

Mental Health in NSW: Getting Beyond Crisis

25th May 2006

9:30am – 1:30pm

Parliamentary Theatrette
NSW Parliament House
Macquarie Street Sydney
(next to the State Library of NSW)

NSW Democrats MLC, Dr. Arthur Chesterfield-Evans will be convening a forum on the subject of mental health in NSW on the 25th of May 2006 at the NSW Parliament House.

Provocatively titled "***Getting Beyond Crisis***", the forum is aimed at bringing together all levels of people involved in the care and treatment of mental illness, and will feature some of the most active advocates for dramatic improvements to the state of mental health services in NSW.

"***Getting Beyond Crisis***" will address issues at the 'coalface' of mental health as experienced by consumers, carers, families, nursing and emergency staff, and will also feature information about mental health and prisons, as well as the opportunities and limitations of the recent announcements regarding federal money for mental health.

A forum highlight will be a panel discussion of how we can achieve better outcomes in mental health at the state level.

An impressive line-up of mental health professionals, carers and consumers will be speaking, including:

Dr. John Mendoza

(Mental Health Council of Australia)

Professor Ian Hickie

(The Brain & Mind Research Institute)

Frank Walker

(Schizophrenia Fellowship of NSW)

Dr. Eileen Baldry

(Beyond Bars)

Laraine Toms

(Carers NSW)

Peter Schaecken

(CSAMHS, Area Coordinator of Consumer Initiatives)

Toby Raeburn

(Matthew Talbot Hostel)

Lyn Shumack

(Former Chair, NSW State Committee - Australian Psychological Society)

Dr. Louise Newman

(NSW Institute of Psychiatry)

Bookings are essential.

This is a free event but places are limited.

Phone 9230 2303 or email

paul.corben@parliament.nsw.gov.au

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Introduction

I was approached in 2001 by four different groups, each of which was asking for an inquiry into mental health. They were community health nurses, carers, psychiatrists and forensic psychiatrists. I got the numbers and moved the motion to establish the Select Committee Inquiry into Mental Health Services in NSW. I asked Dr Brian Pezzutti to chair that inquiry, while I took deputy chair. The findings of that Inquiry, and the subsequent public examination of the sad state of Mental Health services in NSW, moved the State government to increase its Mental Health budget to over \$1.6 Billion over 5 years.

More recently, the Senate Select Committee on Mental Health was instigated and chaired by Australian Democrat Federal Leader, Senator Lyn Allison. In April she released its final report calling for additional funding of up to \$3 billion a year to tackle failings within the mental health system. One week later the Federal Government announced an extra \$1.8 billion of funding for Mental Health care and 650 extra places for crisis accommodation and a Medicare item for psychologists' services. They also increased the numbers of doctors and nurses. It should be noted that the Medicare fee for psychologists is \$45 when the Aust Psychological Society fee for a clinical psychologist's first visit is \$181. So the Medicare fee is just over 25% of the standard rate.

We welcome initiatives, but we must all step back and identify where this money is really needed. Due to the poor management of health de-institutionalisation, 12% of the NSW prison population have a mental illness. Our States prisons have become the "de-facto" Psychiatric Institutions in NSW. Community based treatments, medium to long-term accommodation, return-to-work programmes and other "infrastructure" to help people with a mental illness function, as productive and happy members of the community, seem to be neglected.

The media makes much of hospital bed shortages and the length of waiting list for surgery, but hardly bats an eyelid when three hundred mentally ill people die while in the Care of NSW Health as a result of homicide, suicide, accidents and natural causes every year. We need to get out of 'Intensive Care Ward' mentality and deliver the support to sufferers and carers to prevent people living with a mental illness from becoming homeless, living on the Streets, ending up in our prison system or even worse! This forum intends to bring together people involved in the care and treatment of mental illness, I hope that we can address issues at the 'coalface' of mental health as experienced by consumers, carers, families, nursing and emergency staff and through our panel discussion come up with a plan to achieve a better outcome in NSW. And that is why the NSW Democrats have decided to convene this public forum. This document has been put together to extend the reach of the excellent material presented at the forum.



Dr. Arthur Chesterfield-Evans MLC
Australian Democrats

Speeches and Submissions

Dr. Eileen Baldry (*Senior Lecturer, School of Social Work, University of NSW*)

Mental Health Disorders in Prisons

International studies indicate that the prevalence of MHD amongst prisoners is significantly higher than that found in the rest of the population (7,1,19,45). Additionally homeless mentally ill persons were much more likely to be incarcerated than non-homeless (36,24,27,28,29). People with severe mental illness are more likely to be convicted of misdemeanours than their mentally healthy counterparts, and tend to be incarcerated for longer periods (30, p64). In Australia, around 25% of Victorian prisoners had had contact with mental health services prior to their imprisonment and males with schizophrenia and a coexisting substance abuse were over 12 times more likely to be convicted than males in the general population (33,34). A NSW Corrections Health Survey (11) using the Composite International Diagnostic Interview (CIDI) found a high prevalence of mental illness in the NSW prisoner population. Almost half the reception inmates and one-third of sentenced inmates had suffered a mental disorder in the 12 months prior to the survey. The NSW Legislative Council Select Committee on Mental Health (40) noted the high number of women with acute and ongoing mental health disorders in prison and questioned their presence in the prison system at all. The NSW Department of Juvenile Justice (37) reported that 88% of the young people in custody reported mild, moderate or severe symptoms related to their mental health.

Cognitive Disabilities

International studies from the 1970s onwards have confirmed the high incidence of intellectual disability (ID) in prison populations in the USA, Canada and the UK. In a recent systematic review on the topic, Simpson and Hogg (50) outline problems with definitions of ID and offending, voicing concern over the “inattention to mainstream criminological research and the tendency to downplay the complex and multifarious social processes” (51:397) affecting those with ID. Barron et al (6) concluded “Offenders with ID often receive inadequate services as a result of poor identification through the CJS and research into effective treatments is rudimentary” (51:454).

A Victorian study revealed the gross disadvantages suffered by prisoners with ID and the over-representation of Aboriginal (in this case) men amongst ID prisoners (18). In NSW the high representation of people with an intellectual disability in the CJS has been well recognised (13, 41, 48). In a survey of juvenile offenders in NSW, 17% had cognitive functioning scores consistent with a possible intellectual disability. Remarkably 74% scored below the average range of intellectual functioning, compared to 25% from the standardised sample (37). The NSW Sentencing Council (43) recognises the serious consequences of imprisonment for people with cognitive disabilities (and the same can be said for those with acquired brain injury) as entrenchment within a culture of criminality due to the tendency of those with ID to want to be accepted by their peer group, readjustment problems post-release as people with ID inherently have impaired adaptive skills and vulnerability to assault and mistreatment in the mainstream prison environment. People with MHDCD do not just appear in prison but travel some distance through the CJS, starting with police, of which much less is known.

Police

Internationally there is a recognition that the police carry the major burden of attending to psychiatrically disturbed people behaving in an anti-social or criminal manner and that police must make the determination whether to take such persons to a psychiatric unit or to arrest them (28). Added to lack of training in recognising mental health disorders police often find such individuals may not be accepted into the mental health system due to lack of space, the person being deemed not ill enough or that they should be handled by the CJS (29). In NSW, Police report great concern at the demand and stress placed upon police attending mental health crises, that some mental health workers view police as de-facto mental health workers and the criminalizing of mental illness (40). For people with cognitive disabilities, there is a higher incidence of remand or bail than for those without a disability (31). The lack of information and research on police and people with MHDCD in Australia is most notable.

Courts

In NSW up to 23% of people appearing before NSW Local Courts on criminal charges may have a severe to mild or borderline ID (41). A much higher percentage is estimated to have a MHD with many having dual diagnosis. Some strategies such as diversion for minor offences, screening at reception and courts, intervention treatments and supported housing have been implemented to address the complex needs of such people. Nevertheless it is acknowledged that the lack of an integrated, multi-system policy and practice limits the likelihood of their success in preventing re-offending (25).

While some diversion schemes have shown significant reductions in re-offending many schemes were ineffective (46) due to poor planning; inadequate identification and referral; lack of commitment from and integration with psychiatric services; inadequate resources and lack of suitable accommodation (25, 5). On their own, such specialist court diversions (the model of therapeutic jurisprudence) do not appear to have reduced the numbers of people with MHDCD in prison.

People with complex needs - Dual Diagnosis

Within the population of people with MHDCD in the CJS, there is a high proportion with dual diagnosis and other associated disadvantages, such as homelessness and risky behaviours, referred to in the literature as people with complex needs. The co-occurrence of a MHD amongst those with ID in the general population is around 50% and while the prevalence in the offending population can be expected to be at least as high there is a lack of knowledge regarding the extent and nature of psychopathology among offenders with ID (44). Dual diagnosis also refers to those with MHD (excluding substance abuse) and/or CD and a substance abuse problem (20). These people are doubly disadvantaged (48) and at high risk of being caught up in the CJS (40). There is very little published research on those with dual diagnoses and the CJS in Australia.

Indigenous Australians – multiply disadvantaged

Another group needing particular attention is Indigenous Australians. Indigenous people with cognitive disabilities are highly represented in the criminal justice system and face particular challenges in having their disability related needs identified and met (49). The same may well be the case for Aboriginal people with MHD.

Why are numbers of people with MHDCD increasing in the CJS?

There are a number of theories as to why there appears to have been a significant rise in the appearance of people with MHDCD in the CJS (23). Criminalisation of the mentally ill and cognitively disabled as an effect of deinstitutionalisation is commonly cited (130). Nevertheless the lack of community mental health facilities *in itself* has been shown to not affect the prevalence of mental illness in prisons (17). The rapid rise in the co-occurrence of substance abuse and mental illness has also been cited as a very strong contributing factor. Indeed, in an environment in which substance abuse so closely accompanies mental illness, low tolerance to drug crimes means an increase in the proportion of these people within the CJS.

In NSW, legislative changes increasing the use of remand and the likelihood of re-incarceration for community correction breaches may be having a disproportionate effect on people with MHDCD. The lack of appropriate accommodation for such released prisoners makes their chances of integration slim (4). Importantly the majority of research finds no inherent link between psychiatric disability or ID and crime (50), but a strong causal link between psychiatric disability and incarceration (23). There is a suggestion that “offending by intellectually disabled persons is directly related to the levels of community care and support and the availability of specialist services” (12:315). These raise serious questions, such as whether many people with MHDCD who end up in prison are culpable and what effects system and agency responses to these people have had on their CJS involvement.

Social Exclusion

The social exclusion perspective offers an alternative understanding of the over-representation of people with MHDCD in the CJS. The concept of social exclusion combines a person’s risk and protective factors with system and policy driven problems. Life course studies demonstrate that childhood factors are not reliably predictive of CJS involvement, nor are adolescent and adult personal risk factors (9). This does not mean that early intervention is not crucial and effective. Rather it suggests that the identification, understanding and removal of obstacles to resources are crucial to assisting this group to stay out of the CJS. This research proposes the creation of such knowledge.

Presentation Notes

Prisons

- Prevalence of MHD in prisoners higher than rest of population
- Homeless people with MHD more likely to be incarcerated.
- People with severe MHD more likely to be convicted and incarcerated for longer.
 - NSW: 12-month occurrence of any psychiatric disorder (psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder or neurasthenia) is 74% amongst prisoners (86% for females; 72% for males) compared to 22% in the general population.

Prisons

- 50% reception inmates and 30% sentenced inmates had MHD (9% prisoners Vs 0.42% general population suffered psychosis, 22% Vs 6% affective disorder, 43% Vs 10% anxiety disorder) in the 12 months prior to the survey in 12 months prior.
- JJ 88% of young people in custody reported mild, mod or severe MH symptoms. 61% having symptoms consistent with conduct disorder, 35% with personality disorder and 21% with schizophrenia. Seventy-three percent had symptoms consistent with dual diagnosis.
 - Victoria: 25% prisoners had contact with MH services prior to imprisonment.
 - Males with schizophrenia and coexisting substance abuse 12 times more likely to be convicted.
 - The higher % of MHD amongst reception indicates high level amongst remand.
 - Short sentence prisoners, are at particular risk of disruption to treatment and support.
 - Butler & Allnutt note poor and inadequate services in prisons, and that prison is inappropriate place - evidence around the world that MHD offenders cycle in and out quite rapidly.

Issues for Police

- Police carry burden of attending to and determining whether to arrest or seek admittance to psychiatric facility.
- Limited training in recognising MHD.
- Lack of space in MHS.
- Person deemed not ill enough or should be handled by CJS.
- Police as de-facto MH workers.
- Criminalisation of Mental Illness

Issues for Courts

- High estimated (over 30%) people appearing before Local Courts on criminal charges have MHD/dual diagnosis.
- Responses have included diversion for minor offences, screening at reception and courts, intervention treatments, supported housing.
- International evaluations indicate many ineffective due to poor planning, inadequate identification and referral, lack of commitment and integration with psych services, inadequate resources, lack of appropriate accommodation.
- Such specialist services alone do not appear to have reduced numbers of people with MHD in prison.

People with Complex Needs - Dual Diagnosis

- A high proportion of people with MHD in CJS have dual diagnosis. (MHD/CD/substance abuse) and other disadvantage including homelessness, risky behaviour.
- 50% Co-occurrence of MHD amongst those with ID in general population and expected to be higher in offenders.
- Dual-diagnosis also includes people with substance abuse issues who are at high risk.
- Indigenous people with CD highly represented and its expected that those with MHD similar.
- Extremely poor responses to people with dual/co-occurring disorders - almost no coordinated service response in the community or in the CJS.

Why are numbers of people with MHD/co-occurring disorders in CJS increasing?

- Criminalization of MHD as an effect of deinstitutionalisation.
- Rise in co-occurrence of substance abuse and MHD.
- Increasing use of remand and re-incarceration for community corrections breaches affects people with MHD more.
- Lack of appropriate accommodation for released prisoners means lower chances of integration.
- Changes in welfare policies: burden of care & support increasingly on individual families.
- No inherent link between MHD and crime but strong link between MHD and incarceration.
- Are many people MHD who end up in prison culpable?

Why many of these people should not be in the prison system

- Completely reject the proposition that at least they are getting treatment.
- Prison is not and should not be a default psychiatric or therapeutic institution - security focus is negative context.
- Although focus on forensic prisoners is important, many with co-occurring disorders do not meet the criteria but the combination creates equally severe behaviour problems.

Why many of these people should not be in the prison system

Going to prison and having a criminal record makes a person a target for re-arrest, re-imprisonment, disrupts social connections, does not guarantee good or appropriate treatment, often any treatment started is not continued in the community, makes homelessness more likely, creates connections with criminal culture, ensures the learning of prison culture to survive, does not provide any normal community living skills, often causes self-harm and depression.

A new approach

A new approach - CJS and human service interactions

- Detailed data set on the life-long CJ involvement for cohort of offenders using linked but de-identified extant administrative records from CJ agencies.
- Include info on involvement in MH services and public housing.
- Provide outcome data on key indices such as gender, age, type of first involvement, arrests, court appearances and outcomes, sentence lengths, bail conditions, breaches and revocations of community orders, use of social housing, mental health services and levels of mortality.

New approach (cont)

- Create “life-course criminal justice histories” highlighting points of agency interaction, diversion or support.
- Identify gaps in policy, protocols and service delivery and areas of improvement for CJS and Human Service agencies.
- Provide new directions for intervention.

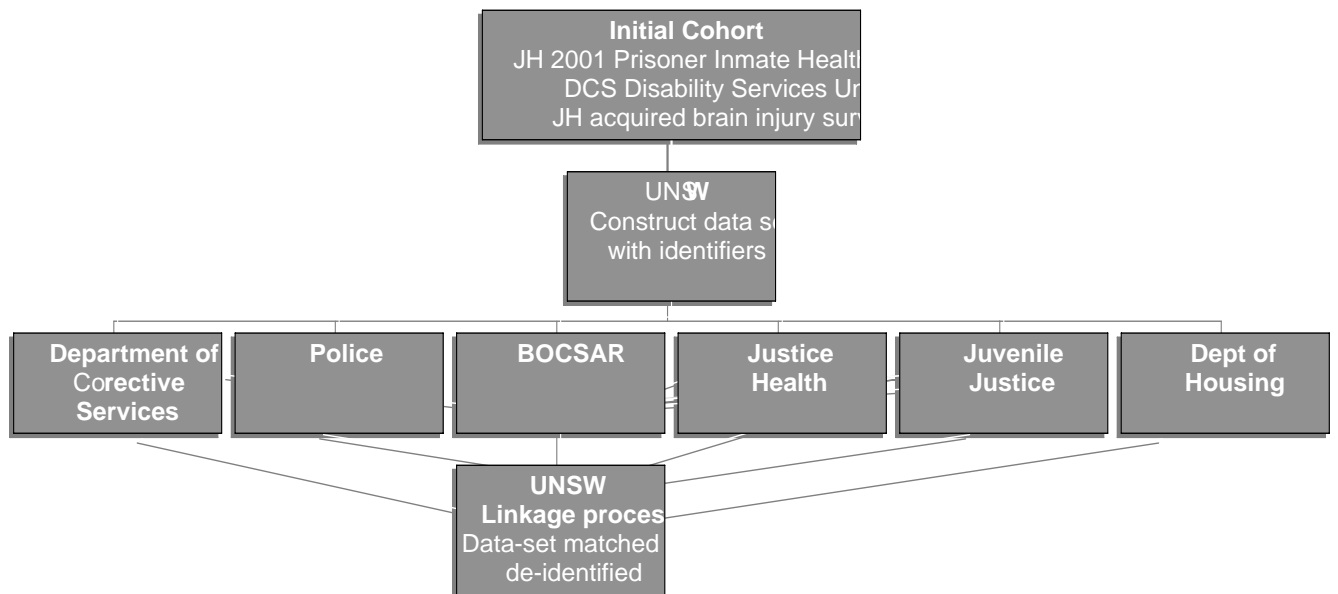
Use of Administrative Data

- Most studies use snapshot data and look at prevalence.
- Research needs to investigate processes that determine movement in and out of CJS.
- There is no Australian agency which looks at cross portfolio coordination and planning for people with MHD.
- Linking data across CJS sub-systems and with human services provides broad and dynamic understanding of CJS involvement.

Mapping the Data

- Participants’ information gathered retrospectively, from the date of the data draw as far back as records will allow, through administrative data from CJ and human service agency databases and non-electronic files based on identifiers supplied by the investigators.
- Data linked, then de-identified, for the purposes of analysis creating a static, linked, data set.

Mapping the Data



Benefits of this approach

- First time draws all CJS agency records + human services for cohort of people with MHD/CD/co-occurring disorders.
- Looks at institutional and individual dynamics.
- Creates 'CJ life course histories' in shorter time than traditional life course study.
- Provides new understanding of system interactions and thus of ways to prevent people with MHD ending up in prison.
- Addresses demands on Public Service agencies for inter-disciplinary and cross agency work.

Kerry O'Neill (The New South Wales Nurses' Association (NSWNA))

The New South Wales Nurses' Association (NSWNA) is the industrial and professional body that represents over 51,000 nurses in New South Wales. The membership of the Association comprises all those who perform nursing work, including Assistants in Nursing (who are unregulated), Enrolled Nurses and Registered Nurses at all levels, including management and education. With the exception of Assistants in Nursing, the members of the NSWNA are also members of the Australian Nursing Federation (ANF), a federally registered industrial organisation, and form the NSW Branch of the ANF.

The Association recognises the difficulties that consumers, carers, families and other stakeholders such as Non-Government organisations (NGO) experience when trying to access mental health services. Our members working in the sector are also cognisant of the difficulties that consumers and families experience when trying to access mental services. Similarly our members often express frustration at not being able to meet consumer's needs.

Given the enormity of the issues and that there are numerous other stakeholders represented in this public forum, the Association has elected to focus our response on two major areas: service deficits and workforce issues.

Funding issues and service gaps

The membership of the NSW Nurses' Association is keenly aware of the problems and issues that plague mental health services and interrupt the delivery of an acceptable standard of care and treatment. It is clear that there has been long term under funding of the sector and a subsequent decline in the attractiveness of mental health as a career option. Most disturbing however, is the almost unanimous opinion among our members working in the sector that standards are continuing to decline. Our members report that the constant pressure to "do more with less" is undermining their capacity to provide a service and their commitment to their work.

The NSW Nurses' Association supports the concept of a national mental health strategy to coordinate nationwide reform of the sector. However, its implementation has not been without difficulty. It is clear that funding is inadequate to meet demand and that while there have been increases in funding over the period of the strategy, these merely reflect overall health spending increases. This funding shortfall has resulted in a trend where resources are rationed according to crisis need, and there are not enough resources to implement effective early intervention strategies.

Resource restrictions translate to mental health nurses and other workers only being able to provide crisis intervention and ongoing maintenance to people with chronic mental illness. People with dual diagnosis or multiple and chronic disabilities are disadvantaged and are not receiving adequate service in the community. People in boarding houses, homeless people, and people with mental illness and/or an intellectual disability are often left without any intervention at all from health professionals.

Despite health promotion and prevention being the focus of the Second National Mental Health Plan, we contend that there are insufficient staff and resources to provide recovery strategies for many in the community with a mental illness. Community mental health nurses also report a dearth of community programs. If community based care for mental health consumers is to succeed, there must be a range of support services available to promote rehabilitation and recovery.

Workforce

The Association remains extremely concerned about the mental health nursing workforce crisis that continues to impact so negatively on the safety of our members in the sector. Mental health remains the nursing speciality most actively being recruited in metropolitan NSW and given the growing demand for mental health services, the shortage of qualified mental health nurses is becoming ever more critical.

The Association welcomes the recently introduced scholarships by the Department of Health (DOH). This initiative, aimed at recruiting and maintaining mental health nursing staff, offers scholarships for further study (to enhance the skills of the existing workforce), orientation programs, mentoring, clinical skills updates and ongoing clinical professional development. This is an example of the success that can be achieved if simple but practical measures are implemented to enhance mental health as a career option for nurses.

The NSWNA acknowledges the significance of the Nurse Practitioner and the potential use of this strategy to recruit and retain nurses. This role recognises the clinical expertise and provides a career path for clinical nurses. It is also an acknowledgement of the expertise of nurses and has the capacity to address issues such as lack of focus on mental health nursing within nursing education. This advanced scope of practise demands application of sophisticated, evidence-based clinical judgments and includes authority to prescribe, initiate diagnostic investigations and make limited referrals. It represents a logical workforce innovation that, if implemented widely, would clearly address some of the most critical issues that are undermining the system's diminishing capacity for optimal performance, such as GP workloads, rising costs, workforce shortages and poor misdistribution, unmet need and the need to strengthen early intervention and preventative approaches.

Concluding remarks

The NSW Nurses' Association is of the view that the Australian public has at last come to the conclusion that people with mental illness are entitled to a decent standard of care and treatment available through the public system. While there is a role for private treatment, there should not be a financial barrier to anyone needing to access mental health care and treatment.

Both the State and Federal Governments have recently recognised the need to provide more resources for consumers, carers and health care professionals working in mental health. The NSW Nurses' Association believes that this is an opportunity to redress the gaps in service delivery. We are of the view that every Australian is entitled to a decent standard of health care and that Australia has the capacity to ensure that it is available in a cost effective and efficient manner.

We believe that the poor outcomes achieved in the area of mental health are the result of choices and it is now time for all Australian governments to fund mental health services appropriately and ensure that we have a skilled workforce capable of delivering high quality care.

Lyn Shumack (Clinical Psychologist in Private Practice)

Introduction

The proposal is that the NSW government agrees to at least match the *funding* offered by the Federal government (staggered \$1.8m) and address the funding shortfall that has contributed to the crisis in the provision of mental health services. Cost-shifting to Medicare funded professional services has resulted in a situation where those individuals and families who can afford it obtain best-practice psychological treatment, and the rest do without.

The emphasis should be on providing *access* to high quality mental health services to all NSW residents, irrespective of their location. This means appropriate funding allocation for mental health services across the State, especially rural areas, and a change in the current model of service delivery.

NSW Health has a responsibility to actively treat mental disorders in an effort to *restore* mental health rather than simply managing it. A bureaucracy based on the medical model of treatment (such as NSW Health) is endemically ineffective for the management of mental health because;

- a) When resources are limited it results in a culture of crisis intervention dictated by the demands of acute/emergency treatment; and
- b) It neglects the primary psychological needs of healthy individuals - autonomy, acknowledgement and reassurance - by identifying mental problems as pathological.

Psychologists are *best placed* to provide access to psychological services across NSW and evidence-based cost-effective treatments for psychological disorders. NSW Health under-utilizes the skills of Clinical Psychologists, has no advocate for psychological treatments or profession, and demonstrates incredible ignorance of current research on mental health issues. It is sadly undesirable as an employer of professional psychologists and as a result new graduates and relatively inexperienced psychologists (with less than 5 years experience) make up the majority of psychologists on staff.

The Proposal

The NSW government must abandon the pretense that NSW Health provides an effective mental health service and create the Department of Mental Health. An *alternative model* of service delivery is required. There are effective models for the delivery of psychological services already in existence in NSW, *including* high quality extensively experienced and cost-effective professionals such as Clinical Psychologists.

Mental Health patients require local service and resources within NSW Health are *inadequately distributed* to provide for proper assessment and treatment for mental disorders. Acute disorders are treated medically, but this ignores the need for appropriate evidence-based treatment because medical treatment is not necessarily an appropriate treatment for mental disorder, and psychiatrists are not available in

most areas of NSW, indeed outside the Sydney metropolitan area. Clinical Psychologists are located and available, statewide, are better trained in psychological disorder than GPs or nurses, and are significantly more numerous than Psychiatrists.

In NSW only the wealthy get state-of-the-art psychological care from highly experienced Clinical Psychologists because psychological services are not covered through Medicare. Contracted professional services, such as those required by insurers, and some sections of NSW government e.g. the NSW Attorney General (best example is the NSW Children's Court Clinic) provide *excellent models* for the delivery of professional services to NSW residents - regardless of residents financial situation, locality or mental condition.

At present no one knows how many Clinical Psychologists are employed by NSW Health, what skills or qualifications they have, or how they are allocated to AHSs. Worst still, the treatment programmes they provide are extremely limited and not properly audited in terms of suitable outcome measures.

The models above provide the *necessary transparency* required by government, flexibility in human resource management, provision of quality service and quality standards, and the capacity for rigorous evaluation to get professional mental health services cost-effectively functioning in NSW.

NSW Health needs to *abandon its ineffective employment of pseudo-professionals* such as the generic Mental Health Worker, and other inappropriately trained cheap labour, and review the now irrefutable and overwhelming evidence in the published literature that psychological treatments *delivered by psychologists* (rather than nurses or general practitioners) are essential for the effective treatment of most mental disorders.

The absence of *an advocate for psychological services, policy and treatment* for mental health patients means that there is little hope that mental health will be effectively managed, and we are destined to repeat past mistakes, especially when resources are scarce. NSW needs a Chief Clinical Psychologist working in together with their existing Chief Psychiatrist.

NSW Area Health Services need to effectively utilize the skills of their in-house senior psychologists and stop treating them as pseudo-administrators - so that they can *actually treat people*.

Expected Outcomes

Access to professional mental health assessment, treatment and recommendations delivered locally to all NSW residents - regardless of their locality, financial resources or mental health status.

Provision of services, by the appropriate, highly trained professionals who can cost-effectively treat each individual, and support their family.

A Department of Mental Health specifically focused on providing psychological and psychiatric services, including proactive interventions and innovative policy changes

that encourage and promote long-term mental health, rather than 'revolving-door' crisis care.

We can move beyond crisis into a realistic, flexible mental health service that promotes a focus on both empathic ongoing care of individuals and best-practice outcomes.

Presentation Notes

Prevalence

Commonwealth Select Committee on Mental Health

Recommendation 1

The committee recommends that the Council of Australian Governments initiates:

A substantial overall increase in funding for mental health services over times, to more closely reflect the disease burden and to satisfy the very significant unmet need.

Increase of between 9% – 12% of the total health budget by 2012 (with significant investment in the short to medium term)

Commonwealth to establish new direct Medicare recurrent funded arrangements for employed or contracted mental health staff [in community mental health centres] – psychiatrists, psychologists, GPs, psychiatric nurses...

Workforce Shortages

Planning benchmarks do not exist in NSW, or in any state of Australia.

Reform of the National Health Service in Britain saw an expansion of its clinical psychology workforce from 780 in the 1980's to 4,896 or 1;10,000 per head of population.

More recently in 200, the Scottish NHS set a ratio of 1;5,000 with clinical psychologists working as specialists complementing a range of services provided at primary levels.

The linking of resources for mental health to the two principles of rights to services, and responsiveness to needs of populations, including:

Definition of benchmark ratios of mental health professionals to populations (based on analysing numbers needed to meet the population's mental health care needs now and in the medium and long term)

Recognizing the range of health professions relevant to the sector.

Health Insurance

One must be discriminating when choosing health insurance for psychological care.

HCF is a notable exception to the general acceptance by health insurers for psychological care of high prevalence mental disorders (like depression and anxiety).

MedicarePlus

Chronic disease items implemented in 2005 provided another means for the public to access psychological care

Rebates for these items are under threat from the proposed new chronic disease item for GPs (who can now bypass the previous push toward a multidisciplinary approach to primary health care).

The Australian Government reform the Better Outcomes initiative to include a new set of Medicare mental health schedule fees and rebates for combinations of private consulting psychiatrists, GPs and psychologists who agree to work together or in conjunction with mental health centres under integrated, collaborative arrangements in the management of primary mental health services.

Consideration should be given to the Division of General Practice managing the reformed Better Outcomes, perhaps restructured as Divisions of Primary Health.

Cost-Shifting

When States shift their costs to the Commonwealth government (Medicare funded treatment) what follows is:

- Lack of treatment follow-through
- Lack of actual psychological treatment
- Gaps in knowledge between science, research and medicine
- No multi-disciplinary care & cooperative best-practice systems

Gaps in treatment coordination for disorders on the continuum between those that are known to be exclusively medically based, and those that can be effectively treated through psychological and behavioural changes

Increasing PBS costs

An Ineffective Model

A bureaucracy based on the medical model of treatment (such as NSW Health) is endemically ineffective for the management of mental health because:

- When resources are limited it results in a culture of crisis intervention dictated by the demands of acute/emergency treatment rather than the high prevalence disorders (representing the vast majority of mental disorders); and,
- The imperative of the obvious threat to physical integrity will generally take precedence over the more subtle psychological disorder, both in terms of restorative treatment, and the utilization of available resources; and,
- It works counter to the primary psychological needs of healthy individuals – the need for autonomy, the need for acknowledgement and the need for reassurance - by identifying mental problems as pathological, uncommon and a sign of defective humanity whose remedy is effected by *external* intervention, such as the administration of medicine.

Recommendation 4

The committee recommends that the Australian Health Ministers agree to: Establish and fund a joint Commonwealth-State mental Health Institute to

Develop a prioritised national framework for research and pilot programs
Review evidence-based research on health needs and cost-effectiveness of treatments

Disseminate best-practice service standards, and;

Assist with establishing service targets and integration of services.

Restoring Psychological Health

Requires the active participation of an individual in his or her own care, and a consistent and autonomous willingness of the person to help himself/herself i.e. *internal* change, usually despite considerable emotional pain.

Recommendation 2

The committee recommends that the Australian Health Ministers agree to:

Include in the next Mental Health Strategy Plan specific, measurable targets and consumer and/or health outcomes that are monitored and reported on annually.

Agree that building public mental health services of high quality and high regard is a key to addressing mental health workforce issues.

Long Term Effective Treatment

For many psychological/psychiatric problems research is available and irrefutable that psychological treatment is at least as effective, and in some cases significantly more effective (especially in the long term) than medical intervention.

Recommendation 48

That governments increase targeted, intensive programs for high risk parents such as those with personality disorders, substance abuse disorders and parents with a history of abuse and neglect.

[Diagnosing Personality Disorders is a special skill of Clinical Psychologists. Implementation of this recommendation is bound to save \$m in the longer term because of this grossly underestimated cost to families, the community and employers – all of who currently shoulder this burden because PDs create chaos and suffering at work, and within families]

Recommendation 73

That utilizing expertise from Clinical Psychology, clinical Psychiatry and institutes of mental health research, standardized risk assessment tools and processes for identifying at risk children be developed specifically for use in a range of community health settings.

Undesirable Employer

Award wages for psychologists are pitiful considering the recommended fee for psychological treatment from a privately practicing psychologist.

The recommended hourly fee for private practitioners is approximately 5 to 6 times that received by those working in NSW Health.

Naturally this makes NSW Health undesirable as an employer and accounts for the relative inexperience of psychologists employed there when compared to the highly skilled professionals whose skills are available to those who can pay.

Assessing the magnitude of system failure in NSW Health:

Considering every quality service perspective: scope and measure – Content, Process, Structure, Outcome, Impact...

A Quality Service?

Conformance with recognized standards (content);
Referral to appropriate service, service delivery (process);
Proper facilities, staffing, qualifications of personnel (structure);
Change in health status, patient dissatisfaction (outcomes);
Appropriateness, availability and accessibility of treatment, and the effect on the community (impact).

Quality Service begins at the design level

Clear structural and procedural failure in service quality – one such example of failure in structural measure is the qualifications of the personnel
Clearly NSW Health is not an effective organization for the provision of quality Mental Health Services.

Performance: Measuring Service Quality in mental health

Measuring service quality is a challenge because customer satisfaction is determined by many intangible factors. This is particularly problematic when it comes to mental health services and particularly psychological treatment because service quality often extends beyond the immediate consultation to have an impact not only on the person's future quality of life but the quality of that person's family life, including perhaps each and every member of that person's family, their occupational functioning, and work and social environment. Indeed our culture is impacted by the way in which we succeed or fail in treating individuals with mental disorders.

Recommendation 36

That access to effective non-pharmacological treatment options be improved across the mental health system through:

- Better access to therapies provided by psychologists, psychotherapists and counsellors* with particular attention to therapy for people with histories of child abuse and neglect; and
- Greater investment in research and alternative treatments.

* Psychologists are offended by being included with psychotherapist and counsellors (who require no particular educational qualifications, or adherence to a professional code of conduct or ethical code, and are not required to be registered practitioners).

Imagine: *Better access to therapies provided by GPs, unregistered doctors and quacks...*

Implementing Professional Contracting

The Office of the Children's Guardian and the Children's Court Clinic has implemented Professional Contracting on previous occasions in 6 to 18 months.

Rural Access

NSW residents living outside metropolitan areas (Sydney, Newcastle, Wollongong) comprise 22.4% of the State's population. Matching this distribution equitably, 70% of psychologists live in metropolitan areas and 30% are located in regional areas.

Availability of Psychologists

The APS estimates that there are 22,000 psychologists in Australia – nine times more psychologists than there are psychiatrists. Of these psychologists about 10,000 are available to treat mental disorders, about one third of these reside in NSW.

Clinical Psychology

The profession is at the forefront of development, provision and evaluation across the full spectrum of health care interventions and are uniquely placed to evaluate outcomes and best-practice, cost-effective treatments across the lifespan.

A Ready Trained Workforce

There should be a national imperative to utilise the workforce of psychologists to reduce psychiatric and GP workforce problems and provide appropriate services in public and private sectors.

Laraine Toms (Carers NSW)

Carers NSW is an association for relatives and friends who are caring for people with a disability, mental illness, chronic condition or who are frail aged. We are the Peak Body for carers in New South Wales and the only statewide organisation that has carers as its primary focus.

Carers: Beyond Crisis

The current caring scenario in mental health: is it sustainable?

- What are the implications for NSW Health if the current caring scenario is not sustainable?
- What are recommendations from carers that will inform systemic change?

Carers and families are at the frontline of care

Any consideration of changes to the current model of development and delivery of mental health services, whether they be changes to framework, funding, structures, or training must acknowledge the role of family carers **and act upon that knowledge**. Families and carers must be considered as a resource by clinicians and the whole community in: prevention of mental illness, in early intervention, treatment and ongoing care of people with a mental illness. Just like any resource families and carers need nurturing, care and services if they are to be a sustainable resource.

Community care can only work, and be sustainable, if families are supported in their own journey towards purposeful coping. Adequate servicing of families and carers needs to be identified as important, both for carers and families themselves, independently of their consumer, and for their consumer family member.

Research demonstrates that many carers of people with a mental illness –including young carers, indigenous carers, and carers from culturally and linguistically diverse backgrounds (CALD) - have significant unmet needs for information, coping strategies, and general support, while others also have a need for psychotherapeutic support and counselling and that meeting these needs can improve the well-being of both the carers and consumers. Research has also shown that carers would benefit from a mental health and counselling workforce who understand carers' situations and is able to focus on their issues as well as those of consumers.

Who are carers?

Australian Bureau of Statistics data show that approximately 75% of care needs within the community are provided informally (Australian Bureau of Statistics, *Survey of Disability, Ageing and Carers*, 1998). Thus, 'care in the community' is essentially care provided by family members, friends and neighbours. Formal service provision accounts for only about 10% of care needs (*ibid*). Therefore, it is crucial for carers to be recognised as the mainstay of our system of community care. This is especially true of the mental health sector where the shift from institutional care to community care has in fact meant a shift in the burden of care to carers and families.

Carers may or may not live with the person requiring support. Carers do caring work on a regular basis. This work may include supervision, personal care, financial support, providing transport, liaising with health professionals and other community services, therapy, paperwork, housework, shopping and so on. Each caring situation is different and a carer may be involved in any or all of these tasks. Carers also provide emotional support day in and day out for some of the most vulnerable and isolated members of society.

The latest information on people with a mental disorder and their family (unpaid) carers is available from the 2003 Australian Bureau of Statistics (ABS) Disability, Ageing and Carers Survey.

In 2003, there were, overall, 748,000 carers in NSW or roughly 11% of the population. 20% of carers were primary carers; that is people who provided most of the assistance for a person who needed care.

In 2003, 10% of all people with a disability in NSW had a mental disorder as their primary health condition; that is, 121,000 people. The published survey does not provide figures for mental disorder as a secondary condition.

58,000 or 48% of the people in NSW with a mental disorder had a profound or severe core activity limitation; that is, they needed help with one or more of the following three activities; communication, mobility or self care. In comparison, only 29% of people with a physical disability had a profound or severe core limitation.

In 2003, 60,100 people with a mental disorder in NSW reported a need for assistance and, of these, 28,000 or nearly half, reported that they were not receiving all the assistance they needed. Informal carers assisted 65,000 people, with a mental disorder. This suggests that more than one person is assisting a number of people with a mental disorder.

Overall 12% of all people receiving some assistance from informal carers reported a mental illness as their main health condition. It is worth noting that approximately 10% of all carers who call the Commonwealth Carer Resource Centre at Carers NSW support someone with a mental illness.

We are talking about large numbers of people. People who face constraints on employment, education, income, as well as their social lives and intimate relationships because of their caring role. Their health, mental and physical, is at risk.

The burden of care remains intolerable for many carers of people with a mental illness. The shift from institutional to community care has meant increased burden for families with no corresponding support services to enable them both to care and maintain their own physical, mental and financial well-being.

The current caring scenario in mental health is not sustainable.

Carer burden and the impact on consumers

What we have learned at Carers NSW, both from what carers tell us and a review of the academic literature, makes it clear that family and carer burden is a major problem that is not consistently or appropriately addressed by mental health services, and Federal or State government agencies, including Departments of Housing, Centrelink and Family and Community services. Best practice care for consumers must include best care, and real choices, for carers and families. Any model for change must address the following:

- **Acknowledgment** - for the contribution of families and carers in the treatment, rehabilitation and support of consumers (people with a mental illness or disorder). Consumer recovery needs family recovery. The pathways are interdependent
- **Information** - to be provided to families and carers regarding behaviour, crisis and medication management issues: this is particularly true for Australians of non-English speaking background and rural and isolated carers
- **Respite** - Carers are experiencing high levels of physical and mental illness
- **Carer Assessment** - Carers are expected to take up and maintain care of their family member without assessment being carried out as to their willingness, competency, financial capacity, physical and/or mental health and the impact of caring on other members of the family, particularly siblings of the son or daughter family member with the mental illness. Carer competency needs ongoing assessment. With support, carers can care longer. They can be a sustainable resource
- **Acquisition of enhanced coping skills** to bring to their care giving role; NGOs like Carers NSW could do so much more if the NSW Family and Carer program were to be enhanced. Recent research emerging from the Carers NSW Mental Health Project (2001-2005) indicates that it is not sufficient merely to provide support but the support must be tailored to individual carer needs, taking into account when and how carers need it. The report (Carers NSW, 2005b) focuses on the development of a theoretically and empirically based framework that can be used as a practical tool to ensure that carers of people with a mental illness/disorder receive appropriate information and support interventions depending upon their place in the caring journey, their life course/life stage, and their relationship to the person with a mental illness/disorder.
- **Urgent crisis support** for families and carers
- **Recognition** of families and carers in the assessment, treatment and discharge planning processes.

Despite sincere efforts to identify and address many of these issues by Federal and State governments in policy, the reality for carers and families of people with a mental illness has not changed enough in the past 15 years. The process might have begun but there is a long way to go. The recent MHCA report *Not For Service* is a testament to this fact.

Hilary Schofield, in the Victorian Carers' Project, reported that carers had significant differences from non-carers in various aspects of their lives. The carers were:

- Lower on life satisfaction
- Lower on positive affect
- Higher on negative affect
- Lower on social support, and
- Experiencing more "overload" than non-carers¹

These effects demonstrate two things. Firstly, that carers can become physically and emotionally exhausted influencing their capacity to care and the quality of care they are able to offer. Secondly, that carers will often put their own health and well-being after that of the person they support. Yet there is a tendency for the health system to focus on the patient and overlook the carer's support and health needs.

With a median weekly income of just \$224 per week (compared to \$435 for non-carers) carers as a group are at great risk of being in poverty. Over half of all primary carers rely on a government payment as the principal source of income and almost a quarter are in the lowest income quintile in NSW (ABS, 2003a). There are numerous Australian studies that have also investigated the social impacts and health risks of carers as they can be forced to give up employment and forego community participation with increasing risk of social isolation (SPRC, 2004).

Appropriate support to carers can minimise the costs of caring to individual carers but also support the quality of life for the person being cared for and facilitate and maintain recovery.

The Shape of Change

Reform depends on attitudinal change as well as funding

Current federal commitment to increased funding for mental health is welcome. Initiatives by NSW government such as the increased funding to HASI and the Family and Carer programs are very welcome and indicate that the Premier's stated commitment to mental health and housing is being translated into action. However, real change in the system and for carers does not depend solely on increased funding or changes in political will. Real change is dependent on changed attitudes in the community (and that includes politicians and the people they represent as well as health service personnel) towards mental illness.

Stigma is alive and well and prevents compassionate understanding of the intentions of policy and rigorous commitment to implementation of policy. Mandating carer

1 (p278). [These results were for female carers].

participation in, say, consumer discharge and treatment plans remains meaningless when day-to-day operations in psychiatric units in hospitals throughout the state do not provide for such participation.

Workforce – the Big Issue

Importantly, stigma also contributes significantly to the major workforce problems of recruitment and retention of all mental health professionals. Mental health work, whether as a psychiatrist, nurse, OT or social worker is not a career of choice. Funding alone, and, for example, creating more university places, will not change that. Building step up, step down facilities will only help if there is staff to work there. Allocating more funding to NGOs will only result in more services if there are people to staff programs. And how will the federal governments changes to primary care, as welcome as they are, impact on state services? Will staff be attracted out of public facilities? How will this impact on families? How are federal and state agencies planning to work together to ensure the best outcomes for new funding allocations?

What will happen if carers cannot sustain their caring role? Who will care?

Major Trends

The ageing of the Australian population is a demographic reality. According to the Productivity Commission (2005) the effects over the next 40 years will be pronounced. One quarter of the population will be aged 65 years or more by 2044-45, roughly double the present proportion of the population in that age cohort. The proportion of the oldest old (85 years and older) will increase even more, from 1.5 to 5% cent over this period.

One of the implications of an ageing population is that there will be many more Australians requiring assistance because of disability (Giles et al, 2003). An important disability trend is the survival of many people with disability (including psychiatric disability) into old age. According to the Australian Institute of Health and Welfare (AIHW 2000), this influences not only the longevity of the caring relationship, but also patterns of service use in health and community care.

The ABS Social Trends (2002, 2003, 2004) have provided evidence of the changing composition of Australian families including:

- Low fertility rates
- Increase in one person households
- Increase in the participation of women in the workforce
- High levels of geographical mobility

Given the high reliance on family members for the provision of care, these statistics show that the current caring scenario will be subject to considerable uncertainty in coming years.

Both AIHW (2003) and the National Centre for Social and Economic Modelling (NATSEM), (2004), have considered the future supply of carers. The AIHW, examining the period 2003 to 2013 suggests that the ratio of carers to people with a severe or profound disability is likely to fall from 0.43 carers per 100 people with a

disability in 2003 to 0.40 in 2013. This is not insubstantial and will increase as the population ages after 2013.

NATSEM in examining the period 2001 to 2031 finds that the potential total pool of carers will not rise as quickly as those likely to require care.

According to Carers NSW analysis (2005a) of the 2003 ABS Survey of Disability Ageing and Carers (2003b) for NSW key trends from 1998 to 2003 include:

- Increases in the number and proportion of older carers (75+)
- Increases in the number of ageing carers who have recently begun caring
- Increases in the proportion of carers not in the labour force - from 61% to 64%
- Increases in the proportion of carers caring for 40 hours or more per week
- A high proportion of people with mental and behavioural disorders who need assistance, but who receive neither formal nor family assistance.

These trends have implications for the psychiatric disability sector. For example, the imperative to accelerate discharges from medical facilities needs to be considered in terms of these trends. Similarly, with regard to the treatment of chronic mental illness, the trend away from acute settings in favour of self-care or community care, does not acknowledge that such care frequently falls onto families.

In short, there will be an ageing population overall and an increasingly aged carer population. It is likely too, given existing policy that in the longer term there will be an increasing shortage of people available to care which raises the spectre of the demand for better formal support systems and closer examination of the relationship between formal and informal care.

Even when new HASI funding is implemented and further state funding to address consumer accommodation is announced (I'm optimistic!) the most likely scenario is that carers will continue to provide substantial support to the health and community care systems over the next fifteen years given government policy and the wishes of members of the community to be cared for at home.

What will happen next? More consumers on the streets of our major cities? More consumers in gaols? A rise in the rate of suicide? More family breakdown?

Recommendations

Carers NSW proposes the following:

- Expansion of the NSW Family and Carer Mental Health Program
- Expansion of HASI (Housing and Accommodation Support Initiative) to alleviate the current strain of care, and lack of choice for carers
- Structural integration of mental health and D&A directorates, and service delivery programs (high co-morbidity of psychosis and substance misuse with consequent destructive impacts on families and carers)

- Intensive assertive community intervention programs
- Increased funding for, and training of, mental health professional workers in Community Mental Health Teams to enhance:
 - carer support and education
 - **early intervention**
 - **on-going treatment**
 - **social and vocational recovery for consumers**

Conclusion

The tipping point has been reached. Both federal and state governments have acknowledged that mental health services are in crisis and are moving to implement change. It is our role to ensure that commitment is maintained, that bureaucracy does not strangle proposed reform, that consumers and carers receive the respect, support and care they deserve.

Leigh Connell (Newtown Neighbourhood Centre Boarding House Project)

The Boarding House Project at Newtown Neighbourhood Centre provides assistance to approximately 200 residents of licensed and unlicensed boarding houses in the Marrickville area.

Funding is received from the Department of Ageing, Disability & HomeCare to provide social support to these residents. Whilst the programs aim to provide social support it is assistance in tasks of everyday living and survival that takes place on a daily basis. Many of the residents are living with a mental illness, and are faced with the challenges of keeping well in an environment that is often one of oppression and hopelessness.

These projects don't sit neatly into a housing or health service, but this non-clinical support can be vital to each resident's everyday being. The team that makes up the boarding house project come from a range of disciplines and experiences and are motivated by a spirit of inclusion and compassion. We are not coming from a clinical model but from the understanding that this support has the ability to enhance people's lives.

Over the past ten years, the Neighbourhood Centre has gained valuable experience in the area of boarding houses in the Inner West area of Sydney. This includes conducting the only known research in Australia around tenants and tenancy in unlicensed boarding houses, and setting up a day program and art group for residents of licensed boarding houses long before funding was made available for this type of support. When the Active Linking Initiative (ALI) was introduced in 2000, as part of the NSW boarding house reform, the Newtown Neighbourhood Centre was successful in obtaining funds for this program and currently provides services to 87 residents of licensed boarding houses. There are currently about 1,000 people residing in licensed boarding houses (known as Licensed Residential centres) in NSW with 50% of these in the Met South West area alone.

Who lives in a licensed boarding house ?

To live in a licensed boarding house each person is assessed through a tool that aims to screen out those of high need and "screen in" those who require some supervision. Approximately 90% of these residents are living with some form of mental illness.

How do you live in a licensed boarding house?

Governing legislation – Youth and Community Services act 1973 Not tenancy rights

The Boarding House manager/owner provides board & lodgings along with some medical management at a cost of 85%-100% of each resident's pension and rent assistance. The boarding house does not receive any direct government funding and are basically private for profit business.

Government assistance is provided for personal care, medical and social support :

As interest in boarding houses is growing the Neighbourhood Centre has taken on a greater role in sharing its 10 years of experience and knowledge. It has had been involved in presenting and training community sector workers at forums and a regional conference and to the greater community through the media reports such as Four corners "out of sight out of mind " and the 7.30 report.

It is envisaged that this role will continue with more training planned for later in the year. We are all challenged by fear, and the boarding house environment is still unknown to many. Practical buddy up support in accompanying community workers in the field is one way we can offer support, this along with greater understanding of mental illness can only be complementary to each residents clinical support.

Where to from here?

The ALI model and the flexibility that the community sector can offer appears to be a cost efficient way in which to enhance individuals lives. However, questions of the appropriateness of a boarding houses industry for some of the most vulnerable people in our community need to be continually asked.

Ian Hickie AM MD FRANZCP

(Brain and Mind Research Institute, University of Sydney)

Presentation Notes

New Monies, New Services

(New Outcomes, New Experiences!)

Norman Sartorius: Updating 1789

Fighting for Mental Health 2002

“Today it is clear that, at least in relation to mental health problems, equality before the law should be complemented by **equity** in resource distribution, fraternity needs to be understood as **solidarity** with people who need help, and liberty should be interpreted in the light of **duties and responsibilities** that all of us should accept as members of societies that strive to be civic”

ANZJPH: April 2006

Symptom-Disability Gap in Early and Late Phases of Psychiatric Disorders

MHCA Reports 2002 & 2005

National Crisis = National Response

Recognition of Crisis

Up to Late 2005:

Health Minister and Working Groups Collective Denials

2006 Onwards:

Prime Minister, NSW Premier and COAG

Beyond 2006?:

New Leadership Options:

- Politically
- Community

Australian Government Response: May 2006 - \$1.8billion

- Improved Access to Specialist Services - \$538m
- Psychology, Psychiatry
- Enhanced mental health workforces
- Mental Health Nurses \$192m
- Indigenous Mental Health Workers
- Suicide Prevention
- Continuing Broad Public Education
- Family and Carer Support
- Respite Care Options - \$225m
- Family Support - \$45m
- Personal Helpers - \$285m

Not administered by Health

Professional Support/Expertise

- Early intervention for Parents, Children and Young People
- Structured Activity Programs
- Telephone and web-based counselling
- Drugs and mental illness education
- Support for NGO management of mental illness and drug problems
- Tertiary education places for nurses and psychologists

State Responses

Resources:

Areas of Great Need:

- First Episode Services
- Adequacy of acute and hospital care
- Preventing Relapse
- Accommodation Support
- Recovery, education and workplace-based support schemes
- New Service Partnerships

Old dichotomies:

- Public vs private
- Hospital vs. community
- Serious vs. other mental illness
- Providers vs. Consumers/Carers
- New Language

New Partners:

- Providing the health, welfare, accommodation and services needed at the relevant stage of illness
- Not just the health sector
- Role of Community sector, business, education, training, academic sectors
- Participation by all those affected

Evaluation

No Data = No Outcomes

- **Data:**
 - Health Outcomes
 - Social and Economic Outcomes
 - Experiences of Care

Resources and Initiatives Referenced by Forum Speakers

Existing Services and Initiatives

EPPIC - Orygen (Victoria Health)

Early Psychosis Prevention and Intervention Centre, Statewide (EPPIC Statewide)
The statewide component of EPPIC supports other specialist mental health services across the state to achieve best practice in first onset psychosis through consultation, education and training and the provision of key resources. EPPIC Statewide is part of Orygen Youth Health, an early psychosis program operating in the western and north-western suburbs of Melbourne.

NSW Family and Carer Mental Health Program

Family and Carer Support Services

Component of the Family and Carer Mental Health Program

HASI

HASI is a partnership between NSW Health, Department of Housing and New Horizons. NSW Health funds New Horizons to deliver support services to people with a mental illness.

The objectives of HASI are:

- *To maintain people in their own accommodation*
- *To facilitate living skills*
- *To enable people to live to their maximum potential*
- *To reduce hospitalisation*

The target group is people who:

- *have a mental illness*
- *have experienced psychiatric hospitalisation*

The services provided include:

- *Psychosocial rehabilitation including living skills, financial management and healthy lifestyle*
- *Counselling*
- *Advocacy*
- *Referral to other services providers in the local community*

Mobile Assertive Treatment Teams

Ambulatory care services. Health services dedicated to the assessment, treatment, rehabilitation or care of non-inpatients. These include crisis assessment and treatment services, mobile assertive case management services, outpatient services (whether provided at a hospital or community centre) and day programs such as social and living skills programs.

Desired Services and Initiatives

DOH scholarships

Initiatives to recruit, as well as maintain and advance the skills of mental health nursing staff. Supports the concept of a national mental health strategy.

Funding Increases for Community Mental Health Teams

Increased funding for, and training of, mental health professional workers in Community Mental Health Teams to enhance: carer support and education, early intervention, ongoing treatment, social and vocational recovery for consumers.

Funding Increases for Assertive Community Intervention Programs

Intensive assertive community intervention programs