

# CHAPTER 4

## RESOURCING

4.1 There is no doubt that more resources need to be devoted to mental health services. Time and again the committee heard from every stakeholder in mental health, from individual consumers to federal and state governments, saying that more money needs to be spent on services.

4.2 This message is not new. It was clearly articulated in the Burdekin Report of the early 1990s:

Lack of resources has bedevilled community-based care in much the same way that inappropriately allocated resources contributed to the ineptly executed demise of the large institutions. Clearly, resources and effective coordination are imperative if mainstreaming is going to work.<sup>1</sup>

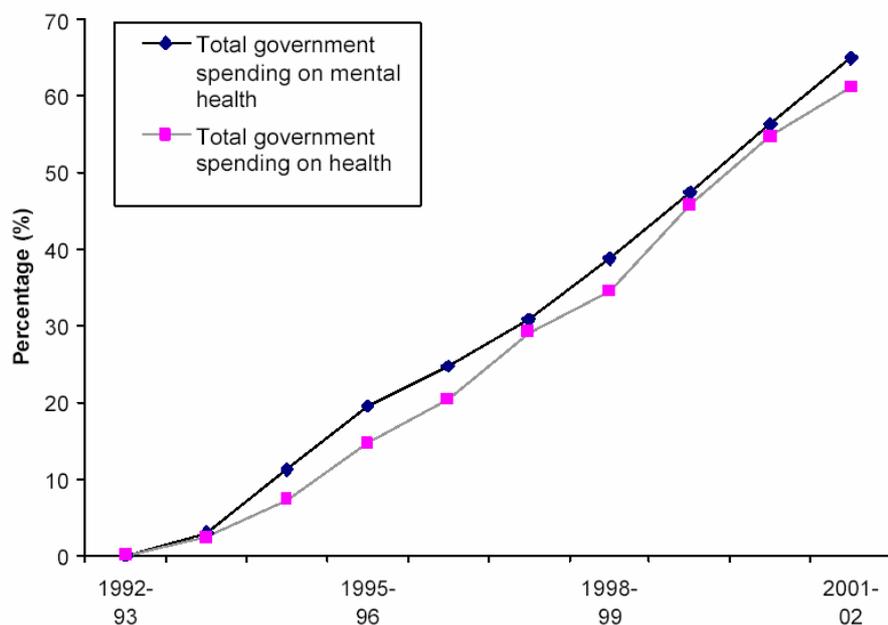
4.3 The committee heard that mainstreaming, despite the rhetoric, has not been successful; that a 'silo' mentality continues to exist within government departments, both state and federal; and that the integration of services to provide resources where they are most needed has, to a large extent, simply not occurred. It was suggested that nothing has changed since the Burdekin Report and that the quote above is as relevant today as it was in 1993.<sup>2</sup>

4.4 Calls for greater resources certainly appear to have been met with relatively little action. This is not to say, however, that resources for mental health have been static for the last ten years. Funding for mental health has increased steadily (Figure 4.1):

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1 Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*, vol 1, Canberra 1993, p. 137.

2 Mental Health Association of Queensland, *Submission 312*, p. 2.

**Figure 4.1 Growth in health expenditure and mental health expenditure.<sup>3</sup>**

4.5 The graph shows that mental health expenditure rose by about 65 per cent from 1992–93 to 2001–02. It also reveals the reason why resources for mental health remain a prominent issue. Ten years ago, mental health was a neglected field of health care. Since that time, expenditure on mental health has risen no faster than health expenditure in general. This suggests that mental health is not being given the priority it needs. Throughout this report evidence is presented of capacity constraints and neglect across the sector indicating that resource levels need to rise.

4.6 This chapter outlines the cost of mental health problems, demonstrates the need for more resources, and outlines debate about where those resources should go.

### The Costs of Mental Illness

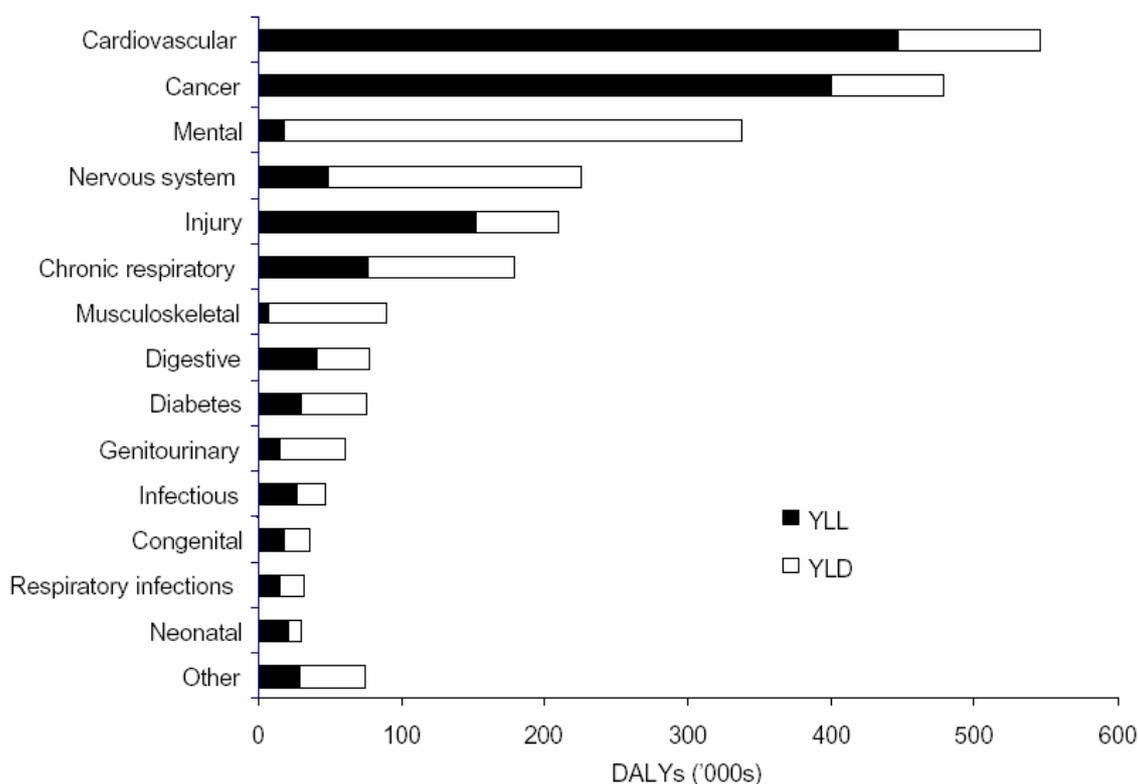
4.7 Mental illness costs the country a great deal in many different ways. There are the human costs in terms of time lost to disability or death, and the stresses that mental illnesses place upon consumers, carers, and the community generally. There are financial costs to the economy which results from the loss of productivity brought on by illness. Then there is the expenditure by governments, health funds, and individuals associated with combating mental illness and facilitating mental health.

4.8 It is well established, but not well enough understood, that mental illness is the number one health problem causing years lost to disability (YLD) in the

3 I. Hickie, G. Groom and T. Davenport. *Investing in Australia's future: Summary*, December 2004, p. 9. See also DoHA, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, 2005.

Australian community.<sup>4</sup> Other diseases like heart disease and cancer may take more lives, but nothing causes as much ongoing suffering and disablement as does mental illness. The level of health burden caused by a disease can be measured in terms of disability-adjusted life years (DALYs), and Figure 4.2 compares these figures for major types of illness:

**Figure 4.2 The burden of mental illness compared.<sup>5</sup>**



4.9 Behind the figures showing the very high level of disability due to mental illness lie two stories, one about health and one about human suffering. In health terms, mental illnesses are different to most other illnesses. The overwhelming burden of mental illnesses falls upon the young, while most other conditions are more likely to affect the old. Thankfully most mental illness is not fatal. However, the early onset of much mental illness can mean that sufferers, particularly of acute conditions, can face varying degrees of disability for many years of their lives. As shown below, this means mental illnesses can create enormous costs for our health system and our society – costs that are exacerbated if effective treatment and care are not provided.

4 C. Mathers, T. Vos & C. Stevenson, *The Burden of Disease and Injury in Australia*. AIHW Cat. No. PHE 17, Australian Institute of Health and Welfare, Canberra, 1999.

5 C. Mathers, T. Vos & C. Stevenson, *The Burden of Disease and Injury in Australia*. AIHW Cat. No. PHE 17, Australian Institute of Health and Welfare, Canberra, 1999, p. 63. YLL: years of life lost (to death). YLD: years lost due to disability.

4.10 The human story behind the high level of disability caused by mental illness is the story of considerable hardship faced by people experiencing mental illness as well as those who care for them. These hardships are documented throughout this report, but are borne particularly by the families of, and other carers for, those experiencing mental illness, and this is a focus of Chapter 11.

4.11 With so many people who experience mental illnesses becoming ill at relatively early ages, it should be no surprise that these conditions have major economic impacts. No comprehensive estimates are available, but research on three conditions – depression, bipolar disorder and schizophrenia – gives some indication of the issues. *Beyondblue* commented that the economic impact of depression was large:

Apart from the social impact of depression, we know that over \$3 billion is lost to our economy each year by not addressing the illness. These costs are not just to the health sector but include indirect costs that impact on other portfolio areas, for example welfare and disability support costs.<sup>6</sup>

4.12 SANE Australia commissioned research on the costs of two particular mental illnesses. That research showed for bipolar disorder:

The direct and indirect costs of bipolar disorder and associated suicides are substantial. Real financial costs total \$1.59 billion in 2003, 0.2 per cent of GDP and over \$16,000 on average for each of nearly 100,000 Australians with the illness. Around half of this cost is borne by people with the illness and their carers.

– Direct health system costs are estimated at \$298 million in 2003, with two-thirds being hospital expenditure, 13 per cent medical expenditure (GPs and specialists), 11 per cent residential care, 2 per cent pharmaceuticals and the remainder on allied health, pathology, research and administration.

– This represents only \$3007 per person with bipolar disorder, even less than spending on the average Australian's health care and 0.43 per cent of national health spending.

– 42 per cent of costs relate to depression, 36 per cent to mania or hypomania and 22 per cent to prophylaxis.

– Real indirect costs are estimated at \$833 million, including \$464 million of lost earnings from people unable to work due to the illness, \$145 million due to premature death (the net present value of the mortality burden), \$199 million of carer costs and \$25 million of prison, police and legal costs.

– Transfer payments are estimated at \$224 million of lost tax revenue (patients and carers) and \$233 million in welfare and care payments, primarily comprising disability support pensions.<sup>7</sup>

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6 *beyondblue*, *Submission 363*, p. 2.

7 Access Economics, *Bipolar Disorder Costs: An analysis of the burden of bipolar disorder and related suicide in Australia*, Report for SANE Australia, 2003.

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The results for an analysis of the economic impact of schizophrenia reveal even larger costs:

The direct and indirect costs of schizophrenia and associated suicides are enormous. Real financial costs of illness totalled \$1.85 billion in 2001, about 0.3 per cent of GDP and nearly \$50 000 on average for each of more than 37 000 Australians with the illness. Over one third of this cost is borne by people with the illness and their carers.

- Direct health system costs were \$661 million in 2001, including 60 per cent hospital costs, 22 per cent community mental health services, 6 per cent medical costs (GPs and specialists), 4 per cent nursing homes and 2 per cent pharmaceuticals.

- This represents nearly \$18 000 per person with schizophrenia, over six times the spending on the average Australian's health care and 1.2 per cent of national health spending. Even so, it is clear that public health spending in Australia is at the low end of the international spectrum (1.2 per cent of health spending compared to 1.6 per cent to 2.6 per cent in other comparable countries)

- Real indirect costs were \$722 million, including \$488 million of lost earnings from people unable to work due to the illness, \$94 million due to premature death (the net present value of the mortality burden), \$88 million of carer costs and \$52 million of prison, police and legal costs.

- Transfer costs were \$190 million of lost tax revenue (patients and carers) and \$274 million in welfare payments, primarily comprising disability support pensions.<sup>8</sup>

4.13 As these studies have noted, a considerable proportion of the economic costs of mental illness are borne by consumers and carers. However, there is obviously also major government expenditure on mental illness. For many years now, expenditure on mental health by governments and private health funds has been outlined in the National Mental Health Reports.

### ***Expenditure on mental health***

4.14 The different levels of government have different roles in funding the mental health care system:

State and territory governments are primarily responsible for the management and delivery of public specialised mental health services while the Australian government, as well as providing leadership on mental health issues of national significance, also subsidises the cost of primary mental health services, principally through the Medicare and Pharmaceutical

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8 Access Economics, *Schizophrenia Costs: An analysis of the burden of schizophrenia and related suicide in Australia*, Report for SANE Australia, 2003.

Benefits Schemes. The Australian government also subsidises private health insurance and directly funds a number of other initiatives...<sup>9</sup>

4.15 Total expenditure on mental health services by federal, state and territory governments and private health funds was \$3.3 billion in 2002–03.<sup>10</sup> Detailed description of historical trends and breakdowns of how the sector is resourced are covered by the National Mental Health Reports, and are not reproduced here. More detail is included in Appendix 2 to this report. Mental health funding has risen in real terms, but it has risen no faster than health funding generally.

4.16 In addition to this direct spending on mental health, there is significant indirect expenditure by governments. Indirect expenditure 'refers to the estimated costs...of providing other social, support and income security programs for people affected by mental illness'. The Commonwealth indicated it spent \$3,648.6 million across the following items:

- Income support payments.
- Workforce participation programs.
- Department of Veterans' Affairs disability compensation payments.
- Housing and accommodation programs.
- Aged care residential and community services.
- Home and Community Care programs.
- National Suicide Prevention Strategy (NSPS).<sup>11</sup>

4.17 Government expenditure due to mental illness is even broader, however. As Chapter 13 will show, a significant number of people who come into contact with the justice system, do so as a result of mental illness, and this is an economic cost of caring for the mentally ill that is 'hidden' in the budgets of state and territory correctional services authorities.

4.18 The private sector plays a significant role in mental health care:

The private sector contribution towards hospital admission that relate to MDC 19 Mental Disease and Disorders is substantial and it has increased. In the last 12 months the proportion of all mental disease and disorders treatments performed in the private sector increased by 5.7 per cent, from 37.5 per cent to 43.2 per cent (2001-02 compared with 2002-03, Data source AIHW).

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9 Mr Philip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 2.

10 Department of Health and Ageing, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005, p. 20.

11 Australian Government, *Submission 476, Attachment 2*, p. 3.

The private sector provided 95,672 in-hospital treatments for mental diseases and disorders in 2002-03. This included 73,137 same day separations and 22,535 overnight admissions. ON average each overnight admission had an average length of stay of 16.4 days. The private sector provided 443,210 patient days in private hospitals.

In 2002-03 the private sector contributed at minimum \$135 million toward the funding of in-hospital treatments for mental diseases and disorders.<sup>12</sup>

4.19 There are many non-government organisations that provide care and assistance for people experiencing mental illness. Some of these do so under government funding arrangements. Many others, such as Lifeline and GROW, do so largely on the basis of volunteer time, and donations. Lifeline Australia informed the committee that approximately 80 000 (or 27 per cent) of its counselling calls in 2002 were known to be about mental health and that a study conducted of Sydney callers found that 69.5 percent of those callers suffered from high levels of psychological distress.<sup>13</sup> Except in Victoria, Lifeline does not receive any recurrent government funding 'to manage increasing demand of mental callers'. It is interesting, however, that government agencies refer clients to Lifeline, if they are in crisis.<sup>14</sup>

4.20 A great part of the cost of care of many people experiencing mental illness is carried by their families and carers. Individual carers on average contribute 104 hours per week caring, or being on call to care, for people with mental illnesses.<sup>15</sup> Without the sustained efforts of carers and family members, the current mental health system would not function.

4.21 The costs to these families and carers are substantial. As well as direct and indirect financial costs, families bear the social and emotional costs of their family members' illnesses. Direct and indirect financial costs borne by families include:

- Ongoing expenses of health professionals, medication and health programs;
- Costs of travel whether public transport or personal petrol costs of car & parking fees;
- Replacing everyday items destroyed from loved ones inability to use or care for items (saucepans; washing machines; vacuum cleaners to personal items of clothing etc.);
- Payment of abnormal expenditure and debts incurred by loved ones;

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12 Australian Health Insurance Association, *Submission 292*, p. 4.

13 Lifeline Australia Inc., *Lifeline in Mental Health: A Perspective on the Mental Health Needs of the Australian Community 2002*, p. 9.

14 Lifeline Australia Inc., *Submission 329*, p. 3.

15 Mental Health Council of Australia in partnership with the Carers Association of Australia Inc, June 2000, *Carers of People with Mental Illness Project Final Report*, pp. 4, 12, 54.

- Loss of incomes with the need to give 24-hour care to loved ones;
- Loss of housing opportunities, living with ageing parents, substandard housing, homeless shelters; and
- Loss of careers – carers and family members' inability to fully commit to study and/or careers.<sup>16</sup>

4.22 Social and emotional costs include:

- Significant health and psychological distress experienced as a result of caring;
- Breakdown in relationships due to the burden of caring;
- Reduced quality of life – handling the myriad of issues from ongoing crises and/or relapses; and
- Loss of self worth because of the stigma of mental illness.<sup>17</sup>

4.23 Carers described the sacrifices they had made in their own lives in order to carry out their caring role. One major impact of providing ongoing care was the inability of carers to maintain full-time employment. Having to give up jobs, or reduce working hours, not only affected carers' financial wellbeing, but also their own sense of self and achievement.

I have had to leave my position as a senior social worker...after 20 years in ICU/CCU hospital settings...<sup>18</sup>

I was a very good teacher of maths and science, and, what is more, enjoyed doing it very much – all my education and experience has been lost to both myself, and the community, and my role as a carer has ensured that I enjoy an old age of certain poverty – no superannuation for me!<sup>19</sup>

4.24 For some families, lack of employment combined with the additional costs of providing care leads to poverty.

We just become poorer and poorer. I cannot get dental care; I'm on the waiting list for that. You name it; I'm on the waiting list for a number of things ranging from health care through to accommodation. I probably won't be able to keep the car going after this year. The payment I get is just not enough to live on. I can't remember our last holiday. I shop at St Vinnies, haven't had new clothes for ages. It is just so tiring trying to make

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16 Mental Health Carers Network Inc, *Submission 286*, p. 4.

17 Mental Health Carers Network Inc, *Submission 286*, p. 5.

18 Name withheld, *Submission 144*, p. 2.

19 Name withheld, *Submission 518*, p. 2.

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ends meet. It can come down to, do I buy milk and food or go to the doctors.<sup>20</sup>

4.25 This wide range of sources of funding and support does not hide two fundamental problems: not enough is spent on mental health services; and it is not clear the resources are being applied wisely.

### **Not enough is spent on mental health**

4.26 Just about every witness, whether government or non-government, peak group or special interest group, health care professional or consumer, indicated that the level of resources is inadequate.

4.27 The Mental Health Council of Australia's (MHCA) first point about resources for mental health is that there aren't enough:

The burden of mental illness and associated disability within the community is not matched by the funding allocated to prevent, relieve and rehabilitate people experiencing mental health illness.<sup>21</sup>

4.28 This message was explored in detail in their report *Not for Service*. The Australian Medical Association (AMA), in response to the release of the MHCA report stated:

The 'Not for Service' report into Australia's mental health care system reveals a sad story of inactivity, poor planning, under-funding and under-resourcing by all Australian governments in the face of one of the biggest health challenges facing the nation in the 21st century – mental health care.

At a time when demand for quality mental health services is at its highest, our national commitment to the mental health sector is frighteningly inadequate and fragmented.<sup>22</sup>

4.29 Other witnesses agreed including the Victorian Mental Illness Awareness Council, the Mental Illness Fellowship Australia, and RANZCP:

the greatest impediment to policy implementing has been the failure of government to provide adequate funding so that what is written as policy actually can happen in practice.<sup>23</sup>

Federal government needs to lead states and territories in the implementation of reforms and increase the funding allocation for mental

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20 Carer quoted in Mental Health Community Coalition of the ACT Consumer Caucus, *Submission 214*, pp. 6–7.

21 Mental Health Council of Australia, *Submission 262*, p. 1.

22 Dr Choong-Siew Yong, AMA, 'Mental Health Care in Australia in the 21<sup>st</sup> Century – 'Out of Sight, Out of Mind'', Press Release, 19 October 2005.

23 Victorian Mental Illness Awareness Council (VMIAC), *Submission 267*, p. 2. See also evidence from VMIAC, *Committee Hansard*, 5 July 2005, p. 72.

health and allied services. Australia spends less than 7 per cent of the health budget on mental health. This sum places Australia well down on comparable amounts spent by OECD countries. Despite the low funding allocated to mental health, it is the leading cause of disability.<sup>24</sup>

RANZCP believes that the mental health system in Australia has all the right fundamentals but requires additional recurrent funding. Ideally one billion dollars per year is required to reform existing mental health service systems, ensure a sustainable workforce, address equity issues and ensure the provision of an agreed level of service delivery in all geographic areas.<sup>25</sup>

4.30 Medicines Australia considered that 'More resources need to be devoted to treat mental illness, given the disease burden placed on the Australian community'.<sup>26</sup> *Beyondblue* broadly concurred:

One billion dollars is required as an injection for mental health, with the Federal Health Minister taking on portfolio responsibility to lead a reform agenda. The wider costs associated without a social coalition approach cannot be underestimated.<sup>27</sup>

4.31 This need reflects widespread public perceptions, reflected in the 70 letters sent as part of one write-in campaign to the committee's inquiry,<sup>28</sup> as well as many individual submissions by carers and consumers:

One of my adult daughters, who lives in NSW, has suffered from schizophrenia for over ten years. During that time it has become more and more apparent to me and other family members that there are many inadequacies and gaps in the provision of adequate mental health care and community support services for someone with her condition. I think that the majority of these matters are a direct result of inadequate funds and resources being available to mental health services.<sup>29</sup>

4.32 While there was a strong consensus on the general lack of funding for mental health, there were also specific areas where that lack of resources was perceived to create particular problems. The most prominent concern was the lack of support for counselling, psychological services and talk therapies:

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24 Mental Illness Fellowship of Australian Inc., *Submission 402*, p. 2.

25 The Royal Australian and New Zealand College of Psychiatrists, *Submission 323*, p. 3.

26 Medicines Australia, *Submission 389*, p. 3.

27 *beyondblue*, *Submission 363*, p. 2.

28 Standard letter, *Submission 154*.

29 Name withheld, *Submission 55*, p. 1. See also *Submissions 251, 375*.

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Patient out-of-pocket costs are probably a key reason why few people with depression or anxiety currently receive CBT, despite considerable evidence for its cost effectiveness.<sup>30</sup>

4.33 Dr Gil Anaf agreed, saying:

I am most interested to reverse an ill-informed push that aims to reduce access to long term therapy services, and that aims to only promote medication and quick-fix therapies as the main rebatable treatments.<sup>31</sup>

4.34 This position was also supported by the National Association of Practising Psychiatrists, which indicated:

Psychiatrists are placed in an untenable ethical situation of having to refuse appropriate treatment, where no other treatment would be efficacious, because most patients do not fulfil the criteria of Item 319, and because they cannot afford to treat more than one or two, or no, patients at half the fee. Most patients cannot afford to pay half of the schedule fee if they receive intensive treatment because many psychiatric patients are vocationally and thereby financially disadvantaged. This legislation contravenes the mandate of Medicare of equity of access.<sup>32</sup>

4.35 Psychologists Rudd and Jackson agreed:

Cost of services is a major barrier for many in need, and not just at the individual client level. For example, in Victoria, it has been reported that teachers with special needs students (including mental health difficulties) often find it difficult to access specialist Psychologist services because of lack of funding.<sup>33</sup>

4.36 More generally, there was concern that the high level of copayments was an issue, particularly for those without private health insurance:

Co-payments are preventing people access to quality health service. Without measures to reduce copayments, the Commonwealth Fund will continue to document financial barriers to access for a significant percentage of Australians. Those with mental illnesses will be amongst the most likely to suffer.<sup>34</sup>

I can't afford psychological counselling even with the \$50 refund provided by my private health fund. My annual net medical expenses are already about \$7000. Medicare Plus also provides reimbursement of \$50 for up to

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30 C. Mihalopoulos, L. Kiropoulos, S. T-F Shih, J. Gunn, G. Blashki and G. Meadows, 'Exploratory economic analyses of two primary care mental health projects: implications for sustainability', *Medical Journal of Australia*, vol. 183, no. 10, p. S75.

31 Dr Gil Anaf, *Submission 265*, p. 2.

32 National Association of Practising Psychiatrists, *Submission 202*, p. 34.

33 Raymond Rudd and Professor Henry Jackson, *Submission 401*, p. 6.

34 Doctors Reform Society, *Submission 220*, p. 2.

five counselling sessions in a year but five sessions is not enough and it is still expensive.<sup>35</sup>

4.37 The Australian Council of Social Services (ACOSS) and others were concerned about equity of access, citing as an example:

psychological counselling services, [which] are highly restricted within the public system but available to those with sufficient private means and/or private health insurance.<sup>36</sup>

4.38 Australian College of Psychological Medicine noted:

Many sufferers from significant mental health disorders require a multi-disciplinary approach, with the majority of them too socially disadvantaged to afford private health insurance.<sup>37</sup>

4.39 BlueVoices reported a consumer saying 'I cannot afford private health insurance so my only option for treatment is medication'.<sup>38</sup> This seems a recurrent and disturbing complaint. BlueVoices also indicated that:

many consumers report to us that unless they have private health insurance they are unable to afford the recommended fee of the Australian Psychological Society for cognitive behaviour therapy from a Registered Psychologist.<sup>39</sup>

### **Inappropriate targeting of spending on mental health**

4.40 While the dominant theme in the inquiry was the inadequacy of spending on mental health, issues were also raised around how that spending was being prioritised and administered. A question repeatedly raised about the allocation of funding for mental health, is why mental health does not receive a greater proportion of the health budget:

In Australia, the provision of mental health services receives an inappropriately low priority having regard to the large number of people affected, the high burden of disability, the untoward impact on service-deprived sub-groups within the community and the missed potential for the cost-effective achievement of better health outcomes. International comparisons of mental health spending are dated (circa 1993) but suggest a spending shortfall in Australia compared to Canada, the US and the Netherlands. A decade or so after the deinstitutionalisation of mental health,

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35 Name withheld, *Submission 251*, p. 1.

36 ACOSS, *Submission 457*, p. 11.

37 Australian College of Psychological Medicine, *Submission 411*, p. 6.

38 bluevoices, *Submission 259*, p. 22.

39 *Submission 259*, p. 22.

it is now obvious that governments did not ensure enough resources for the new community-based care structures to operate effectively.<sup>40</sup>

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The *Sane Mental Health Report 2004; 'Dare to Care'* states that Australia spends less than 8 per cent of its national Health Budget on mental health. The same report asserts that comparable OECD countries spend upward of 12 per cent of their health budget on mental health.<sup>41</sup>

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While total health funding has grown over the life of the National Mental Health Strategy, spending on mental health has remained static in comparison with overall health spending; yet mental health has grown as a component of the overall health burden.<sup>42</sup>

4.41 Another recurrent theme was the contrast between the mechanisms for Commonwealth funds allocation and those of the states and territories. Victoria argued:

The Commonwealth funded health care system also constrains and provides barriers to improving services to people with serious mental illness. For example, newer atypical pharmaceuticals used to treat psychosis are not always funded by the Pharmaceutical Benefits Scheme so the states must find this funding. Additionally, the Medicare Scheme does not impose significant restrictions on the number of visits to private psychiatrists. Neither are there adequate controls over the distribution of private psychiatrists, nor on priority of access for those people most in need. Few incentives exist for psychiatrists to take on new clients or to work in a public sector with capped funding and more complex clients...

4.42 The South Australian Government described the problems of coordinating services 'when enhancement monies from the Australian Government may promote particular or specific aspects of a service only'.<sup>43</sup> The Queensland Government noted the difficulties faced by the states and territories in 'invest[ing] new monies each year on a recurrent basis, representing real growth in monetary terms', which results in them having to 'fully fund reform'.<sup>44</sup> The Victorian Government argued:

More weight should be given to the constraints the states and territories operate under that impact on the rate and extent of change. These constraints include capped budgets and high levels of non-discretionary expenditure related to meeting statutory obligations to involuntary clients.<sup>45</sup>

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40 AMA, *Submission 167*, p. 1.

41 Standard Letter, *Submission 154*, p. 1.

42 Mental Health Council of Australia, *Submission 262*, p. 2.

43 Department of Health – South Australia Government, *Submission 506*, p. 4.

44 Queensland Government, *Submission 377A*, p. 13.

45 Victorian Minister for Health – Victorian Government, *Submission 445*, p. [5].

4.43 There was particular concern about the direction of funds to medication and away from other therapies. Over the nine-year period of the mental health strategy:

the Australian Government's contribution increased 127 per cent, though 66 per cent of this increase was accounted for simply by the increase in expenditure on medications through the Pharmaceutical Benefits Scheme. While new medications play an important role in improving mental health outcomes, to achieve value for money they need to be backed by complementary psychological, social, informational and self-management strategies. To date, significant developments in these other areas have been promising but limited in scope or reach (Hickie et al. 2004) and now require more overt long-term support by the Australian Government.<sup>46</sup>

Psychotherapy (such as Cognitive Behavioural Therapy) has proved to be a cost effective treatment for some mental disorders, especially anxiety and depression. However, under the current Medicare arrangements, Medicare only funds psychotherapy costs where the provider is either a psychiatrist or a general practitioner with some welcome, but limited provision, for psychology services through new initiatives such as Better outcomes in Mental Health. This effectively restricts longer term psychotherapy access to those people who either have ancillary private health insurance (for a psychologist only) or can afford to pay the costs themselves, or to seek treatment from a psychiatrist or general practitioner, or public mental health services.<sup>47</sup>

4.44 The Western Australian Government also commented on the true basis for the increase in expenditure on mental health by the Australian Government since 1993:

When this increase (65 per cent in real terms) is further examined it is found that in constant prices the major area of growth is in Pharmaceuticals provided under the PBS. The increase in expenditure for psychiatric drugs is nearly 600 per cent during this time period and accounts for nearly two thirds of all the growth in Federal mental health expenditure.<sup>48</sup>

4.45 Other concerns have also been raised about the allocation of resources, including that research on mental illness is under-resourced:

At present, Australia spends 3 per cent of funding on mental health research, compared to 9 per cent for cancer research. The 8.9 per cent of NHMRC funds spent on mental health is small when compared to the 19.1 per cent contribution of mental disorders to disease burden in Australia. Compared to other OECD countries, Australia spends relatively little on research.<sup>49</sup>

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46 I. Hickie, G. Groom and T. Davenport, *Investing in Australia's future*, December 2004, p. 32.

47 Victorian Minister for Health – Victorian Government, *Submission 445*, pp. 6, 11.

48 Department of Health – Government of Western Australia, *Submission 376*, p. 16.

49 Centre for Mental Health Research, *Submission 186*, p. 2.

4.46 The Commonwealth was critical of the argument that money should be allocated directly according to percentage of disease burden. Pointing out that costs of treatment vary from illness to illness, Mr Davies of the Department of Health and Ageing said:

to argue that the spending should be proportionate to the burden of disease is not a safe line of argument to pursue, because obviously the costs of treating different types of conditions vary. Just because something is 10 per cent of our burden of disease, to argue we should spend 10 per cent of our health budget on it is not really a logical line of argument.

CHAIR—What is the argument? What is the line of establishing what the level of spending is for particular burdens of disease?

Mr Davies—Spending in health care and the allocation of resources between different conditions is essentially a social, political, societal decision. In terms of the services we fund, as the Australian government, all that Medicare spending, the PBS spending, is ultimately determined by people's propensity to seek out services and doctors' propensity to prescribe. There is no cap on the total MBS or PBS budget, nor is there an allocation of that as between mental health and other services. It is very much demand driven for the Australian government funding.<sup>50</sup>

4.47 The committee formed a clear impression that while Mr Davies may be correct, the prevailing 'social, political, societal' view is that resources for mental health are deficient.

4.48 Consumer groups are concerned about whether consumers have an adequate role within the funded health care system:

Consumer self advocacy groups, organisations and individuals have insufficient funding to provide the overwhelming support needs of consumers whose rights have been abused. Nor do we have funding to provide the kinds of alternative supports that we know will work for many of us. Nor do we have funding to allow us to hold forums, conferences, communicate with each other. Without funding we remain voiceless and disconnected. Without funding we cannot participate in any of the ways that our mental health policies tell us we should be participating.<sup>51</sup>

4.49 It was also argued that funds provided to advocacy groups have not been targeted appropriately:

Current funding to consumer groups hosted and controlled by groups such as MHCA and 'beyondblue' is a misuse of these limited funds and needs to be redirected to genuine consumer-survivor organisations.<sup>52</sup>

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50 Mr Philip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 53.

51 insane australia, *Submission 2*, p. 1.

52 insane australia, *Submission 2*, p. 8.

4.50 Non-government organisations (NGO) are an integral component of the mental healthcare workforce, providing much-needed services to the community that are either not available – or in short supply – through the public or private systems. Federal, state and territory funding to NGOs, particularly funding allocated on a recurrent basis, is severely limited, reducing the ability of NGOs to provide an optimal level of service. NGOs reported that the shortage of funding has resulted in having to turn away people who are in need of help. These matters are examined in Chapter 9. Instead of funding NGOs, including consumer-run organisations, the vast majority of resources continue to be channelled to the public and private for-profit organisations.

### ***The problem of the pilot***

4.51 As the committee travelled across Australia, it kept hearing about promising pilot schemes, project trials and new program proposals that were not receiving funding support. There were recurrent complaints that pilots were not rolled out to a broader public, regardless of their success; that projects were not placed on a sustainable budget basis; and that groups applying for grants could not effectively plan for the future of their operations.

4.52 The MHCA submitted:

Australia is often known as “the land of pilots”, and with good reason. The mental health sector is littered with project and pilots that are funded for a short period and then abandoned.<sup>53</sup>

4.53 The NT Mental Health Coalition submitted that:

... over the past few years the federal government has funded some very innovative and effective 'pilot projects'. However, the lack of ongoing funding for these projects from either the federal or NT governments has resulted in the loss of good services and clients having expectations being raised only to be disappointed.<sup>54</sup>

4.54 St Luke's Anglicare Limited, which offers Psychiatric Disability Rehabilitation and Support programs stated:

Our agency has been able to provide some pilot recovery programs for young people who experience psychosis but we have no recurrent funding to support these early intervention recovery and rehabilitation programs in the longer term. Philanthropic sources of funding are very limited for this group of consumers.<sup>55</sup>

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53 Mental Health Council of Australia, *Submission 262A*, p. 1.

54 NT Mental Health Coalition, *Submission 409*, p. 4.

55 St. Luke's Anglicare Limited, *Submission 345*, p. 1.

They recommended that recurrent funding be provided for such services so that target programs for young adults could be offered.<sup>56</sup>

4.55 The SA Divisions of Private Practice also raised concerns about the current practice of providing short-term funds for pilot programs:

... Divisions of General Practice have a history of episodic, short-term project, and pilot funding by government. This is also evident in other parts of the health system, especially for work that seeks to bring about system change. By the time one project nears completion, the funding agenda has moved on and hence the opportunity to capitalise on the learnings and apply them more broadly is lost. SADI recently had the experience of a successful pilot project which aimed to re-align private psychiatrist practice. ... This project was terminated by the Commonwealth Government Department of Health and Ageing at the completion of the pilot phase ... The termination occurred before the planned (and paid for) evaluation had been completed or submitted. No evidence was provided as to why this decision was made. It was clearly not based on objective analysis of the comparative evaluation data. Short term episodic funding often makes the whole system worse, as clinicians, consumers and carers become cynical. ... Pilot projects need to be a part of an overall strategy, and if they show benefit, need to be rolled out more broadly.<sup>57</sup>

4.56 Concern about insecure funding and a preponderance of pilot projects was shared by other groups.<sup>58</sup> The committee heard about a dieting disorder pilot program that was neither continued nor expanded, despite no evidence to suggest it had produced poor results.<sup>59</sup> It heard about the lack of recurrent funding to indigenous community-controlled health organisations being linked to service delivery inefficiencies.<sup>60</sup> Similar stories were recounted by many organisations, particularly those in the non-government sector involved in advocacy, support and service delivery.

4.57 MHCA identified a number of difficulties for organisations and programs that receive short-term funding, including that: consumers, their carers and families become distressed, with adverse effects on their mental health, when a successful program is cancelled; uncertainty regarding tenure acts as a barrier to recruiting and retaining quality staff; organisations suffer a loss of corporate knowledge; and organisations can be prevented from engaging in long-term planning.<sup>61</sup> The St.

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56 *Submission 345*, p. 2.

57 SA Divisions of General Practice, *Submission 88*, p. 4.

58 See for example, Council to Homeless Persons, *Submission 315*, p. 6; Mental Health Council of Tasmania Inc, *Submission 455*, p. 1; Anglicare Tasmania, *Submission 464*, p. 18.

59 Centre for Eating & Dieting Disorders, *Submission 307*.

60 Central Australian Aboriginal Congress, *Submission 486*, p. 2.

61 Mental Health Council of Australia, *Submission 262A*, p. 1.

Vincent de Paul Society also identified those difficulties for organisations and recommended a return to recurrent funding to guarantee continuity of programs.<sup>62</sup>

### **What more is needed?**

4.58 More funding is needed for mental health care, but attention needs to be paid to more than just the amount. The committee heard that other areas of concern are that mental health care be extended to more people; that enhanced resourcing must go hand in hand with continuing reform; that there be better integration of services; and there be more accountability for and evaluation of mental health expenditure.

#### ***Greater resources***

4.59 Witnesses made suggestions about how much extra funding was needed. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) believes that:

... the mental health system in Australia has all the right fundamentals but requires additional recurrent funding. Ideally one billion dollars per year is required to reform existing mental health service systems, ensure a sustainable workforce, address equity issues and ensure the provision of an agreed level of service delivery in all geographic areas.<sup>63</sup>

4.60 In an answer to a question from the committee about the application of those funds, RANZCP responded as follows:

... the RANZCP seeks a level of funding for mental health care commensurate with the burden of the disease. We provide below a breakdown of the major targets for increased funding.

- An additional \$500 million a year is required for primary mental health care, including access to allied health professionals, the Better Outcomes in Mental Health Care Initiative, and reform of the Medicare Benefits Schedule rebate for psychiatrists to encourage better delivery of consultancy services.
- Youth mental health requires an additional \$50 million per year.
- Funding for mental health research should be increased from \$15 million to \$50 million per year.
- The remaining funding we envisage would be spent on the following components, although these components are not all individually costed.
- Employment participation, including:
  - Specialised schemes for people on a Disability Support Pension to resume work;

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62 St Vincent de Paul Society, National Mental Health and Homelessness Advisory Committee, *Submission 478*, p. 12.

63 Royal Australian and New Zealand College of Psychiatrists, *Submission 323*, p. 3.

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- Trials of workplace mental health awareness, screening and implementation programs.
  - Population measures (such as destigmatisation programs, community education, prevention, and early intervention).
  - Assistance for consumers and carers.
  - Annual and independent reporting on progress in national mental health reform (\$300,000 per year).<sup>64</sup>

4.61 The RANZCP expected that the money would come from the states and territories, as well as the Commonwealth and did not consider that funds should be transferred from other areas of the health budget.<sup>65</sup>

4.62 As stated earlier Medicines Australia recommended a similar increase in funding, as did the MHCA:

Increase expenditure on mental health by \$1.1 billion per year over the next ten years, refocus funding on the full spectrum of service provision system and adjust existing funding mechanisms to bring them into line with the new funding (not the other way around as is more usual).<sup>66</sup>

4.63 The MHCA also submitted that the recommended increased funding should be applied differently from current funding:

We submit that, while significantly more funds are needed to deliver acceptable mental health care, on their own they will not fix the problems, merely deliver the same sort of services more widely. The Strategy has got the broad policy right but continuation of its present approach will waste money and lives. What is needed is:

- leadership,
- accountability,
- governance, and
- investment in research and innovation.<sup>67</sup>

4.64 ORYGEN provide specialised mental health services for youth aged 12-25 years, and have advocated a roll out of their services to youths nationwide. This involves the establishment of 30 new services units across Australia to serve an equivalent number of young people as is currently occurring through ORYGEN's Victoria-based model. It is estimated that eight specialised mental health services for youth would be required in NSW, seven in Victoria, five in Queensland, three each in

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64 Royal Australian and New Zealand College of Psychiatrists, *Submission 323A*, pp. 1–2.

65 *Submission 323A*, p. 2.

66 Mental Health Council of Australia, *Submission 262*, p. 2.

67 *Submission 262*, p. 11.

Western Australia and South Australia, two in Tasmania and one each in the Northern Territory and Australian Capital Territory.

4.65 ORYGEN have estimated the annual operating costs for each service at \$17.5 million, with a total recurrent cost of \$525 million per annum.<sup>68</sup> Some of these costs would be offset by the re-distribution of existing resources within Child Adolescent Mental Health Services and Adult Mental Health Services. However, capital costs would also be required to establish the new services.<sup>69</sup>

4.66 ACOSS expressed concern about where extra resources should go:

Calls for major increases in the mental health budget must be weighed carefully against other options, which may help lower the incidence and severity of mental illness and its impact at the individual and community level.<sup>70</sup>

### ***More coverage***

4.67 Only approximately 40 per cent of people with mental health disorders access professional help. As the MHCA asked:

What other health sector would accept a non-response rate of 62 per cent in any 12 month period.<sup>71</sup>

4.68 Families, carers and community groups are left to deal with the majority of untreated cases. Yet:

Nobody suggest that we restrict funding for osteoarthritis so that we only treat half the sufferers and require the community groups to provide exercise and weight loss programs to the remainder. Nor do people suggest we restrict the supply of statins to reduce cholesterol levels to half the people with high cholesterol and require community groups to encourage lifestyle modifications for the remainder of people at risk of cardiovascular disease. Why do we accept low coverage levels and inadequate treatment for people with mental disorder? It is one of the enduring puzzles that is not unique to Australia.<sup>72</sup>

4.69 Professor Gavin Andrews argued that the necessity for greater funding is not to improve existing care, but to meet this significant unmet need:

We do not need additional funds to provide care to the 40 per cent of the people currently consulting, we just need good management to ensure that the appropriate care is supplied in the least restrictive environment. We

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68 ORYGEN Research Centre, *Submission 284b*, p. 10.

69 ORYGEN Research Centre, *Submission 284b*, p. 10.

70 Australian Council of Social Service, *Submission 457*, p.2.

71 MHCA, *Submission 262*, p. 4.

72 Dr Gavin Andrews, *Submission 176*, p. 11.

will need to double the funds if we are to double the proportion of people in need who are seeking care, to the level of people with physical disorders who seek care. I cannot think of any justification for the under-treatment of people with mental disorders.<sup>73</sup>

4.70 There are thus at least two drivers of increasing expenditure: the need for better services; and the need to serve more people.

### **More reform**

4.71 As Chapters 8 and 9 will reveal, the transition from the old psychiatric institutions to mainstream hospitals and community-based care is incomplete, and some believe it is a reform agenda that has stalled. One of the key consequences of the slowness of reforms is that funds fail to be freed up for new initiatives and high priority needs. Failure to close stand-alone institutions, a phenomenon most marked in NSW and South Australia, creates budget pressures that prevent the transformation of the mental health care system.<sup>74</sup> This is because without the closures, savings are not available to be reallocated to other services. This is consistent with the experience of reform in Italy, in which the closure of institutions helped force the development of effective community care.<sup>75</sup>

4.72 While the closure of institutions may have forced Australian governments to develop community care, this can hardly be said to be adequate. Anglicare Tasmania quoted from a study of the effects that the closure of institutions has had on homelessness, in which it is suggested that authorities failed to recognise the range of services that institutions provided, including the provision of housing, and to fully cost and transfer those functions to community programs.<sup>76</sup>

4.73 Boystown identified a number of areas for reform:

Review costs associated with the delivery of integrated mental health care. Special attention should be paid to decision making processes for listing psychotropic medications under the Public Benefits Scheme and the availability of comparable generic alternatives; access to bulk billing services; and the criteria for accessing the Disability Support Pension.<sup>77</sup>

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73 Dr Gavin Andrews, *Submission 176*, p. 11.

74 V. Gerrand, 'Can Deinstitutionalisation Work? Mental health Reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review*, vol. 14, no. 3, 2005, p. 267; Commonwealth Department of Health and Ageing, *National Mental Health Report 2000: Sixth Annual Report*, Department of Health and Ageing, Canberra, 2000.

75 M. Hazelton, 'Mental Health Reform, Citizenship and human Rights in Four Countries', *Health Sociology Review*, vol. 14, no. 3, p. 235.

76 Anglicare Tasmania, *Submission 464*, p. 10.

77 Boystown, *Submission 107*, p. 2.

4.74 Many areas for further reform are discussed in more detail in subsequent chapters of the report.

### ***More integration***

4.75 A more collaborative approach between all levels of government is required to address the current 'crisis' in service delivery. The Parliamentary Secretary to the Minister for Health and Ageing, the Hon Christopher Pyne MP, outlined his view of the importance of addressing mental health issues in the National Mental Health Report 2004:

I...am aware that improving the mental health of the community requires coordination across diverse areas of public policy, both within and external to the health portfolio. Coordination with action taken under the National Drug Strategy and the National Suicide Prevention Strategy is especially critical, but the need for linked initiatives extends to areas such as housing, employment, social security, crime prevention and justice. Mental health can no longer be treated as an isolated issue.<sup>78</sup>

4.76 The Parliamentary Secretary went further on a subsequent occasion, saying that

Australia's states and territories stand condemned for their failure to deliver adequate mental health services . . . perhaps it is time for them to cede their responsibility for mental health to the Commonwealth.<sup>79</sup>

4.77 Professor Andrews argued that these comments reflect concern both about the effects of federalism, and the effects of poorly coordinated services:

Part of [Pyne's] rhetoric should be viewed in the light of federal–state relationships. However, part does reflect the uncoordinated way we fund our health systems — Medicare and Pharmaceutical Benefits at the federal level, private health insurance, the state and territory provision of public-sector services, and rising out-of-pocket expenses at the individual level. A coordinated funding system would be preferable.

There are six contributors to Australia's mental health service — general practitioners, private psychiatrists, private psychologists, private hospitals, state inpatient and community services, and non-government charitable

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78 Department of Health and Ageing, *National Mental Health Report 2004: Eighth Report – Summary of changes in Australia's Mental Health services under the National Mental Health Strategy 1993-2002*. Commonwealth of Australia, Canberra, 2003, p. i.

79 C. Pyne, States stand condemned over their failure to deliver on mental health care [media release], Canberra: Australian Government Department of Health and Ageing, 24 February 2005, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2005-cp-pyn006.htm>, (accessed March 2006).

organisations. The work of these contributors is poorly coordinated. It is like a six-horse chariot with six horsemen who seldom communicate.<sup>80</sup>

4.78 Others expressed similar concerns, complaining that both governments and some individual agencies were 'passing the buck' for providing better services:

There needs to be more resources as well as a better use of existing resources and an acknowledgement that all Australian governments must work together to provide adequate services for the mentally ill...

The statement by Christopher Pyne, Australian Government Parliamentary Secretary for Health: "Australia's States and Territories stand condemned for their failure to deliver adequate mental health services" indicates a buck-passing mentality that is part of the problem.<sup>81</sup>

A whole-of government approach to mental health policy and funding should emerge from the Commonwealth, in order to see the same level of integration in the States' delivery of services. ...resources could be better utilised if various silos of government were to develop more effective collaborative arrangements...

The prerequisite to achieving this is that the policy dialogue moves away from what have become traditional notions of 'core business' beyond which an agency will accept no responsibility, towards a 'without prejudice' discussion of those issues which no single agency can hope to resolve and which are therefore 'everybody's business'<sup>82</sup>

4.79 The patchwork of federal and state funding, coupled with the provision of direct and indirect government funding to non-government organisations, and a growing and changing role for the private sector, means that integration, while vital, is a constant challenge.

4.80 The AMA was also critical of the way in which funds are utilised within the mental health service sector:

Existing funding mechanisms favour defined episodes of care. However the mental health conditions that generate the highest burden of disease are chronic conditions and they require longitudinal care. The Commonwealth/State funding arrangements are dysfunctional, funds are wasted in duplication of administration and policy formulation while a silo mentality detracts from the continuum of care.<sup>83</sup>

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80 G. Andrews, *The crisis in mental health: the chariot needs one horseman*, Medical Journal of Australia, vol. 182, no. 8, 2005, p. 372.

81 St Vincent de Paul Society, National Mental Health and Homelessness Advisory Committee, *Submission 478*, p. 7.

82 Office of the Public Advocate – Queensland, *Submission 303*, p. 9.

83 AMA, *Submission 167*, p. 1.

4.81 A consumer group said:

One of the biggest sticking points for mental health services, including community non-government organisations, is that the co-ordination of funding between commonwealth and state governments via the CSDA agreement is an absolute bureaucratic nightmare, full of gaps, centres more on “let’s try and short change this government or that health service provider” than actually adequate[ly] funding in ‘real’ terms the ‘real’ costs of mental health service delivery that meets the needs of people with a mental illness.<sup>84</sup>

4.82 RANZCP submitted that care must extend beyond mental health care to all other relevant services needed by patients (general health care, financial support, housing, substance abuse, rehabilitation etc.) and that the development of a single integrated health system would require the removal of structural barriers at state and Commonwealth levels, and substantial reform in both sectors.<sup>85</sup>

4.83 RANZCP suggested the following strategies to achieve better coordination:

- the re-integration of drug and alcohol and dementia services with mental health services;
- inclusion of developmental disability services as an essential component of the service matrix;
- funding of nursing and allied health professionals in private psychiatric outpatient practices such as More Allied Health Services (MAHS);
- development of “stepped care” systems linking GPs and state mental health services in the care of common and severe disorders, including prioritisation of GP referrals over self-referrals in state services; and
- encouragement of integrated staffing models, with more flexible arrangements for public and private psychiatrists to work together will also strengthen system effectiveness.<sup>86</sup>

### ***More accountability and evaluation***

4.84 As already outlined, funding for mental health is a complex patchwork of direct and indirect expenditure, by different levels of government, with spending based on numerous different policies, formulae and guidelines. The National Mental health Strategy is meant to place the resourcing of mental health in a coherent strategic framework, but it lacks a sharp focus and was widely condemned for having few measurable performance benchmarks:

Unfortunately, what has been lost in this complex model of funding and evaluation is effective service provision to the consumers, the people at the

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84 Northern Beaches Mental Health Consumer Network, *Submission 60*, p. 6.

85 Royal Australian and New Zealand College of Psychiatrists, *Submission 323*, p. 5.

86 *Submission 323*, p. 5.

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heart of the issue. The National Mental Health Strategy is not delivering mental health services effectively or efficiently because it focuses on the process of managing funds and statutory relationships, not on providing services to those people who desperately need them.<sup>87</sup>

4.85 The regular publication of National Mental Health Reports provides a mechanism for accounting for expenditure on and provision of mental health services at an aggregated level. However, dollar figures and trends alone do not provide a complete picture on whether expenditure has had any meaningful impact on service provision and better mental health outcomes:

Whilst there have been eight National mental health reports since 1994, there is still no accounting in them for the number of people that are actually seen and treated in mental health services and whether they are seen face-to-face, or merely by telephone contact. This contrasts with very specific details of the number of Australians treated and even the number of hours spent treating consumers by private psychiatrists in the private mental health sector. While the private mental health sector has been collecting outcome measures of consumers treated in private psychiatric hospitals over the last three years, the public mental health system is only just starting to approach such a project. There are also rumblings from public sector clinicians that unless there is a very significant increase in funding for such data collection, the outcome measurement process is likely to further undermine the management of consumers in the public mental health system.<sup>88</sup>

4.86 Additionally, it is not clear that the data that is contained in the National Mental Health Reports findings necessarily reflect the real position. The Australian Psychological Society (APS) submitted:

Although financial reports support the conclusion that funding for mental health services has kept pace with that provided to other areas of health, there is a strong sense from workers in mental health facilities that positions have been lost, budgets reduced and less and less services are able to be provided. Repeated reports from APS members working in institutions or under specific programs have raised concerns regarding this reduced level of funding for mental health services by state and local instrumentalities. Although these situations are clearly anecdotal, they are indicators of a crisis which we believe currently exists in public mental health services.<sup>89</sup>

4.87 The MHCA also criticised the lack of accountability for the provision of mental health services:

Over half of all public mental health services had not even reviewed their performance against these standards [National Standards for Mental Health

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87 Mental Health Council of Australia, *Submission 262*, p. 4.

88 AMA, *Submission 167*, p. 19.

89 The Australian Psychological Society Ltd, *Submission 50A*, p. 11.

Services] by June 2003, some seven years after they were agreed to by all governments. This is a very clear example of the lack of accountability and commitment to mental health by all Australian governments. The reality of the reports of consumers, carers and providers is that they put flesh on the difficulties of a system struggling to cope with the human cost of the huge gap between policy and its implementation.<sup>90</sup>

4.88 The National Mental Health Centre submitted:

Crucial to addressing underlying impediments to realization of these rights, such as disproportionately low mental health service funding and priority from a whole-of-government perspective is the development of a mechanism to ensure transparent service delivery and proper accountability of mental health providers. Lack of accountability and secrecy systemically undermine the legitimacy of complaints of people who have mental illness and the confidence the community can have in the complaints systems and services themselves.<sup>91</sup>

4.89 Part of the dysfunction of current funding arrangements may well be attributable to the lack of discernable population health monitoring. Professor Anthony Jorm of the ORYGEN Research Centre advised:

It is amazing that we know so little about whether mental health in Australia is improving, worsening or stable. The only routinely collected indicator of population mental health is the suicide rate.... We need to have other population indicators which will monitor how we are doing as a nation and allow resources to be focussed on sub-groups that are not doing well.<sup>92</sup>

4.90 Professor Jorm further posits the question:

Why doesn't Australia already have population monitoring? The Australian Bureau of Statistics has been collecting national data on mental health since the 1980s. However, they have changed the measure they have used several times, making comparison over time impossible. Even when a consistent measure has been used, other aspects of the methodology have been changed. There is a need for consistent measures collected at regular intervals using the same methodology.<sup>93</sup>

4.91 Catholic Health Australia stated that governments should be aiming towards marked percentage improvements in the health status and quality of life in the population generally and in particular for vulnerable groups and recommended that:

Commonwealth and State/Territory Governments ... set targets for improvements in mental health outcomes across the community and for

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90 Mental Health Council of Australia, *Submission 262*, p. 14.

91 The Mental Health Legal Centre, *Submission 314*, p. 6.

92 Professor Anthony Jorm, *Submission 178*, p. 3.

93 *Submission 178*, p. 3.

specific groups in greatest need and be held accountable for meeting these targets.<sup>94</sup>

4.92 The AMA suggested that the following themes should be included in accountability mechanisms:

The importance of a proper econometric analysis of the need, including the unmet need, for mental health services in Australia with this analysis incorporated into future National Mental Health reports.

- The desirability of mandatory reporting by State and Territory jurisdictions of the number of people treated and whether those people are treated face-to-face or by telephone.
- The need for a significant increase in the resources for outcome measurement in the public mental health system.<sup>95</sup>

4.93 It was widely argued that the establishment of a national mental health commission would be a major step towards ensuring proper accountability for mental health provision. A group of Australia's most prominent mental health experts made a compelling case for the establishment of an independent Mental Health Commission to fill the role of anti-discrimination campaigner, information repository and leader of coordinated mental health reform.<sup>96</sup> The authors cited the successful New Zealand Commission as particularly suggestive for Australia, but also referred to similar bodies in the United States and the United Kingdom.<sup>97</sup> The New Zealand Commission has widespread powers encompassing:

- human rights and anti discrimination agendas without being restricted to these agendas (as would a commission set up under the HREOC);
- a formal mandate to monitor and identify service gaps, oversee training and performance management and conduct evidence based reviews and consultations;
- an ability to provide continuity through government change; and
- the capacity to pursue a positive political agenda, avoiding sequential and often unproductive inquiries.<sup>98</sup>

4.94 The model is distinctive in that the Commission is established by legislation for a defined period, to perform specified tasks to a set time frame, with the options of

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94 Catholic Health Australia, *Submission 276*, p. 16.

95 AMA, *Submission 167*, p. 28.

96 A. Rosen, P. McGorry, G. Groom, I. Hickie, R. Gurr, B. Hocking, M. Leggatt, A. Deveson, K. Wilson, D. Holmes, V. Miller, L. Dunbar and F. Stanley, 'Australia Needs a Mental Health Commission', *Additional Information: item 11*.

97 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

98 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

extensions until its work is assessed to be completed.<sup>99</sup> 'ultimately, doing itself out of a job becomes the measure of its success'.<sup>100</sup>

4.95 Particularly promising is the potential to override federal, and state and territory tensions with their resulting 'buck passing' and compartmentalisation of services. Despite concerns that the NZ Commission would act as an unconstructive critic of Government, the NZ Ministry of Health, Directorate of Mental Health, has found it has been a most effective partner 'walking alongside us' in the reform process.<sup>101</sup>

4.96 Under the auspices of the New Zealand Commission, mental health reform has replicated or adapted several Australian mental health initiatives.<sup>102</sup> However, in New Zealand these reforms were embedded after wide consultation and appraisal of the international evidence base; service gaps were then identified and resources accurately costed to fill these gaps.<sup>103</sup>

4.97 Many others were supportive of a commission. The Mental Health Legal Centre, for example, submitted:

... the establishment of an adequately empowered and independent national complaints and accountability mechanism may well be the only way to address the serious deficiencies in terms of both 'civil libertarian' and service access and quality rights which endure, Burdekin Report and National Mental Health Strategy notwithstanding.<sup>104</sup>

4.98 The MHCA suggested:

That the Commonwealth Government establish regular, frequent and formal reporting mechanisms to the Prime Minister and Heads of Governments on specific key indicators including an annual public report to the Prime minister, 'The State of our Mental Health', with data which reflects user and carer experience, not just system measuring indicators. Leadership of this process should be vested in an independent, empowered national office or person with direct access to the Prime Minister.

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99 The Commission became a separate Crown entity with the enactment of the *Mental Health Commission Act 1998*, which was amended to extend it from 2001 to 2004. It was recently further extended until 2007. 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 214.

100 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

101 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

102 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 218.

103 Resulting an increase of funding to 250 percent of the average per capita expenditure in Australia and considerably more than public and private mental health per capita expenditure combining public and private expenditure. 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 216 and see table in *Additional Information: item 11*, p. 214.

104 The Mental Health Legal Centre, *Submission 314*, p. 6.

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That the day-to-day responsibility for the National Mental Health Strategy within the Commonwealth Government rests with the Cabinet level Minister.<sup>105</sup>

4.99 The Centre for Psychiatric Nursing Research and Practice and many others argued for a commission that would provide independent monitoring and recommendations to guide performance of mental health services.<sup>106</sup>

## **Conclusion**

4.100 This chapter has given a broad picture of how mental health services are resourced, and a brief sample of the barrage of criticism levelled at the system. It is not often that a committee hears such a united chorus of criticism from such a diverse array of organisations and individuals, and the concerns obviously raise serious questions about the adequacy of mental health care in Australia.

4.101 Later chapters look in more depth at specific areas of mental health care. First, however, the committee considered the diversity of mental illnesses, and some of the fundamental assumptions that underpin their treatment.

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105 Mental Health Council of Australia, *Submission 262*, pp. 37–38.

106 Including Centre for Psychiatric Nursing Research and Practice, *Submission 217*, p. 5; insane australia, *Submission 2*, p. 1.

