

Senate Community Affairs References Committee

Inquiry into Poverty in Australia

Submission by SANE Australia 28 March 2003



SANE Australia draws the Committee's attention to the very large number of Australians with a psychiatric disability who are trapped in extreme poverty, and who are not being provided with effective help by government programs to help themselves out of this situation. As the recent *SANE Mental Health Report* (attached) demonstrates, radical action is required to improve community support to people seriously affected by mental illness, so that they can take their rightful place as equal citizens in Australian society.

Research commissioned by the Commonwealth government itself has provided high-grade evidence of the circumstances in which people with a psychiatric disability live. Seventy-two per cent are unemployed and over 85% are dependent on the Disability Pension as almost their only source of income. Only 14.5% live in their own home, and 44.7% live in hostels, institutions and similar accommodation, with around 11% of the total effectively homeless (Jablensky, A, et al. *People Living with Psychotic Illness: An Australian Study*. Commonwealth of Australia, 1999). These conditions are a national disgrace.

Disability employment programs have proven ineffective in helping this group. Research by the Department of Family and Community Services (*Final Evaluation Report: Case-based Funding trial*. Commonwealth of Australia, 2002) shows that only a very small proportion of those with a psychiatric disability are supported and helped to find work (despite comprising one of the largest groups claiming the Disability Pension). Furthermore, of those assisted by disability employment programs, 75% were not able to sustain employment of eight hours a week for six months (the criterion for an 'outcome') – reflecting the very limited resourcing, training and structural flexibility of such programs to provide real help to this group to break out of poverty.

The poor physical health endured by people with a psychiatric disability can also be associated with poverty-related issues such as poor diet and housing and social isolation. The mortality and morbidity rates of this group are shamefully higher than those of the general population (Coghlan, R, et al. *Duty to Care: Physical Illness in People with Mental Illness*. University of WA, 2001).



Despite being one of the largest disability groups living in poverty (comprising almost 1% of the adult population), people with a psychiatric disability remain largely 'invisible' and disregarded. As stated in the SANE Charter, there is an urgent need to restructure and properly resource community support for this group so that they are not 'warehoused' in poverty but are able to live free of poverty, in dignity, and in conditions which provide them with opportunities as equal members of our society.



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SANE Mental Health Report
2002-03



SANE Mental Health Report

This Report expresses what thousands of Australians think about the mental health service they receive, and the National Mental Health Strategy which underlies it.

The Report is based on almost 200 interviews, analysis of 6,000 calls to the SANE Helpline and data supplied by the World Health Organisation (WHO), Commonwealth and State governments, and Access Economics. It is in two parts: the first examines how well the Strategy has performed against the four fundamentals of the SANE Charter: access to effective treatments; support in the community; help for family and other carers, and action to end stigma. The second part of the Report examines each State and Territory individually, noting good news, bad news and specific recommendations for action.

The main findings of the Report are:

- mental health services are in disarray around the country, operating in crisis mode and with numerous official inquiries under way
- proven effective treatments for mental illness are not routinely available under Medicare
- untreated mental illness is a leading contributor to Australia's suicide rate
- the cost of schizophrenia alone will spiral to \$10 billion a year this decade unless services are improved
- the current Mental Health Plan is faltering, and there is an urgent need for action to maintain the impetus of the National Mental Health Strategy.

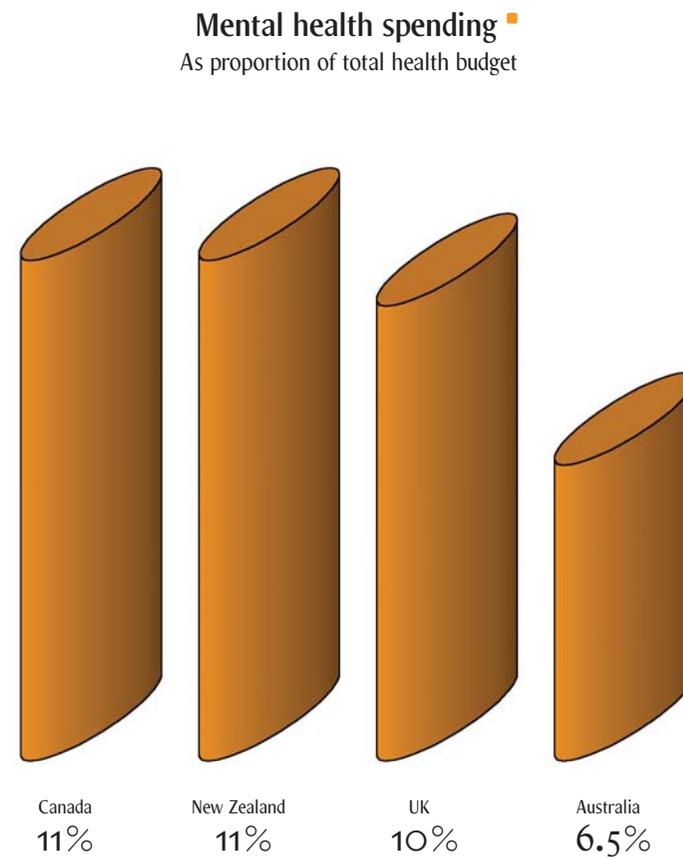
Principal Recommendations

- # A Third Mental Health Plan is urgently required to consolidate the National Mental Health Strategy (as recommended by the mid-term review of the Second Plan). The Third Plan, to commence in 2003, needs to get 'back-to-basics' and focus on improving core clinical and and community support services.
- # The Third Mental Health Plan should include provision for access to effective treatments and support services not currently available to the majority of Australians affected by mental illness. The Victorian *Framework* mental health plan should be recognised as a valuable model which other States could adapt to their own circumstances.
- # The Third Mental Health Plan should include a commitment to lift the mental health proportion of the Australian health budget from the current 6.5% to 10%, bringing it into line with comparable countries such as Canada, the UK and New Zealand. Without this commitment, the capacity of the Plan to achieve the goals of the Strategy will be severely restricted.

How Australia rates . . .

Australia spends a mere 6.5% of its health budget on mental health services – this urgently needs to be lifted to the level of comparable countries such as Canada, the UK and New Zealand...

Barbara Hocking, SANE Australia



Source: WHO, 2001



What was promised

Clinical treatment: a basic right

A core document of Australia's National Mental Health Strategy is the 1991 *Mental Health Statement of Rights and Responsibilities*. This acknowledges that:

The consumer has the right to have possible mental health problems or mental disorders assessed, diagnosed and, where appropriate, treated and regularly reviewed in accordance with professionally accepted standards.

What we got

From mainstream to muddle

Australia's National Mental Health Strategy, adopted in 1992, was an ambitious and complex enterprise. After a bold start on the transition to wholly community-based services, which rightly won admiration overseas, the Strategy is widely recognised to be losing momentum and faltering. However well-designed the plan, it will fail unless the funding is there to make it happen.

Case management has been introduced in every State and Territory; yet if staff are too few and caseloads too high to function effectively, then this is 'case management' in name only. Calculations of how many community-based beds and other resources would be required were, it is increasingly clear, seriously underestimated.

The Strategy has funded excellent pilot projects in specialised areas, yet all too often these have shrivelled and died once the final report was posted off to Woden.

Australia's alarming suicide rates are recognised as a priority area, yet little attention is paid to those most at risk at the time when they are most likely to take their own lives – people with a mental illness in the vulnerable months after discharge from in-patient care (when they are seventeen times more likely to complete suicide than the population average).

Access to effective treatments

Recommendations

- # Increase funding to a level where psychiatric treatment is provided at an optimum level to all Australians who require it, in order to achieve the goals of the National Mental Health Strategy.
- # Clinical service levels need to be defined more tightly to enable benchmarking of caseload limits and other criteria (without consumers being 'exited' from services to achieve them).
- # Nationwide implementation, with public funding mechanisms, of interventions which are proven effective yet are not generally available in Australia. Examples include cognitive behavioural therapy (CBT) provided by psychologists for people with depression, and family group therapy for carers of people with schizophrenia.
- # A refocusing of suicide prevention strategies on improving continuity of care after discharge from psychiatric in-patient care.

*We've asked all the time by
Helpline callers why CBT is
not available on Medicare, as
it's shown to be so effective for
depression...*

 SANE Helpline worker



What was promised

Community support is an essential complement to clinical services

A core document of Australia's National Mental Health Strategy is the 1991 *Mental Health Statement of Rights and Responsibilities*. This acknowledges the importance of a range of psychiatric disability support services in the community:

The consumer has a right to a coordinated and ongoing range of adequately-resourced public, private and non-government care, treatment, rehabilitation, information and support services.

What we got

Few and far between

Accommodation, rehabilitation, outreach and other forms of community support are generally supplied by non-government organisations (NGOs), which receive around 5% of the mental health budget nationally. This is a very inadequate proportion when it is considered that NGOs, with families, took on most of the burden of day-to-day care when the stand-alone hospitals began to be decommissioned. Outside Victoria they are few and far between, with funding usually going to NGOs as block grants rather than systematic allocations to cover specified catchments from region to region.

Without a proper service provision context and adequate funding, some day programs are acutely aware they do little more than provide 'somewhere to go' – with no capacity to provide true rehabilitation, addressing the cognitive and functional deficits associated with psychiatric disability.

The funding split between Commonwealth and State for different forms of community support is an added source of frustration in the lives of people with a mental illness.

Support in the community

Recommendations

- # Development and implementation – as an integral part of the National Mental Health Strategy – of a systematic plan for a range of support services to be introduced in all regions of all States, with a special focus on accommodation and rehabilitation.
- # Access to education and training for Community support services, to encourage provision of high quality rehabilitation.
- # Community support services should not be isolated in an NGO or mental health ‘ghetto’, but have regular liaison with clinical services and local community facilities to promote community integration.

*Somewhere to live, meeting
people, learning stuff, having
fun, getting a job – all that's
as important to my son as
seeing his psychiatrist ...*

 Carer, Queensland



What was promised

Mental health services rely heavily on a vast army of carers

A core document of Australia's National Mental Health Strategy is the 1991 *Mental Health Statement of Rights and Responsibilities*. This acknowledges the vital role played by family and other carers:

carers have a right to comprehensive information, education, training and support to facilitate the understanding, advocacy and care of those consumers they care for.

What we got

Lip service

The role of carers is now formally acknowledged by governments and mental health services, through the Community Advisory Groups (CAGs) and other bodies. Some services are even beginning to employ carer consultants. Funding of carer support organisations has also increased in line with the growth in NGO funding, but this started at such a low base that it is still inadequate to the need. Generic organisations such as the Carers Association are also starting to recognise the needs of those caring for someone affected by mental illness.

The acknowledgments and consultations are little more than lip service, however, without provision of support for what is often a very demanding role. Hardly any State ensures carer support by funding it on a strategic regional basis. Hardly any State gives carers the legal right to be included as part of the treatment team and have relevant information shared. All too many psychiatrists still ignore family concerns and do not refer them to support organisations. Family-sensitive training (FaST) for health workers is practically unknown outside Victoria and the ACT.

Family group therapy barely exists in Australia – yet there is strong evidence that this reduces the frequency of psychotic episodes and saves mental health services money, as well as helping the family.

Help for family and other carers

Recommendations

- # Strategic region-based provision of carer support services supplied by an NGO.
- # Family-sensitive training (FaST) for all mental health professionals, with refresher courses provided on a regular basis.
- # National implementation of family group therapy programs acknowledged as clinically effective.

*We were coping on our own
for years – no one ever told us
there was such a thing as a
carer support group ...*

 Carer, Victoria



What was promised

The dignity of people with a mental illness is integral to the Strategy

A core document of Australia's National Mental Health Strategy is the 1991 *Mental Health Statement of Rights and Responsibilities*. This acknowledges the effect of stigma on people's lives and the need to tackle it, stating consumers have:

the right to respect for individual human worth, dignity and privacy . . . equal to other citizens.

What we got

Getting smart about stigma

Stigma has a subtle and corrosive effect on people's lives, treating them as though they were not deserving of the same respect as other people. Research by SANE Australia shows that stigma and being made to feel excluded from society is a primary concern of people with a mental illness.

The Commonwealth's 'Community Awareness Program' in the mid-1990s used a TV and print ad campaign to attempt to change attitudes. This simplistic approach was unsuccessful; evaluation showed it had little or no effect on public attitudes.

A more sophisticated understanding of stigma has led to a strategy of attempting to cut off the constant reinforcement of stigma by the media, which plays such a major role in determining public attitudes. This understanding was helped by a major research study, the Media Monitoring Project.

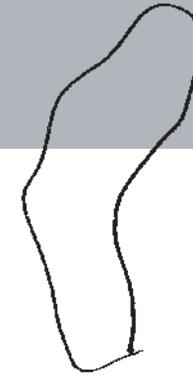
The Commonwealth now supports the independently-established SANE StigmaWatch program, ResponseAbility (a package to educate journalism students about reporting mental illness and suicide) and Mindframe (a resource for journalists on reporting these issues). Education programs through schools are also important in helping stop stigma from taking root through ignorance.

Recommendations

- # Many consumers and carers commented that they felt community attitudes were slowly improving. It is essential that the impetus to reduce stigma is kept up, and that programs to combat its promotion in the media continue to be supported.
- # Education programs through schools should be maintained and expanded. Tackling ignorance at this stage is especially important as stigma can discourage young people with symptoms from seeking help.
- # Iatrogenic stigma from health professionals needs to be recognised as a problem, and tackled at the initial training stage and through ongoing consultative engagement with consumers and carers about their experiences.

The worst stigma I've seen has been in hospitals. Some of the staff make you feel like you're just a nuisance to them...

 Consumer, NSW



Good news

The advantages of being compact

The ACT's population is the same as a single region in Sydney. Like the Northern Territory it has a small population and no tradition of stand-alone facilities. Unlike the Northern Territory, the ACT is a highly compact jurisdiction, with all the advantages that brings.

ACT mental health services have been able to introduce a number of innovative programs, such as FaST (family-sensitive training) for staff and early psychosis family education sessions (both based on Victorian models). Another specialist service praised was *Keeping Families Connected* for carers of young people with a mental illness and substance abuse problem.

Non-government organisations providing a wide range of services, including employment, are also funded, and are highly valued by consumers and carers.

Bad news

No room at the inn

While Canberra has plenty of hotels for visiting bureaucrats, there is a complete absence of boarding houses and a shortage of accommodation options for people with a mental illness was reported.

In common with every other State and Territory, it was reported by consumers and carers that there was a 'shortage of beds' in the ACT. As elsewhere, this is an index of under-resourced community services as much as a reference to limited beds in psychiatric wards.

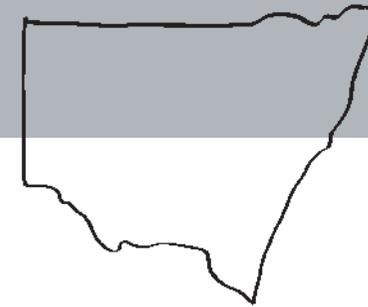
How the ACT rates . . .

Recommendations

- # The ACT's per capita expenditure on mental health services is the lowest recorded in the *National Mental Health Report 2000*. There is clearly a need to increase funding, especially in relation to the NGO sector which is particularly active and valued.
- # Attention is needed to the issue of people with a mental illness having few accommodation options and becoming homeless.

Outsiders find it hard to believe that Canberra has homeless mentally ill people . . .

 Consumer, ACT



Good news

Beacons of excellence

New South Wales showed that deinstitutionalisation could work in Australia, with implementation of the Richmond Report recommendations in the 1980s and establishment of the first community-based services.

The State still has many programs which are exemplary and beacons of excellence; the pity is that they remain isolated examples rather than the norm. If these could be built on and replicated throughout the State in a systematic way, NSW would have a world-class mental health service.

Consumer consultants reported feeling that their contributions were valued by mental health services. Support for carer organisations by the Centre for Mental Health was also acknowledged.

Bad news

Coming adrift

Mental health services in NSW need serious attention – both in terms of funding levels and management. Consumers and carers reported a widespread feeling that mental health services were ‘coming adrift’. There were many expressions of concern about people not receiving treatment (and the sometimes tragic consequences of this). There were also a number of disturbing reports about the standard of care in psychiatric wards of public hospitals around the State – reports of dignity and human rights being violated, unhygienic conditions and stigma by health professionals.

Community services provided by NGOs, including psychosocial rehabilitation and supported accommodation, are not only grossly underfunded, they are not planned or resourced according to any coherent Statewide population-weighted model. Provision of forensic services in a prison setting at Long Bay is a cause for serious concern.

A further potential issue in NSW is the Liberal-National Opposition’s plan for a massive new 400-bed stand-alone psychiatric facility on the Rozelle Hospital site at Callan Park. Opinions differ sharply on the desirability of this, but there is no doubt it is wholly contrary to the National Mental Health Strategy. Whether called a ‘centre of excellence’, asylum or any other name, it would also set a worrying precedent of breaking bipartisan support for the Strategy.

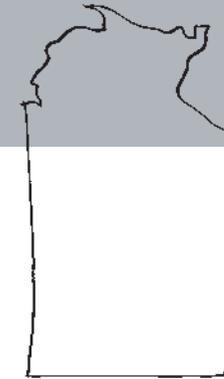
How New South Wales rates . . .

Recommendations

- # There are some indications that increased funding will be made available for mental health services in NSW. It is essential that any increase is sustained and expanded so that the necessary structural changes can be made. Merely providing 'more beds' is not the answer; this needs to be accompanied by concomitant provision of community-based clinical staff on an equitable Statewide basis. Concerns about undignified and stigmatising treatment in some hospitals need to be urgently investigated and addressed.
- # It is also hoped that the NSW Centre for Mental Health will institute a rehabilitation plan, resourcing NGOs in a systematic way for the first time. This should provide a range of psychiatric disability support services (as well as carer support services) with a focus on achieving optimum levels of recovery.
- # NSW needs a dedicated forensic facility sited and managed away from the correctional system.

*I see more and more people
with a mental illness living on
the streets, and I always think
that could so easily be me . . .*

 Consumer, NSW



Good news

'But we always were mainstreamed . . .'

The Northern Territory never had a stand-alone psychiatric institution to decommission in the first place. Implementation of the National Mental Health Strategy and community-based services has therefore had a less dramatic impact than in other parts of Australia.

The recent passing of a Mental Health and Related Services Act through Parliament, and establishment of a Mental Health Review Tribunal, was welcomed by consumers and carers.

An Aboriginal Mental Health Guidelines and Action Plan has been implemented, alongside recruitment of Aboriginal mental health workers.

The Northern Territory Consumer Advisory Group (NTCAG) was one of the first established, and consumers reported they felt genuinely consulted in the planning of services in the Territory.

Bad news

A stable life starts with stable accommodation

The lack of supported accommodation for people with a range of needs is the most prominent failing of Territory mental health services noted by consumers and carers.

Community support services provided by NGOs are seriously under-resourced. Funding increased seven-fold during the 1990s, but as this started from a base of just 1% of the mental health budget, the overall sum is still grossly insufficient.

Staffing levels were reported to be inadequate, with long waiting periods to see a psychiatrist even in the urban centres of Darwin and Alice Springs.

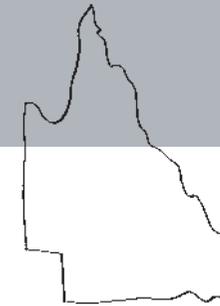
How the Territory rates . . .

Recommendations

- # The special nature of the Northern Territory, with its young population sparsely spread over a vast area and high proportion of indigenous people, is added reason for a radical increase in funding of mental health services. As well as improving access to clinical services, community support – especially psychosocial rehabilitation – needs to be taken far more seriously.
- # The lack of a range of supported accommodation is a priority area for action in the Northern Territory.

Somewhere to live is pretty basic, but if you need support too and it's not there then life gets difficult very quickly . . .

 Carer, Northern Territory



Good news

Making haste slowly

Consumers and carers acknowledged that services were improving in Queensland, but at a very slow pace. Mainstreaming of psychiatric beds into general public hospitals has been enabled by a \$100 million mental health capital works program, the largest undertaken in Australia.

A new Mental Health Act passed in 2001 was generally approved of, as was the implementation of a Queensland Mental Health Review Tribunal.

A number of initiatives for special needs groups were also noted, including a valuable project to identify the needs of deaf and hearing-impaired consumers, followed by a program to make mental health services more 'friendly' to this group.

Bad news

When the media go feral . . .

Stigma was uppermost in the minds of consumers and carers during consultations for this Report. Following the absence without leave of a forensic patient, the Queensland media went into a frenzy of sensationalisation and stigmatising of people with a mental illness. This incident (later investigated by the Office of the Public Advocate) made consumers and carers feel highly vulnerable and persecuted.

Increases in funding for capital work and clinical services have not been matched by appropriate increases for NGOs providing support services in the community. The proportion of 5.2% of the mental health budget allocated to them is around the average for Australia, but remains wholly inadequate for a sector that provides the lion's share of day-to-day care for consumers. (The 5% national average is also heavily weighted by Victoria, which allocates 9.6% to the NGO sector.)

Supported accommodation, especially for those with high needs, is in extremely short supply. The *National Mental Health Report 2000* shows no 24-hour residential services whatsoever in Queensland.

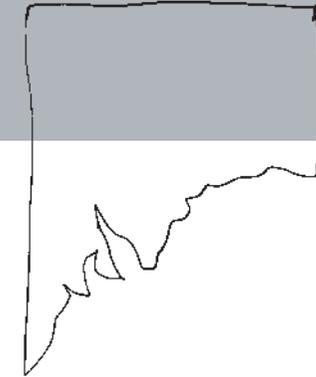
How Queensland rates . . .

Recommendations

-  More assertive community education about mental illness, including taking the Queensland media to task for their promotion of stigma. The *TasmaniaTogether* project is a valuable model for such activity.
-  Development and implementation of a strategic plan across all regions for NGO-run support services, especially psychosocial rehabilitation programs, to work in close liaison with clinical services.
-  A fast-track program to introduce supported residential services for consumers with a range of needs, across all regions of the State.

you think attitudes to mental illness are improving, then — bang — the newspapers do a sensationalised story and you're back to square one . . .

 Carer, Queensland



Good news

Between a rock and a hard place

The rock is a State government long unwilling to support the radical reforms implicit in the National Mental Health Strategy; the hard place is Glenside Hospital. Between the two, consumers, carers and mental health workers have had to put up with a mental health service still stubbornly structured around the nineteenth century institutional model.

There are signs of hope in adoption of the 2001 *Action Plan for Reform of Mental Health Services* and the drafting in of senior staff from outside the State. Discussions have been held with the new Mental Health Coalition, formed by seventeen NGOs, about what community support services are needed.

Following national media attention on the shackling of psychiatric patients in Adelaide emergency wards, new funds have been allocated to training staff on these wards in helping people with a mental illness who present for treatment.

Bad news

A question of attitude

The South Australian government seems to have had 'an attitude problem' in accepting the spirit of the National Mental Health Strategy. It claims that 'mainstreaming . . . was completed in the final years of the First National Mental Health Plan.' What this means is that administration of Glenside was 'mainstreamed' to area health authorities – the institution itself carried on as before. The *National Mental Health Report 2000* states that 47% of the entire State mental health budget went to this one hospital.

Support services in the community are consequently poorly funded and extremely sparse, especially in rural areas. A paltry 2.5% of the mental health budget is allocated to the NGOs which provide such services – less than half the national average which is already low.

Supported accommodation in the community is also very under-resourced – expenditure on 24-hour residential services is just 00.03% of the mental health budget. This compares to the national average of 6.2%.

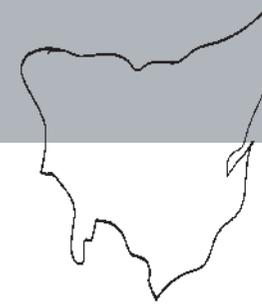
How South Australia rates . . .

Recommendations

- # South Australia's mental health services urgently need the political support and funding to embrace the National Mental Health Strategy. Talk of retaining Glenside as a 'centre of excellence' is missing the point and clinging onto an irrelevant institutional model.
- # The resources which Glenside sucks up every year urgently need to be diverted to community-based care – Statewide provision of genuinely mainstreamed clinical services (including 24-hour CATT teams) and NGO-supplied services such as rehabilitation, accommodation and carer support.
- # Supported accommodation in the community is a high priority, requiring radical attention and new funding.

It's a four hour drive each way for me when I have an appointment with the psychiatrist – last month he cancelled but no one told me . . .

 Consumer, South Australia



Good news

Tasmania's mental health services are full of contrasts

Tasmania contains some of the most up-to-date mental health facilities in Australia alongside one of the worst. There is a commitment to the National Mental Health Strategy's principle of mainstreaming, and the State's stand-alone facility – the Royal Derwent Hospital – has been replaced by wards in general hospitals in Burnie, Launceston and Hobart, as well as a range of community-based clinical services.

Tasmania's mental health services for older people were widely praised.

Community education about mental illness was also said to be having a real effect on public attitudes. The State government's *TasmaniaTogether* initiative to promote social cohesion includes the goal of reducing stigma against people with a mental illness.

Bad news

Service levels drop fast as you move further from Hobart

There is a sharp contrast between the level of mental health service provision in the Hobart area and the rest of the State. Outside the Southern region, for example, there are no CATT (Crisis Assessment and Treatment Triage) teams to provide 24-hour service.

Community-based support programs – including rehabilitation, accommodation and carer support – are funded on a block grant basis rather than according to a coherent strategic plan. Psychosocial rehabilitation is almost impossible to access beyond Hobart.

Forensic services are currently provided within Risdon Prison, in conditions widely acknowledged as unacceptable. (A new facility is planned, sited away from a new prison, but this will not be ready until 2004 at the earliest.)

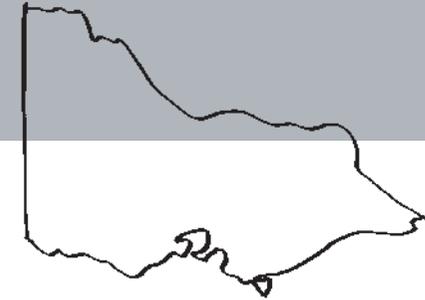
How Tasmania rates . . .

Recommendations

-  Prompt action is needed to give Tasmanians the same level of clinical care regardless of what part of the State they live in. Bringing services in all regions up to the level of the South - including provision of 24-hour CATT teams - is a priority.
-  Development and implementation of a strategic plan across all regions for NGO-run support services, especially psychosocial rehabilitation programs, to work in close liaison with clinical services.

*if you live outside Hobart,
don't get sick after office
hours . . .*

 Consumer, Tasmania



Good news

Victoria's *Framework* is a model mental health plan for Australia

The Victorian *Framework*, introduced in 1994 and continuing to be developed, is a model of what a State mental health plan should look like. Regionalised and funded on a population-weighted basis to provide a range of clinical and support services in 21 areas, Victoria's mental health services no longer have any stand-alone psychiatric facilities.

Alongside the helter-skelter push to mainstream clinical services in the 1990s, there was also a major investment in NGO-operated support services for each region. (Victoria accounts for 50% of the total Australian mental health budget spent on the non-government sector.)

The State has excelled at developing innovative specialist services in areas such as early psychosis intervention (EPPIC), dual diagnosis (SUMMIT), family-sensitive training (FaST), forensic services (Forensicare) and borderline personality disorder (Spectrum).

Bad news

The best laid plans . . .

The best-laid plans will go awry if inadequately resourced, and this is what happened to the *Framework*. Community-based services were introduced at a speed and funding level inadequate to the demand created by closure of the stand-alone psychiatric hospitals. This placed extraordinary and often painful pressures on consumers, their families and NGOs. Mental health workers, too, confessed to feeling angry and impotent at being unable to admit people clearly in need of hospitalisation. The official line that 'there is always a bed available for anyone who needs it' omits to mention the caveat that this might mean a long ride to a distant part of the State where a bed is available, only to be moved again a day or so later.

Inadequate funding of area mental health services means that Case Managers frequently have unreasonable caseloads, and are only able to provide minimal service.

Finding affordable accommodation (especially with support) is becoming a particular problem for people with a mental illness. Melbourne in particular is experiencing a rapid transformation of older and inner suburbs into expensive, desirable areas – resulting in a dramatic reduction in the amount of housing stock available for cheap rental by people on a disability.

How Victoria rates . . .

Recommendations

- # Increased funding of mental health services. The Victorian budget allocation of an extra \$60 million over the 2002-2006 period actually amounts to an increase of only a few percentage points of the mental health budget per annum. A far more radical budget boost is required if the *Framework* plan is to achieve its potential fully and make Victoria's mental health service world-class.
- # Victoria has some of the best specialist clinical and support programs in the country for people affected by mental illness. These remain shining exceptions and 'conference stars', however, instead of becoming the norm throughout the State. Victoria needs to identify and implement these programs more rigorously and effectively in all 21 areas.
- # While Victoria has led Australia in funding carer support services, it has failed to implement family group therapy as an integral component of mental health services, despite sound evidence that it reduces frequency of psychotic episodes and is highly cost-effective as well as helping families. This omission from the *Framework* plan needs to be addressed, as in all other State plans.

The Victorian Framework is a model mental health plan –

It's a pity it's never been funded enough to work properly here . . .

 Mental health worker, Victoria



Good news

Western Australia is moving in the right direction

Consumers, carers and workers generally agreed that services in the State had begun to improve since adoption of reforms outlined in the *Making a Commitment* mental health plan for WA of 1996. Additional funds have been made available for community-based services, and efforts are being made to direct these towards areas of greater need.

Community education initiatives funded by the WA Health Department about mental health issues were singled out for praise, with the comment that public understanding did seem to be changing.

The high prevalence of drug and alcohol problems among people with a mental illness has been recognised as an issue needing attention, with a special Statewide unit established to train health workers in both areas in treating people with a dual diagnosis of this type.

Bad news

Despite recent changes, there is still a long way to go

Western Australia was late in seriously adopting the goals of the national Mental Health Strategy, and has made significant progress since 1996. However, consumers carers and others reported that improvements had been patchy. Despite regionalisation and direction of funds to rural and remote areas, services are still said to be inadequate in these areas. A big slice of the mental health budget (31.5% according to the *National Mental Health Report 2000*) is still committed to maintaining Graylands Hospital, one of the last stand-alone psychiatric hospitals remaining in Australia.

Funding of day programs and other form of rehabilitation in the community still seems to be ad hoc, with no indication of strategic, Statewide population-weighted planning of such services. While support for NGOs has grown, these are said to be regarded as 'extras' rather than an essential and integrated part of community-based services.

Carer organisations reported that many health workers in Western Australia still disregarded families – not acknowledging the impact of mental illness on their lives, nor their status as de facto members of the treatment team (despite often caring for the person affected in a full-time capacity).

How Western Australia rates . . .

Recommendations

- # Increase funding of community-based clinical services, to achieve a service-level agreed in consultation with consumer and carers as well as mental health workers.
- # Development and implementation of a strategic plan across all regions for NGO-run support services, especially psychosocial rehabilitation programs, to work in close liaison with clinical services.
- # Training for mental health workers in family-sensitive practice, and introduction of family group therapy programs in all regions.

Services aren't to the same standard across different regions. You still get some areas with great services while others have next to none . . .

 Mental health worker, WA

Methodology

The Report is based on 186 face-to-face or telephone interviews; analysis of 6,000 calls to the SANE Helpline, and data supplied by the World Health Organisation (WHO), Commonwealth and State governments, and Access Economics. Interviews were conducted between March and May 2002 with consumers, carers and mental health workers from every State and Territory. Commonwealth and State Health Departments were also invited to contribute. Responses were then prioritised and synthesised with information relating to changes in service patterns of the States and Territories since inception of the National Mental Health Strategy.

SANE Australia

SANE Australia is a national charity helping people affected by mental illness, through campaigning, education and research. It relies wholly on donations and philanthropic grants to carry out its work.

For information about the work of SANE Australia see www.sane.org

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ACT

ACT Consumers Group; Canberra Schizophrenia Fellowship; Serenity; Richmond Fellowship of the ACT.

NSW

ARAFMI New South Wales; New South Wales Transcultural Mental Health Service; Schizophrenia Fellowship of New South Wales; Carers Association of New South Wales; Consumers Group of New South Wales.

NT

Mental Health Association of Central Australia; Northern Territory ARAFMI; Northern Territory Carers Association; Northern Territory Consumers Group.

QLD

Queensland Council of Carers; ARAFMI Queensland; Mental Illness Fellowship of North Queensland; Queensland Visitors Program; Queensland Association for Mental Health; Consumers Group of Queensland.

SA

ARAFMI South Australia; Mental Illness Fellowship South Australia; Mood Disorders Group of South Australia; Mental Health Resource of South Australia; Consumers Group of South Australia.

TAS

ARAFMI Tasmania; Carers Association of Tasmania.

VIC

ARAFEMI Victoria; Carers Victoria; Mental Illness Fellowship Victoria; North East Alliance for the Mentally Ill.

WA

Western Australia ARAFMI; Schizophrenia Fellowship of Western Australia; Western Australia Carer Resource Centre; Consumers Group of Western Australia; Tendercare; Banbury Pathways; Western Australia Association for Mental Health.



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