requirement across Australia to commission 1000 step-up/step down CSRS-type places over the next four years with further investment required from 2010.

To develop these CSRS places, it will be necessary to build new stock or re-commission existing community hospital stock. There will be movement of patients from more expensive acute care beds in general hospitals which are estimated to cost as much as $800 per day. By contrast, it is estimated that properly configured CSRS accommodation services would cost in the order of $200 per day. The balance of the CSRS funding is for the community supported recovery services necessary to make this model work. These services would be spread between those provided at, or from home, and those provided as part of short-medium term accommodation solutions.

It is envisaged that CSRS could be run and managed by public, private or non-government organisations.

Estimated Cost: **$330m for community supported recovery services per annum**
$70m for step up/step-down accommodation options
$400m in total

Priority 5

Vocational Rehabilitation and Employment Support

My son has paranoid schizophrenia. He's on new medication and he's the best he has been for 20 years. He wants work but we can't get any help. *Carer, Mother, Ballarat, Melbourne Forum #11, Not For Service p.215.*

Australia is poorly served with employment programs for people with a mental illness and associated disability. Traditional vocational rehabilitation services are far less effective than supported employment. As an example successful employment programs in Trieste in northern Italy report and employment rate of 60 % of people with schizophrenia whereas in Australian 75% of people with schizophrenia are not working and on a disability pension. *Mental Illness Fellowship of Australia, submission #331, Not For Service p.840*

It is ***Time for Service*** for people needing help to get back to work and study following an episode of mental illness.

In 2006, people living with mental illness constitute 26% of people on the Disability Support Pension. An estimated 70% of people living with mental illness want to work. There is an estimated untapped demand of at least 64,000 people currently on the DSP who would be interested in working if there were appropriate employment support services available to them.

The MHCA recognises the significance of employment to good mental health.

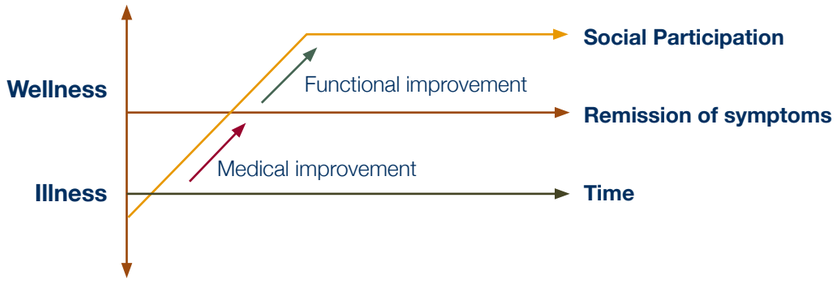
Soon the demand for labour in Australia will outstrip population growth – the baby-boomers will be retiring and Australia will start to not have enough workers[12]. It is critical for the maintenance of living standards that the nation does everything possible to ensure that those who can work are given an opportunity to do so.

Employment support for people with a mental illness is currently managed extremely poorly. Australia's rate of employment for this group is very low at 29% in comparison to similar OECD countries where the rate is up to 60%.

Figure 4 below indicates that the ultimate goal of mental health services is to enable recovery, and social and workforce participation.

Currently, the vast bulk of the investment made in services is aimed only at medical improvement and remission of symptoms. It is ***Time for Service*** geared towards achieving the higher objectives of functional improvement and social participation. This is real recovery.

Figure 4 Good Mental Health is social and workforce participation



12 Ross Gittins, O*ur Next Big Problem Wage Growth*, Sydney Morning Herald, 17 Oct 2005

Properly targeted support programs are required to render assistance to both employers and employees. Pre-vocational funding and support for people with a mental illness has been a key omission from past Commonwealth/State agreements and consequently there are few programs available. Co-operation between governments and with employment service providers is vital for individual vocational goals to be realised.

Perhaps most critically, many Australian employment support programs are designed to operate during the pre-vocational period. There is now very considerable evidence suggesting that efforts would be better placed increasing the level of post-placement vocational support designed to help someone keep their job and advance their career[13].

There are some examples of good practice already operational in Australia but these require more resources and more promotion.

Many employment service providers have identified serious deficiencies in their capacity to provide a comprehensive and effective service to many of their clients with mental illness. Of particular concern is the fragmented nature of these services and the inability of existing arrangements to meet the total needs of these clients.

There is a requirement to develop initiatives to promote enhanced delivery of holistic services which meet the multiple needs of clients.

This includes improved networking between mental health, drug and alcohol, accommodation, youth and employment services. The following are suggestions to enhance vocational rehabilitation options for people recovering from mental illness:

a) development and implementation of a National Mental Health Employment Strategy;

b) review and enhance the existing Disability Open Employment Services to better incorporate the vocational support needs of people with mental illness (acknowledging that 'one size does not fit all'). The model should cater for the episodic nature of illness and support individual vocational capacity building. The mental health sector should be involved in setting the terms of reference for any assessment of the Service;

c) acknowledge good practice in post-placement vocational support programs and provide real resources to maximise the impact of these effective programs. These programs must take into account the episodic nature of mental illness and be flexible enough to provide continuity;

d) establishment of a national work experience program – a current major barrier to the inclusion of people with mental illness in the workforce;

e) establishment of a new Career Advancement Model as part of all government employment support programs to provide work experience opportunities for job seekers with mental illness. This package must include the provision of a national insurance coverage arranged by the Commonwealth;

f) a Mental Health Specialist Job Capacity Assessment (JCA) Service - a standard JCA appointment is not considered adequate to assess mental health issues in job seekers who may be reluctant or fearful to disclose symptoms or who lack the awareness and recognition of their condition;

g) lift the 'cap' on funding for Disability Open Employment Services to better respond to unmet need. Regular reviews of demand in the capped program are critical;

h) remove the cap to increase access to the Personal Support Program (PSP);

13 Waghorn et al. *The employment of people with mental illness*. Australian e-Journal for the Advancement of Mental Health (AeJAMH), Volume 4, Issue 2 (Supplement), 2005

i) develop a comprehensive 'Employer Demand Strategy' (as announced in the 05/06 Federal Budget). The strategy should incorporate the review and enhancement of existing employer incentive programs (including the Supported Wage System, Workplace Modification Scheme, Wage Subsidy Program) to better reflect the specific support needs of people with a mental illness. The mental health sector should be part of this review and regular data on program usage by people with a mental illness should be available to facilitate this review;

j) establish Participation Accounts - PSP providers have been calling for the provision of a participation account to enable them to purchase services for job seekers to overcome their barriers to participation;

k) ensure fees payable to employment service providers properly reflect resource intensity of clients; and

l) remove the 12 month mandatory break between PSP service periods.

Expenditure Required: $370m per annum.

The vast bulk of investment made in services is aimed at medical improvement and remission of symptoms. It is ***Time for Service*** geared towards achieving the higher objectives of functional improvement and social participation. This is real recovery

Other Issues

Addressing Stigma in the Community

Stigma is a big problem in this community – people fear what they don't understand. I've experienced a change in body language of a specialist when they ask you what medications you are on. I've been told by a solicitor not to tell anyone that – sometimes our integrity is questioned just because we have a mental illness – we might be unwell but that doesn't mean we're stupid. *Consumer, New South Wales, Broken Hill Forum #24, Not for Service, p. 250*

It is ***Time for Service*** to end the continuing negative attitudes towards people that experience mental illness and their families.

Raising community awareness of mental health issues must be a key priority for future action on mental health. Research conducted by Curtin University for the WA Healthway Foundation, VicHealth and Queensland Health all point to low levels of mental health literacy in the Australian community.

People have a poor understanding of mental illnesses and what they can do individually and together to reduce the likelihood and impact of mental illness. This lack of community understanding also leaves those that experience mental illness isolated and fearful.

To date, there has not been a broad-based national community education campaign on mental health. Relatively small-scale state or locally based programs have been developed in Victoria and most recently in Western Australia and far North Queensland.

Community campaigns can achieve a number of beneficial outcomes including:

- reducing stigmatisation and discrimination experienced by people with mental illnesses and their families;
- promoting good mental health and preventing the development of mental illness through emphasising strategies to help people stay mentally healthy;
- more early intervention for people with mental illnesses by raising everyone's awareness of the symptoms and where to go for help; and
- promoting appropriate treatment for mental illnesses by raising awareness of various treatment options and how well they work.

Australia needs a national comprehensive mental health campaign - Mentally Healthy Oz – to promote simple strategies to enable people to take control of and improve their mental health.

Expenditure Required: $10m pa

A New Approach to Accountability

It is ***Time for Service*** for the community at large to know the truth about the quality of Australia's mental health system.

A new approach to accountability is required, at all levels – strategic, program, service and individual.

It is strongly recommended that a national accountability mechanism be adopted to report on the implementation of this new approach to mental health in Australia.

The current National Mental Health Plan is largely devoid of specific goals and targets and has failed to deliver good governance of mental health in Australia.

As the Council of Australian Governments' (COAG) Human Capital report acknowledges, the issue of mental health is broader than health and includes a range of other areas such as employment, education, housing, community services amongst others[14].

These services are provided by federal, state and local governments, as well as community and private sector providers. Any accountability mechanism adopted must have the scope to investigate the effectiveness of Australia's mental health system across all these levels.

Independence and transparency are critical to robust accountability. The National Reform Council outlined by COAG at its February meeting may be the most suitable body, at least in the short term, to ensure all governments adhere to agreements and to apply sanctions if necessary. We also note the announcement of the Intergovernmental Action Plans (IAPs) and the Individual Implementation Plans (IIPs). We concur with the COAG Human Capital report which emphasises the requirement for clear outcomes to be articulated, monitored and reported routinely.

Consistent with the recognition that improvements in mental health will be dependent on partnerships beyond governments, ***Time for Service*** advocates that a taskforce be established, comprising governments, consumers, carers, representatives of the general community and the private sector. The taskforce would work in partnership to oversee accountability in the mental health system for at least the next three years. The goal of the taskforce would provide advice to the National Reform Council on the development and progress of the IAPs. Similar taskforces should be established to assist each state and territory set and meet their obligations under their own IIP.

14 *Human Capital Reform*, Report by the COAG National Reform Initiative Working Group, February 2006

10-Year Targets for Mental Health

Time for Service recommends adopting the following ten-year targets for mental health outcomes:

1. 60% of those with mental disorders be provided with care in any 12-month period (currently this figure is 38%);
2. national disability costs attributable to mental disorders be reduced from 27% to 20%;
3. national disability costs among 15-34 year olds attributable to mental disorders be reduced from 60% to 40%;
4. participation in work among those on disability support pensions for psychological reasons be increased from 29% to 60%; and
5. national suicide rates be reduced from 11.8 to 8 per 100,000 persons.

These targets are realistic and achievable provided that governments invest in a community based model of mental health care emphasising prevention and early intervention activities now.

As the Senate Inquiry Report states, a further key element of national accountability must be the regular (annual) and systematic monitoring and reporting of the experiences of those receiving care.

The Mental Health Council of Australia would be the most appropriate body to implement this element of a new accountability framework.

The current National Mental Health Plan is largely devoid of specific goals and targets and has failed to deliver good governance of mental health in Australia..

Our Challenge

The new mental health system for Australia outlined in ***Time for Service*** is designed to help people get well and stay well and reduce demand on acute hospital services. It focuses on early intervention and ensuring that people experiencing their first episode of illness receive high quality, targeted care. This is to avoid the development of chronic mental illness and reduce the burden of disease on the community into the future.

The need for fundamental and coordinated reform of the mental health system is clear. Simple, piecemeal investments in existing systems and services will not end the crisis in mental health and will offer services that are poorly integrated and fail to deliver quality care. There are already big gaps and new services are urgently required to meet increasing demands.

Australia urgently needs systemic changes to its mental health system and these require new ways of thinking and funding.

Reform of mental health services cannot be achieved through a quick fix – it will require a sustained contribution…from both the Commonwealth and the States and Territories to ensure long term fundamental improvements in services for the mentally ill. Together, our investment in mental health will support reform of the system and ensure that it remains sustainable into the future.

John Howard, 5 April 2006

It is ***Time for Service***