MENTAL HEALTH COUNCIL OF AUSTRALIA

NEWSLETTER
APRIL 2010

MENTAL HEALTH COUNCIL OF AUSTRALIA

www.mhca.org.au

Contact:
Ph: (02) 6285 3100
Fax: (02) 6285 2166
Email: admin@mhca.org.au

Promoting the mental health of all Australians

COAG – THE WRONG VEHICLE FOR MENTAL HEALTH REFORM?

David Crosbie
CEO, Mental Health Council of Australia

What a day it was when the Prime Minister released the final National Health and Hospitals Reform Commission (NHHRC) report in July 2009!

In hindsight, there were clear signs of things to come. Health lobbyists, professional and consumer groups from across Australia packed into a lecture room with TV crews and journalists, all eagerly discussing the 123 health reform recommendations developed over more than 12 months of hard work and consultations.

The circus was in town and there was a buzz in the room, an excited anticipation that real health reform could now be a possibility.

Then came the surprise Prime Ministerial announcement that he was going to do his own consultation and visit hospitals across the country so he could talk to people within the hospital system.

The image of Dr Rudd displaying his bedside manner is now familiar to almost every Australian.

As many have pointed out since the hospitals consultation strategy commenced, hospitals are only a small part of what keeps a community healthy. The goal of most health activity is to keep people out of hospitals. In many ways, the higher the hospital admission rates, the worse the rest of the health system is performing. Australia has one of highest hospital admission rates in the world.

Following the launch of the NHHRC final report, the focus of health reform seemed to shift to hospital reform. The early excitement edged towards concern.

The recommendations of the NHHRC were starting to be treated as extraneous - they were about changing the way we respond to health needs and reducing our dependence on hospitals. The NHHRC saw upstream changes as critical to all hospital reform. Dental and mental health care, the two priority areas for reform in the NHHRC final report, faded into the background.

The mental health sector expressed their concerns, publicly pushing for more attention as well as reinforcing the need to look beyond hospitals to achieve real health reform.

In response, the Health Minister suggested that preventative and community health would be attended to over time and through other processes, that there will be new initiatives in the mental health area and that hospital reform was needed to get the foundations right for further action.

In a final pre COAG media appearance the Health Minister said that she was committed to taking over 100% of community mental health. The mental health sector took a collective breath and held on in hope. Maybe real mental health reform was on the cards?

There is no doubt that achieving a national COAG agreement on health reform is a positive for the Rudd Government. Negotiating the tricky politics of state and territory economic and political interests is not a job for the faint hearted. Increased health funding and greater transparency are both good outcomes and will deliver improved health services in the longer term.

Mental health is a part of the final COAG health reform agreement. There are incremental increases in funding for important mental health programs and services. These increases are welcome. The commitment of the Federal Government to become a major player in community mental health is restated in the agreement, but it is not enacted.

For the Federal Government to take on a leadership role in areas like mental health reform involves challenging the current service provision in states and territories. Premiers and Chief Ministers publicly acknowledge the need to improve mental health services. The problem is that states and territories see themselves as the service providers.

In mental health, the service they spend most on is acute hospital based mental health care. Hospitals are under incredible pressure, including pressure from people with a mental illness. It is not surprising that the primary focus of state and territory leaders in any discussion about mental health is how to provide more support for hospital beds and more mental health professionals to service them.

This mantra – we need more funding for hospital based acute mental health beds – is actually a revealing indicator of mental health service system failure.

Through their preoccupation with acute hospital care, states and territories have dropped the ball on mental health. They have largely retreated inside their hospital based walls, reluctant to peer out into a community where carers and mental health consumers struggle from crisis to crisis with little or no semblance of planned care.

In the last 15 years, the number of non acute or community based mental health treatment beds have been halved from 4,500 to 2,200 beds.

The new COAG health reform agreement will establish publicly accountable targets for hospitals including emergency department and elective surgery waiting times. It is difficult to see how these targets will not further force resources into hospitals in the short term and become unsustainable in the long term if there is no work on reducing demand.

How many of the 1300 new sub acute beds funded under the agreement will end up on hospital grounds as de-facto hospital wards, effectively becoming more money into hospitals?

As we begin the discussions about further aspects of health reform, about prevention and primary care, I hope the lessons of the last few months are heeded. We do not want the policy processes around prevention and community care driven by states and territories.

Their primary interest has been clearly revealed through their COAG foot stamping performances: 'give me more money for hospitals, now!' The record of states and territories on preventative health and community health clearly demonstrate their strong bias as acute health service providers.

COAG health agendas are always going to be hospital centric and mostly about money rather than health. It is, therefore, an ill equipped vehicle to drive health reform.

Those of us in the mental health sector now understand that real mental health reform is only going to happen through strong federal leadership, armed with significant investment and informed through external expertise. The same probably applies to other areas of health reform.

Almost a year ago the health sector welcomed the NHHRC final report. The buzz from that event is well and truly gone. The hope for real heath reform remains alive, but it is in very real danger of being buried under a hospital somewhere.

*****

NATIONAL COMPACT CHAMPIONS

Compact Champions are change agents and leaders in their fields. They come from all levels of government, business and across the sector. Through their experiences and interests they share a common desire to improve the wellbeing of Australians. They are also committed to promoting the potential of the National Compact to change the way we work together.

If you would like to be a Compact Champion please email nationalcompact@fahcsia.gov.au

Dr Jeff Harmer AO
Secretary, Department of Families, Housing, Community Services and Indigenous Affairs

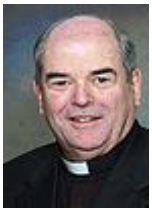
The National Compact offers opportunities to form innovative partnerships between Government and the Third Sector, to tackle the long-term challenges of disadvantage and social exclusion. I encourage all FaHCSIA staff to adopt the Compact principles in their partnerships with the Sector and call on my colleagues across Government to do the same.

Dr Ingrid Burkett
Social Innovations Manager at Foresters Community Finance (Qld);Vice President, International Association for Community Development; Chair, Upatree Arts Co-operative

I am proud to be a champion of the Compact. I see this as a momentous step towards building positive partnerships between the Federal Government and the third sector so that together we can create an inclusive, just and innovative civil society in Australia into the future.

Mr David Crosbie
CEO, Mental Health Council of Australia

At its heart, the National Compact is not just about organisations and governments, but communities and the way we relate to each other. The Compact seeks to strengthen the role of both individuals and organisations in our community that support our connectedness and our inter-dependence. Unfortunately, Australia is a place of increasing isolation, yet our health and wellbeing is grounded in the way we connect with others, the value and meaning in our lives. There is much work to do. It is therefore a great honour to be part of the movement to implement the Compact across Australia. I look forward to contributing to real change in the way we all value and engage with our communities. Through the Compact I hope we will be able to both acknowledge and build on the wonderful work being done every day in Australia to make us a more resilient and inclusive community.



Fr Brian Lucas
General Secretary, Australian Catholic Bishops Conference

Promoting human flourishing is not the work of any one sector of society. The combined resources of government, business, and not-for-profit organisations, when well co-ordinated, and carefully deployed can make a difference to those who might not otherwise be able to share in the goods of our society. A compact between government and the third sector is one means whereby we can articulate and implement a commitment to identifying and supporting those who are marginalised, and enabling all in society to reach their full potential.

Ms Elizabeth Ann Macgregor
Director, Museum of Contemporary Arts

I hope that this compact will strengthen the voice of the arts in partnership with other non-profit organisations and lead to wider recognition of their value. By working together in partnership with government, we can make best use of our pool of talent and resources to nurture a healthy and inclusive society.

Andrew Daly
Executive Director, Royal Society for the Blind of SA (Inc)

Developing a cohesive connection across government, business and the not for profit sectors is a positive step forward in facing the social challenges within our community. The Royal Society for the Blind(RSB) is hopeful that such an initiative will assist in improving the

*****

CENTRELINK DISABILITY ACTION PLAN

Liz Ruck – Policy Officer

On Tuesday the 9 February two MHCA officers attended a consultation on the draft Centrelink Disability Action Plan.

Late in 2009, the MHCA had the opportunity to provide some feedback on Centrelink services through its submission to the Commonwealth Ombudsman's Own Motion Investigation: *Engagement of customers with a mental illness with the social security system*. This submission is available on the MHCA website (www.mhca.org.au). It is understood that the Commonwealth Ombudsman is working with Centrelink on some of the issues raised through the investigation.

Given the dissatisfaction that many mental health consumers and carers have with the services provided by Centrlink, we thought that this would be a good opportunity to talk to Centrelink officers about what they are proposing to include in the plan to address these.

Unfortunately, the draft plan does not seem to have considered issues such as the ways in which many of its clients are disadvantaged by multiple layers of disability and socioeconomic disadvantage and how this necessitates better service coordination and improvements in the way in which Centrelink engages with other service agencies and community organisations to work on improving services for these clients.

Yet we know that there are areas within Centrelink who are grappling with some of these issues. There are anecdotal stories of agencies working well with Centrelink on specific issues and for particular clients. Why wasn't this work reflected in the plan and more importantly, why does there not seem to be attempt made to standardise these processes within Centrelink? Officers who were asked thought this may have something to do with Centrelink not wanting to be held too accountable for specific activities in its Disability Action Plan. Hm…..

For further information on the Centrelink Disability Action Plan contact the Diversity Team diversity@centrelink.gov.au or the National Disability Coordinator on 02 4251 4169 or by TTY on 133677.

*****

SUICIDE AND THE POLICE – WITH A HAPPY ENDING...

Simon Tatz - Director of Communications

Last week I telephoned a regional police station in NSW to thank them for their outstanding care and consideration in dealing with a potential suicide in their district. The officer on the other end of the telephone was stunned. "We don't get many calls thanking us," he spluttered, incredulously. Maybe they should.

My call was prompted by the actions of officers at the station who demonstrated that police can, and often do, deal very professionally and appropriately with sensitive mental health

issues. They showed how vital police are in the frontline of mental health and suicide. The story unfolded this way.

A close female friend of almost 30 years has been struggling with her mental health problems. Sue (name has been changed) is a former drug addict and lives a reasonably isolated life on the North Coast. In the past few years, she's been hospitalised a number of times and, although not a clinician, her condition appears to be deteriorating. Sue's husband cannot cope with her 'episodes' and they are estranged. She has few friends in the region.

Very late on a Sunday night Sue sent an SMS to a few of us – words to the effect of how much she loved us and what great friends we were (past tense) and that it was now time for her to go.

Her message could only be interpreted one way – this was a suicide note.

We desperately tried to contact her, however Sue's only 'connection' to the outside world is a mobile telephone, which was not being answered. Given her history of self harm and other factors, I contacted the local police station and told them the story and asked if an officer could visit to see if she was okay. I didn't know Sue's address or even if she was living there under her maiden or married name. Sometimes, even with close friends, we forget to note the basics. The policeman couldn't have been more helpful. I described the road and together we located the right house.

Shortly afterwards, another officer called me from his patrol car. He was parked outside her house and asked: "What should I expect to find inside?" We talked for about 10 minutes. The officer sounded young, but he wanted to know about Sue and how to approach her. The officer asked pertinent questions and showed genuine concern.

An agonizing half hour later the officer called me to say Sue was fine – drunk, angry and upset, but fine. She had given the policeman "a mouthful" and was very angry. She told him she was drunk and suicidal. Her husband then arrived and by the time the officer left, Sue was alright and being helped.

The officer didn't once say a negative or pejorative word. He didn't seem upset at being abused or berated and to me he sounded as relieved as I was that Sue was alive.

Sue hasn't spoken to me since. She is angry that I called the police and embarrassed at (another) interaction with the local cops.

My friends and I have talked this over and we know that we would take the same action again. Our friend is alive and getting help and she'll forgive us, someday.

We also saw how police respond to situations like this. It is indeed reassuring to know that there are officers out there who are trained and who care.

*****

A SENSE OF COMMUNITY – MENTAL HEALTH CARERS

Linda Rosie – Consumer and Carer Project Officer

The Carer Engagement Project gave rise to more than the annual carer survey and *Adversity to Advocacy*.

A need was expressed at the Carer Engagement workshops for connections with other mental health carers, wherever they were located, and the formation of a wider carer community.

The MHCA began to address this need, in part, by providing an easily accessible fortnightly communication with carers. This Update is a simple effective method to provide a mixed bag of information, news reports, media releases and comment to all mental health carers who request it (including consumer and community organisations and others). The content is directed by the idea of inclusion.

There is something in the Update for everyone: learned articles, media snippets and particularly popular is the new ideas or applications coming from within Australia or overseas. The Update is collated from information that mental health carers may find hard to access. As rural and remote carers can be discouraged from using the internet to access information as their dial-up download capacities become quickly exhausted by image rich, megabit hungry websites, the Update is sent within the body of an email and is attached as a pdf documents (for those who prefer to print and read it off-line). Formatting is kept to a minimum to maintain low kilobytes.

The most recent concept to help create a sense of community is the carer's internet bases discussion Forum. This came about because carers requested a way of talking to each other over the internet. A pilot listserve was set up for about 70 carers. Within a week carers were sinking under the weight of emails from other carers, and within a fortnight the MHCA realised we had to do something to alleviate the flow and the Forum was born.

The computer skills needed to use the Forum have proved a challenge to some of the original carers, but they persist. While the amount of emails received via the listserve was not sustainable, the direct communication was welcomed by carers.

Having to log onto the Forum has made communication less immediate. Some of the original listserve carers have continued to email each other privately and to that extent the short-lived listserve was a success, putting carers in touch with each other for support and information sharing.

The Forum will move from its fledgling beginnings and out of its pilot role when it is made available to all carers via the MHCA website in April this year. While the MHCA is firmly and solidly based in Canberra with no finding for further carer workshop activity or the like, its connections to carers throughout Australia remain strong and supportive. Currently these services are not funded…

*****

WHAT IS MENTAL HEALTH PROMOTION?
A VIEW FROM THE MENTAL HEALTH PROMOTION WORKING GROUP

Sue Thompson – Senior Policy Officer

Mental health is a term that attracts many definitions; one prominent one is that it is often associated with the absence of mental illness. More recently, there has been growing consensus that mental health is not only an individual construct, but that which exists throughout the many layers of society.

Mental health is embedded within social relations and the promotion of mental health therefore functions at many inter-connected levels. Such complexity presents challenges to the creation of meaningful strategies for promoting mental health and also to their evaluation and measurement of outcomes and impact.

In 2001, the World Health Organisation (WHO) defined mental health as:
…a state of well-being in which the individual realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

In other words, mental health is a foundation for well-being, and should not be viewed solely as an absence of illness. Rather, it would be better understood as a state that balances many human factors between the individual and his/her environment such as physical, mental, cultural, spiritual, and other personal factors.

Therefore, to promote mental health one must look at interventions that don't target treatment alone, but rather ties treatment to overall good physical, mental, financial, and social health. Therefore activities to improve health are multi-faceted. They include the prevention of disease, treatment of illness, and the promotion of health. All are quite different activities, yet are all complementary.

The Dual Continuum Model tries to move ideas of health promotion beyond simply categorising people as either mentally healthy or mentally ill. In many cases it is not that simple. Some people experience mental illness episodically and often have periods of recovery and good mental health. Alternatively, a person can experience mental well-being in spite of having a mental illness, or the flip-side, experience poor mental health without having a diagnosis of mental illness.

The Dual Continuum Model therefore provides four possible options that people may experience regarding their mental health.

They are:

1. people with good mental health and not mental illness;

2. people who have symptoms of mental illness but still experience good mental health, i.e. they are coping, have social support, feel empowered, can participate in activities that are important to them, and generally believe to have a good quality of life;

3. people who have symptoms of mental illness as well as experience poor mental health as a result of other factors such as unemployment, poor housing, being homeless, no social support, or low income; and

4. people who experience poor mental health or have difficulty coping as a result of situational factors without having symptoms of mental illness.

This model is designed to demonstrate that a person's mental health can improve regardless of mental illness diagnosis, and is believed to be fundamental in understanding how mental health promotion can be targeted.

With this in mind, the MHCA's Mental Health Promotion Working Group's strategy is to make a positive difference to the mental health and well-being of people living with mental illness, and its primary focus is on the promotion of mental health and not just the treatment of mental health problems.

*****

NEW DATABASE FOR THE MHCA

The Mental Health Council of Australia has recently implemented a new database to support a variety of our internal and external activities.

ChilliDB is a web-based product, designed for organisations including agencies, NGO's, not-for-profits, community services organisations, associations and peak bodies.

With the help of ChilliDB, MHCA now has its information in a uniform format and in a central location which is already proving to have many benefits.

One benefit includes the simplicity of recording and monitoring attendees of the upcoming Grace Groom Memorial Lecture. Once an Event is created, both individuals and organisations can be entered as 'registered' and from there you can easily monitor who attended, no-shows, cancellations etc. as well as who has paid and who has not.

The database also allows you to link individuals to an organisation as a staff member or as a general contact for the organisation, which is very helpful when searching for certain contacts such as the delegate or chair.

Another helpful feature is the performance reporting tool which allows the user to create reports from data that they import (via word, excel etc). Other great features include a survey creating tool and a name badge creator.

Staff recently completed a training session with a ChilliDB consultant and are now ready to start using the database!

For more information, see ChilliDB's announcement of MHCA choosing them as their database provider:
http://www.chillidb.com/PressreleaseMentalHealthCouncilofAUSFeb2010.aspx

*****

MHCA CHAIR'S REPORT

All members have now been emailed the latest MHCA Chair's report containing various important items. If your organisation did not receive this email, or details within your organisation have changed, please email Natalie (natalie.soar@mhca.org.au) with your name, email address/s and position (contact person, delegate, CEO or chair/president) in order for you to receive important items in the future.

Please be reminded that whilst we make every attempt to deliver information to all of our members, we are only able to do this if we are updated with the correct contact details.

*****

DISABILITY EMPLOYMENT SERVICES – JOB IN JEOPARDY ASSISTANCE

Most people know or have heard about the help that is available for people wanting assistance to find a job - but what about if you need help to keep your job? Ever heard of Job in Jeopardy assistance?

So what is Job in Jeopardy assistance?

Job in Jeopardy is help that is available to people who are at risk of losing their employment as a direct result of their disability. Often it's not until you've been in employment for a while that your disability might start to impact on your work.

This can happen for any number of reasons – and in many cases the job can fall over as a result. Employers might not know how to help, or may not even be aware that there is a reason for what is happening. Individuals can be worried about what it might mean if they disclose their disability or mental illness, or perhaps might not have supports in their lives that can help with work.

Job in Jeopardy assistance is specialist support through Disability Employment Services that can help you manage the impact your disability or mental illness is having on your employment - and keep you in your job. And it's a free service.

It is important to note that Job in Jeopardy assistance can provide with help that includes your employer – or if you don't want to disclose your disability, the support can be provided off the job.

Who is eligible?

To be eligible for Job in Jeopardy assistance you need to have been working in paid employment for at least 3 months for an average of 8 hours a week. In addition you must be at risk of losing your job because of your disability or mental illness (and not for any other reason).

Employers can also access Job in Jeopardy assistance as long as their employee fits the above eligibility.

How do I access Job in Jeopardy?

Accessing Job in Jeopardy assistance is easy – you just need to approach your local Disability Employment Service (DES) provider and they will be able to directly register you with their service. No Job Capacity Assessment is needed to access Job in Jeopardy. And to make things even simpler - all DES providers provide Job in Jeopardy assistance – and with no cap on the DES program can access help as soon as you need it.

If you don't know who is providing Disability Employment Services in your area you can go to http://jobsearch.gov.au/Provider/providersearch.aspx and search for providers.

Further Information

If you require any further information please don't hesitate to contact Bec Jackson, Industry Development Officer at ACE National Network Inc on 03 8676 0353 or at bec.jackson@acenational.org.au

Case Study

Anna has an anxiety disorder. It has been treated and stable for the last 12 months. She has been working with her employer for 9 months and things were going really well. Anna enjoyed the routine of her job and was able to manage her anxiety while at work. However, Anna's job description changed when a co worker resigned suddenly and she is finding it hard to manage. Anna hasn't disclosed her anxiety disorder to her employer and doesn't know how to approach it. Her anxiety is now impacting on her work – and her ability to deal with customers. Her employer has received a number of complaints about her attitude and has let Anna know if things don't improve she will need to look for another job. Anna knows that it is not really her attitude but her anxiety that is being seen as a bad attitude that is the problem. She doesn't want to lose her job but is anxious about what will happen once she tells her employer what is really happening.

Anna is eligible for Job in Jeopardy assistance. She goes to see her local Disability Employment Service (DES) provider to see what help they may be able to provide.

With the help of her DES employment consultant, Anna is able to put a plan into place to talk to her employer about anxiety disorder. They organise a time to meet with Anna's boss, explain her anxiety and the impact that it is having on her position, and put some supports in place to assist Ann when she is finding it difficult – like allowing her to take a break in a quiet office when she feels anxious. They also discuss the level of disclosure with her co workers and Anna is comfortable with her direct management team knowing. Her employment consultant is also able to arrange for some disability awareness training for the management at Anna's office.

With the ongoing support of her employment consultant and her employer Anna is able to manage her anxiety at work and continue in her position.

*****

MENTAL HEALTH INPUT TO PBAC DECISIONS

Consumers and others are invited to provide input to the Pharmaceutical Benefits Advisory Council (PBAC) to consider in its deliberations about funding for new medicines under the Pharmaceutical Benefits Scheme (PBS).

This can be done through an online feedback form at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PBAC_online_submission_form.

The July 2010 PBAC meeting information will be online at: http://www.health.gov.au/internet/main/publishing.nsf/Content/PBAC-Meeting-Agenda-and-Consumer-Comments-lp from 26 May 2010, with comments on the agenda items due by 9 June 2010.

It is unclear at this point if there will be any mental illness-specific medicines on the agenda for this meeting, so if you are interested keep an eye on this website.

More information about PBAC, its membership and process is also available at the above website.

Consumers Health Forum of Australia (CHF) consultation on community pharmacy and members policy forum

In February 2010, MHCA Deputy CEO Melanie Cantwell attended the CHF consumer consultation on the Fifth Community Pharmacy Agreement and CHF members' policy forum.

Discussion at the event focused on consumer dissatisfaction with many of the services pharmacies are already funded to deliver. Participants noted that many individuals pharmacists deliver excellent and supportive community care, however there was concern that the Pharmacy Guild, which advocates for the benefits of its' member pharmacy owners, should not be the only entity involved in negotiating community pharmacy services with government.

An excellent summary of the key consumer issues can be found at http://www.chf.org.au/pdfs/cns/cns-593-Fifth-CPA-implementation-discussion-paper.pdf and CHF is also open to further input on this paper.

Therapeutic Goods Administration (TGA) National Manager Dr Rohan Hammett also presented at the session, outlining what the TGA is doing to enhance information provision to consumers about medicines regulation.

Australian Public Assessment Reports (AusPARs) are now available post-evaluation for new prescription medicines. This is an enormous step forward for the TGA, who have negotiated with industry for many years to achieve this.

More information is available at http://www.tga.gov.au/pmeds/auspar.htm

LIST OF RECENT SUBMISSIONS FROM THE MHCA AND THE NMHCCF

The following submissions are available on the MHCA website www.mhca.org.au:

April 2010 National Quality Framework to support quality services for people experiencing homelessness.

April 2010 MHCA submission to the Senate Inquiry into Consumer Access to Pharmaceutical benefits

March 2010 Response to the Draft Report of the Scoping Study to Inform the Establishment of a New Peak National Mental Health Consumer Organisation A Joint submission with the NMHCCF

March 2010 Response from the NMHCCF and the MHCA to the consultation on Recovery Principles A Joint submission with the NMHCCF

The following submissions are now available on the NMHCCF website www.nmhccf.org.au:

March 2010 Joint NMHCCF & MHCA response to the Draft Report of the Scoping Study to Inform the Establishment of a New Peak National Mental Health Consumer Organisation (March 2010)

March 2010 NMHCCF comment on the Consultation Draft - Diversion and support of offenders with a mental illness: guidelines for best practice (2010)

March 2010 Response from the NMHCCF and the MHCA to the consultation on Recovery Principles