MENTAL HEALTH COUNCIL OF AUSTRALIA

NEWSLETTER
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Promoting the mental health of all Australians

Starting at the MHCA …

By Frank Quinlan, MHCA CEO

It certainly has been an exciting time to come to the Mental Health Council of Australia as its new CEO.

I have now been with the MHCA for just over 8 weeks now, and it is hard to imagine that mental health could have received any more attention in that time. The announcement of the Commonwealth Government's budget initiatives set the agenda not just for those few short weeks, but perhaps for the next couple of years as the sector seeks to implement what has been announced and sets about to argue for the future investment that will be also required.

While the merits of various initiatives that were included in the budget, and the cost of leaving various initiatives out of the budget, will be debated for some time yet, I do not intend to conduct that debate here. Rather, I would ask the question (particularly as a relative new-comer to the mental health sector per se) "How was it that mental health came to lead a Commonwealth Budget?"

I suspect the most important factor leading up to the budget was the fact that mental health is an area of real need that is recognised by so many in the community. While it is certainly true that various research and reports helped to illustrate the nature of that need, the fact that those reports were read against a backdrop of community awareness is a significant factor.

In addition to the organisations that documented community need, and the failure of many systems of support, it also seems true that vigorous public advocacy played a role in the lead up to the budget. High profile voices, including the voice of Australian of the Year Professor Pat McGorry, helped to build a momentum for change that culminated in resources for new initiatives. Once again, it is hard to escape the conclusion that the fact that these public voices were speaking against a backdrop of widespread community concern was an important factor.

Finally, the build up to the budget occurred in a political climate that saw substantial cross-party support for a significant investment in mental health initiatives. While there will always be debate about the relative merits of the initiatives proposed, the facts were that the Coalition announced a very substantial initiative from opposition and the Greens had also flagged the high priority they saw for mental health.

So what does all this say about the future? I think the challenge for the mental health sector will be to ensure that the initiatives from the budget are implemented in such a way as to maximise effectiveness, and to minimise waste. To a certain extent, the risk has now been shifted to the sector.

If the sector is even perceived to have failed in implementation, then the substantial public and political support of recent years could evaporate quickly. While I am not suggesting that this is fair, I do think it is the challenge that we face.

The greatest challenge of the months ahead will be finding ways to ensure greater service coordination and linkage. In this regard, we might expect non-government agencies and services to have a greater flexibility and creativity than is sometimes possible from within government. NGOs have traditionally identified innovation and flexibility as a core value. Notwithstanding goodwill on the part of government, portfolio driven initiatives seldom give rise to new and creative ways of working across portfolios. (While there are some signs that this is changing in government, the scale of change means that the timetable will inevitably be slow.)

At a time of such great challenges, the Mental Health Council of Australia seems well placed to be a facilitator of change. The diverse membership of Council represents a vast pool of expertise and commitment. The challenge of the weeks and months and years ahead will be for us to harness that diverse expertise to create lasting improvements in mental health services and programs.

If we fail to rise to this challenge, we may well put at risk the public and political support that underpinned the recent budget announcements. If we are successful, we will be well placed to go to future budget processes with convincing arguments for further investment, and the public support to make that investment politically attractive.

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Grace Groom Memorial Oration 2011

The 5th annual Grace Groom Memorial Oration was held at the National Press Club in Canberra on 2 June 2011.

The MHCA Board initiated this annual oration series as a tribute to former CEO Grace Groom. To honour her legacy, the Board wanted to create a special oration which would further the debate and understanding of mental health in Australia.

The first oration, in 2007, was delivered by Professor Ian Hickie, who had known and worked with Grace Groom for many years. In 2008, the Health Minister Nicola Roxon delivered her first major speech on mental health at the Grace Groom oration. In 2009 the guest orator was former Western Australian Premier, Professor Geoff Gallop. In 2010, the special guest was Professor Pat McGorry, the Australian of the Year.

In 2011, the MHCA invited Mr Craig Hamilton to present the annual oration.

Craig Hamilton started his career as ABC radio's 'Sideline eye' on weekend Rugby League broadcasts. Since then he has been a member of the ABC team working on the past 16 Grand Finals, every State of Origin series and a number of Test Matches.

Craig was born and raised in the Hunter Valley town of Singleton and spent 16 years working as an underground coalminer in the Newcastle area before embarking on a radio career fulltime in 1999. He represented both the Newcastle and NSW Country cricket teams, with a career highlight being selected to play against the touring Sri Lankan side in 1990.

In 2000, on the eve of the Sydney Olympic Games, where he had been assigned to work as a broadcaster, Craig experienced a psychotic episode and was diagnosed with bipolar disorder. He spent 12 days in hospital and, since his recovery, has become an Ambassador for *beyondblue*, worked as an advocate for mental health issues, and has addressed many conferences, community forums, high school mental health sessions and lobbied government representatives for increased funding to support people and their families who have experienced depressive illness.

In 2004 Random House released his highly acclaimed memoir "Broken Open" which gives a very personal account of living with Bipolar Disorder.

Craig is a much sought after speaker around Australia and he brought to the Grace Groom oration series a very different personal story about what it's like to battle a serious illness.

Craig talked openly, and with great humour and insightfulness about his lived experience, his recovery and resilience. It was a moving and engaging presentation and the feedback from consumers, carers and stakeholders was overwhelmingly positive.

The 2011 Grace Groom Oration proved to be another very successful fundraiser and luncheon. Over 140 guests attended, filling 18 tables at the National Press Club, the 5th year in a row we have filled the venue

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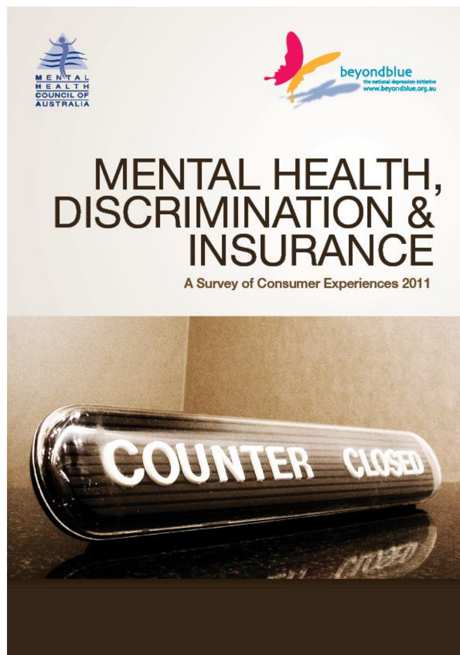
Launch of Mental Health, Discrimination and Insurance: A Survey of Consumer Experiences 2011

By Kate Judd, Policy/Project Officer



Last month at the Grace Groom Memorial Oration, the new MHCA/*beyondblue* publication entitled *Mental Health, Discrimination and Insurance: A Survey of Consumer Experiences 2011* was launched by Australian Greens Senator, Rachel Siewert.

The survey was the first of its kind in Australia and the results revealed that people who have mental health conditions experience significant difficulty and discrimination when applying for insurance products and making claims against their policies. Over 35 per cent of respondents strongly agreed that it was difficult for them to obtain any type of insurance due to them having experienced mental illness. This almost doubled, increasing to 67 per cent for life and income protection insurance. Forty-five per cent of people indicated their application for income protection insurance was declined due to mental illness, while 50 per cent received their insurance products with either increased premiums or exclusions specifically for mental illness.

This report will inform the continuing work of the MHCA and *beyondblue* to improve insurance outcomes for Australian's with experience of mental illness. Both the MHCA and *beyondblue* are looking forward to continued collaboration between the mental health and insurance and financial services sectors on this very important issue.

Electronic copies of the report are available for download on the MHCA website. If you would like a hardcopy of the report, please send your details through to our Mental Health and Insurance Project Manager, Kate Judd at kate.judd@mhca.org.au.

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Senate Inquiry into Mental Health

In June 2011, the Senate passed a notice of motion to hold an inquiry into aspects of the Government's proposed mental health changes announced in the May 2011 Budget. Here are the Terms of Reference and submission details.

Commonwealth Funding and Administration of Mental Health Services

Terms of Reference

Senator Fierravanti-Wells, also on behalf of Senator Siewert, amended business of the Senate notice of motion no. 1 by leave and, pursuant to notice of motion not objected to as a formal motion, moved—That the following matter be referred to the Community Affairs References Committee for inquiry and report by 16 August 2011: The Government's funding and administration of mental health services in Australia, with particular reference to:

(a) the Government's 2011-12 Budget changes relating to mental health;

(b) changes to the Better Access Initiative, including:

(i) the rationalisation of general practitioner (GP) mental health services,

(ii) the rationalisation of allied health treatment sessions,

(iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and

(iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;

(c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;

(d) services available for people with severe mental illness and the coordination of those services;

(e) mental health workforce issues, including:

(i) the two-tiered Medicare rebate system for psychologists,

(ii) workforce qualifications and training of psychologists, and

(iii) workforce shortages;

(f) the adequacy of mental health funding and services for disadvantaged groups, including:

(i) culturally and linguistically diverse communities,

(ii) Indigenous communities, and

(iii) people with disabilities;

(g) the delivery of a national mental health commission; and

(h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and

(j) any other related matter.

For further information, contact:
Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
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Phone: +61 2 6277 3515
Fax: +61 2 6277 5829</
Email: community.affairs.sen@aph.gov.au</

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Trying to change attitudes towards mental illness - that's mental!

By Simon Tatz, Director of Communications

Research by the Canadian Medical Association has found that after more than 50 years of anti-stigma campaigns, people with mental illness continue to suffer from what the *Vancouver Sun* calls "a stigma so intense that it is often worse than the illness itself."

Australia is the only English speaking OECD country that does not have a nationally funded mental health anti-stigma campaign. In the recent Federal budget, there was no specific allocation for an anti-stigma campaign.

New Zealand, by contrast, has a well funded and effective campaign (*Like Minds*) which has made significant inroads in reducing stigma and negative attitudes.

The difficulty with broad anti-stigma campaigns, as with most campaigns aimed at changing public behaviour and attitudes, is that what works for the target group does not necessarily work for others. The Canadian research found that the most effective campaigns are small, targeted to a specific audience and designed to address specific attitudes.

For the mental health sector, this is complicated by what words we use to describe mental illness. There are hundreds of different mental health disorders, from depression, anxiety, eating and mood disorders to bi-polar disorders and schizophrenia.

The age group where the incidence of mental illness is greatest in people aged 18-24 years. Yet young people are the least likely to seek help. Less than a quarter of young people with a mental illness use mental health services, and stigma is a significant factor in why young people do not seek help.

A campaign to reduce the stigma of mental illness needs to target this cohort as a primary target, yet not offend or disenfranchise others. *beyondblue* and SANE have created very powerful adverting campaigns that arguably have made a significant difference in reducing stigma and raising awareness.

What words do we use to target particular groups?

Within specific (target) groups, there are words and phrases used by 'insiders' to describe themselves – words and phrases that create enormous offense when used by others/outsiders.

If you have seen Chris Lilley's *Angry Boys* on ABC TV you'd recognise the issues about what is offensive and what is 'edgy' and biting. There's a brilliant review of Angry Boys (www.brisbanetimes.com.au/opinion/society-and-culture/safe-australian-comedy-needs-edginess-of-angry-boys-20110514-1enhs.html) which argues that Australian comedians "don't send a confronting social message", rather they play it safe and are unwilling to be threatening or tackle uncomfortable issues.

Comedy and 'cutting through' to get a message across is complex and there is no manual or guidebook that we all adhere to. What was once acceptable is now highly offensive, and in years to come who knows what words and expressions will have different connotations and meanings.

Adding to this is the debate about 'reclaiming' words, that is, groups who have been victims of stigmatisation and abuse through the use of particular words seek to 'reclaim' them. Recently there was the controversial 'slutwalk' where women sought to reclaim the word 'slut' is the same way the LBGTI community seek to reclaim the word 'queer.'

An obvious example is the way some African Americans may refer to themselves as ‘nigger’. Used by white people, this is a most vile and offensive term of abuse; yet anyone who has watched *The Wire* or listened to rap music will understand how it is used within a milieu as a term of inclusion and acceptance.

Where we draw the line changes with our values and norms. Recently there has been a move to change the texts of some classic American novels to remove the word ‘nigger’, including from Mark Twain’s *Huckleberry Finn*.

Another example is homophobia and bullying. Some gay people may proudly call themselves ‘poof’ or ‘dyke’, but that doesn’t make these acceptable words to use. Likewise, in the mental health community, I’ve met consumers who have referred to themselves as ‘mad’ or said things that an outsider has a right to use.

In this context, an advertising creative working with the MHCA devised a series of anti-stigma adverts, one of which used the lines:

Mental disorders affect one young Australian in four. Having them ... that’s no big deal. Ignoring them ... that’s mental!

The word ‘mental’ means something different to the younger generation. According to Wikipedia, mental is “a slang, pejorative term used to describe people who act like lunatics.” Other dictionaries say “informal, slightly daft; out of one's mind; crazy: *He's mental.”*

I showed this advert to some young mental health consumers and they loved it. ‘That’s mental’, they said, is how we speak. They related to it. As mental illness is a condition that primarily affects young people, then why shouldn’t we use the language they connect with?

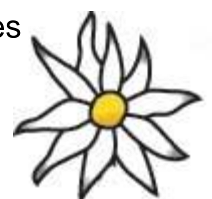
For older mental health consumers, carers and advocates, saying someone who has a mental health problem is ‘mental’ for not seeking help came across as offensive and actually entrenching stigmatisation. Using ‘mental’ in this way was likened to the way some people use the word ‘gay’ to describe something deemed weak or lame.

As the *ThinkB4youspeak* organisation highlights, the use of words like ‘gay’ and ‘fag’ in American schools is a particularly nasty form of bullying that has resulted in suicide, assault and harassment of lesbian, gay, bisexual and transgender people.

So how do we target young people and create a message that resonates and has impact if we don’t use the language they use and respond to?

There is a valid criticism of campaigns designed to change attitudes that they are often safe, soapy and pull their punches. Anti-smoking ads are the exception. Yet decades of drink driving ads haven’t stopped drivers getting behind the wheel when over the limit.

The *Life Be In It* campaign was hardly a success either - our national obesity rates are among the highest in the world.



The answer may be in having small, targeted campaigns designed for niche groups. It's been put to me that if telling a 20 year old bloke 'you're mental' for not seeking help works, then we should use that in the media and environments they respond to. It's hard and edgy and may make them seek professional help.

I'm not so sure.

Even if it works, I'm inclined to take the doctors approach and cause the least possible harm. Later this year you may see World Mental Health Day ads on billboards and TV. They will be edgy and designed to attract the attention of young people, but they won't offend anyone by using words or expressions that entrench stigma.

To see the MHCA's WMHD ads, visit: **1010.org.au**

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National Disability Insurance Scheme – the Productivity Commission Inquiry into Disability Care and Support

By Liz Ruck, Policy Officer

With a small funding grant from the Department of Families, Housing, Community Services and Indigenous Affairs, (FAHCSIA), both the MHCA and the NMHCCF were able to dedicate a Policy Officer to work with members and to develop submissions to the *Productivity Commission Inquiry into Disability Care and Support*. This Inquiry was set up in May 2010 to provide advice to FAHCSIA on the costs, cost effectiveness, benefits, and feasibility of a long term disability care and support scheme for Australians with disabilities and their carers. The Inquiry was also asked to examine a social insurance model funder a National Disability Insurance Scheme.

In November 2010, Bruce Bonyhady, Chair of Yooralla Disability Services and champion of the NDIS, made a presentation to the MHCA *Members Policy Forum* on the Inquiry. He advised how the proposed NDIS would use a self directed funding approach by which consumers and carers with disabilities would be able to choose to manage their own funds for disability support services, directing their own spending choices and ultimately determining the scope of services provided.

In August 2010 the MHCA and the NMHCCF made a joint submission to the Commission supporting the inclusion of mental health consumers and carers with a severe and persistent mental illness in the NDIS.

The Productivity Commission released its *Draft Report Disability Care and Support* on 28 February 2011, seeking clarification on the "*boundaries between the mental health sector and the NDIS"* (page 3.29*, Productivity Commission Draft Report on Disability Care and Support*).

In response to the Inquiry, the NMHCCF developed a *Position Statement on Psychosocial Disability Associated with Mental Health Conditions* as the basis of its final submission. The Position Statement explores the role of disability in mental health conditions, defines psychosocial disability and highlights that the psychosocial disability support needs of people with mental health conditions have been ignored for too long. It advises that the mental health system is not designed to provide disability support, nor has it been able to initiate the strategic development of mechanisms to address psychosocial disability support needs despite nearly three decades of national documentation calling for urgent reform in this area. The NMHCCF proposes that provision for psychosocial disability support needs must be included in any long term disability care and support scheme.

The NMHCCF believes that the Position Statement will be an important reference for mental health consumers and carers, policy makers and service providers in the mental health and disability sectors and in the broader community. They propose that it will assist policy makers to focus on the strategic provision of appropriate community based disability supports for mental health consumers and carers with a psychosocial disability and that this should be a key action for any long term disability support scheme.

The MHCA submission also recommends that disability supports for people with a psychosocial disability should be provided under an NDIS. This must include provision to ensure that service providers are able to maintain the provision of high quality support services under the scheme and that its services are integrated with those of mental health service provision.

The MHCA has met with the Productivity Commissioners several times to discuss the challenges that they face when considering the eligibility of people with psychosocial disability in the NDIS. These have included:

- lack of evidence and statistical information that can identify and quantify psychosocial disability support
- the cost of supporting psychosocial disability threatening the viability of the scheme
- proposals that
    - the mental health system has the most appropriate skills to provide disability supports for people with mental health conditions
    - community based disability services for people with mental health conditions are already being provided by the mental health system
    - the newly announced budget initiatives in mental health would make the inclusion of people with psychosocial disability in an NDIS unnecessary.

The MHCA is currently in discussion with the Productivity Commission, who are scheduled to report on 31 July 2011.

The NMHCCF submission and Position Statement is available on the NMHCCF website: http://www.nmhccf.org.au/submissions or by contacting Kylie Wake, NMHCCF Executive Officer on 02 6285 3100 or kylie.wake@mhca.org.au.

The MHCA submission is available on the MHCA website: http://www.mhca.org.au/submissions.

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Challenge for policy on mental illness

BY FRANK QUINLAN

This article appeared in the Canberra Times on 12 July 2011

Drawing on Martin Luther King, the Assistant Treasurer Bill Shorten told a recent gathering of disability advocates that:

> "This nation has written a cheque, it has issued a promissory note, to people with disabilities and their carers for a very long time. It is now time, in a nation that is as wealthy and as clever and as generous as Australia, it is time that cheque is honoured."

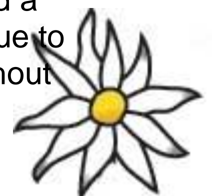
Shorten was referring to the establishment of a National Disability Insurance Scheme (NDIS). His speech was justifiably rich with lofty ideals; his advocacy for the NDIS both within the community and within government has left no doubt regarding his personal commitment to achieving lasting and substantial change in the lives of people with disabilities and their carers.

As disability advocates, carers and people with disabilities eagerly await the Productivity Commission's final report into the feasibility and structure of a National Disability Insurance Scheme, the difficult task of translating these ideals and aspirations into reality means that hard decisions will have to be made.
As the Presiding Commissioner, Patricia Scott indicated during the Productivity Commission's hearings:

> The broader and broader and broader the number of people to which assistance has to be provided, to be frank, the less feasible it becomes.

Fairness and universality are core ideals of a National Disability Insurance Scheme. To be fair and universal, all people with a similar level of disability ought to be afforded a similar level of support.

Historically, this has not been the case. For example, some people who acquired a brain injury were covered by road accident insurance or had access to support due to successful claims of medical negligence; whereas others with similar injuries without insurance or resources of their own had little or no support.



Part of the rationale for a universal insurance scheme rests on the principle that the cause of disability is irrelevant to the needs of the person experiencing the disability.

It is a harsh reality however, that in order to be sustainable, such a scheme will have to rule some people in and others out.

In this context, consideration of how disability related to mental illness will be dealt with by the National Disability Insurance Scheme becomes critical. While many people can experience a mental illness that is at the mild end of the spectrum, and has minimal impact on other areas of their life, some people's experience of mental illness leads to significant psychosocial disability.

The World Health Organisation recognises psychosocial disability as the interaction of long-term physical, mental, intellectual or sensory impairments, and attitudinal or environmental barriers that hinder full and effective participation in society on an equal basis with others.

Such a definition potentially places a far broader safety net under those whose participation in society is constrained as a consequence of mental illness, and this is a genuine challenge for the Productivity Commission and for the Government.

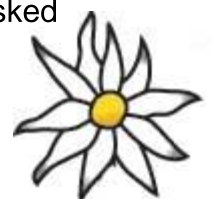
The inability to establish and maintain relationships, to take medications and maintain personal health and hygiene, to prepare meals and manage a household is debilitating whether it arises from an acquired brain injury or from a mental illness. The effect on the individual is the same. The challenge for policy makers will be to identify robust and objective measures of functional impairment rather than simply basing eligibility for support under a National Disability Insurance Scheme on a list of diagnoses.

The Productivity Commission will not need to venture far into studies of stigma, homelessness, employment, and specific mental disorders to determine that the long-term cost of psychosocial disability is likely to justify a very high expenditure on early intervention and support.

The Productivity Commission's draft report made some provision for the daily support costs associated with severe and enduring mental illness to be addressed by a National Disability Insurance Scheme. The fear in the sector is that those with "milder" or more episodic mental illness, who never-the-less experience severe or lasting psychosocial disability may be ineligible to qualify for the very scheme that had its genesis in the principles of universality and fairness.

Shorten exhorted his audience to persistent and strident advocacy, because, as he put it "the door to great change is ajar. It just needs more pushing by more people to open the door."

Time will soon tell whether those experiencing disability due to mental illness will be invited to cross the threshold, or whether they will passed another cheque and asked to wait outside.



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National Register and National Mental Health Consumer & Carer Forum (NMHCCF) 2011 Workshop

By Kylie Wake, Executive Officer NMHCCF and national Register

The fourth annual training workshop for National Register and NMHCCF representatives was held on 5 & 6 May in Melbourne. Over the two days, sixty members representing all states and territories, discussed a broad range of issues affecting mental health consumers and carers across Australia.

While many positive mental health reforms and initiatives were discussed, the workshop participants identified key themes for action, including:

- Providing mental health consumers and carers, at all levels of government, with a genuine voice in decision making related to mental health reforms and their implementation.
- Ensuring that mental health reforms are from a whole of government perspective and are not relegated to an improved health/medical response alone. Areas for particular attention include improved access to education and employment, housing, family services and other community support
- Advocating for linked-up approaches to mental health recovery and recognition of the specific needs of individual consumers and carers depending on their specific circumstances.
- Expanding and mainstreaming workplace programs aimed at staff better recognising and supporting colleagues dealing with mental illness.
- Requiring the media to present balanced and informed coverage of mental health issues.

The workshop also included a keynote address from 2011 Australian of the Year, Simon McKeon, and sessions on being effective on national committees, self-leadership, political lobbying, self-care, and the risks of over-extending when undertaking advocacy work. Members reiterated the need to support each other, including via mentoring schemes and other peer support models.

It was agreed that the Federal budget provided a unique opportunity for mental health reform, however a lot of hard work would lie ahead in ensuring the funding was directed to areas most likely to improve outcomes for mental health consumers and carers across Australia, including those in rural and regional areas.

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