Select Committee on Mental Health
Parliament House
Canberra
ACT 2600

Attention: Committee Secretary
Ian Holland.

April 27th 2005.

Working For Mental Health

Mental Health
Co-ordinating Council

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Dear Mr. Holland,

We would like to thank the Select Committee on Mental Health for providing the Mental Health Co-ordinating Council (MHCC) with the opportunity to make a submission regarding mental health issues particularly with regard to the Commonwealth's National Mental Health Strategy.

MHCC is the state peak body for non-government organisations working for mental health throughout NSW. MHCC represents the views and interests of over 150 NGOs in the formation of policy, and acts as a liaison between the government and non-government sectors. Our member organisations specialise in the provision of services and support for people with a disability due to mental illness. MHCC is a Board member of the Mental Health Council of Australia.

In 2002, MHCC made its first submission to the Select Committee - Inquiry into Mental Health Services in NSW, whilst the Final Report was in draft, and subsequent to the release of the report in December 2002, MHCC established working groups whose participants included member organisations, other stakeholders, consumers and carers who focussed on specific areas of concern such as carers, forensic, mental illness and substance use, homelessness and young people's issues.

Since that time, MHCC and the working groups have been in regular correspondence with the Premier and State Ministers and have made several submissions in response to the Select Committee on Mental Health Services in NSW, 2002. In putting these documents together, MHCC consulted widely across the sector and its member organisations in addition to the working groups. Many of the issues raised in the report closely resemble those listed in the Terms of Reference of your own Select Committee.

MHCC also responded in detail to a Review of the Mental Health Act 1990, which the State Government instigated as the second part of the review inquiry. MHCC are sure that your committee will find the attached submissions (which relate to the NSW Inquiry) useful references for the work that your committee is undertaking.

MHCC is the peak Body for mental health Organisations in NSW
Funded by NSW Health

Clearly, our comments are in the context of a NSW experience and perception of services, where per capita expenditure on specialised mental health services 2001 – 2002 was third lowest of all states and territories, and only fractionally above QLD and the ACT. [1]

MHCC wish to make the following comments with reference to the Terms of Reference of the Commonwealth Select Committee on Mental Health:

a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

- According to the OECD, Australia ranked 10th among OECD countries in terms of health spending as a proportion of gross domestic product in 2001. However, historically, funds committed to the National Mental Health Strategy are 6.4% of the Health Budget, [2] which according to the World Health Organisation falls far short of comparative spending in other OECD countries on mental health. [3] This proportion of funding against GDP has remained static for many years.

- ***"In the last recent federal election, the coalition government committed to increase funding for mental health care by $110 million over 4 years, with an emphasis on youth health, enhanced primary care and increased community awareness of mental disorders. The large deficits in specialist care, particularly within the public sector, however, have been left to the state and territory governments. Between 1992–93 and 2001–02, the federal government proportion of national mental health expenditure increased from 27% to 37%. About two-thirds of this increase was accounted for by an almost sixfold increase in the costs of medications reimbursed through the Pharmaceutical Benefits Scheme."*** [4] It has been estimated that the $110 million, which has been promised by the Commonwealth over the next four years, represents only 10% of the federal government investment that is needed.[5]

[1] Department of Health and Ageing. (2004). *National Mental Health Strategy*, (8th Report) Commonwealth Government of Australia: Canberra, p.16.

[2] Department of Health and Ageing. (2004). *National Mental Health Strategy*, (8th Report) Australian Government, Commonwealth of Australia: Canberra, p.2.

[3] Organisation for Economic Co-operation and Development. *OECD Health Data 2004*, (3rd edition). Available: http://www.oecd.org/dataoecd/13/13/31963469.xls (Accessed: April 13th 2005).

[4] Hickie, I.B., Groom, G.L., McGorry, P.D., Davenport, T. A. and Luscombe, G. M. (2005). *Australian mental health reform: time for real outcomes.* MJA 2005; 182 (8): pp.401-406.

[5] Hickie, I.B., Groom, G.L., P.D., Davenport, T. A. (2004). *Investing in Australia's future: the personal, social and economic benefits of good mental health.* Canberra: Mental Health Association.

- In addition to funding shortfalls, another barrier to progress is that on a state-wide level in NSW there is no accountability to the Commonwealth to spend the funds as stated in the Strategic objectives, [6] and no authority on the part of the Commonwealth to implement the strategy, [7]

b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

- Whilst there has been emphasis in NSW to increase the availability of acute beds, there is a shortage across all sectors with regard to prevention, early intervention, community care, after hour crisis services, and respite care. This is reinforced by the Government's response to Recommendation 6 of the Select Committee on Mental Health Services in NSW (2002).[8]
- Across NSW services are inequitable, for example South West Sydney does not have a 24hour crisis team at all.
- Mental health issues requiring ongoing long-term interventions for people such as those suffering from chronic psychotic disorders, anxiety disorders, anorexia or borderline personality disorder are almost entirely unavailable except in the private sector. [9] [10]
- There are considerable difficulties with regard to availability and barriers to access, particularly with regard to mental illness and substance use (MISU), (otherwise known as dual diagnosis /co-morbidity) because they are often found to be more difficult to engage and treat in view of their higher levels of physical, social and psychological impairment (Gafoor & Rassool, 1998).[11] Hence this group often experience high levels of vulnerability and burden on family/carers, and are at greater risk of stigmatisation and exclusion from existing service provision (Rassool, 2002).[12] [13]

c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

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[6] Department of Health and Ageing. (2004). *National Mental Health Strategy*, (8th Report) Australian Government, Commonwealth of Australia: Canberra, p.14.

[7] Department of Health and Ageing. (2004). *National Mental Health Strategy*, (8th Report) Australian Government, Commonwealth of Australia: Canberra, p.14.

[8] NSW Government Response to the Select Committee Inquiry into Mental Health Services in NSW , p. 7.

[9] McLean Hospital Psychiatric Update. (1999). *A Promising Treatment for Borderline Personality Disorder. Available:* www.mclean.harvard.edu/psychupdate/psyupI-3.htm

[10] Monadock Family Service. *DBT opens the door to recovery.* Available: www.mfs.org/hh37.htm
Briere, J. PhD. (2001). *Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model.* The APSAC handbook on child maltreatment, 2nd Ed. Newbury Park, C.A: Sage Publications.

[11] Gafoor, M. & Rassool, G.H. (1998). The co-existence of psychiatric disorders and substance misuse: working with dual diagnosis patients. Journal of Advanced Nursing, 27: 497-502.

[12] Rassool, G.H. (2002). *Substance misuse and mental health: an overview*. Nursing Standard, 16(50): 47-53.

[13] Hegarty, M. (2004). *Mind the Gap* :The National Illicit Drug Strategy (NIDS) Project to Improve Support for Children from Families where there are Mental Illness and Substance Abuse (MISA) Issues. Literature Review for the NIDS MISA Project. Sydney: Mental Health Coordinating Council/ DoCS.

- There is both the opportunity and motivation for greater collaboration and capacity building in the NGO sector, and a desire to work together with Area Health to provide appropriate services. Whilst there has been support from the State Government to enhance funds allocated to raise figures from those of 2001 – 2002, NSW expenditure on the NGO sector remains at 30% of the VIC figure, and 64% of the QLD figure. [14]
- The NGO sector run services with dedicated staff employed under SACS salary awards that fall way below comparable salary rates in the government sector, and they are often obliged to run their services under very demanding circumstances with extremely poor resources, this causes difficulties in attracting and retaining skilled staff.[15]
- Whilst some funds have been made available particularly through the Centre for Mental Health in NSW to research 'evidence based' practice and develop collaborative models and workplace training, funding is required to establish ongoing services and ensure that successful pilot projects (having proved their worth) do not 'fall by the wayside' as identified in the National Mental Health Report (2004) [16].

d) the appropriate role of the private and non-government sectors;

- The private sector plays an important part in providing many services that are unavailable either in the NGO or the government sectors. However, even in the private sector these services (e.g. interventions for anxiety disorders) are not broadly available or adequately covered by private insurance schemes, particularly on a long-term basis.
- Access to beds in the private sector affords a greater ability for clients to enter as an inpatient at a level of need lower than in the public sector. Clients in the private sector are less likely to be discharged as quickly, and also are more likely to be provided as an outpatient with weekly supportive group therapy, these factors have a positive effect in relapse prevention.
- However, services are least available in the public sector whereas NGO services battle to resource a wide range of services provided by poorly funded agencies and voluntary organisations. [17]
- NGOs are well placed to provide non-clinical community support services to consumers and carers whilst Area Health Services provide clinical services. The focus should be on creating 'holistic' service provision through collaborative interagency networks that are adequately funded.

e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

- A barrier to better mental health outcomes is often due to an absence of interest, both politically and within the community to focus on the needs of unempowered people whose profile is frequently characterised by a circle of poverty, poor education,

[14] Department of Health and Ageing. (2004). *National Mental Health Strategy*, (8th Report) Australian Government, Commonwealth of Australia: Canberra, p. 49.

[15] Kirkland, A. (2002). *An important message about funding for the SACS Award* .NCOSS. Available: http://www.ncoss.org.au/search/index.htmlrg Accessed: April 2005

[16] Commonwealth of Australia (2004). *National Mental Health Report* -2004. Canberra : Australia, p. 53 (Table A4).

[17] Mental Health Coordinating Council (2002). *Submission to the Select Committee Inquiry into Mental Health services in NSW*. Sydney: MHCC

inadequate parenting skills, unemployment, lack of affordable housing, mental illness, co-morbidity and involvement with the criminal justice system. [18]

- The shortage of early intervention programs, supported accommodation, employment, family and social support services compound to create a social underclass unlikely to experience satisfactory mental health outcomes and contribute to social capital [19]
- Mental health issues and comorbidy are amongst the complexity of problems exacerbated by socio-economic factors and scant availability of alternative supported accommodation.
- **"*NSW Health stated that, depending on the population sample, 30 – 80% of people with a mental illness have a co-existing substance use disorder. A recent study of inpatients with an early episode of psychosis conducted in Queensland … found that 70% of young people admitted also had a current substance use disorder.*"** (The Legislative Council Select Committee Inquiry into Mental Health Service in NSW, 2002, p.168).

- MHCC and its members stress the importance of supporting families and carers who provide essential support for people with mental illness, often identifying early warning signs, assisting and maintaining consumer recovery, and keeping them out of hospital. As mentioned in later comments (item L) in this submission, NSW Health Department has funded various family and carer support services during the last 3 years in some areas across the State. However, due to funding constraints there are high levels of unmet needs that require urgent attention.

f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

- Persons suffering comorbidity, particularly young people frequently end up living on the streets, their needs unable to be met by the limits of the existing services and the barriers to access due to risk management, inadequate availability of professional clinical staff and suitable accommodation.[20]
- Some of the most vulnerable people in the community have least access to services and find themselves involved in the criminal justice system as a result of inadequate mental health and support services rather than inherent criminality. [21]
- Particular problems exist for rural and remote consumers and carers who have little or no access to services. Ageing carers particularly have concerns around access to support services when they are no longer able to care for their family member, and concerns as to what might happen when they die.

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[18] Mental Health Coordinating Council (2002). *Submission to the Select Committee Inquiry into Mental Health services in NSW.* Sydney: MHCC.

[19] Australian Institute of Family Studies. (2000). *Social capital and public policy in Australia* (edited Winter, I.) p.13-14..

[20] New South Wales Parliament. (2002). Select Committee on Mental Health. *Inquiry into mental health services in NSW.* Final Report, Chap. 7).

[21] New South Wales Parliament. (2002). Select Committee on Mental Health. *Inquiry into mental health services in NSW.* Final Report, Chap. 14.

- The problem of chronic psychosis and homelessness is one that requires urgent attention both in the cities as well as rural and remote areas.

g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

- The National Mental Health Plan: 2003 – 2008, stressed the need for consumer and carer participation at all levels of policy, planning and treatment.[22] Development of policy has progressed well, whilst funding and implementation are less advanced. The establishment of numerous advisory and consultative groups has been instrumental in affording consumers and carers avenues through which their voices can be heard, however further progress needs to be made in terms of service delivery and accountability at all levels of the mental health system.

- The Senate Inquiry into Mental Health Services in NSW (2002) noted the overwhelming responsibility of care that families and carers have assumed for their mentally ill family members since the de-institutionalisation of mental health services. Carers can no longer continue to provide that level of care without more support both financial and emotional.

- NSW Health and Carers NSW have developed a number of initiatives to create 'family and carer friendly' services that involve primary carers in the treatment, care and recovery process, and that offer education, information and respite programs.[23] This is a positive first step, however, more needs to be done particularly where projects are under-funded pilot programs lacking continuity. There is also inadequate equity in services across NSW both in NGO and Area Health services.

- MHCC wishes to draw attention to the special needs of carers who are children of people with mental illness, disability and/ or co-morbidity. Frequently, services do not take into account the responsibilities that these young people have to shoulder, and the effects that '*parentalising*' has on a population who may feel stigmatised in the community. Services, often unaware of other family members or carers involved (whatever their age) who may not be readily visible, frequently neglect to consult those most directly affected in the care and safety of an individual suffering from mental illness.[24]

- MHCC support the statement made by The Hon. Morris Iemma, Minister for Heath, in the NSW Parliament (Dec 2003) when responding to the Upper House Inquiry, he stated that the government were adopting a strategy in NSW for a "whole-of-government" approach to mental health service provision. [25]

h) the role of primary health care in promotion, prevention, early detection and chronic care management;

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[22] Commonwealth of Australia (2003).*National Mental Health Plan 2003-2008.* Canberra, p. 24.

[23] New South Wales Parliament. (2002). Select Committee on Mental Health. *Inquiry into mental health services in NSW.* Final Report. (Chap 3: point 3.50,p.28).

[24] Aldridge, J. and Becker, S. (2003). *Children caring for parents with mental illness: Perceptions of young carers, parents and professionals. (Outcomes for children when they care.)* The Policy Press: Bristol, UK., p.22.

[25] NSW Parliamentary Media Release. (Dec 2003). Available at : http://www.health.nsw.gov.au/news/2003/html (Accessed : April 12th 2005).

- Increased attention needs to be paid to educating medical practitioners as to promotion, prevention, early detection and chronic care management. The National Mental Health Strategy has begun to focus on a 'holistic' approach to health and mental health. GPs and community clinical service providers must be trained to automatically question the mental health implications of any physical symptom or injury brought about by either natural or accidental circumstances, and investigate as to who may be involved in the chronic care and management and are unsupported in the community. [26]
- In circumstances where a patient's psychiatrist, psychologist, counsellor, etc., is unavailable, a GP is often the first 'port of call'. It is important that GPs are encouraged and supported to acquire greater understanding of mental health problems and skills training for chronic care and risk management.

    i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

- Opportunities for reducing iatrogenesis is an issue that needs to be addressed through ongoing education and training of clinicians as well as through increased consumer involvement.
- Promoting recovery focussed care through consumer and carer involvement embodies longer-term involvement of consumers and carers in decision-making, planning of health services and a more active relationship between the health service, local communities, consumers and carers. Rather than just receiving feedback, the process of participation enables consumers and carers to be involved with health service providers in problem solving of areas of mutual concern and planning.[27]
- It is critical that consumers be involved in, and participate in their own treatment plans. There is strong evidence that such involvement is empowering, and an important part of the recovery process. [28] [29] This point is highlighted in the study " Mental Health Recovery: What helps and Hinders?" ***"Independence is achieved through making one's own choices and decisions, exercising self-determination (such as advanced directives), enjoying basic civil and human rights and freedom, and having a liveable income, a car, affordable housing, etc. Paternalistic responses, lack of respect, involuntary and long-term hospitalisations, stereotyping, labelling, discrimination, the risk of losing what benefits and supports one does have, all undermine independence. Repeated encounters with such experiences instil fear, lack of confidence, and negative attitudes and beliefs."*** [30]

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[26] Hickie, I.B., Groom, G.L., McGorry, P.D., Davenport, T. A. and Luscombe, G. M. (2005). *Australian mental health reform: time for real outcomes.* MJA 2005; 182 (8): pp.401-406.

[27] NSW Health (2001). *Partners in Health: Sharing information and making decisions together*. Report of the Consumer and Community Participation Implementation Group. NSW Government.

[28] NSW Health (2001). *Partners in Health: Sharing information and making decisions together*. Report of the Consumer and Community Participation Implementation Group. NSW Government.

[29] NSW Health (2001). *Partners in Health: Sharing information and making decisions together*. Report of the Consumer and Community Participation Implementation Group. NSW Government.

[30] NAMI (2002). *National Alliance for the Mentally Ill.* Santa Cruz County: California, p.5

- Pathways of Recovery (2004), acknowledged a growing awareness that the majority of people diagnosed with mental illness will achieve significant improvement or full recovery. ***"Relapse prevention and the related concept of rehabilitation are placed under the umbrella of recovery which comprises treatment and continuing care"*** (Rickwood, 2004:p.3).[31] Specifically, relapse prevention is defined as ***"a specific component of the recovery process. It entails maximising wellness for people with mental illness by reducing the likelihood and impact of relapse. It involves empowering people with mental illness to recognise early warning signs of relapse and develop appropriate response plans. It requires identifying risk and protective factors for mental health, and implementing interventions that enhance protective factors and eliminate or reduce the impact of risk factors. Relapse prevention is based on communication and understanding between the person experiencing mental illness, their family and carers, primary health care, the specialist mental health system, and community support services about access to support or 'retreatment' if there are early signs of relapse. Relapse prevention is an essential, but not sufficient, component of the recovery process for people with mental illness."*** [32]

    j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

- According to a Justice Health (previously NSW Corrections Health) census completed in 2004, 78% of the male prison population and 90% of the female population present at reception with a broad spectrum of mental disorders.[33]

- In NSW, people with a mental illness frequently encounter the criminal justice system as a result of an inability of access mental health services, either through absence of services or barriers to access, rather than because of inherent criminality. Many of these people have not received treatment for their mental illness prior to being imprisoned, and would benefit greatly from treatment.[34] Unfortunately this treatment is not available or appropriately provided for within the criminal justice system. The problem is exacerbated by high prevalence of co-existing substance disorder with mental illness which exists, depending on the population sample, in 30% to 80% of people with a mental illness in the community [35]

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[31] Maraz, S. (2005).*Exploring Recovery*. View from the Peak (ed. Summer). Mental Health Coordinating Council: Sydney Australia, p.8-10.

[32] Rickwood, Dr. D. (2004). ***Pathways of Recovery: Preventing Relapse.*** A discussion paper on the role of relapse prevention in the recovery process for people who have been seriously affected by mental illness. Prepared for the National Mental Health Promotion and Prevention Working Party.

[33] Halpin, R., Barling, J., and Levy, M. (2004). *Capturing Perceptions: 2004 NSW Inmate Access Survey*. Justice Health: NSW, Australia.

[34] Ibid.

[35] NSW Health (2000). *The Management of People with co-existing Mental Health and Substance Use Disorder – Service Delivery Guidelines*, NSW Health Department: Australia,p.2.

- The National Mental Health Strategy acknowledged that the forensic population is a group requiring access to the same range of services as the wider community. The National Mental Health Plan 2003 – 2008 identifies the forensic population as one of the target groups for which the following reforms are essential:

  - Improved service access
  - Better service responses
  - Evaluation of appropriate service models

- Services available to the entire community should reflect 'world best practice' and support the concept of ***"the best treatment in the least restrictive environment,"*** - the most effective treatment with an emphasis on recovery, and appropriate support for integration back into the community for all individuals with a mental illness. This is no less applicable to forensic patients for whom goal is an unsuitable environment in which 'management' and 'medication' rather than 'recovery' and 'rehabilitation' are the main focus.[36]

- The NSW State Government have approved the building a new mental health facility in the precincts of Long Bay Goal. This is in the early stages of development and is to follow the Thomas Embling model in Victoria. This should do much to improve on the conditions, treatment and care of forensic patients, but unfortunately this project is still a long way off completion.

k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

- Please refer to reference 36, in answer to item j). MHCC advocate that the Inquiry also refer to the United Nations, General Assembly Resolution A/Res/46/119 – The protection of persons with mental illness and improvement of mental health. MHCC believe that the 25 principles of the resolution should be embodied in all the Mental Health state and territory Mental Health Acts.[37]

l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

- The above raises two separate issues, that of de-stigmatisation and service provision
- The issue is de-stigmatisation is of serious ongoing concern that needs to be addressed, particularly in terms of stigma in the community and attitudes promoted by the media. A number of NGOs in NSW have taken steps to deal with these issues. More funding and attention needs to be paid to tailoring programs for increased community awareness addressing specific local area needs.

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[36] *NSW Mental Health Sentinel Events Review Committee (2003).* Tracking Tragedy. First Report of the Committee (December 2003). NSW Health: Australia. Available: http://www.health.nsw.gov.au/pubs/t/serc_contents.html (Accessed : April 12th, 2005)

[37] United Nations General Assemby. Resolution 46/119. Available: http://www.un.org/documents/ga/res/46/a46r119.htm

- Carers NSW (funded by NSW Health) has developed *a "Carer Life Course Framework: An Evidence Based Approach to Effective Carer Education and Support*," a service provision research project conducted by Dr. Deanna Pagnini, which is about to be released.
- ARAFMI have also almost completed a Carer Services Mapping Project, which has made numerous recommendations for improvement of services, training, education, information, advocacy, planning and support, and will eventually lead to a carer services information database.

- NSW Health has also funded the Carers Support Unit (which is the largest service provider to carers of people with mental illness in NSW) in regard to direct service provision initiatives. NSW Health is also drafting a "Framework for Family and Carer Support in Mental Health Services."
- The NSW Government have agreed to allocate funds for a Working with Families Project, and this is a framework for family and carer support. This program is to facilitate capacity building and thereby provide better outcomes and sustainable change.
- The New Health Records and Information Privacy Act 2002 (HRIP Act) commenced on July 1, 2004. MHCC is supportive of the determinations of this Act around protecting the privacy of individuals while at the same time allowing for limited disclosure of information to carers. The review of the Mental Health Act in NSW is considered a much welcomed opportunity to clarify the processes that protect the rights of consumers to privacy, and address issues surrounding carers 'right to know.'[38]

m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

- A 'Standards for Treatment' must be embedded in the policies that underpin the processes used for service delivery across all states and territories, encompassing all aspects of: human rights access; education; training; living standards; and support, in accordance with professional standards, integrated into accepted 'National Standards.' In order to be effective and not merely 'bench marks' for 'best practice,' these standards must be embodied in the Mental Health Acts of each state.[39]

n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

- A number of organisations such as MHCC, Mental Health Association, Black Dog Institute, Schizophrenia Fellowship (Research Trust Fund), the Australian Centre for the Study of Sexual Assault, the Universities and the drug companies publish a broad spectrum of research including studies on the current state of mental health services, the adequacy of funding and extent to which best practice is disseminated, consumer and carer perceptions, treatment analysis, diagnosis and biological aspects as well as legal and human rights issues. Whilst MHCC support all of this work, increased research on quality management systems, evidence based 'best practice' in service delivery, outcome measurement and accountability in both the community and government sectors also

[38] Furlong, M. and Leggatt, M. (1996). *Reconciling the patient's right to confidentiality and the families need to know."* Australian and New Zealand Journal of Psychiatry, Vol 30, pp 614 – 622.

[39] Commonwealth of Australia (2003).*National Mental Health Plan 2003-2008.* Canberra, p. 7.

needs to be undertaken. This work needs to encompass 'best practice' models of delivery supported by ongoing funding to establish such models in action.[40]

- It is recommended that a survey be initiated to establish data on research projects currently in process nationally, recently completed, and implemented both in the private and public sectors. A process of evaluation is necessary to determine the areas of most need with regards to treatment, outcomes and service provision, and cross match whether suitable research had been completed overseas that could be utilised in the Australian context.

o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards;

- See comments to item m) and n) above.

p) the potential for new modes of delivery of mental health care, including e-technology.

- MHCC support the concept of new models of health delivery including e – technology, particularly to improve access for rural or regional areas where specialist clinical expertise is markedly scarce. Telehealth NSW, are currently providing very important services in the area of health. However, MHCC question how realistic such a service might be in relation to mental health in situations for example when a 'patient' is experiencing psychosis. What needs to be addressed is access to crisis teams in rural and remote areas.

- MHCC are also conscious of the legal implications that need to be addressed with regard to safety for both clients and professionals in providing these 'arms length' services, and advocate that research into these matters receive urgent funding.

Summary.

In 2002, 2003 - 2004, Mental Health Council of Australia conducted surveys of Australia's leading health organisations. The top priorities highlighted in those reports remain, and are as follows:[41]

- After 12 years of national mental health reform, major service gaps exist and dissatisfaction with services are all too common;
- The mental health community reports little progress in implementing its key priorities, such as expanded early-intervention programs, "stepped-care" interagency collaboration of community services for co-management of people with mental health problems and related alcohol or substance misuse, sexual assault and homelessness. Medical care needs to be linked with the appropriate and timely use of specialist resources.

[40] Commonwealth of Australia (2000). *The National Mental Health Strategy. Mental Health statements of rights and responsibilities.*

[41] Hickie, I.B., Groom, G.L., McGorry, P.D., Davenport, T. A. and Luscombe, G. M. (2005). *Australian mental health reform: time for real outcomes.* MJA 2005; 182 (8): pp.401-406.

- Rapid expansion of youth health and primary care services. This requires education and training programs for GPs to emphasise long-term functional outcomes as opposed to short-term medically managed relief.
- Expansion of acute care services to be made available across a spectrum of mental health needs in a variety of community based settings, and enhanced services to rural and regional areas.
- New 10year National targets for reducing the social and economic costs of poor mental health to the community, this includes increased access to effective care, reduced suicide rates and improved rates of return to full social and economic participation.
- The standard response to crises in mental health has been to 'build more beds.' This knee-jerk reaction has not delivered an effective or safe system of care. Expanded community based services and support are also necessary.
- Establishment of National Standards for people held in custodial settings.
- Investment in medical research and innovation agenda.
- New independent and national reporting systems on outcomes and the progress of mental health reform are urgently required.
- Commitment by the Government to be accountable with regards to human rights and equal opportunity for people with mental illness. [42]

MHCC would like to express their support for the Commonwealth Senate Inquiry into Mental Health, and have welcomed being a part of this consultative process. Please direct any questions with regard to this submission to Corinne Henderson at corinne@mhcc.org.au or Ann MacLochlainn at ann@mhcc.org.au - Telephone MHCC : (02) 9555 8388.

Yours sincerely,

Jenna Bateman

Executive Officer

References.

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[42] Ibid.

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