Mental Health Council of Australia Submission to:
Standing Committee on Finance and Public Administration
(References) Inquiry into the Council of Australian Governments
Reforms relating to Health and Hospitals
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Introduction
The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health service consumers, carers, special needs groups, clinical service providers, community and private mental health.

The MHCA is extremely concerned that the key outcomes agreed at the COAG meeting on 19-20 April 2010 and the initiatives announced as part of the 2010-11 budget, do little to address the crisis in the mental health sector in Australia. Nor do they reflect the outcomes of the process of consultation undertaken prior to the agreement.

The final report of the National Health and Hospitals Reform Commission (NHHRC) was released in July 2009. It made 123 key recommendations to improve the national health system and change the way Australia responds to its health needs by reducing our dependence on hospitals for services that could be better provided elsewhere. This would free up hospital services to provide the level of care that is desperately being required of them now and which they are currently failing to deliver.[1] These recommendations included key changes to assist the health system to deliver urgently needed improvements to its care to people with serious mental illness. Many in the mental health sector considered these an important first step in mental health reform.

The Australian Government has expressed support for the mental health related recommendations of the NHHRC report and continues to acknowledge the need for significant reforms in mental health. Yet since the release of the NHHRC report and the development of the COAG National Health and Hospitals Network (NHHN), the focus of the Australian Government has been on reforms to the hospital sector with only limited changes in the form of new funding initiatives to the mental health sector.

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[1] National Health and Hospitals Reform Commission, 2009, *A Healthier Future for all Australians*, Australian Government.

In 2009, Australian Health Ministers outlined their commitment to significant reforms to the mental health system under the Fourth National Mental Health Plan.[2] It is still unclear how such an ambitious plan will be implemented in the mental health sector under current structural and funding arrangements. These latest reforms in the health sector could have provided an opportunity to operationalise the outcomes of the Fourth National Mental Health Plan in a way that has not been achieved under the National Mental Health Strategy to date. Instead, the MHCA considers, the outcomes for the mental health sector under the NHHN and budget initiatives are a lost opportunity for real improvement.

The MHCA does, of course, welcome those budget initiatives announced in the NHHN report, *A national health and hospitals network for Australia's future: delivering better health and better hospitals,* including more mental health nurses, more early intervention services for young people, better coordination of primary mental health care through Medicare Locals, some flexible care packages for people with serious mental illness, and sub acute beds to be shared between mental health, aged care and palliative care. However, for the mental health sector these constitute vague in-principle support and incremental increases in just a few areas of urgent unmet need. For example, the welcome endorsement for proven youth mental health models is not matched by appropriate funding levels. As a result of this announcement just 3% of young people with mental ill health who are currently unable to access these services will benefit.

These announcements are not the strategic approach to reform that is needed in the sector. They do little to address the cycle in which mental health funding is used to support the increasing need for acute services in the hospital sector and little to address the urgent areas of unmet need in mental health, particularly in the community sector. If use of mental health funding in this way continues to remain a priority for state, area, local health services and hospitals, the access to mental health services, community support and early interventions that are so desperately needed will continue to remain elusive.

These budget initiatives do not reflect the urgency of need for reform in the mental health sector. This urgent need was documented at crisis point five years ago in the 2005 MHCA report *Not for Service: experiences of injustice and despair in mental health care in Australia*. The report described consumer and carer experiences of a mental health system increasingly unable to meet the mental health needs of the Australian community since the late 1990s.[3] (This report is available on the MHCA website www.mhca.org.au.) As one clinician described a local mental health service in 2005:

> "The system is chronically underfunded and under-resourced. There is a chronic shortage of psychiatric beds. Community clinics are overworked and under-resourced. Supported accommodation options for mental health clients are severely lacking. The Psychiatric Emergency Service is viewed as a joke

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[2] Australian Health Ministers, 2009, *Fourth National Mental Health Plan – an agenda for collaborative government action in mental health 2009-14*, Australian Government.
[3] Mental Health Council of Australia, 2005, *Not for service: experiences of injustice and despair in mental health care in Australia*, MHCA, page 20.

by clinicians and clients alike and functions as little more than a telephone advisory service."[4]

The situation seems hopeless for many mental health consumers, carers and those working in the sector. Since the MHCA report was released, successive governments have committed to achieving more in mental health and yet this has not resulted in any fundamental reform. The significant financial commitments made under the COAG National Mental Health Plan 2006-2011 were welcome but comprised less of a strategic approach to reform than a group of loosely related projects that did not match the results of years of serious neglect. With lack of any real data on mental health outcomes in Australia, the effects of this plan are not able to be effectively monitored.

Yet there is evidence to support good practice models and demonstrated areas of excellence do exist. These have been documented and reported by the MHCA[5,6,7,8] and have informed the recommendations of the final report of the Senate Inquiry into Mental Health Services[9] and the report of the NHHRC.

What is urgently needed now is serious consideration of why such services are not the norm in Australia's mental health system today and the implementation changes to the funding system that support this status quo.

Fundamental challenges in mental health, which should have been addressed under the most recent health reforms, are summarised below.

The key role of hospital based acute care and emergency departments in the Australian mental health sector.
Nowhere are the current challenges of the Australian health system more clearly demonstrated than in the mental health sector where the bulk of funding spent on mental health is in the area of hospital based acute services.[10] In 2009, the Mental Health Council of Australia undertook a national survey of mental health carers in Australia who advised that:

> Carers are forced to watch consumers wait until their conditions become sufficiently florid to demand the attention of the largely hospital based acute care system currently in place. This is often despite repeated calls from

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[4] Ibid, p ix.
[5] Mental Health Council of Australia, 2006, *Time for Service*, MHCA.
[6] Mental Health Council of Australia, 2007, *Let's Get to Work: A national mental health employment strategy for Australia*, MHCA.
[7] Mental Health Council of Australia, 2009, *Home Truths: mental health, housing and homelessness in Australia*, MHCA.
[8] Mental Health Council of Australia, 2009, *Adversity to Advocacy: the lives and hopes of mental health carers*, MHCA.
[9] Australian Senate Select Committee, 2006, *A national approach to mental health – from crisis to community*, Australian Senate.
[10] Department of Health and Ageing, 2007, *National Mental Health Report 2007: Summary of twelve years of reform in Australian's Mental Health Services under the National Mental Health Strategy 1993-2005*, Commonwealth of Australia, p2.

carers for help and assistance prior to the issues escalating into more dangerous, unhealthy and long lasting situations. [11]

It is the case that many people with mental illness have little access to appropriate medical and other support in their local community and increasingly become unwell. This results in a vicious cycle that leads them back to the need for acute hospital based care, which could have been averted with adequate access to treatment options and community supports.

Lack of strategic alternatives for many mental health consumers to adequately manage their illness in the community means that hospital emergency departments are a significant first point of contact in the mental health system. The Australian Institute of Health and Welfare reported that in 2006-7, emergency departments were a first point of contact for people seeking help with mental health for the first time or trying to access out of hours care.[12] Sixty three percent of these mental health consumers were not admitted or provided with referral to another hospital.[13] This is alarming given the crisis that many would be experiencing when attending a hospital emergency department. The common experience of one mental consumer in this situation was recently documented in The Australian newspaper:

> "For three days, Vittoria Tonin took a cocktail of drugs she expected would kill her, then when it did not, she presented herself to the emergency department of the Royal Melbourne Hospital asking for help. She was 17 and in the final year of school. Although she had "some quite developed suicidal plans", the psychiatrist who saw her only offered her a late school pass."[14]

Another alarming statistic is that two thirds of people with mental illness report that they did not receive mental health care in 2006-07, and that they had unmet needs in counselling, social intervention, information, skills training and medication.[15] Other evidence shows that one in four people who made a suicide attempt did not access services for mental health problems in the previous twelve months.[16]

These figures are a major concern given the evidence for early intervention to assist individuals in managing mental illness.[17] The figures should also be of concern to policy makers who are seeking to relieve funding pressures on the hospital system, remove access block and prevent episodes of serious mental illness which require acute care. Yet it is still unclear how mental health services that adequately address these issues will be provided any more effectively using local health and hospital networks or Medicare Locals while still using existing primary, acute and community service options.

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[11] Mental Health Council of Australia, 2009, *Adversity to Advocacy*, Opcit, page 10.
[12] Australian Institute of Health and Welfare(AIHW), 2009, *Mental health services in Australia 2006-07*, AIHW, p24
[13] Ibid, page 28.
[14] Cresswell A and Rintoul S, 2010, *Mental health funds 'tiny'*, The Australian 21 April 2010.
[15] Australian Bureau of Statistics, 2007 *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, accessed from the ABS website on 20 May 2010.
[16] Slade T, et al, 2009, *The Mental Health of Australia 2. Report of the 2007 Survey of Mental Health and Wellbeing*, Department of Health and Ageing.
[17] McGorry P, Killackey E and Yung A, 2007, *Early intervention in psychotic disorders: detection and treatment of the first episode and the critical early stages*, Med J Aust 2007; 187 (7 Suppl): S8-S10

Health funding and mental health

If there is to be significant reform in mental health it is clear that the current arrangements, whereby state and territory health budget allocations are largely determined by the huge and growing need for funds for the public hospital system and other health areas, will need to be challenged. This will need to be combined with a strategy to address the significant deficits in community based service provision including sub acute treatment options and integrated service delivery.

The NHHN report does outline the commitment of the Australian Government to improve community mental health services but no details are provided about actions or funding. Further, there is nothing in the report to address better mental health funding arrangements.

The NHHN report does acknowledge that the National Preventive Health Agency will play a key role in the improvement of mental health prevention but it is not clear what its role will be. The dire need in the mental health sector should warrant the development of significant interim initiatives in the sector.

With respect to management of chronic conditions, the NHHN report advises that:

> "The Government will commence with voluntary enrolment arrangements for people with chronic disease, initially from 2012-13 for people with diabetes. The Government intends to move over time to include other chronic diseases in these arrangements, where this is clinically appropriate, and as early evidence from this initiative becomes available."[18]

However, this is not soon enough to address the acute need for support in the management of chronic mental illness on which evidence for effective service arrangements is already available nationally and internationally.

The NHHRC report also included a number of significant mental health recommendations which the NHHN advises will be raised with the states and territories.[19] For example, two of the recommendations have been acknowledged as areas of need for many years:

> "73. We recommend that every acute mental health service have a rapid-response outreach team for those individuals experiencing psychosis, and subsequently have the acute service capacity to provide appropriate treatment…
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> …79. We recommend that state and territory governments recognise the compulsory treatment orders of other Australian jurisdictions."[20]

The MHCA is extremely concerned that raising the issues with the states and territories will not result in any satisfactory outcome, based on the track record to date. A more strategic approach, detailing specific actions, is needed to progress

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[18] NHHN, 2010, *A National Health and Hospitals Network for Australia's Future: delivering better health and better hospitals*, Commonwealth of Australia, page 132.
[19] Ibid, page 149.
[20] Ibid, page 149.

these issues and the lack of such detail in the responses in the NHHN report effectively undermines any real commitment to addressing these areas.

More and better integrated acute, sub acute and community services for mental health

Mental health consumers and carers consistently identify that access to services beyond appropriate medical treatment is a key factor in recovery from mental illness.[21,22,23] These supports include community based treatment options linked to accommodation, rehabilitation services, employment and support with day to day living.

Acute hospital based services are characterised by a lack of focus on these recovery supports. As a consequence, consumers are often discharged into the community with little regard for their needs outside the hospital setting and without adequate supports, such as accommodation, despite the threats to their mental health that this poses.

Consumers and carers regularly highlight the 'revolving door syndrome' whereby consumers are discharged from hospital into the community where lack of accommodation, support or employment options means that a consumer's mental health declines until they are again unwell enough to be able to access acute services again.

At the same time, consumers and carers also report that consumers are regularly being discharged from acute care too early. This situation also emerged as a key national theme in consultations undertaken by the MHCA in 2005.[24] This lack of service is presumably due to the constant need for acute care mental health beds by consumers whose mental illness remains unmanaged.

A more integrated model of mental health services, which acknowledges the whole of life needs of consumers and which effectively links treatment to ongoing recovery outside the hospital based acute setting, would improve treatment effectiveness and long term health outcomes.

Some funding was provided for more integrated service delivery as part of the COAG National Mental Health Plan 2008-11 but this has not addressed the extremely urgent need for the supports required for people with mental illness to maintain a healthy quality of life. It is clear that a well planned multifaceted strategy is needed to ensure that the mental health system can provide supports that enable consumers to manage their own recovery in the long term. Such a plan has not informed the recent health reforms.

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[21] Australian Health Ministers, 2009, *Fourth National Mental Health Plan – an agenda for collaborative government action in mental health 2009-14*, Australian Government.
[22] Mental Health Council of Australia, 2007, Op cit.
[23] Mental Health Council of Australia, 2009, *Home Truths: mental health, housing and homelessness in Australia*, Op cit.
[24] Mental Health Council of Australia, 2005, Op cit, page 46.

Are 'Medicare Locals' a solution?

The Medicare Locals initiative[25] does have potential to better link mental health consumers and carers with the services that they need, but at this stage there is too little detail on this initiative to determine its potential effectiveness. Development of the Medicare Locals initiative will need to include adequate measures to ensure that they provide service linkages that are relevant to consumer and carer identified needs.

Feedback from the community reveals that high value is placed on mental health care delivered through those GPs with the interest and training to provide it. However, there are a number of significant barriers to accessing this care, such as declining rates of bulk billing and difficulties in identifying a GP with an interest and training in mental health care. Reliance on bulk billing also limits the ability of people with mental illness to find a suitable GP. This situation is further exacerbated by difficulties in getting a consultation, and then by limitations on GPs' time for lengthy mental health consultations. Many mental health consumers report great difficulty in getting short-notice access to GPs during a mental health crisis.

It will therefore be extremely important that this initiative works not only with clinicians and the primary care services which focus on clinical care such as GPs and medical clinics and acute hospital services, but works with the whole range of community supports that mental health consumers and carers have identified that they also use to support their mental health. These include community services that provide assistance and support with day to day living activities such as the Personal Helpers and Mentors Program and Home and Community Care services, as well as providing links to employment and accommodation services. People who do not have ready access to GP services, such as those who are homeless or those in rural areas, may also be more likely to be able to access Medicare Locals through these other mechanisms.

It will be imperative that local consumers and carers play a key role in the development and governance of Medicare Locals to ensure that they meet complex consumer and carer identified needs in an integrated way.

Lack of any real accountability in mental health

The MHCA has long argued the need for better accountability mechanisms to drive improvements in mental health services. There is little or no comprehensive national public reporting of significant areas of interest to mental health consumers and carers such as health outcomes or service quality indicators. This means that there is little urgency for change and no way of evaluating the outcomes of initiatives that are implemented. The NHHN report provides some detail on how this will be improved:

> The National Performance Authority will be established from 1 July 2011 to provide regular reporting through Hospital Performance Reports and Healthy Communities Reports. The COAG Reform Council will report on the

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[25] National Health and Hospitals Network 2010, Op cit.

performance of all jurisdictions against national performance indicators, including those agreed by COAG 2008.[26]

Yet the performance indicators identified by COAG in 2008 do not provide the level of detail about mental health services that is useful to consumers and carers or mental health advocates in determining the performance of services. This problem is exacerbated by the fact that such state and territory data collection processes are not consistent and that reporting is done in such a way to make sure that states' and territories' performance cannot be compared in any meaningful way.

If these new reports are to be useful mechanisms for the mental health sector it will be extremely important that:
- a consistent national reporting process is developed to ensure that data can be meaningfully and usefully collated to inform service improvement; and
- substantial development of key national performance indicators is undertaken, using input from consumers and carers, to give an accurate picture of health outcomes that are relevant to the Australian community.

The role of stigma in mental health policy
The negative perception of mental illness in the Australian community plays a major role in the quality of services. The resulting stigma is one of the key reasons that mental health consumers and carers are excluded from influencing service planning and delivery within mental health services.[27] It is also a major barrier to consumers living and working in the community and, understandably, people are often reluctant to admit that mental illness is part of their life. SANE Australia's Stigmawatch report identifies that discrimination against people with mental illness remains high in Australia.[28] Fear of stigma and discrimination is a key reason for not seeking help early.[29]

Reducing stigma is a major challenge for mental health reform and in providing better integrated hospital acute care, primary care and community services.

Comprehensive anti-stigma or social inclusion initiatives exist in New Zealand, Scotland, USA, Canada and England and produce positive outcomes.[30] These anti-stigma campaigns demonstrate impressive cost/benefit results and provide governments with a return on investment and increased productivity. This is because less discrimination increases employment and education opportunities and increases the likelihood of people seeking support and/or treatment earlier. Earlier support and treatment means less money is spent on health, social, and hospital services in the long term.

A number of valuable anti-stigma programs such as Mindframe or Stigmawatch and successful awareness and prevention programs, like beyondblue or Mental Health

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[26] NHHN, 2010, Op cit, page 128.
[27] Hocking B, 2003, *Reducing mental illness stigma and discrimination – everybody's business*, Medical Journal of Australia, 2003, 178 (9 Suppl): S47-48.
[28] SANE Australia 2004, *Dare to Care SANE Mental Health Report*, SANE .
[29] SANE Australia, 2009, *SANE Research Bulletin 10: Stigma, the media and mental illness*, SANE.
[30] Thornicroft G, Brohan E, Kassam A and Lewis-Holmes E, 2008, *Reducing stigma and discrimination: candidate interventions*, International Journal of Mental Health systems Vol 2:3.

First Aid, already exist in Australia. However, a more significant and comprehensive approach like those already occurring in all other OECD English speaking countries is urgently required.

The Senate Inquiry into Mental Health Services in 2006 and the NHHRC have both recommended that Australia invest in a national anti-stigma initiative. But while the first action in Australia's Fourth National Mental Health Plan 2009-2014 is "a sustained and comprehensive national stigma reduction strategy"[31], it is not yet clear that this action will be high on the priority list of the Mental Health Standing Committee's implementation working group.

The role of consumers and carers
Mental health consumers and carers are acknowledged as a key expert resource in their own recovery and in the development and delivery of services for people with mental illness.[32] Yet despite being a key resource for mental health services and policy makers seeking to implement change, consumers and carers continue to experience limited choices when it comes to influencing their own care and in the delivery of policy and services more broadly.

The NHHN report advises that funding of the National Mental Health Consumer and Carer Forum (NMHCCF) [33] is a key mechanism to ensure that a consumer and carer voice is heard at a national level. Yet the jurisdictional funding for the NMHCCF allows it only to meet face to face twice a year and by teleconference twice a year. No funding is provided to progress project or development work.

Despite being formed in 2002, the NMHCCF was only invited to participate in the national policy setting agenda in 2008. It could be argued that under such circumstances its existence is tokenistic. NMHCCF was also recently declined a request for a funding increase and the states and territories and the Australian Government were unsure about expanding its limited membership. If governments were truly committed to mental health consumer and carer participation, they would support the provision of additional funding to allow the NMHCCF to carry out its 2009-11 Forward Plan activities as well as better support the development of grass roots consumer and carer activities at a national level and in each state and territory.

Since defunding the Australian Mental Health Consumer Network and commissioning a report on a replacement body in July 2009, the status of this important organisation's replacement entity is unclear.

Conclusion
The range and complexity of issues that need to be addressed in the mental health sector has been at crisis point for years. It is shameful that these problems are readily acknowledged, that the solutions are readily available, yet this area is not addressed under the NHHN agreement and the 2010 budget initiatives.

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[31] Australian Health Ministers, 2009, *Fourth National Mental Health Plan – an agenda for collaborative government action in mental health 2009-14*, Australian Government.
[32] Ibid.
[33] NHHN, 2010, Op cit, page 152.

With 42% of all cigarettes sold in Australia being smoked by people with mental illness[34], the fact that the COAG health agreement is to be funded by the new excise on tobacco suggests that the primary role of mental health consumers is to underwrite improvements in systems that do not meet their needs.

Unfortunately, despite the rhetoric, state, territory and Australian governments do not seem to be committed to providing appropriate mental health services for consumers and carers or the Australian community.

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[34] Access Economics, 2007, *Smoking and Mental Illness: Costs*, SANE Australia, accessed from SANE website on 25 May 2010, www.sane.org.au.