

PERSPECTIVES

*Mental Health
& Wellbeing
in Australia*



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Mental Health
Council of Australia

Thirty-one articles from Australia's leading sector professionals working for not-for-profit organisations, professional associations, universities and other tertiary establishments, covering mental and physical health, society, the economy, cultural change, technology, community and care across urban and regional Australia.

*Welcome to the Mental
Health Council of
Australia's (MHCA)
strategic publication,
Perspectives — Mental
Health & Wellbeing
in Australia.*

This publication represents a snapshot of an important moment for the mental health sector in Australia, a time of real and meaningful reform.

Within these pages you will hear from Australia's leading minds on mental illness and wellbeing.

We have strived to provide you with viewpoints from across the many sectors of society that are touched by mental illness.

You will hear from mental health clinicians and service providers, and you will also gain insights from experts in employment, housing and education, among others.

The MHCA is truly grateful for the work of the contributors, and their ongoing commitment to reform. Their work within these pages is excellent.

This publication is about solutions, not just problems. We hope that through reform and change, we can truly improve the everyday lives of millions of Australians.

Regards



Jennifer Westacott
*Chair, Mental Health
Council of Australia*



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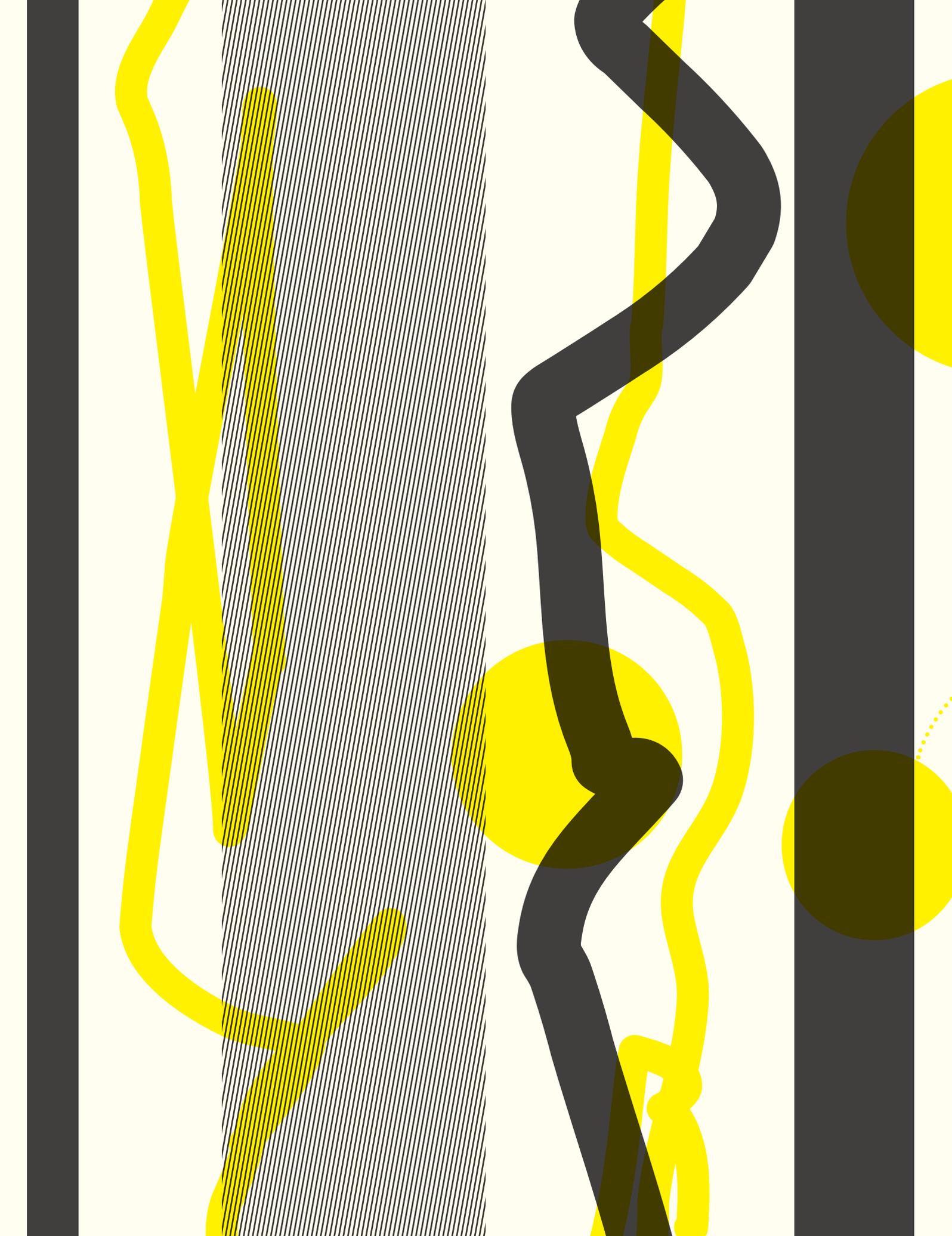
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PREVENTION
of Suicide

WHY SUICIDE PREVENTION IS EVERYONE'S BUSINESS

by Alan Woodward

Suicide affects thousands of Australians. Its impact is widespread. The phrase, suicide prevention is everyone's business, is often mentioned in suicide prevention strategies, but it is unclear why or how this is so.

We have to move in Australia from our old understandings of suicide as an isolated behaviour by the mentally ill to a tragic loss of life that occurs when an individual perceives, irrationally and perhaps because of underlying mental health disorders, that the best step they can take for themselves, and for others, is to end their life. We need to accept that the motivational factors for suicidal behaviour occur in the context of how an individual views themselves and the world around them.

We need to better understand why people die by suicide and what can be done to prevent such tragic deaths so that in all of our communities we understand why suicide prevention is everyone's business.

Each year, in Australia, about 2200 people die by suicide, according to the Australian Bureau of Statistics (ABS) causes of death reports. This number has remained stubbornly around the same level for the past decade. The ABS National Survey of Mental Health and Wellbeing reports 65,000 attempts of suicide each year. Around 38,000 of these are recorded through interactions in our health system, principally at accident and emergency departments of public hospitals, as reported by the Australian Institute of Health and Welfare. Estimates from research (Botha et al: 2009) are that around 21,000 people throughout Australia are impacted by another's suicide each year – in the past decade a population the size of Wollongong has grieved the loss of a friend, a brother, a father, a sister, a football team member or a work colleague.

Mental illness is frequently behind the torture and pain of the person who chooses to end their life. In his book on suicide prevention published in 2008, Australian researcher Professor Robert Goldney from the University of Adelaide identified that more than 70% of people who died by suicide would have been diagnosable with clinical depression at the time of death. This figure is replicated in international research. Clearly, mental illness and, especially mood disorders such as depression, play a big part in suicidal ideation and action.

Yet the pathological elements do not fully explain suicidal behaviour. A simple causal link does not exist. There is more to suicide than this: research going back to the 1960s by Dr Ed Shneidman and his colleagues, and recorded in the book *The Suicidal Mind* (1996), described the experience of psychological pain in a crisis state as a precursor to a suicidal impulse. Trigger factors and events often precipitate this state of crisis, for example, a relationship ends, a job is lost, a humiliating situation occurs, the money runs out.

More recently Professor Thomas Joiner at Florida University developed an interpersonal theory of suicide, drawing on psychological autopsies concerning people who have died by suicide; this model approaches suicidal ideation from the perspective of psychosocial factors that influence how a person views themselves and the world around them. These forces may create the notion that suicide is a preferred option – a person comes to the belief that the world will be better off without them. Additional perspectives on suicide are identified by researchers in the United Kingdom, including Professor Rory O'Connor of the University of Stirling, who, in the 2010 *International Handbook of Suicide Prevention: Research, Policy and Practice*, present an integrated motivational-volitional model. This shows the inter-relationships between background factors and motivational factors, which spur a person onto suicidal behaviour.

A STRONG CHALLENGE TO SUICIDAL THINKING, THEREFORE, IS THE MESSAGE: 'YOU ARE NOT ALONE'.

Alan Woodward
Executive Director
Lifeline Foundation
for Suicide Prevention

This research tells us that perceptions around burdensomeness and thwarted belongingness, as Joiner terms them, a sense of hopelessness, feelings of being alone and unable to cope with life's difficulties and see options or solutions, play a very real part in suicidal behaviour – and therefore must be addressed in suicide prevention.

Through a greater understanding of these psychosocial factors we may see more clearly how suicide prevention is everyone's business.

Support services

To illustrate the relevance of helplines in suicide prevention, 43.6% of calls to the Lifeline telephone crisis line have as a main issue presenting for the caller an aspect of their relationship with family and friends. Moreover, in 32.7% of calls, issues around the caller's sense of themselves and the social scene surrounding them are raised as features of the need for help. Loneliness is expressed as a crisis support issue in 14% of the calls; almost a quarter (23%) of these calls is from people who are actually living with others.

A strong challenge to suicidal thinking, therefore, is the message: 'you are not alone'.

This is the thinking behind helplines as non-judgemental and accessible services for people to contact when seeking help, with research in Australia and internationally suggesting between 25 and 30% of callers to such services are experiencing suicidal ideation at the time of the call.

It is also the thinking behind community campaigns such as R U OK? Day, which reinforce the power of positive conversation in supporting another's wellbeing and encourage help-seeking when times are tough, including the promotion of helplines and crisis support services.

Friends and families

All of us live with connections to family and friends and to communities, in various forms, including our local area. Our experiences of these connections impact on our psychosocial outlook and we, in turn, influence the impacts on others.

Accordingly, we can influence how the psychosocial factors operate for a person. We can, through our actions to show compassion and acceptance of people experiencing difficulties, and through giving them encouragement to seek help, interrupt the steps a person may be taking on the road to suicide.

Social exclusion

Social exclusion is of particular concern because of the direct attack it can have on a person's perceptions of belongingness. Very high rates of suicide among populations which are vulnerable to discrimination seem to bear this out; persons of indigenous background are 2.5 times the general population dying by suicide, persons identifying as lesbian, gay, bisexual, transgender and intersex are estimated to at least 3.5 times more often die by suicide. Discrimination on the basis of race, sexual preference, gender or disability heightens risks of suicide for some individuals.

An inclusive and accepting society is a suicide-safer society. Our efforts to directly remove social exclusion and discrimination from our communities contribute to suicide prevention.

There is also a socioeconomic disadvantage aspect to the spread of psychosocial factors in the Australian population. Most recently, the Council of Australian Governments Reform Council's Report

on Healthcare Performance for 2011–12, for the first time reporting on measures of psychological distress, found that in 2011–12, people living in the most socioeconomically disadvantaged areas were more than twice as likely to experience distress levels as those in the least disadvantaged areas.

We understand now that psychological distress can foreshadow the onset of mental illness; the crisis state that occurs surrounding this distress can give rise to suicidal ideation. A more equitable society will support suicide prevention.

What we can do

In considering how suicide prevention is everyone's business, therefore, we need to give greater attention to the psychosocial factors that are associated with the development of a heightened intention to die.

While few of us are able to provide the clinical treatments and programs to address mental illness, we are all able to contribute to suicide prevention in the following practical ways:

- Building the protective factors that reinforce positive wellbeing in how those around us regard themselves and their social environment.
- Creating stronger social networks, an inclusive Australia.
- Promoting help-seeking and the provision of caring responses to others in times of personal crisis.

In all of this, suicide prevention is everyone's business.

PREVENTING SUICIDE ACROSS SECTORS & COMMUNITIES

by Susan Murray

Chief Executive Officer,
Suicide Prevention Australia

In December 2012 the Lancet reported that globally in 2010 suicide took more lives than war, murder and natural disasters combined; 36 million years of healthy life were lost in that same year alone.

Where are the protests, the community outrage at these figures? Where is the justice? Where is the funding for a concerted long-term, multi-faceted whole-of-community effort to turn this around?

Perhaps the numbers are too big to grasp. Perhaps we need to individualise it as someone's daughter; a sister's brother; a child's father. What will make our community sit up and take notice of this unacceptable wicked social predicament?

Some decades ago the leaders of community-

funded organisations, the state cancer councils and the National Heart Foundation, recognised that smoking was the most significant preventable cause of ill-health and thus began a concerted community education and advocacy program. Today, Australia is recognised globally as a leader in tobacco control. The rates of smoking have dropped below 20% (across the population) not because of the work of a few people but because, layer by layer, the whole community was educated about the ill-health effects of smoking and individuals were supported to quit. Government legislation and policy implementation, fiscal imposts, supportive environments like smoke-free workplaces, and controls on advertising were just some

of the initiatives that combined across the whole community to achieve this remarkable turnaround.

It is this approach that needs to be adopted for prevention of deaths by suicide. Australasia has a small population and it is ageing. It cannot sustain 111,700 healthy years of life lost annually (GBD: 2010).

No one factor can be held to account if a person decides to take their own life. It is this multiplicity of factors that have made it so difficult to gain traction in reducing suicides in Australia. A review of the statistics published by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare shows just how hard it has been to make headway in reducing deaths from suicide.

Deaths have plateaued for all people over the last decade. Certainly the focus on reducing youth suicide has led to a decline in young people taking their own life – and this is extremely praiseworthy.

It must also be sustained. Every year another cohort of young people faces the challenges of gaining an education and securing employment, maintaining strong and supportive family structures and remaining connected to those who can help in troubled times.

What is good practice?

Suicide Prevention Australia (SPA) strongly agrees with the World Health Organization

WE ARE UNDER NO ILLUSION ABOUT THE CHALLENGES WE FACE BUT WITH STATISTICS HAVING PLATEAUED THE CHANGE IN OUR APPROACH CANNOT COME SOON ENOUGH. COLLECTIVE IMPACT IS THE WAY AHEAD TO PREVENT SUICIDES IN AUSTRALIA.

and the National Mental Health Commission that suicide prevention requires an innovative, comprehensive multi-sectoral approach. This includes health and non-health sectors, for example, education, employment, justice, immigration and media.

Interventions in high-risk groups and settings and appropriate responses to individuals identified at imminent risk of suicide are needed to reduce suicide rates across the entire population.

There is evidence to support strong components of action such as:

- Improved awareness and skills for frontline personnel, whether they be general practitioners and ambulance services,

families, schools or work communities.

- Improved mental healthcare.
- Restricting access to the means individuals may use to end their lives (NMHC: 2012, 139).
- Using the emerging evidence that supports new e-health services as positive ways to increase access and timely interventions. The evidence suggests that more intensive approaches are needed to follow up after a suicide attempt, beyond standard discharge procedures. This means supporting people for up to 12 months after their suicide attempt (NMHC: 2012, 139).

What does the future hold?

We must continue to invest resources into this intractable and wicked social problem. Why? Because human lives are at stake.

How can we change our approach to begin to show a downward trend in national suicide statistics? The National Coalition for Suicide Prevention, created within the principles and framework of Collective Impact, is crucial in this respect.

Collective Impact is a structured and sophisticated approach that is much more valuable than the sum of the parts. It has shown great promise in communities in the United States addressing intractable social problems. Members of the National Coalition firmly believe that it has potential to make a difference in suicide prevention in Australia.

But it will take a lot of effort and engagement just as we have seen in smoking control. Similarly the most successful US initiatives have engaged all three sectors – community –like SPA, businesses –small, medium and large –, and government – local, state and federal.

First published in Stanford Social Innovation Review, there are six elements to successful Collective Impact:

- An agreed common agenda to which all participants will commit.
- Shared goals and measures.
- A common reporting framework.
- Mutually reinforcing activities.
- Continuous communication.
- A backbone organisation to drive the common agenda.

At its heart Collective Impact enables us to solve challenging social problems with currently available resources, as illustrated in a Collective Impact success story. First documented in the US, the Strive education initiative – cradle to career – was developed over the second half of the 20th century, when the US dropped from being world leader in high school graduates to 18th among the top 24 industrialised nations. Individual schools had good results but there were no system-wide improvements.

Strive brought together 300 leaders in heads of private and corporate foundations, city and government officials, presidents of eight universities and community colleges, and executive directors of hundreds of education and not-for-profit organisations. They agreed on:

- The common agenda – improve education participation rates at every stage of life from cradle to career.
- Goals, measures and reporting – develop a single set of goals for 15 student success networks, which then measured and reported in the same way.
- Mutually reinforcing activities – rather than develop new activities, the 300 organisations charted their own course consistent with the common agenda and informed by shared measures and results.

- Continuous communication – the major challenge when bringing such diverse players together was building trust, which we did through facilitating communication within – and across – the network.
- Backbone organisation – Collective Impact needs a backbone; it controls everything. This is a separate organisation responsible for driving the agenda, maintaining the communication and mediating conflicts among stakeholders, a role that Strive played. They leveraged their own \$1.5million budget to coordinate organisations with a combined budget of \$7 billion – a figure only most of us can dream about.

What do we want to achieve?

We want to halve the number of suicides; we want to halve the attempts. That is our agenda – to reduce suicides in Australia by 50% over the next decade.

The formation of the National Coalition for Suicide Prevention includes more than 20 not-for-profit organisations. – beyondblue, Lifeline, Black Dog, R U OK?, SANE , LGBTI (lesbian, gay, bisexual, transgender, intersex) Health Alliance and many others. All of them are committed to making this change.

SPA is to be the backbone organisation. We are under no illusion about the challenges we face but with statistics having plateaued the change in our approach cannot come soon enough. Collective Impact is the way ahead to prevent suicides in Australia.

TIME *to* FOCUS *on* PREVENTION of MENTAL HEALTH DISORDERS

by Prof Helen Christensen
Executive Director, Black Dog Institute, UNSW, Randwick, Sydney

& Katherine Petrie
Black Dog Institute, UNSW, Randwick, Sydney

Nearly a decade ago, Gavin Andrews at the Clinical Research Unit for Anxiety and Depression (CRUfAD), at St Vincent's Hospital and the University of New South Wales (UNSW), determined that preventing depression could lower the disease burden by 22%, the same percentage as that associated with optimal treatment. However, the prevention of depression and common mental health disorders in general, has not been a focus of research effort or of health practice in Australia.

A recently published report on Australian research priorities in mental health reveals that prevention in mental health remains radically underfunded (Christensen, Batterham, Griffiths et al: 2013, 355-62), despite its considerable unrealised potential.

Epidemiological, treatment and neurobiological research has dominated in the last 10 years. Competitive grant funding for prevention and promotion has been low, in fact declining between 2000 and 2008 relative to other funding.

Depression is a major contributor to the global burden of disease, making it an important target for prevention. In the Institute of Health Metrics and Evaluation's Global Burden of Disease Study (IHME: 2013), depression ranked eleventh among disorders responsible for the global disease burden (a 37% increase since 2002) while, in Australia, major depressive and anxiety disorders were the seventh and eleventh leading causes of disease burden respectively (DALYs) (IHME GBD Profile: 2010).

This worldwide burden of mental health disorders is projected to rise dramatically in coming decades (Mathers and Loncar: 2006).

We believe promoting the prevention of common mental health disorders in the first place should be a focus for research, practice and prevention activities.

What is prevention?

Prevention encompasses any intervention aimed at preventing the onset of new cases of mental disorder in those who do not currently meet criteria for the disorder (US Institute of Medicine: 2009). Prevention can target the whole population (universal), high-risk groups (selective) or those displaying early symptoms but do not yet meet criteria for a clinical diagnosis (indicated).

Prevention needs to be distinguished from mental health promotion, which primarily aims to promote positive mental health practices. Prevention, on the other hand, aims to stop people at risk from developing the disorder. It is also different from early intervention, which, strictly speaking, refers to the timely intervention of treatment to individuals who already have significant mental health problems, usually of a level to warrant diagnosis. In short, prevention applies specific techniques, programs or interventions in groups of people who are at risk of mental health disorders so that they do not develop such a disorder. Examples of prevention activities include the Triple P Program to prevent development of childhood conditions in

young children, MoodGYM in the prevention of depression and anxiety in adolescence, physical activity programs in older adults to prevent vascular depression, drug and alcohol programs that stop youth from taking up illicit drugs, and building barriers to prevent suicide attempts at suicide hot spots.

We are focusing on prevention rather than treatment for three reasons.

- Treatment alone will never be enough to lower the disease burden associated with mental health disorders. Despite currently available and effective treatments, treatment on its own will not avert this high disease burden given the increasing prevalence and consequent demand for services. Andrews and colleagues (2004: 526-33) for example, found that treatments averted only 13% of the disease burden of depression. Even with improved coverage, competent clinicians and adherence to treatments, only 36% of depression could be averted using current knowledge and therapies, failing to address the remaining burden of major depression (Andrews, Issakidis, Sanderson et al: 2004, 526-33). Prevention is likely to be the single biggest contributor to lowering this burden.
- Prevention is better than a cure. If something can be prevented ahead of time, it will always remain a better option than treatment, particularly in terms of the suffering averted.
- Prevention works. Strong evidence that depression can be prevented includes meta-analysis by Munoz

and colleagues in 2010 of over 30 randomised controlled trials (RCTs), which demonstrated prevention interventions can lower the incidence of new episodes of major depression by around 25%, and up to 50% for stepped-care preventive interventions. A recent report in the Journal of the American Medical Association (Cuijpers, Beekman, Reynolds et al: 2012, 271) reviewing additional research trials reinforced similar conclusions.

Effective preventive strategies from these high-quality prevention trials include psychotherapy and psychoeducation. Such interventions may also be cost-effective, particularly in the long term, by averting considerable future costs of treatment, disorder-related disability, unemployment and reduced productivity (Smit et al: 2006, 330-336; Cuijpers et al: 2012). Prevention of mental health disorders can also reduce the global disease burden and ease over-stretched medical and treatment services (Munoz: 2010).

Prevention in children & adolescents

Prevention programs for children and adolescents are likely to have the greatest long-term benefit and best bang for buck. A recent systematic review in Australia identified screening and psychological treatment, and screening and bibliotherapy (brief self-guided manualised Cognitive Behaviour Therapy), as two cost-effective strategies to prevent

anxiety and depression in children and adolescents (Vos, Carter, Barendregt et al: 2010). With half of all cases of mental disorder experienced in a lifetime beginning by age 14, and three-quarters by age 24 (Kessler et al: 2005: 593-602) this is a critical time to implement prevention.

Ricardo Munoz, an internationally recognised professor with expertise in prevention and treatment of depression, and colleagues note that if caught early enough and implemented systematically, prevention could prevent development of disorder, or at least delay first onset and establish a solid foundation of effective coping strategies and cognitive skills (Munoz et al: 2010; Munoz: 2010). There is relatively strong evidence that school-based prevention and early intervention programs can prevent and treat these mental health disorders (Merry et al: 2011; Neil and Christensen: 2009, 208-215). Schools are an ideal environment for systematic implementation of prevention strategies to a large, captive audience (Calear et al: 2009, 1021-32), with stepped-care interventions also feasible in this setting.

Between 2006 and 2007 Alison Calear and colleagues conducted an RCT of an online self-help cognitive-behavioural therapy (CBT) program, MoodGYM, in 30 schools across Australia, aiming to prevent and reduce symptoms of anxiety and depression (Calear et al: 2009). Anxiety symptoms in students completing the MoodGYM course were reduced significantly as were depression symptoms for young males. Furthermore, a smaller percentage of students in the intervention group developed clinical levels of anxiety, and significantly fewer males developed depression post-intervention and at six-month follow-up. This case study suggests the utility of an online self-guided CBT program to treat,

and potentially prevent, depression and anxiety in adolescents.

Yet prevention does not get its due recognition. It is not prioritised, we believe, because of the following barriers:

- Resources are already stretched in mental health when even basic treatment is not available. Short-term, focused treatment is more important than longer-term preventative measures.
- Many mental health practitioners are not convinced by the research evidence.
- Prevention needs to cover a wide population to pick up individuals at risk. This extends beyond the medical system to workplaces, schools and universities, and a broader audience who may not be easy to reach. Human resource managers, CEOs, school principals, teachers and families need to get involved.
- Prevention can be expensive, although using the internet means programs can be widely disseminated online at relatively low cost. Virtual clinics with mental health prevention programs, like mindhealthconnect (<http://www.mindhealthconnect.org.au/>), allow for centralised access to online resources.
- The implementation science of prevention is not fully formed. Although we have promising programs, prevention interventions require the same degree of rigorous clinical evaluation as other medical devices or pharmaceuticals, and many programs are not yet ready to be disseminated (Flay et al: 2005, 151-75).
- The public needs to engage with prevention programs to date. This requires individual effort, but if you have no symptoms of depression, why would anyone think of engaging with a CBT prevention program?
- There are few champions for prevention or prevention research.

So how can we promote the importance of prevention?

Solutions to these barriers may include:

- Convincing policy makers of the long-term importance of prevention by providing real-life scenarios and solid economic arguments. The prime driver will be leadership – recognition by those in power that prevention is needed combined with the strength to take money away from treatment or recovery programs that are uneconomical.
- Convincing health professionals of the importance of prevention by demonstrating and implementing best-practice evidence-based programs.
- Convincing workplaces that prevention is required. Employers are concerned about the costs of depression to the workplace and recognise that mental health problems are a major contributor to workplace disability. We need more evidence about how much money prevention in the workplace saves.
- Introducing prevention programs should be introduced into the school curriculum and the effects publicised on relevant outcomes, such as academic performance and school attendance. Making the outcomes broader than mental health will help convince teachers of the importance of prevention activities.
- Harnessing the power of technology to promote effective prevention trials and programs.
- Investing in prevention research to consolidate promising programs for later dissemination.
- In the future, designing new prevention programs that will rely less on the initiative of the recipient. If we can engineer the environment to promote prevention activities (such as erecting barriers at hot spots to lower the risk of suicide), or legislate to enforce preventative practices, it will make it easier to adopt them. Gaming technology may help in promoting some activities, such as exercise (for example, <https://www.zombiesrungame.com/>) or cognitive behaviour therapy (Merry et al: 2012).
- Finding prevention champions, for instance, the formation in 2011 of a Global Consortium of Depression Prevention (<http://www.preventionofdepression.org/>), which includes Australian researchers such as (will need to work out how best to add these websites, perhaps best to put in Reference list) Patrick M'Gorry (ORGYEN Youth Mental Health), Andrew Chanon (ORGYEN Youth Mental Health), Catherine Mihalopoulos (Health Economics Unit, Deakin University, Melbourne), Kathy Griffiths (Australian National University, Canberra) and Helen Christensen (Black Dog Institute, UNSW), and the newly established national Alliance for the Prevention of Mental Health Disorders (officially launched in May 2013 in Canberra). The Alliance supports an increased focus on population health to prevent mental disorders and promote emotional wellbeing (Jacka et al: in press). The Rotary Health Foundation will also consider prioritising funding for prevention.

Treatment alone is unlikely to be enough to reduce the burden of mental health disorders whereas we know prevention is both effective and cost-effective. It is finally – and definitely – time to focus on prevention.



EARLY
Intervention

.....
*Prof Patrick
McGorry AO*
.....

ROOTS



In the first decade of this century, Australians have recognised that mental ill-health poses one of the greatest threats to our health and wellbeing across the lifespan, as well as to the social and economic health of the nation.

Australians now understand that mental health is everyone's business, and want a better deal for those living with mental illness, whether it be a family member, friend or colleague. Greater awareness has been fostered, especially by beyondblue and SANE, revealing substantial unmet need, and a shameful gap in access and quality of care between physical and mental healthcare. This results in so much unnecessary suffering and wasted potential.

The World Economic Forum recently calculated this waste worldwide, highlighting the enormous cost to world economies. This is because mental disorders are the chronic diseases of the young, with maximum impact across the main productive decades of life. Despite loads of rhetoric, endless process, and some genuine but modest funding initiatives, Australians still have to tolerate a mental healthcare system that is nowhere near the true scale of the problem, and is consequently fragmented, beleaguered and cannot, despite the dedicated efforts of countless clinicians, produce the required results.

Dr Thomas Insel, the Director of the National Institute of Mental Health in Washington DC, has pointed out that unlike in cancer and cardiovascular disease, where there have been substantial improvements in outcomes in recent decades, people experiencing mental ill-health have not benefited from improvements in premature mortality and disability. What is needed is not only more research, but an immediate, genuine and sustained root-and-branch reform process that is transformational, not incremental, and which gives a lot more weight to prevention and early intervention. Crucially, this reform must deliver equal access to quality care for mental and physical health conditions.

Today, most of the 19th century asylum model has been swept away through a process of mainstreaming of the mental healthcare of people with severe mental illness. This, like the asylum model itself, was well-intentioned but has been poorly designed, funded, executed and maintained. From the 1970s, beds were created within acute hospitals and a minimalist community mental health system was established as a base camp for ongoing care. State governments never really got beyond this base camp and have actually retreated down the mountain.

The post-asylum system was not built to scale, and has buckled under the strain of rising demand and population growth. Mental healthcare has retreated from its embryonic community base, with risk management now overshadowing care and the magnetic pull of the Emergency Department taking over. The ambulances are all at the bottom of the cliff. The system has largely abandoned acute care in the community to the ambulance system, the police and the emergency departments, in that order. The poorly-targeted investment in non-governmental organisation-based programs has fragmented care further, with poor coordination and widespread confusion the rule. Rather than dealing with the fundamental problem here, we are apparently to have more coordinators.

Even the grossly inadequate budgets that are allocated to mental health within the public health system have not been ring-fenced, and in the cash-strapped environment of acute hospitals, community mental health resources, block-funded each year independent of activity and services throughput, are a soft target for the insatiable needs of other health areas that are perceived to be more pressing. Things are likely to worsen unless community mental healthcare is included in activity-based funding. Heartened by the lessons of the former National Disability Insurance

Scheme (now DisabilityCare Australia), our best hope is for a dramatically stronger federal government stake in the leadership, design, funding and governance of community mental healthcare, which should be linked conceptually and operationally to primary care, with the states retaining responsibility for hospital care. It would allow them to concentrate on fixing a serious problem. Inpatient care is in a parlous state Australia-wide with very negative experiences for staff and patients alike. It is in urgent need of root-and-branch redesign, with a serious review of work practices and an expansion of alternatives also needed.

.....
Signs of transformational reform
.....

However, there has been more positive evidence of transformational reform from the federal side, though its future is in the balance. The advent of much stronger support for the role of primary care and allied health in mental healthcare and for a wide variety of psychosocial programs was a major contribution of the Howard government. The establishment of headspace, Australia's National Youth Mental Health Foundation, in 2006 was a major innovation that built on these reforms.

BRANCHES

Reform

The Gillard government, through the leadership of the former Minister for Mental Health and Ageing, Mark Butler and with the personal support of the Prime Minister, has continued and added to these reforms, producing a significant initial package of investment and reform in 2011, which did cover the full lifespan. This was claimed to be a first step in a 10-year program of further growth and investment in mental healthcare, though competition from other policy initiatives has distracted from this commitment. This risks following the old familiar pattern for mental health reform: a surge in advocacy and community concern, followed by a loss of interest and momentum. The National Mental Health Commission, of which much is expected, has yet to hold government accountable for implementation of its reforms. Instead of a true report card on the performance of the system, their first contribution is yet another plan, which many see as having narrowed the agenda again (see Frank Quinlan's article). It remains unclear whether this mechanism on its own will really help.

In Canada and New Zealand, the impact of mental health commissions has been relatively modest and they do not appear to have stood the test of time. Many in Australia believe the Commission needs to become a true commission, to be strengthened and made more independent of government, so its report cards are unconstrained.

This independent voice needs to be backed by a large-scale grassroots voice for hundreds of thousands of people with mental ill-health, powered by internet-based platforms and community activism.

Furthermore, in contrast to other fields, notably disability and cancer, mental health advocacy lacks maturity and unity, and we have been unwilling to prioritise and offer government a range and sequence of achievable reforms that we as a sector will back with solidarity. We simply cannot afford to waste money on new, poorly conceived programs which, while stakeholder-friendly, are untested and not informed by evidence. There are several examples of this. This is especially so when assertive community treatment, employment programs, Housing First programs and early intervention for young people are all ready to go national. We must go with the best buys and the transformational investments. While we have had an overdose of plans, talkfests and roadmaps, all with little sustained impact, what we really need is a high level national inquiry with real teeth, perhaps via the Productivity Commission this time.

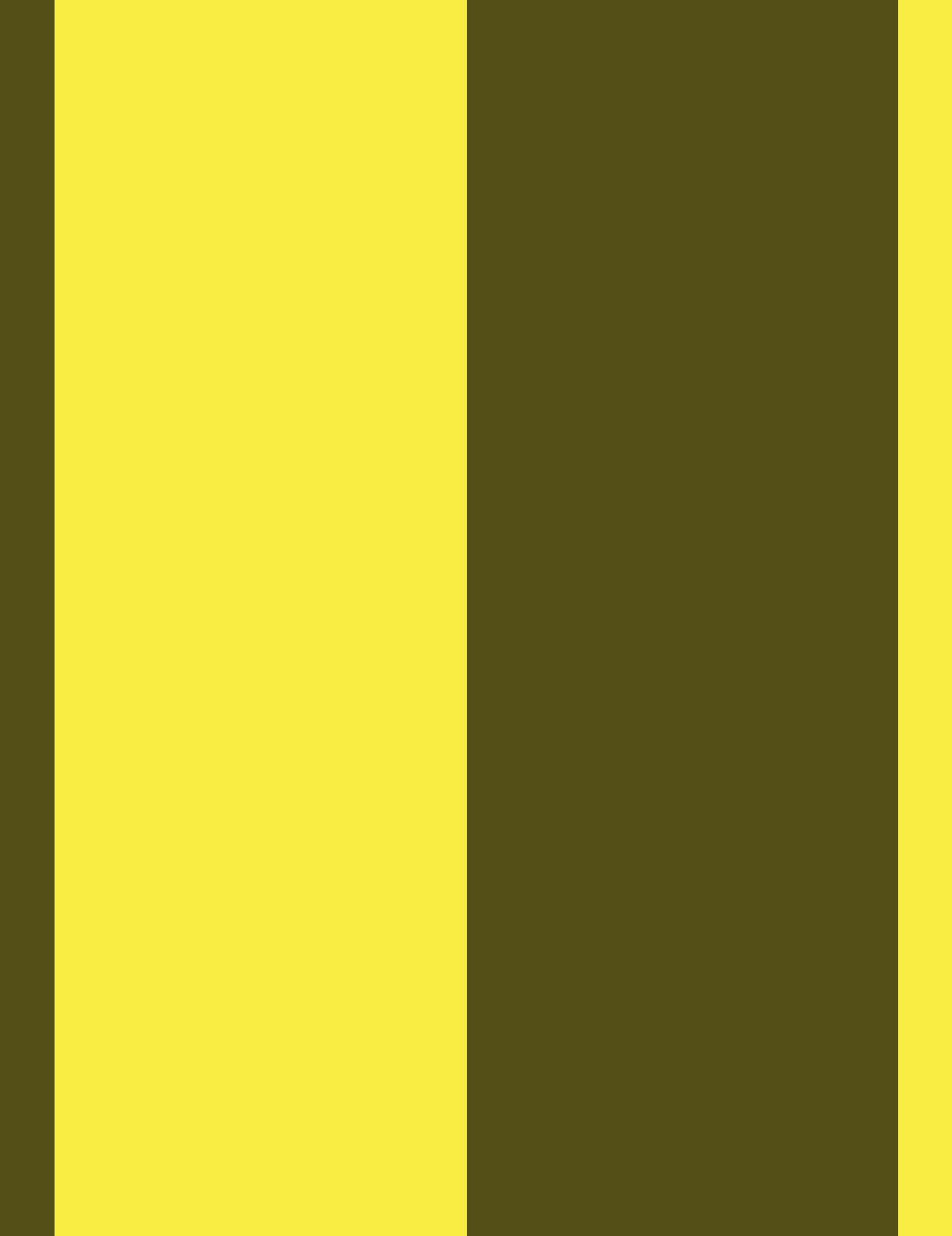
The partnership between the Early Psychosis Prevention and Intervention Centre and headspace, which has bipartisan support, represents an emblematic transformational reform

in the provision of mental healthcare not only in Australia, but worldwide. There is intense interest in this Australian innovation in Europe and North America, where youth mental health is increasingly seen as a major priority. In addition to completing this reform agenda, we also need similar federally funded and led initiatives in housing, employment and primary care-based community mental healthcare for children, older adults and the elderly.

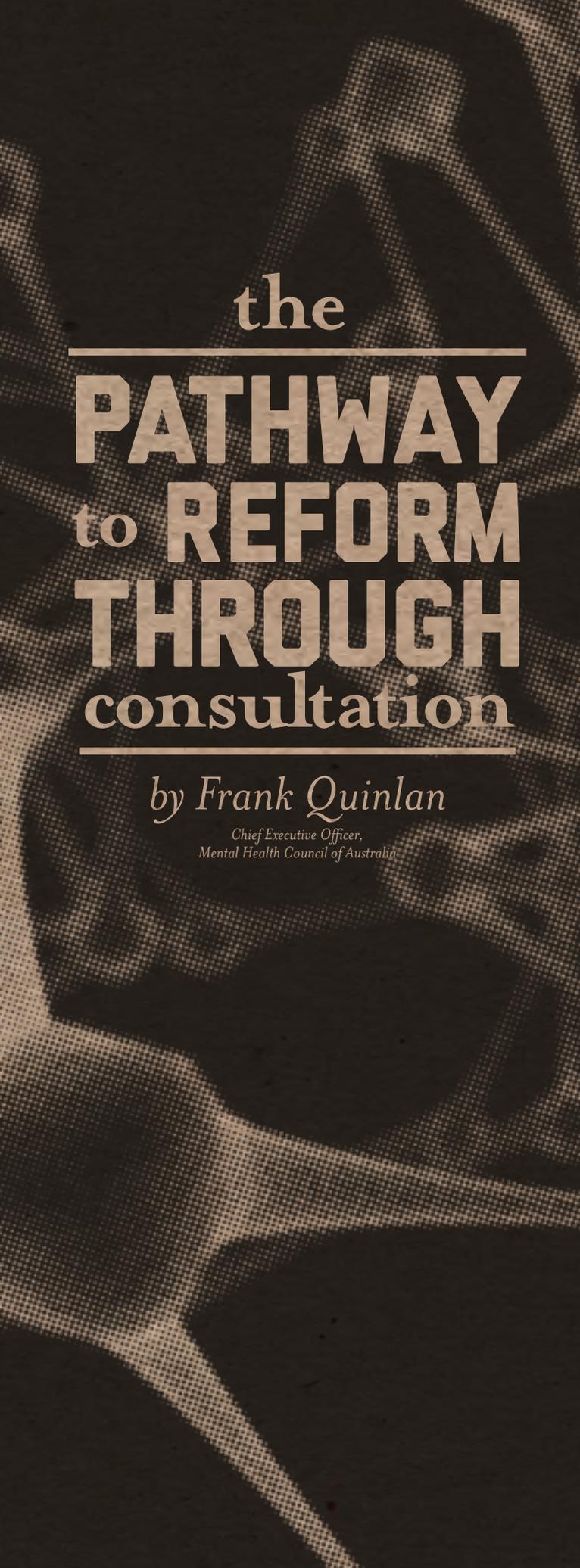
My personal view, fuelled by the harsh day-to-day experiences of so many ordinary Australians, is that while we have solutions at hand we need to mature as a sector, fight a lot harder for those impacted by mental ill-health and not merely for our own organisational goals, and in the current financial environment ensure that we invest wisely in transformational evidence-based programs that will be successful and represent the best buys in mental healthcare. While Australia leads the world in the development of innovative responses, we still have a long way to go to reach our ultimate goal of equality in care and providing the right care and supports for not only some of the most vulnerable people in our community and their families but for every one of the four million Australians with mental ill-health, who deserve a vastly better deal than they have now.

WHAT IS NEEDED IS NOT ONLY MORE RESEARCH, BUT AN IMMEDIATE, GENUINE AND SUSTAINED ROOT-AND-BRANCH REFORM PROCESS THAT IS TRANSFORMATIONAL, NOT INCREMENTAL, AND WHICH GIVES A LOT MORE WEIGHT TO PREVENTION AND EARLY INTERVENTION. CRUCIALLY, THIS REFORM MUST DELIVER EQUAL ACCESS TO QUALITY CARE FOR MENTAL AND PHYSICAL HEALTH CONDITIONS.

Prof Patrick M'Gorry AO
*Executive Director,
Oxygen Youth Health and
a founding member of headspace*



**ESTABLISHMENT
+ MEASUREMENT**
of National Targets



the

PATHWAY

to REFORM

THROUGH

consultation

by Frank Quinlan

*Chief Executive Officer,
Mental Health Council of Australia*

For a long time, the mental health sector in Australia has required meaningful and substantial reform, driven by the basic principle that Australians should have the same access to quality care for mental ill-health as for other health problems. While steps have been taken along this pathway, the need for comprehensive reform remains pressing. Too many people who experience mental illness do not receive the services they need, when they need them.

Governments across the country now broadly embrace the need for mental health reform, with many creating portfolios, and even cabinet positions, for this important recognition. But for many of those who experience mental illness, the pace of change is too slow.

So this experience begs the question: 'How can we shape the reform process and how will we measure if reform has been effective?'

The answer to this question forms the basis of a major task the Mental Health Council of Australia (MHCA) has set itself. For many of our members and friends, reform is welcome news, but only if it results in a tangible improvement in the everyday lives of people living with a mental illness, and the people who care for them.

The MHCA, its members and friends have been active in the creation of measurable targets for mental health reform, and indicators that show us that reform has had an impact.

Early on, when reform for the mental health sector was outlined in the Draft Ten Year Road Map, we identified the need to create targets and indicators, and began a carefully designed consultative process to build and advocate for this important plank in successful change.

The creation and ownership of targets and indicators for mental health reform are a national issue - something that the whole community should be part of. Governments can create the impetus for change, but can only take us so far. Government forums like the Council of Australian Governments (COAG) often struggle with developing meaningful targets and indicators because of competing political and financial interests. Politicians face elections every few years, and public servants must act in the service of politicians within these short-term political cycles. This timeframe can, and does, affect their ability to develop long-term solutions. That is a negative feature of our modern democracy; however, it offers an opportunity for those outside of the political cycle to take a front seat in the development of long-term change.

The MHCA is dedicated to realising reform and sees its role as working closely with its membership, consumers and carers, and the broader community sector, to build the case for measuring the effectiveness of change.

MENTAL HEALTH REFORM MUST MAKE LIFE BETTER, SENSIBLE, MEASURABLE AND MEANINGFUL FOR THOSE WHO DEAL WITH MENTAL ILLNESS EVERY DAY.

Frank Quinlan

Chief Executive Officer, Mental Health Council of Australia

The case

The first report card from the National Mental Health Commission highlighted the notion of a 'contributing life', for those experiencing mental illness and those who care for them. This is not simply focusing on the absence or management of symptoms, but allowing people to contribute to the society's story; a whole-of-life, whole-of-community approach. The catch phrase they used (for good reason) is 'thriving, not just surviving'.

This notion of 'thriving not just surviving' was our starting point when the MHCA began to explore the creation of targets and indicators that would be identified by the community, be of the community and could be delivered and measured within the community.

The MHCA represents a very broad range of stakeholders, and is well-placed to facilitate the conversation that would establish a defined set of targets and indicators that could be advocated to governments through COAG.

Governments need leadership from the community. At the MHCA's first Council of Non-Government Organisations on Mental Health (CONGO) in 2012, a gathering of experts from the mental health and related sectors agreed that the gathering of data,

and ensuing identification of targets and indicators, was something that could, and should, be driven from outside of government. The motivation for this was to ensure the sector was ready to assist COAG to set targets that have meaning in the community.

Reflecting on the Draft Ten Year Road Map for Mental Health and Suicide Prevention, it was recognised that while the map was aspirational and contained a hopeful vision for the future, it missed the mark regarding meaningful and measurable goals, the very stuff that is needed to effect true change in people's lives.

Together, with the sector, the MHCA wrote an open letter to COAG, outlining the gaps in the road map, outlining the value that targets and indicators have for meaningful reform. To COAG's credit, they recognised the gap, and reached out to the sector for help. They responded by setting up a Ministerial Advisory Group, consulting immediately with an Expert Reference Group including the MHCA to seek advice on the way forward. The MHCA and the National Mental Health Commission recognised that only through a robust and vigorous consultation process could we identify targets and indicators that would work for the sector and the broader community.

The consultation

Supported by the National Mental Health Commission, the MHCA undertook a three-staged consultation, gathering data and opinion from a range of stakeholders, both within the mental health sector and the broader community.

The first stage involved rolling state and territory consultation forums. Meetings were held across the country where people could begin identifying targets and indicators that were meaningful to them, and to the places in which they lived. This allowed for community input from people within their own environment, close to their homes and local services, and with a focus on the everyday issues they faced within their communities.

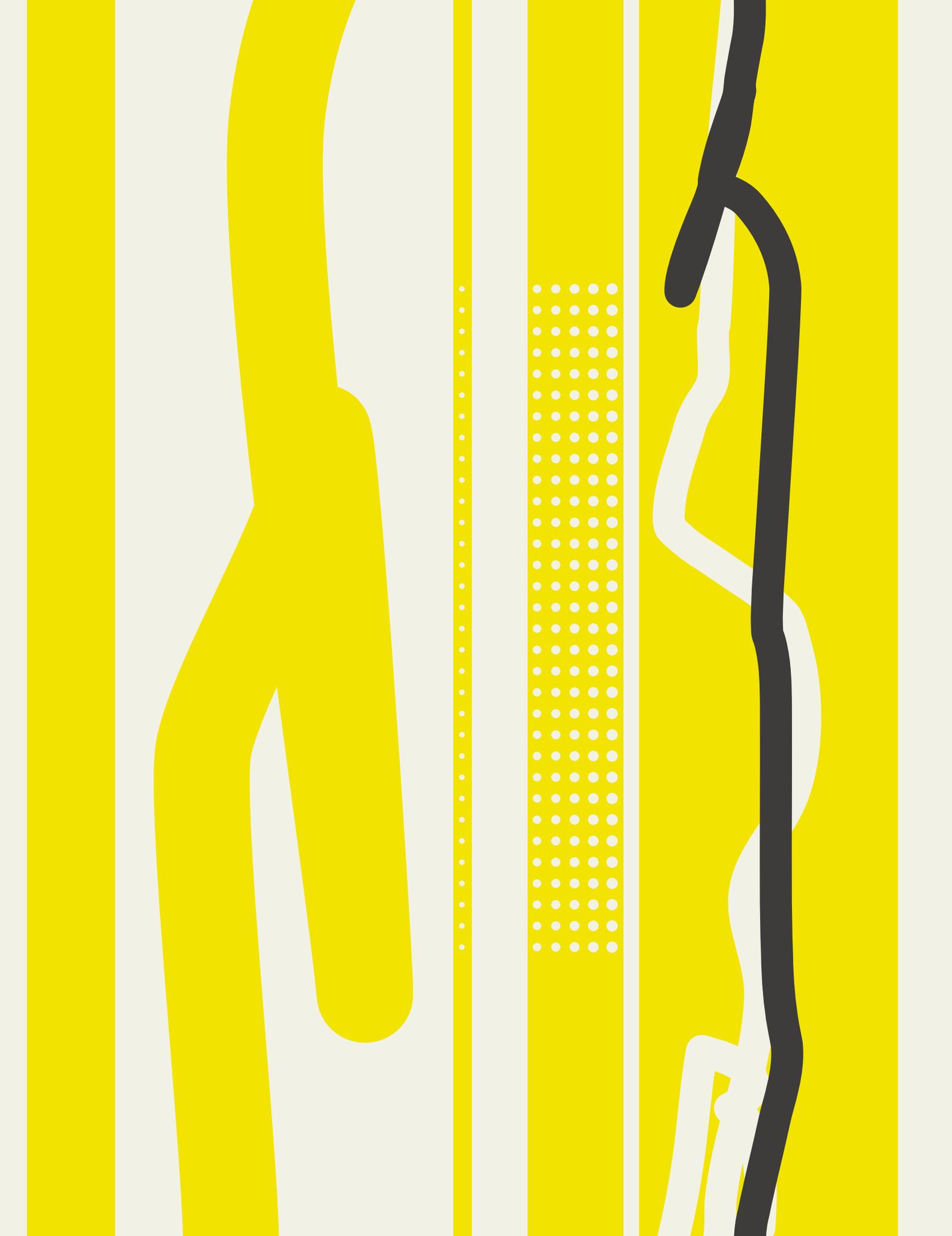
Following this, and using the data gathered at these consultations, a workshop was held with the National Consumer and Carer Forum, representing the very people that reform would impact the most. This workshop allowed for refinement of the targets and indicators identified at the state and territory consultations. In addition, this Forum explored the lived experience of people directly affected by the reform processes. The Forum was able to define outcomes that would have a meaningful impact on the lives of people with lived experience, and those who cared for them. This part of the process gave our initial targets and indicators a human face.

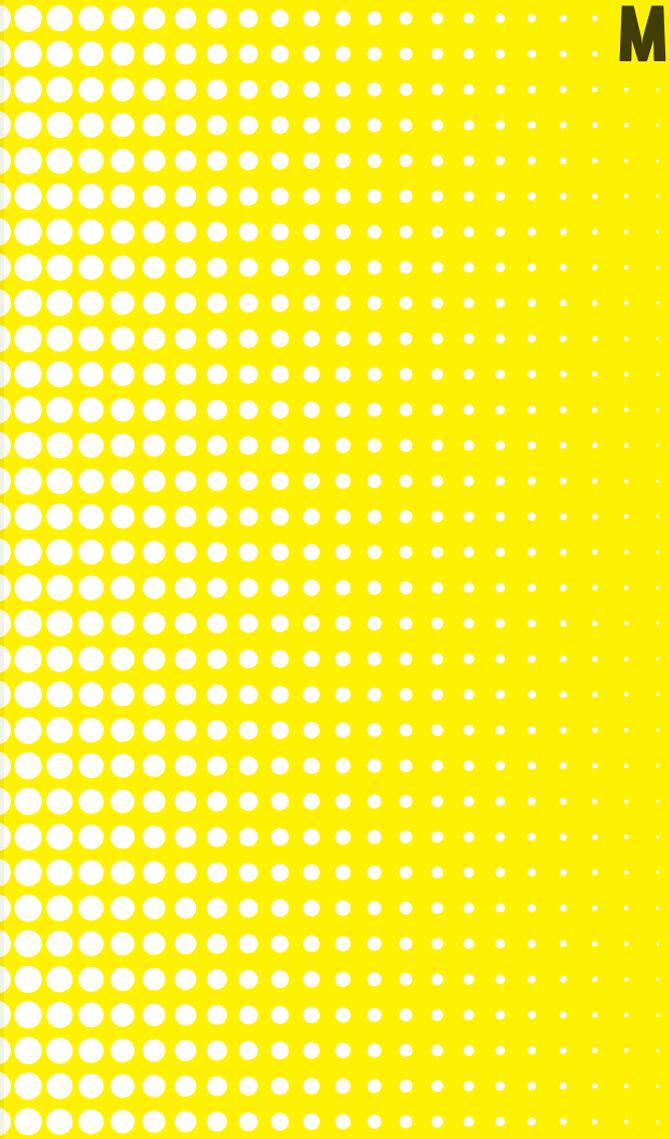
Finally, stage three involved the re-convening of CONGO, where representatives of the community sector joined MHCA members to review and refine the range and potential of indicators and targets identified through the process. The CONGO developed a defined set of targets and indicators based around early intervention, life expectancy, workforce participation, education and contribution in addition to the important issues of suicide prevention, stigma reduction and closing the gap.

The future

These targets and indicators are the stepping stone to positive change. By providing guidance to governments, based on the advice of those who live and work in mental health, the MHCA is confident that lasting, positive change can occur.

Mental health reform must make life better, sensible, measurable and meaningful for those who deal with mental illness every day.





MAXIMISING ACCESS
to Mental Health Services

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LOOKING BEYOND HOSPITAL BEDS FOR MORE FLEXIBLE INTERVENTIONS

by Paul Senior

*Executive Manager,
Support Training & Intervention Services,
Centacare Catholic Family Services*

At the beginning of 2013 – and not for the first time – there were very public debates expressing dismay about the growing use of practices which have mental health consumers in emergency departments restrained by handcuffing and other means, and isolating them in locked rooms through what is known as seclusion and restraint. South Australia (SA)'s Chief Psychiatrist Peter Tylliss acknowledged what appears to be an 'upward trend', suggesting this is in part due to SA now being one of only three states to collect data (ABC Radio: 2013).

In this same interview the South Australian Health Minister Jack Snelling suggests that demand for seclusion and restraint is a contributing factor to the current situation. The National Mental Health Commission calls for all jurisdictions to collect data on its use (NHMC: 2012).

The reality for many consumers (and their carers) of mental health services is that emergency departments continue to be the main source – and first point – of access to mental health services. This is coupled with police and emergency services also fulfilling a frontline and first responder role for mental health services. As a result, few alternative support or intervention options are available to them other than to take consumers to the Emergency Department.

After over two decades of reform, and after substantial federal and state government investments and initiatives, we continue to fail our community by not providing clear pathways, timely intervention, access to flexible and responsive acute care and recovery services to people confronted with mental health issues. Access to services is influenced by where the service is located and the stepped level of care that might or might not be available and the appropriateness of the services offered.

Stepped models of care include crisis respite services instead of emergency departments, recovery centres following acute admissions rather than extended hospitalisation before discharge, intensive home-based support rather than hospitalisation and recovery-orientated community support services. The dominant service, mind you, remains a hospital based in-patient model. Access to flexible acute care interventions remains an elusive alternative for consumers.

AFTER AT LEAST TWO DECADES OF REFORM, AND AFTER SUBSTANTIAL FEDERAL AND STATE GOVERNMENT INVESTMENTS AND INITIATIVES, WE CONTINUE TO FAIL OUR COMMUNITY BY NOT PROVIDING CLEAR PATHWAYS, TIMELY INTERVENTION, ACCESS TO FLEXIBLE AND RESPONSIVE ACUTE CARE AND RECOVERY SERVICES TO PEOPLE CONFRONTED WITH MENTAL HEALTH ISSUES.

Stigma and mental health literacy, our personal understanding of mental illness, its signs and its impact, contribute to patterns of help-seeking (Smith and Shochet: 2011, 37-41). Many people are reluctant to seek assistance. Often, confronted by symptoms, spiralling distress and uncertainty about care responses, a consumer might delay or postpone seeking help. Many will first rely on family and informal supports, delaying help-seeking until circumstances result in the need for urgent intervention.

This delay is not about system navigation. Rather, it is about the dominance of service models. It is not sufficient to understand access merely as a stigma and literacy issue. To do so is to place the responsibility back on the consumer.

When most people think mental health and mental health services they think of hospital-based services and the stigma and uncertainty that go with it (CMHA: 2012).

Even if these barriers were resolved, consumers would still be confronted by the limited options for seeking assistance such as:

- Limited opportunities for consumers to access high quality, responsive, relevant community-setting acute care and recovery supports.
- Local services focused on recovery and stepped to meet the varying states of a consumer's wellbeing.

The presence and availability of services need to be built up. While there is evidence that after decades of reform there is a shift in resources from standalone psychiatric resources and acute psychiatric beds to community-based services (Whiteford: 2002, 210-215), there remains a substantial belief in the delivery of services from an acute hospital-based perspective (Saraceno: 2007). This hegemony, or dominant narrative, is reflected in the ongoing public debate for an increase in funding for more acute beds.

Contra to this, there is ample practice and research evidence to support the position that mental health services are optimally delivered in community settings and in an integrated way (Saraceno: 2007). This goes beyond the concept of a step up and step down continuum of care, but embraces a model of care that seeks to deliver person-centred services concerned not only with a person's psychological needs but with their social and physical wellbeing as well (COAG: 2012). This would be service that practices collaborative care.

A number of services' models have been developed, funded and delivered by community and not-for-

profit organisations such as the PARC (Prevention and Recovery Care) model to support short-term early intervention, Intensive Home Based Support, Headspace, EPPIC (Early Psychosis Prevention Intervention Centre; an integrated comprehensive service) and psycho-social rehabilitation and crisis respite services. But there are still too few of these outlets.

The community-managed mental health sector is central to the development of quantity, quality and accessible services such as the ones mentioned. The sector has been, and continues to be, a leader in the development of person-centred, recovery-orientated services promoting a narrative of care that is in opposition to that based on access to hospital beds.

Historically, this is a sector that has received little of the public spend on mental health and yet there is compelling evidence that investment in this sector will increase access to timely, effective and responsive services. With recent reforms, investment in the community mental health sector has increased from less than 2% of the investment to a little better than 5% (Whiteford: 2002, 210-215) but by international standards this remains low. New Zealand, for example, expends up to 30% of its mental health budget on dedicated community-managed services (Rosen, Goldbloom and M'George: 2010, 593-603).

Access will only be addressed by investment in a diversity of services that are relevant to the communities and target populations they seek to serve. Access will not be resolved with great investment in hospital-based beds. Developing a political and community understanding of mental health needs that is more sophisticated than a plea for more beds is a fundamental step in this direction.

IMPROVED
by Jackie Crowe
National Mental Health Commissioner

IMPROVED HAS THE HEALTH IMPROVED ACCESS

The drive to reform – and improve – the mental health service system in Australia began with the aspirations of mental health professionals, consumers, their families and carers.

In 1991, the United Nations Declaration Principles for the Protection of Persons with Mental Illness was released, followed a year later by the report of the National Inquiry into the Human Rights of People with Mental Illness, which recorded the extent of mental illness and its treatment in Australia.

Additionally, state inquiries highlighted abuse and violation of human rights.

It was while all this was going on that Australia became the first country in the world to develop a national strategy for the transformation of mental health services across the country.

Twenty one years later, there have been:

- 1 national mental health report card.
- 2 national mental health policies.
- 11 national mental health reports.
- 4 national mental health plans.
- Several national strategies.
- Numerous national surveys of mental health.

There have also been state and territory mental health plans to meet local requirements.

In agreeing to a national mental health strategy, health ministers recognised, as in the 2010 National Mental Health Report's summary of 15 years of reform, that it was important to monitor and publicly report on its progress (National Mental Health Report: 2010).

Part of this has been achieved through independent evaluations of each five-year national mental health plan.

First national mental health plan

Improving the rights of consumers, their families and carers was a pivotal theme of the first plan (1992-97). The commitment to empower the consumers, their families and carers of mental health services was a stark contrast to the neglect and gross human rights abuses that characterised mental health services over the past century.

The 1997 evaluation of this, the First Plan, acknowledged that the mental health system was in poor shape at the start of the strategy (National Mental Health Strategy Evaluation Steering Committee: 1997), in particular, that 'there was widespread dissatisfaction with services, consumers, their families and carers who all reported problems with access to services'.

The evaluation of the plan concluded that while significant gains had been made in mental health reform, reform had been uneven across, and within, jurisdictions, and that further action was required to maintain and build on the momentum generated under the plan. Major structural reform achieved during these five years was not necessarily accompanied by improved service quality (Whiteford, Buckingham and Mandescheid: 2002, 210-15) – and thus access.

Second national mental health plan

The second plan (1998-2003) built on the achievements to date and identified additional areas for national activity, such as:

- Promotion and prevention.
- Partnerships in service reform.
- Quality and effectiveness.

Consumers, their carers, mental health service providers and professional bodies were consulted and their views and recommendations helped identify priority areas of national activity.

The evaluation of the Second Plan acknowledged that the challenge to mental health service reform was to achieve a system of care that met the needs of individual consumers 'across the entire course of their illness, across their multiple areas of need, and across the lifespan; however the complexity of the system reform required to deliver integrated care has become increasingly evident'. The evaluation concluded that Australia has continued to pursue and make progress towards implementing the objectives of the National Mental Health Strategy, including the three additional priority themes identified in the Second Plan. However, progress has been slower and less extensive than hoped. In particular, the national community consultations, where for the first time, consumers, their families and carers were part of the evaluation, revealed a high level of dissatisfaction.

STRATEGY TO SERVICES? ACCESS?

Third national mental health plan

The intent of the Third Plan (2003-08) was to unite the achievements of the First and Second Plans, address gaps identified in both, and to provide new directions for the National Mental Health Strategy. In evaluating the plan, many felt it had an aspirational quality and was thus too broad to achieve reform by trying to be all things to all people. In the evaluation, people indicated that they could not say if the key directions or outcomes had been fulfilled because the required actions were not clearly defined.

It was during the lifetime of this plan that reports from the Mental Health Council of Australia and the Senate Select Committee on Mental Health (2006) were published capturing the persisting, distressing and daily experiences of inadequate mental health and community care. The reports detailed personal stories of people with mental illness, their families and carers. They also stated that such stories were often excluded from other national reports. The reports judged harshly the results of reforms over the previous decade.

Fourth national mental health plan

The Fourth Plan (2009-14) had actions in five priority areas that had been developed to achieve the vision of 'a mental health system that enables recovery, which prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community ... with an outcome to have improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services.'

An evaluation to the Fourth Plan is underway.

Future issues

Bringing together different governments and stakeholders, including consumers and their families and carers, to agree to a national approach to mental health is quite an achievement. And there seems to be consensus that national mental health plans are necessary to maintain and focus momentum for ensuring ongoing reform of mental healthcare throughout Australia (Currie and Thornicroft).

It is clear that the aims of the strategy and thus the plans themselves have not yet been fully translated into the expected benefits for consumers, their families and carers or the general population. This is especially when it comes to improved

access to appropriate care. There is widespread dissatisfaction with the state of service, and a strong consensus that further change is needed, including the need for more resources in mental health and in the way that these resources are used.

Although it important to say that Australia has continued to pursue, and make progress in implementing the objectives of the national mental health plans, a quandary does arise. Disquiet about service delivery from consumers, their families, carers, advocates and communities indicates that there are continuing problems with access to timely and effective mental health services (Groom, Hickie and Davenport Tracey: 2003). Given this, have the national mental health plans become increasing irrelevant as a driver for reform at the grassroots level?

Future directions

When the National Mental Health Strategy began no information was available about the extent and impact of mental illness in Australia. Now there is significantly more data but this does not extend to qualitative data from consumers, their families and carers at a national level, nor does it collect recovery data from services delivering mental health programs. As all plans have recognised the need for a change in the way governments respond to mental illness (2009) this is where the Australia could make vast improvements.

Outcome data from consumers and their families and carers must inform the evaluations of the national mental health plans, the Strategy and the way forward. Without this crucial data, the National Mental Health Strategy's evaluations are incomplete and we will never truly know if access to timely, effective mental health services has improved for Australians currently experiencing a mental health difficulty.

THE REPORTS JUDGED HARSHLY THE RESULTS OF REFORMS OVER THE PREVIOUS DECADE. NOW THERE IS SIGNIFICANTLY MORE DATA BUT THIS DOES NOT EXTEND TO QUALITATIVE DATA FROM CONSUMERS, THEIR FAMILIES AND CARERS AT A NATIONAL LEVEL NOR DOES IT COLLECT RECOVERY DATA FROM SERVICES DELIVERING MENTAL HEALTH PROGRAMS.

IMMIGRANT + REFUGEE COMMUNITIES & SYSTEM REFORM

by Prof Harry Minas

*Chair of the Executive, Mental Health in Multicultural Australia,
and Director, Centre for International Mental Health,
School of Population and Global Health, The University of Melbourne*

& Prof Nicholas Procter

*Member of the Executive, Mental Health in Multicultural Australia,
and Chair, Mental Health Nursing, Division of Health Sciences,
School of Nursing and Midwifery, University of South Australia*

*‘Multicultural
Australia is
not a vision or
an ambition,
much less an
ideology or creed.*

*It describes us
as we are and
as we are
destined to be’*

*(The People of Australia,
The Australian
Multicultural
Advisory Council)*

All Commonwealth, state and territory mental health policy documents recognise that Culturally and Linguistically Diverse (CALD) populations need special attention to ensure equity. Reforming the national mental health system requires a clear statement of rights and responsibilities, the development of national standards for service delivery, a commitment to evidence-informed policy development, service delivery and reporting of progress against policy intent, and a focus on the results of this service.

Within all this protocol, are we able to judge whether mental health reform has benefited CALD communities particularly non-English speakers, the most recently arrived, and refugees and asylum seekers, who are among the most vulnerable members of the general community?

Although most mental health policies include statements on the importance of population diversity,

such statements generally do not come with implementation objectives nor funding to support implementation of CALD community policy. Reporting of progress against CALD-related policy intent is also inadequate. Yet, to ensure that all Australian residents benefit from mental health reform, CALD-relevant mental health policy statements need to be translated into those very implementation objectives and resources allocated to meet them.

It is essential to evaluate and report on progress against CALD-relevant policy objectives – something that does not happen at the moment. Mental Health in Multicultural Australia (MHiMA) has designed and is trialling what is known as the Organisational Cultural Responsiveness Assessment Scale that will enable mental health services to track their own provision of culturally responsive services.

We know that many (but not all) immigrant and refugee communities access specialist mental health services far less than the Australian-born, and rates of service use vary enormously across country-of-birth groups. Yet the National Survey of Mental Health and Wellbeing (2007) found that the prevalence of common mental disorders in the overseas-born is not substantially different to that in the Australian-born, although the national survey sample was not sufficient to allow any specific conclusions about even the largest immigrant communities.

While we do not have population data on the

psychoses and other severe mental disorders, the international literature suggests that the risk for schizophrenia among immigrants and refugees is substantially greater than for host-country populations. So the rates at which state and territory mental health services are used, particularly in-patient services, should be substantially higher for immigrants and refugees than for the Australian-born. But they are not, which suggests that specialist mental health services are under-used, with possibly large numbers of immigrants and refugees receiving no effective treatment or care. We do not understand the causes and consequences of this under-use and they need to be fully investigated.

..... **Gaps in data collection**

The general commitment to evidence-informed policy and mental health service design and delivery only makes sense when the resources needed to gather, analyse and use the required evidence are provided. But there are major gaps in relation to CALD populations, in particular in our collection of data on national mental health outcomes. Because CALD variables are not included as part of such collected data, it is impossible to know whether treatment and care for immigrants and refugees have the same affect on them as on Australian-born. This makes it extremely difficult to plan effectively for the future. Ensuring that national outcomes data

can be used to evaluate clinical and social outcomes for immigrants and refugees, consequently, is an urgent priority.

Routine data collections, generally, do not include sufficient CALD-relevant variables or, if they do, they are not systematically analysed and the findings are not reported. None of the National Mental Health Strategy reports, for instance, have included any CALD-relevant analysis, making it impossible to determine whether service standards are met, where the gaps are and whether our mental health system is moving towards equity.

MHiMA is collaborating with the National Mental Health Commission to develop strategies that will improve the quality of CALD-relevant evidence to inform the continuing mental health reform process and contribute to the Strategy's equity objectives.

Cultural and linguistic diversity presents many challenges but also represents an opportunity to improve our understanding of health and illness determinants, and how we can develop more effective promotion, prevention and treatment programs. In the non-communicable diseases field, for instance, there has been an early study of the cardiovascular benefits of the Mediterranean diet.

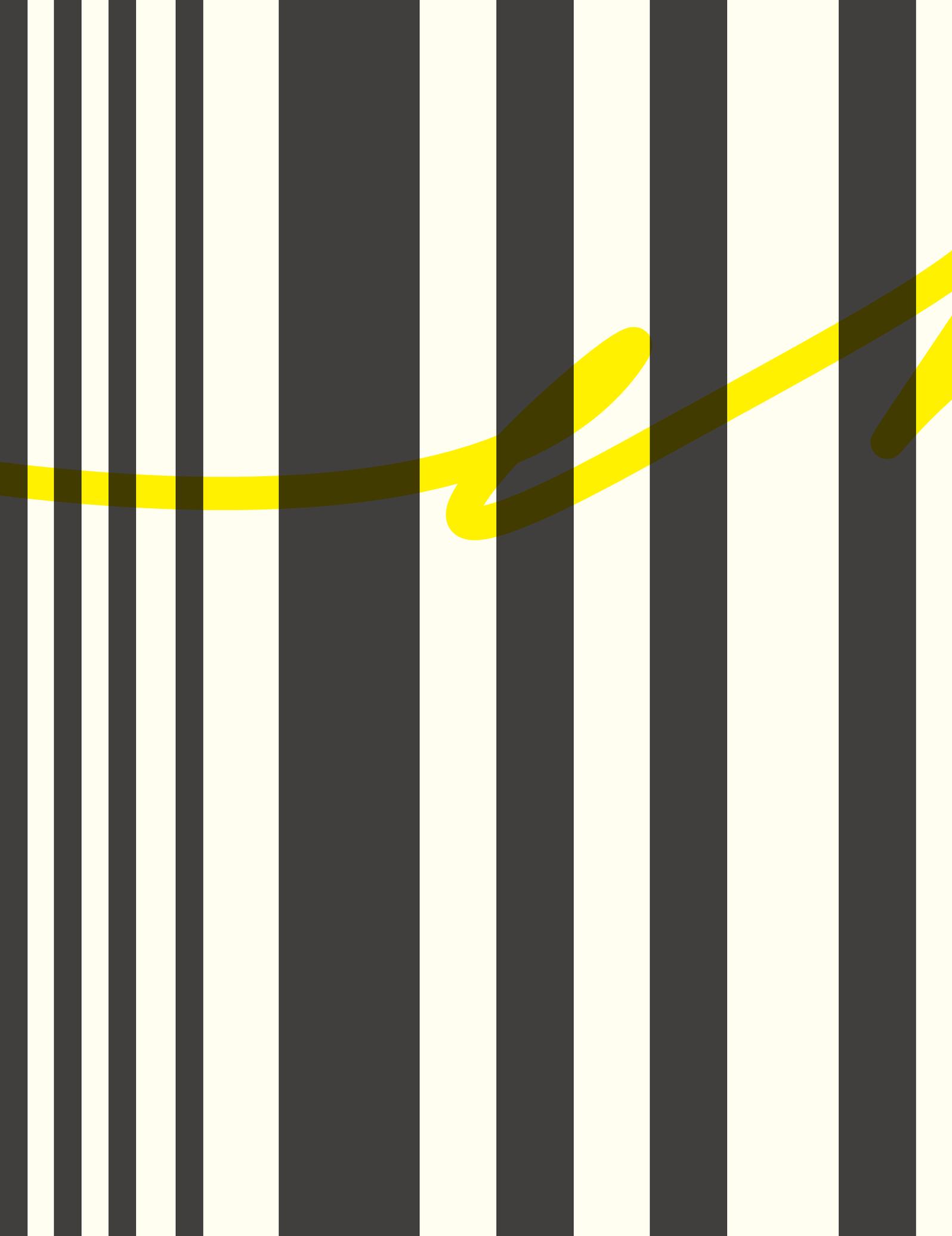
The drive to develop more effective suicide prevention programs will illustrate the point in the mental health field where suicide rates vary widely among different country-of-birth groups in Australia, as they also do

across countries. Systematic examination of this variation will contribute to a better understanding of both risk and protective factors and development of suicide prevention strategies that are designed and targeted for particular circumstances and population groups to make them more effective. By not already investigating these, we both limit our understanding of them and the development of new knowledge that can benefit all Australians.

Although these days we can respond better to the diverse mental health needs of a culturally and linguistically diverse population, much still needs to be done. Representatives of immigrant and refugee communities must be more effectively included in decision-making about all aspects of mental health policy and services, and within consumer and carer organisations themselves. In particular, the quality of evidence that informs such decisions needs to be improved, so that our mental health system fully reflects the diversity of the Australian population.

Most importantly, clear and consistent policy statements on cultural and linguistic diversity need to be implemented, and then that implementation must be monitored, evaluated and reported on. We must move from the rhetorical commitment of policy documents to go on to allocate resources that will create the necessary institutional arrangements to turn policy intent into action that will match the reality – and demands – of Australian cultural and linguistic diversity.

**REPRESENTATIVES
OF IMMIGRANT
AND REFUGEE
COMMUNITIES
MUST BE MORE
EFFECTIVELY
INCLUDED IN
DECISION-MAKING
ABOUT ALL
ASPECTS OF MENTAL
HEALTH POLICY
AND SERVICES,
AND IN CONSUMER
AND CARER
ORGANISATIONS.**





LIFE EXPECTANCY
& Physical/Mental Health

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WHAT ABOUT THE REST OF ME?

Physical disease within Mental Health

BY JANET MEAGHER AM

Despite unprecedented investment in Australia's mental health system in recent years and the establishment of the National Mental Health Commission to help drive a stronger, more coherent and equitable, response to mental health, it is becoming apparent that many people who use our system are struggling more than was previously acknowledged. The largely under-recognised burden of physical disease is rapidly testing our ability to improve quality of life and recovery outcomes for people who live with mental health issues.

People with a mental illness have a life expectancy that is from 10 to 32 years less than the general population. That statistic will surprise a lot of people. Similarly, the death rate for people with a mental illness is two-and-a-half times greater than for the general population – and the disparity is not attributable to suicide rates.

Mental health consumers are at higher risk of chronic physical health conditions such as diabetes, heart disease, and obesity, and have much higher mortality rates from all main causes compared to the general population. This is due primarily to the effects of mental illness and its medications. However, reduced access to healthcare including timely screening, assessment and treatment, also has an impact.

For people living with mental illness, poor health does not happen in isolation from the effects of the prescribed medications, the person's genetic make-up and the more sedentary lifestyle to which mental illness contributes.

People living with mental illness have a 30% higher chance of dying from cancer compared to the general population, yet the occurrence of cancer is statistically similar to that of the general population. Death rates are higher because access to screening and treatment comes too late in the trajectory of the cancer.

Regrettably, a higher risk of premature death is not confined to those with ongoing mental illness – depression is now known also to increase the risk of death from heart disease.

These health disparities are greater for people living with a psychotic disorder as well as for Aboriginal and Torres Strait Islander Australians (see Pat Dudgeon and Tom Calma's article). People with illnesses such as bipolar disorder or schizophrenia have cardiac problems, metabolic or endocrine disorders (diabetes and obesity) at much higher rates than the rest of the community. For these two groups, cardiovascular disease and mental illness have been found to be the two leading drivers for their unacceptable burden of disease.

The national survey of psychotic illness exposed the extent of physical health problems for people in this group:

- Diabetes rates at over three times those found in the general population.
- One third carrying the risk of a cardiovascular event within five years.
- Half affected by metabolic syndrome, which is associated with an increased risk of cardiovascular disease and diabetes as a side effect of prescribed antipsychotic medications.

Most Australians are not aware that treatment with prescribed psychiatric medications can seriously affect physical health and longevity. Where anti-psychotic medications and treatments increase risks, prescribers need to ensure they respond appropriately in particular with:

- Routine reviews of medication regimes.
- Use of psychosocial/ talking therapies as alternatives to pharmaceuticals alone.
- Screening for known risk elements.
- Avoiding polypharmacy (multiple medications) whenever possible.

As professionals, planners, funders, service users and advocates, we must ask ourselves, how did we omit this for so long, and what can we do about it?

We know from one study that while nearly 90% of people living with psychosis had visited a general practitioner (GP) in the past year, two-thirds reported they did not have a general health check or a cardiovascular-related health check during the visit. It is estimated that only one in five people with a mental illness has a mental health treatment plan from their GP and that those plans usually do not refer to physical health checks or improving physical health.

The persistent and significantly higher levels of cardiovascular disease for people with persistent mental illness indicates a lack of understanding of how to implement interventions and service protocols to reduce risks, such as motivating individuals and introducing and encouraging self-management programs that target weight, blood glucose, lipid control and physical activity.

Barriers to coordinated management

Evidence suggests that there are significant barriers to effective, coordinated management of co-existing physical and mental health conditions, including:

- People with a mental illness being treated solely for symptoms of mental illness.
 - Poor recognition of the
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UNLESS WE SERIOUSLY REFLECT ON HOW MUCH WE PERPETUATE THE LIFE EXPECTANCY GAP FOR PEOPLE WITH MENTAL ILLNESS, WE WILL NEVER CLOSE IT.

Janet Meagher

National Mental Health Commissioner, mental health consumer activist and advocate for over 30 years

relationship between mental health and physical health.

- Primary healthcare professionals' low-confidence or discriminatory response to whole-person care when working with people who have a mental illness.
- Mental health workers' unwilling or slow response to medical health issues.
- Concerns of people with a mental illness about using the services from transport and access to discrimination.

In its first-ever national report card on mental health and suicide prevention, the National Mental Health Commission (NMHC) found that the low levels of physical health monitoring of people with mental illness made it difficult to know how best to increase that monitoring and close the gap on life expectancy for people with complex and demanding health needs.

Nevertheless, the Commission made several recommendations regarding further research into the metabolic side effects of psychiatric medications, as well as improved primary care service protocols more actively to address the physical health needs of people experiencing mental illness, with particular reference to the disproportionate

prevalence of cardiovascular disease among people with mental illness.

Encouragingly, a national summit held May 24, 2013, discussed how to address increased mortality in the mental health consumer population. The May Summit Communiqué reported that:

The Summit agreed to a new national commitment to reversing the trend of people with a serious mental illness dying early and experiencing disproportionately adverse health outcomes with this to be based on the following principles:

- People with severe mental illness should have the same expectations of a rich and contributing life as the general population. This includes having good mental health, physical health and wellbeing as well as the same access to timely and quality healthcare and the other supports and services critical to a contributing life.
- To achieve these improvements, there is a need for the active engagement of all relevant portfolios across governments, noting the importance of a rehabilitation and recovery framework.
- Any action to reverse this trend must be informed by the experience and knowledge of individuals living with mental illness and also that of their families and carers.

- Improving the physical health of people with severe mental illness requires the active engagement and participation of all levels of healthcare and across all specialities particularly with regard to primary healthcare.

To progress action, it was agreed that immediate attention would be given to developing a series of commitments across jurisdictions, with further detail on implementation including targeted outcomes to be provided in due course.

.....
Where does this leave us?
.....

We must continue to support action on more effective service delivery for dealing with the unacceptable levels of morbidity and mortality linked to poor physical health among people affected by mental illness. This work is urgent. Acknowledging that it will take time we must, in accelerating our responses, ensure that our approaches are consistent, based on sound consumer empowerment and health promotion principles, and are tailored to meet the real needs of mental health consumers and those who support their efforts to get health equity and an all-round better deal.

With government interest and policy development and planning approaches

underway, it is timely that we address the largely unspoken dynamic that underpins much of the historic oversight in this area of mental health – that people experiencing mental illness are still primarily defined by their mental illness, as needy and to be managed, rather than seen as a whole person with potential and a right to have a healthy, worthwhile contributing life.

It is time we shone some light on attitudes in clinical practice and challenge the shroud that a psychiatric diagnosis brings to other symptoms and markers.

How often do medical people pass off physical symptoms as psychosomatic? Why do not we undertake routine cardiovascular and metabolic investigations in mental health practice? Do we listen and observe, do we offer or refer to appropriate screening and health promotion services?

We can, and must, do better. Better practice is driven as much by progressive attitudes as by clinical protocols. Mental health consumers can tell the difference, and are much more likely to work in partnership with services that acknowledge their broader health needs in meaningful ways.

Unless we seriously reflect on how much we perpetuate the life expectancy gap for people with mental illness, we will never close it.

BRIDGING *the* GAP by EMPOWERING



CONSUMERS

Over the past two centuries clean reticulated water, mass health screening, immunisation and antibiotics have revolutionised physical public health. In this century, the parlous state of public mental health has the potential, likewise, to be transformed by the delivery of mental health mass screening, public awareness, prevention, treatment and recovery programs direct to the public via the internet, mobile and other new technologies. Indeed, it is already happening, and Australia is one of a handful of countries leading the way in these new developments.

e-mental health environment now

Much of the e-mental health service innovation in Australia has originated within universities where researchers have not only developed online and mobile applications to deliver mental health services but have also carried out rigorous research to demonstrate their effectiveness.

This development work is within the context of Australia's high internet use. According to the latest figures from the Australian Bureau of Statistics, as many as 79% of households in Australia have internet access and 92% of these are connected by broadband (ABS: 2012). Moreover, most households access the internet every day (ABS: 2012).

To their credit, successive federal governments have been quick to recognise the potential of e-mental health. As a consequence, the Department of Health and Ageing has partly or fully funded the ongoing delivery of a number of e-mental health services. A key driver here has been the evidence that these programs work and are cost-effective especially given consistent findings that only one-third of Australians receive mental health help from the conventional health system.

In 2006, the Australian government established the Telephone Counselling, Self-Help and Web-based Support Programme, which provided funding to maintain existing internet-based mental health services

and to develop new e-mental health programs. These services range from education and automated self-help prevention and treatment programs to internet-based, peer-to-peer support forums and clinician-guided programs. These e-mental health tools have proved popular. For example, one program funded under the initiative is the well-known MoodGYM.anu.edu.au prevention and treatment program, which was launched in 2001. In its current version, the third, MoodGYM receives approximately 34,000 unique visitors per month, has 670,000 registrants from 222 countries and has been translated into Chinese, Dutch and Norwegian with German and Finnish translations underway. Of MoodGYM users, 22% globally are from rural and remote regions and 22% of the Australian registrants are referred by general practitioners.

In 2012, the Department of Health and Ageing released the e-mental health strategy for Australia. This strategy identifies a need to promote the growth of the e-mental health sector, to provide a 'new layer of service in the health system' that was integrated into existing services, and to assist consumers to identify high quality online services. In particular, the strategy aims to deliver effective e-mental health services to Australians with less need for intensive face-to-face services and to those not currently accessing formal treatment.

To this end, the government continues to fund the services established under the original 2006 initiative and has provided additional funding to support new services. Consistent with the e-mental health strategy, it has also established a mental health portal, MindHealthConnect.org.au, to provide consumers with information about available Australian e-mental health and other services. The visitor to MindHealthConnect can select their own pathway through the site or be guided through the portal based on the findings of a brief screening questionnaire.

The strategy has also established a national virtual clinic, MindSpot.org.au. This clinic operates on a stepped-care-model, is designed to reduce the barriers to help-seeking among Australians by delivering services via the internet, telephone and postal services, and by facilitating referral to face-to-face services where required.

Each visitor to MindSpot is first screened and assessed. The intensity of the services delivered (e.g. low intensity self-help via the internet; referral to high intensity face-to-face treatment) depends on the individual consumer's assessed need. A final initiative, designated by the e-mental health strategy as The E-Mental Health Support Service, is expected to commence soon. It involves the delivery of training to general and allied healthcare practitioners to make it easier to incorporate and take up e-mental health services in the conventional primary healthcare system.

CONSUMERS

Keeping at the forefront

While Australia's service policy and funding track record in the e-mental health arena is impressive, it is critical that we do not rest on our laurels.

In his foreword to the national e-mental health strategy, the former Mental Health Minister Mark Butler emphasised that MindHealthConnect will provide consumers access to high quality and trustworthy information. However, this portal has no explicit quality assurance mechanism for determining the services it incorporates. MindHealthConnect does indirectly link to Beacon.anu.edu.au, a portal that incorporates such a mechanism, but the government has ceased funding this initiative.

Significantly, the e-mental health strategy identifies The E-Mental Health Support Service as being responsible for providing 'advice on quality assurance and new innovations' in the field. With the disbandment in September 2012 of the E-Mental Health Expert Advisory Committee, which informed the development of the e-mental health

strategy, this expert role will be critical if Australia is to continue to capitalise on developments in e-mental health and maintain high quality services. Equally, if the government is serious about its commitment to consumers and carers, the consumer and carer sectors must establish a mechanism to ensure both sectors are formally and actively incorporated into the advisory process.

The government's integration of e-tools into the current healthcare system is important. However, it ignores the huge potential of people and systems outside this conventional system to promote and deliver these programs. These include consumer and support groups, teachers, sports environments and the workplace. The possibilities are extensive as evidenced by the establishment of bibliotherapy book clubs in Scottish libraries.

The E-Mental Health Support Service is charged with delivering training programs to individual practitioners. Again, clearly this is important. However, there is also a need to change organisational systems. Programs that have been demonstrated effective within these systems need to be implemented in practice.

For example, MoodGYM has been demonstrated effective when integrated into Lifeline telecounselling. Callers who were referred to MoodGYM showed decreased depression and reduced alcohol use compared to those with usual access to Lifeline services (Farrer et al: 2011, e28099; 2012, e68). Similarly, in a study conducted in almost 30 schools in metropolitan and rural and remote Australia, MoodGYM has been shown to prevent new cases of anxiety, and new cases of depression (boys) (Calear et al: 2009, 1021-32). Despite this, MoodGYM has not been implemented in Lifeline nor systematically rolled out in schools across the nation.

Both are lost opportunities. We know that current treatment techniques optimally delivered to all who could benefit would avert only 34% of the burden of depression (Andrews et al: 2004, 526-33). This suggests that it is critical to implement evidence-based prevention interventions. Clearly schools provide an ideal setting in which to deliver such programs. Prevention programs are well established in the domain of physical health. It is past time to implement prevention programs in the mental health domain using

e-mental health tools delivered en masse, at low cost and with high fidelity.

Finally, the science of the development, evaluation and delivery of e-mental health programs is fast-moving. Other countries, such as the United Kingdom and the Netherlands, have funding programs which support the development of new interventions and their research evaluation. Australia has no such research and development funding programs and innovative and pragmatic e-mental health research is not favoured by standard funding bodies such as the National Health and Medical Research Council. There is a real danger that we will slip from the forefront of these developments and that future governments will be forced to buy technological solutions at inflated prices from commercial operations located overseas. Even more serious is the risk that, in the future, Australians will continue to suffer high levels of avoidable mental ill-health problems. Consideration is needed to preserve the geese that have until now laid the close-to-free golden e-mental health eggs.

by PROF KATHY GRIFFITHS

Director of the ANU Centre for Mental Health Research

the
**SOCIAL &
EMOTIONAL
WELLBEING** of
**ABORIGINAL
& TORRES
STRAIT
ISLANDER
PEOPLES**

article by

PROF PAT DUDGEON

*Inaugural chair and now
steering committee member of
the Australian Indigenous
Psychologists Association*

&

DR TOM CALMA AO

*National Coordinator, Tackling
Indigenous Smoking; co-chairs
of Aboriginal and Torres Strait
Islander Mental Health and Suicide
Prevention Advisory Group*

Over half a million Aboriginal peoples and fifty thousand Torres Strait Islanders live in Australia (ABS: 2011). This figure includes people who identify as both. They are a relatively young population, with a median age of 21 years, compared to 37 years for other Australians (ABS: 2012a). There are many varied Aboriginal and Torres Strait Islander language groups, cultures and traditions but also collective elements: a shared cultural history and ancestry in populations that suffered invasion by a colonising power; and racism, social exclusion and intergenerational poverty that are all too common as contemporary lived experience.

Across a range of indicators there is a gap between the mental health of Aboriginal and Torres Strait Islander peoples and other Australians. Particular population groups face further challenges. Among Stolen Generations' survivors, mental health conditions occur at twice the rate as among those who had not been removed from their families (ABS: 2012b).

Improving mental health remains a critical challenge for Aboriginal and Torres Strait Islander leaders, communities and policy makers in Australia, and not just for its own sake. Mental health conditions influence or impact upon many other forms of disadvantage, as, indeed, social, political, historical and cultural conditions determine mental health.

Up to 22% of the overall health gap between Aboriginal and Torres Strait Islander peoples and other Australians has been directly attributed to mental health conditions (Vos, Barker, Begg, Stanley: 2007, 2). Over one-quarter of all prisoners at June 2012 were Aboriginal and Torres Strait Islander peoples (AIHW: 2011, 29), with very high rates of mental health conditions reported among them (Heffernan, Andersen, Dev et al: 2011, 37-41).

Social and emotional wellbeing

Aboriginal and Torres Strait Islander peoples have consistently asserted that their physical and mental health should be understood in holistic terms (National Aboriginal Health Strategy Working Group: 1989), with a foundation for both in social and emotional wellbeing – a positive state of existence within a network of healthy relationships that includes between the individual and their family and kin, community, traditional lands, ancestors and the spiritual dimension of existence (Social Health Reference Group: 2009, 4, 7-8).

Social and emotional wellbeing is a protective factor against the stresses of life that can impact on mental health. As an example, a positive cultural identity and Aboriginal spirituality has been reported to assist Aboriginal children and young people to navigate being an oppressed minority group in their own country (Department of Education and Early Childhood Development: 2010, 45); and provide meaning in adversity (Centre for Rural and Remote Mental Health: 2009, 9, 11, 19)

Conversely, negative challenges to social and emotional wellbeing can undermine resilience and leave individuals

and communities exposed to stressors, psychological distress and trauma that can lead to mental health conditions. In this context, protecting and promoting families, communities, cultures, languages and identity can be understood as preventative mental (and indeed physical) health measures.

Trauma across the life cycle

Supporting social and emotional wellbeing is particularly important because stressors, psychological distress, trauma, and associated and compounding factors, are reported at high rates across the life cycle of Aboriginal and Torres Strait Islander peoples, particularly on young persons.

Stressors reported include: illness, disability, accidents, pregnancy, divorce or separation, death of a family member or close friend, witnessing violence, racism and abuse or violent crime. Some are associated with poverty: overcrowding at home, losing a job and unemployment (ABS: 2010). Exposure to multiple stressors is associated with psychological distress – reported by Aboriginal and Torres Strait Islander peoples at 2.5 times the rate of other Australians (ABS: 2012c).

Trauma refers to the potential mental health impact of a major stressor, such as violent assault, disasters, severe automobile accidents and life-threatening illnesses. Further, Aboriginal and Torres Strait Islander peoples' experience of trauma has been linked to repeated exposure to multiple, repeated severe and sustained stressors (such as racism) over time (Galma: 2009, 153-154). A 2008 survey in Queensland among Aboriginal and Torres Strait Islander prisoners reported 12.1% of males and 32.3% of females with post-traumatic stress disorder (Heffernan, Andersen, Dev et al: 2012).

Access to mental health services

Mental health services designed with non-Indigenous Australians in mind do not always fit with Aboriginal and Torres Strait Islander peoples' cultures and communities' lives, nor with their lived experiences. This lack of cultural and other fit can act as a barrier to using these services, or benefitting from them.

There are other access barriers. Services and professionals may not be available locally in remote areas where a quarter of Aboriginal and Torres Strait Islander peoples live. But even for the majority who live in, or near, urban centres, the cost of working with psychologists and psychiatrists can be prohibitive. On average, Aboriginal and Torres Strait Islander peoples earn significantly less income than other Australians (AIHW: 2011, 29).

The way forward

There are several approaches to consider:

- Protecting and promoting social and emotional wellbeing.

As discussed, strong culture and identity and healthy families and communities help protect Aboriginal and Torres Strait Islander peoples against the stresses that life can deliver, including some of the unique challenges they face.

Empowerment, ownership of problems, and leadership by Aboriginal and Torres Strait Islander individuals and communities is critical here; just as disempowerment is part of the problem, so empowerment must be part of the solution (Dudgeon et al: 2012).

Australian governments must support, and work in partnership with, Aboriginal and Torres Strait Islander communities to tailor culturally appropriate solutions that protect and promote social and emotional wellbeing as critical preventative responses to mental health conditions.

- Mental health services tailored for Aboriginal and Torres Strait Islander peoples.

For many decades now there have been calls for mental health and social and emotional wellbeing services within Aboriginal Community Controlled Health Services. These health services, operated by and for Aboriginal and Torres Strait Islander communities, offer many advantages. They are uniquely placed to offer traditional and innovative contemporary mental health and holistic social and emotional wellbeing services. Critically, they also have a history of improved health outcomes in their communities where other services have not, or simply did not exist, as examples, in relation to diabetes management and mothers and infants health services (Robert Griew Consulting: 2008).

In particular, it is vital that suicide prevention services are culturally tailored and that trained Aboriginal and Torres Strait Islander staff are available for people at risk of suicide.

Overall, it is critical that all mental health services are able to provide culturally competent mental health workers and professionals and a culturally safe service overall. In a nutshell, these concepts mean that professionals and

workers can work across cultures when necessary, and that services overall are welcoming to, and respectful of, Aboriginal and Torres Strait Islander peoples (Hayman, White and Spurling: 2009, 604-06).

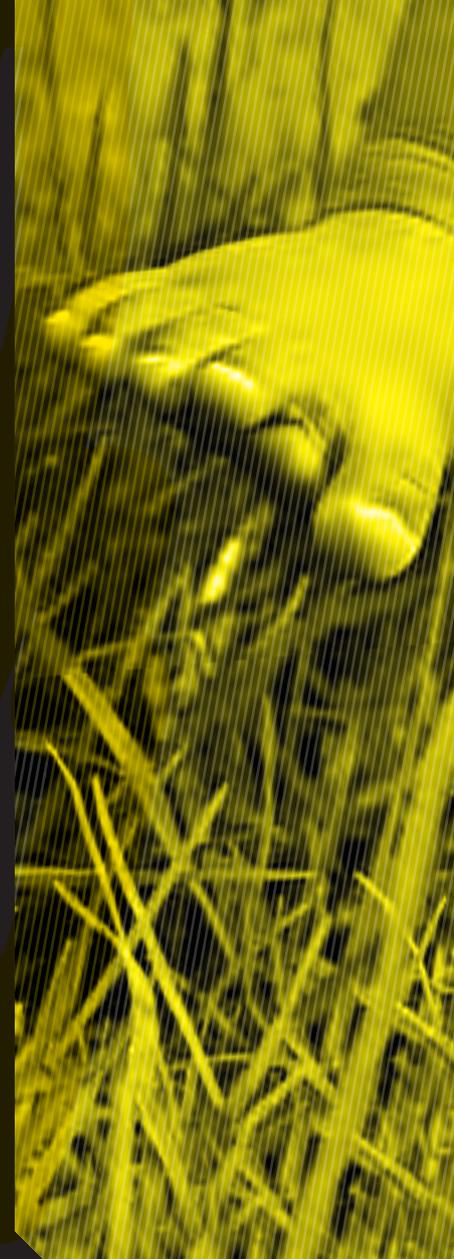
- An integrated and whole-of-government policy response.

At the time of writing, significant national mental health reform processes are taking place alongside the development of a plan to close the gap in Aboriginal and Torres Strait Islander health outcomes and life expectancy. These include the release of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and the renewal of the Aboriginal and Torres Strait Islander National Strategic Framework for Mental Health and Social and Emotional Wellbeing as well as the existing drug and alcohol strategy.

It is vital that the opportunities in the space are grasped. To that end, in 2012 the National Mental Health Commission, echoing calls from Aboriginal and Torres Strait Islander peoples, called for a mental health target to be included in the Council of Australian Government's (COAG) Closing the Gap National Reform Agenda, and a dedicated Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing Plan (National Mental Health Commission: 2012) that integrates the responses discussed above into a coherent, holistic and whole-of-government policy response.

In particular, the high levels of stress and trauma reported cannot

be reduced through the actions of the mental health system but through the combined work of many agencies and all Australian governments working in partnership with, and under the leadership of, Aboriginal and Torres Strait Islander peoples. In that regard, the COAG Closing the Gap National Reform Agenda provides a good starting point for integrating mental health responses into many areas of government activity.





THE HIGH LEVELS OF STRESS AND TRAUMA REPORTED CANNOT BE REDUCED THROUGH THE ACTIONS OF THE MENTAL HEALTH SYSTEM – BUT THROUGH THE COMBINED WORK OF MANY AGENCIES AND ALL AUSTRALIAN GOVERNMENTS WORKING IN PARTNERSHIP WITH, AND UNDER THE LEADERSHIP OF, ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES.

Dr Tom Calma AO





**SOCIAL
INCLUSION**
& Participation

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SOCIAL INCLUSION + PARTICIPATION

by Lin Hatfield Dodds

Chair, Australian Social Inclusion Board

Social inclusion is about both the degree to which individuals feel connected with their communities and the strength of governments, other organisations and communities to sustain and nurture the positive mental health of members of the community. It is about belonging, contributing and being valued and fits in with the Australian national social inclusion agenda in which all Australians can participate in our community as part of nation-building (Social Inclusion Board: 2013).

The Centre for Economic and Social Inclusion (2007) further describes social inclusion as:

‘the process by which efforts are made to ensure that everyone, regardless of their experiences and circumstances, can achieve their potential in life. To achieve inclusion, income and employment are necessary but not sufficient. An inclusive society is also characterised by a striving for reduced inequality, a balance between (an) individual’s rights and duties and increased social cohesion’.

Mental illness is the leading cause of disability and almost half of Australians will experience some form of mental illness during their lives (SANE Australia: 2013). Mental illness impacts not only the person experiencing it, but their family, friends, colleagues, and carers. As a result of mental illness, it can be difficult to finish school or studies, maintain stable housing or employment, and remain connected with family and friends. It is a significant problem for our society and our values of a fair go.

Good mental health is crucial to living a satisfying life and social inclusion is a key factor in promoting mental health and wellbeing. Research from the Mental Health Co-ordinating Council (2007) shows that:

- People do recover from mental illness.
- Social inclusion aids recovery.

- Social exclusion impedes recovery.
- Attitudes of other people strongly influence how well people recover.

The image below shows social inclusion as having the depths of an iceberg. Deinstitutionalisation has enabled people with a mental illness to be present in society but to fully participate they still have to overcome exclusionary barriers, stigma and discrimination. Governments can help support social and economic participation, and promote positive attitudes towards people with mental health issues. Yet for people to fully belong, the community as a whole must embrace diversity, strengthening families, communities and the informal networks around each person who is isolated or stigmatised.

The stigma and lack of support for people with mental health issues often facilitates attitudes that are in opposition to our sense of Australia as an inclusive society. People who have had mental illness talk about the loss of hope and the lack of belief of others (including services) in their recovery journey. In many ways we have replaced the physical walls of the big institutions with the invisible walls of stigma, locking people out of the opportunities that enable them to create a decent life for themselves and their loved ones.

People who have experienced mental health issues must have the same opportunities and potential for participation as other Australians. A social inclusion framework focuses on people’s strengths and capabilities rather than their deficits. A social inclusion-driven public policy approach is holistic, considering economic, social and cultural participation. Such civic participation includes opportunities for consumers of mental health services to re-imagine how our society

can support them in the recovery journey and to experience full inclusion in our community. While there are no easy answers, social inclusion provides new ways of looking at old problems.

Health, education, employment, housing, family, youth and community sectors need to work together, with all levels of government, to ensure that people receive the support they need. This can be achieved most effectively through constant communication between sectors and service providers, collaboration facilitated by a community-based catalyst or a governance body, co-location of services, and key leaders within the community driving the people-centred approach. However, we can see from the iceberg analogy that the actions of governments and organisations are not enough – social inclusion is a whole-of-community issue.

Services in Australia need to be accessible, affordable, quality based, holistic, coordinated, and available when, where, and for as long as people need them. A good example of such a program is headspace. headspace – the National Youth Mental Health Foundation – was established in 2006 (see Patrick M’Gorry’s article) and is funded by the Department of Health and Ageing under the Youth Mental Health Initiative Program. The primary focus of headspace is the mental health and wellbeing of young Australians aged 12-25. It brings together multiple practitioners under one roof, providing services that span physical health, drug and alcohol assistance, mental health and vocational advice.

The Foundation also provides referrals to a broader range of services, its multidisciplinary nature increases the accessibility of services for young people, enabling them to address issues across their whole life.

Personal stories

The following stories illustrate the use of a multifaceted approach to promote social inclusion for people experiencing mental health issues.

Lucy has been unemployed or underemployed since 2006. A mature age person with no family and a small mortgage, she has to be self-reliant. Her underlying condition is a form of paranoia and schizophrenia. Since losing a librarian position in a university cutback, she has had a number of short-term contract or temporary roles but has been hampered by paranoid thoughts and negative experiences caused by rare delusional behaviours.

Lucy was volunteering in an op shop and gradually improved her trust and socialising confidence. With support from an employment service, she applied for many jobs without much success.

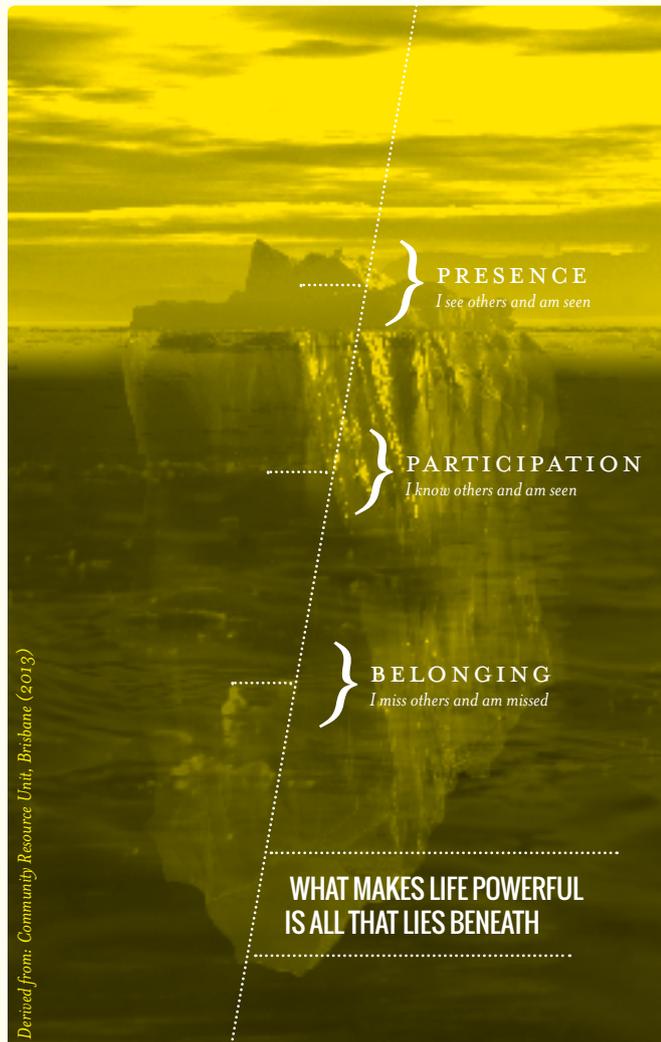
Lucy had been aiming for backroom work where social interactions might be minimal in order to feel comfortable with her condition and being in a workplace. She successfully trained and started a part-time job as a driver and noticeboard worker. During this time, Lucy successfully obtained a contract full-time position with the Australian Bureau of Statistics undertaking data processing for the census. She is now working in a small team and has established good relations with

colleagues and supervisors. Lucy feels well supported there and is receiving ongoing support from her employment consultant.

Mary is a 43-year-old woman diagnosed with schizophrenia and anxiety in her early 30s. She lives with her long-term partner who also has a serious mental illness. She maintained full-time work for a number of months after her diagnosis, but was unable to continue. Mary and her partner experienced significant financial stress from living on their low fixed income while paying private rental. Mary's illness results in difficulties with sleep, diet, exercise, housework, self-care and engaging in community activities. Mary's general practitioner (GP) referred her to a service called GP

Access for support, with a request for support with social isolation and financial difficulties.

GP Access's multifaceted approach to assisting Mary linked her with financial counselling and affordable housing. It engaged with her psychiatrist and GP in treatment and making healthy lifestyle options, leading to a more physically active and mentally engaging lifestyle. Her partner was also involved and this has particularly helped them with their finances. Mary is now participating in a range of community-based activities including a weekly cooking group, volunteer work with the Red Cross, Tai Chi and a monthly walking group. She plans to study and return to employment.



Supportive attitudes

Supportive and accepting attitudes, linked with the identification of appropriate pathways and opportunities, are needed to support people with debilitating mental illnesses to re-engage with work. To prevent society's assumptions and prejudices from limiting people, we need to identify and build on people's strengths, and address the structural factors that limit their involvement in the workforce or the community.

There is a swing within social policy towards people-centric, social inclusion approaches in many social service sectors. This approach is becoming more ingrained within policy making; with socially inclusive service delivery becoming a more common way to assist people with multiple and complex needs, including all people in our community, regardless of disability or mental health issues. The government is pursuing a diverse reform agenda: over the last few years it has announced a \$2.26 billion National Mental

Health Reform package and the insurance scheme, DisabilityCare Australia. These reforms have been developed within a social inclusion framework and its parameters.

The social inclusion approach provides service providers and government agencies with a rationale and roadmap for working that has been shown to enhance the life experiences of people living with a mental illness, and to be of benefit to the broader community. But it is not just the responsibility of government or service organisations. Social inclusion is about engaging that broader community – business, sporting clubs, neighbourhoods, schools, hospitals – in the development of an inclusive and just society, communities in which everybody can contribute, belong and be valued.

Thanks to the people supported by UnitingCare Prahran Mission and UnitingCare Wesley Pt. Adelaide for sharing their stories of inclusion.



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ACCESS
*to Affordable
& Stable Housing*

sustainable

COMMUNITIES, SERVICES & MENTAL HEALTH

TARGETING SUSTAINABLE HOUSING

by Adrian Pisarski | Chairperson, National Shelter

Physicists speculate that a grand theory of everything may be possible but that its comprehension requires accepting that we live in a multiverse rather than a universe. From my perspective, it already seems like I live in a multiverse where the laws of my universe are completely different from the laws governing others.

It often seems to me to be the only explanation for the continuing silos of service and I sometimes wonder about cabinet discussions that seem to drop all difficult things between the edges of their different responsibilities. Perhaps government cabinets are microcosms of the multiverse.

Since the 1970s state housing authorities, homelessness services and community housing providers have increasingly housed people who previously might have been accommodated in asylums. The deinstitutionalisation of mental health facilities was big news,

a breakthrough in social policy, an end to stigmatisation and the demonisation of people suffering mental illness, heralding a new enlightened approach by incorporating people into the community.

It would have helped had we established the community-based facilities, housing options, and support services required to properly complement this illumination of 1960s and 70s thinking. Instead, far too many people have become homeless or, when housed, suffer isolation and concentration in housing units jammed with other tenants with very high need, without the walls and locked gates but with insufficient care and connection.

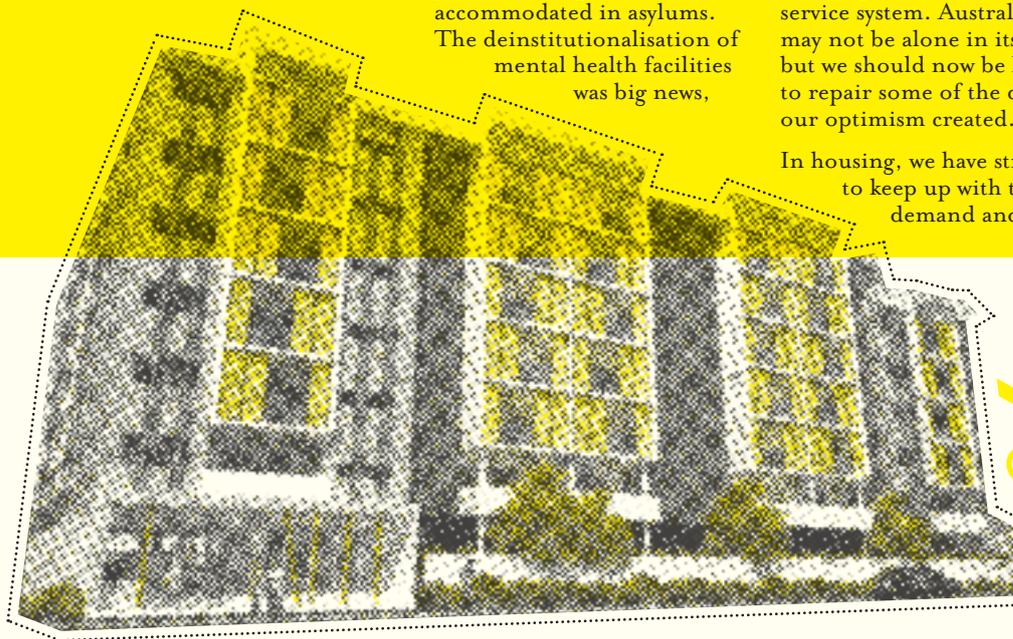
Forty years later, it is tempting to look back on the asylums fondly but that would be as wrong as the expectation we could end institutionalisation seamlessly without first building an alternative service system. Australia may not be alone in its follies but we should now be looking to repair some of the damage our optimism created.

In housing, we have struggled to keep up with the demand and have

even been losing some of our scant resources. The major decline in the Howard government's time in fact began during the Fraser, Hawke and Keating eras. In response to the economics then we increasingly targeted our spending on those in need, desperate for solutions beyond our limited means and justified by ensuring we were spending taxpayers' dollars frugally.

We were also laying the ground for an increasingly unsustainable housing system set for inevitable decline, though we had the best of intentions. Social housing uses a proportion of income (typically 25%) as a rent benchmark so that as we further target low-income households we also undermine the system's financial viability. By the 2010s, every public housing property represents a deficit to every state government.

By the time Brian Howe was the nation's housing minister, there was a realisation that we could never grow our social housing system large enough while targeting only those on low income and high need because the low rent paid could never meet the cost of the system. We were also increasingly seeing



Example of new development by Brisbane Housing Company incorporate a mixed tenure model with public housing, NRAS and for sales on the market.

le housing

housing stress grow in the private rental market. The response was to develop Commonwealth Rent Assistance, an income-support supplement to help meet the costs of low-income households in the private rental market and to create a permanent payment to assist housing outcomes that could grow based on need.

It was a laudable goal though, in hindsight, it helped increase the concentration of people with very low incomes and high needs in social housing. It has helped many people secure and maintain their private rental property but residualised public housing for those with the lowest income and the highest needs. This has meant housing many more people with mental health histories, dual diagnosis and so on but has largely ignored the supports and connections people require to live their lives well.

Traditional public housing tenants are often pensioners unable to secure housing in the market. Public housing was once a low-cost housing alternative to home ownership for many different household types with a range of income which cross-subsidised the very low

income households within it. Many public tenants still come from that background and feel overwhelmed by the behaviours that are part of the combined deinstitutionalised and over-targeted new public housing world.

Affordable housing

Since 2007 we have been building a new approach that has elements of the old approach but is trying to develop new tools and approaches to overcome the limitations of the thinking of the past 40 years.

The National Affordable Housing Agreement replaced the previous Commonwealth State Housing Agreement in 2008. It is a more broadly framed agreement in theory, if not in funding, which is complemented by National Partnership Agreements on Remote Indigenous Housing, Homelessness (NPAH) and Social Housing. It has been supplemented by the National Rental Affordability Agreement (NRAS) and the Social Housing Initiative as part of the nation building stimulus response to the global financial crisis.

In all, these programs have added billions of new dollars

in funding to the base program and have begun to repair some of the decline in social and affordable housing. In addition we are also moving, with variations between states, significant amounts of previous public housing across to the community housing sector to help broaden the base of social and affordable housing (using NRAS, for example) and improve its financial viability. The end game of this is to regrow our supply of high-need, low-income housing but within a system that has lower concentrations of disadvantage and better connections to social, health, employment, training and other systems required.

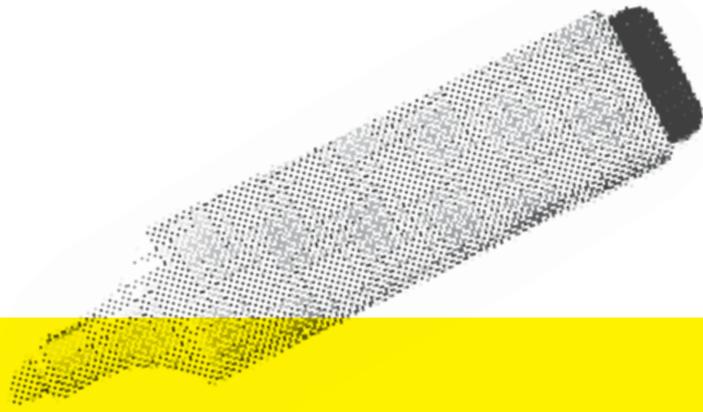
There have been many interesting developments in homelessness as well as improving the linkages and responsibilities of different players in our systems. An example is the development of the Health Homelessness Outreach Teams in Queensland. Initially part of the Beattie government's Responding to Homelessness Package, these services have been enhanced through the NPAH to cover more areas. They deliberately target people ending a stay in hospital, who may have previously been exited into,

or back into, homelessness. They provide a housing response via the health system to ensure a housing outcome after treatment.

They have been universally welcomed by the homelessness sector and provide an example of how in future we need to build the service systems we did not build when deinstitutionalisation began.

Another example is the development of various common ground approaches. These provide housing with on-site supports, also using mixed tenure to ensure they are not over-concentrated but are housing people characterised as chronically homeless and making sure the supports they may call on are in the same facility. They tolerate relapses and behaviours, which many services struggle to cope with, to target the previously chronically homeless and build success and resilience.

I am hoping that in future we can begin to unify our theories and practice around housing, homelessness and mental health and begin to build a new theory of everything so we are not consigned to the multiverse within which I sometimes fear I live.



HOMELESS PEOPLE NEED STABLE HOUSING TO HELP RECOVERY

by *Nicole Lawder*
former Chief Executive Officer, Homelessness Australia

& *Travis Gilbert*
former Policy and Research Officer

ON CENSUS NIGHT 2011, HOMELESS SERVICES HELPED OVER 105,000 PEOPLE AS PART OF THEIR DAILY SUPPORT FOR PEOPLE WHO PRESENT IN CRISIS. THE EXPERIENCE OF HOMELESSNESS CAN HAVE A DEVASTATING IMPACT ON INDIVIDUALS AND FAMILIES, EMOTIONALLY, MENTALLY AND PHYSICALLY.

Specialist homelessness services deal with large numbers of clients who have high levels of psychological distress and/or symptoms of mental illness but who cannot secure access to mental health services. This is often due to factors such as inequitable access to systems, lengthy waiting lists, clinical diagnostic criteria or cost. There are services specifically to provide accommodation, housing and support to people with both histories of homelessness and complex mental health needs, and severe and persistent psychiatric illness, such as MIND Australia/ The Richmond Fellowship. Many other services are not designed to accommodate and support people with complex needs and this places them under significant strain.

The new institutions?

Boarding houses and homelessness services appear to have become default accommodation options for significant numbers of people who 50 years ago may have been institutionalised in asylums. A 2011 report commissioned by Baptist Community Services found that one third of residents in unlicensed boarding houses had a mental health disorder, the majority (55%) also having high levels of psychological distress (7-9).

People without strong family and social support networks are often unable to access or sustain housing and require frequent stays in psychiatric settings before being discharged into tenuous accommodation. They end up in the homelessness service system that is often inadequately resourced to address complex psychiatric and psychological care needs.

Not unwell enough for hospital?

While it is preferable to have people treated in the community, homelessness services are dealing with significant numbers of people in crisis at any one time. Specialist homelessness services make an assessment of a person's health, social circumstances and wellbeing. Increasingly this requires staff to assess a person's mental state and their level of psychological distress and its impact on social functioning.

Having done this, they then have to seek referrals to external services that cannot be fully provided by staff on-site. Yet when they do so, they find their clients are not unwell enough to be accepted by mental health services, in particular providers of in-patient care.

This group of clients are too unwell to be fully supported by specialist homelessness services but are not unwell enough to be accepted for referral to specialist mental health services.

What comes first?

People with mental illness are at greater risk of homelessness for several reasons: the requirements of personal care, social isolation, family breakdown, stigma, discrimination and a breakdown in housing tenure due to hospital admissions.

People in insecure housing or who are living in unstable accommodation are more likely to have higher levels of psychological distress or symptoms of anxiety and depression than people with security of tenure.

Being homeless is stressful and even short periods of homelessness can trigger anxiety and despair. If homelessness recurs, it is even more likely to trigger an anxiety disorder or depression.

People who have spent more time in homelessness settings, boarding houses or sleeping rough are significantly more likely to develop severe and persistent disorders such as affective disorders and schizophrenia (MHCA: 2009, 10-12).

Homelessness, trauma and violence

Recent studies by Sacred Heart Mission and Mission Australia have documented a strong correlation between exposure to trauma and long-term homelessness. Both studies found that a majority of participants had been exposed to traumatic events, such as witnessing a murder or attempted murder, repeated assault, regular exposure to violence and kidnapping or deprivation of liberty (Mission Australia: 2011, 5-6, 9; Sacred Heart Mission: 2012). Exposure to trauma, either a severe single event or recurrent exposure to violence or sexual abuse, is correlated with the development of post-traumatic stress disorder, multiple-personality disorder and/or schizoid-type disorders (American Psychiatry Association: 2008, 774-776).

Homelessness itself, particularly rough sleeping and being on a cycle between crisis services and rough sleeping, increases the likelihood of exposure to violence or trauma, which may trigger mental illness or exacerbate an existing condition. Further research has found that people sleeping rough or staying in crisis services are 13 times more likely to be victims of aggravated assault or assault involving a weapon than people who were stably housed prior to arrest (Australian Institute of Criminology: Homeless People, Their Risk of Victimisation, Crime Reduction Bulletin no.66, 15 April 2008).

The trauma of repeated exposure to domestic violence in the family home may have a link to the development of mental illness for children, as demonstrated by the findings of a United Kingdom study of children's exposure to and/or involvement in domestic violence that found:

'...while only 13 per cent qualified for a full PTSD (post-traumatic stress disorder) diagnosis, larger numbers suffered from traumatic symptoms which included intrusive and unwanted remembering of the traumatic events (52 per cent); traumatic avoidance (19 per cent); and traumatic arousal symptoms (42 per cent)...' (Laing: 2009, 10).

In addition, we know that many women who experience domestic and family violence require intensive counselling and support after leaving the violence to support their transition to life without that threat. This will often include the need for referral to mental health services. For example:

'... Domestic violence can lead to other common emotional traumas such as depression, anxiety, panic attacks, substance abuse and posttraumatic stress disorder. Abuse can trigger suicide attempts, psychotic episodes, homelessness and slow recovery from mental illness...' (American Psychiatric Association).

Getting in early

Rates of mental illness in Australia are highest among people aged 18 to 24, a problem amplified by the inclusion of substance use disorders given that the rate of drug use is generally higher for this group than it is for other demographics (AIHW: 2011, 96, 150-153.)

Youth homelessness services frequently provide accommodation and support to young people who are showing signs of mental illness. Sometimes workers are able to identify a need for access to youth mental services at early onset, while other young people reach youth homelessness services in crisis.

The onset of mental illness in adolescence and young adulthood can be devastating and immensely disruptive to the life of the young person and their family who will usually shoulder most of the care burden. The impact of mental illness during high school years can disrupt education and can result in some young people being excluded and becoming economically disadvantaged.

Older Australians

Given our ageing population and in recognition that homeless, older people often present to services in crisis with high and complex needs, older Australians are a group that need greater consideration by both the homelessness and mental healthcare sectors.

For older Australians whose psychosocial functioning is such that they are able to live independently, care at home and assistance managing their medication may be enough. We also need increased access to the aged care system for older Australians with limited means.

Conclusion

We know that many people develop symptoms of anxiety and depression following the loss of housing. We know that mental illness is a contributing, if not causal, factor that can lead to the loss of housing and contact with the homelessness service system.

We know from mental health providers and consumer/carer networks that families are bearing a heavy burden of the costs, both personal and economic, of mental healthcare. Mental illness often leads to family breakdown, which we know is a common trigger of homelessness, particularly for young people. Early intervention could have prevented family breakdown many times if families, carers and people living with mental illness had been given support in the early onset of mental illness and, quite simply, if they had known where to go to get help.

We need to ensure strong linkages between the homelessness and mental health sectors and expand those services that join up the delivery of both.

The inability to access stable housing in conjunction with support services necessary to sustain tenancies and participate in the life of communities has again emerged as the preferred solution. The lack of affordable housing is well documented and must be addressed as part of the solution.

We can, and must, do better for people living with mental illness and those who are at risk of becoming homeless. We need to ensure system access and housing supply with appropriate support services across the continuum of care to break this cycle and promote and support recovery, housing security, health and wellbeing and community participation.

by Arthur Papakotsias

Chief Executive Officer, Neami National

MORE T

THREE YEARS AGO WHEN NEAMI NATIONAL, A SPECIALIST MENTAL HEALTH SUPPORT SERVICE, TOOK ON RESPONSIBILITY FOR ONE OF SYDNEY'S HIGHEST PROFILE HOMELESSNESS INITIATIVES, THE WAY2HOME PROGRAM, IT RAISED A FEW EYEBROWS.

39



INDIVIDUALS SURVEYED

DEMOGRAPHICS

Male / Female	87% / 13%	
Mean Age / Range	49 / 24-85	
Australian born	79%	
English as first language	87%	
Indigenous	13%	
Unemployed (formally)	100%	
Disability support pension	72%	

HOMELESSNESS

Slept rough for more than 5 years total	74%	
Slept rough prior to age 18	34%	
Contact with the juvenile/adult justice system or police	74%	

HEALTH

Diagnosed or undiagnosed mental illness	79%	
Acute distress from diagnosed or undiagnosed mental illness	61%	
Presentation to emergency department in last 12 months	67%	
Used ambulance services once or more in previous 12 months	38%	
Smoking daily	95%	

Was this an organisation straying from its core business or was this new positive step towards breaking down the silos between deeply connected but functionally separate service systems like homelessness, mental health, primary health, disability, education and employment?

The rationale for Neami's interest in Way2Home comes from our mission to 'improve the mental health and wellbeing of local communities' and our focus on working with the members of our community who have the most complex needs.

This was a chance to apply our experience in mental health recovery and complex case management services, build on the foundation that stable housing provides and creates significant change in people's lives.

About Way2Home

Neami National is a community-based recovery and rehabilitation service supporting people with mental illness and psychiatric disability to improve their health and live a meaningful life in line with their own strengths, values and goals.

Way2Home is a partnership between Neami National, St Vincent's Health's Outreach Team, The City of Sydney's Homelessness Unit, Platform 70 and Housing NSW. It comprises two teams, working in collaboration with shared clients, one made up of community rehabilitation support workers who conduct assertive outreach, the other of clinical staff working in hospital and outpost settings.

Way2Home is based on the Street to Home model, which is a Housing First approach to ending homelessness for people with long histories of primary homelessness and/or sleeping rough and whose severe health problems place them at greatest risk of death without intervention.

Housing First models provide immediate access to housing followed by support services to help sustain that housing. This is in contrast to other services that require people to be housing-ready by meeting certain goals before they can enter housing.

Way2Home uses a tool known as the Vulnerability Index and outreach-based surveys of known rough-sleeping locations to identify and prioritise individuals for support.

Street to Home-based programs are also running in Adelaide, Brisbane, Fremantle and Melbourne funded under the Federal Government's White Paper on Homelessness and the National Partnership Agreement.

Neami's approach is unique in Australian Street to Home programs in its use of a team-based case management model developed initially for mental health support and integration of peer workers with a lived experience of homelessness into our assertive outreach team.

We have also benefitted from the support of Platform 70, a philanthropic housing initiative that involves headleasing of private properties. Headleasing in this context means that a community housing provider

MORE THAN A HOME

leases a property from the landlord, takes responsibility for rent and tenancy issues, and then sub-leases it to an individual or family.

Platform 70, together with Housing NSW, have provided most of the permanent housing that has made successful outcomes possible. Without housing, there can be no Housing First.



Service users

The University of Queensland's Institute for Social Science research report, Service users: a baseline report on Sydney's Way2Home Program (2013), has confirmed the deep connections between homelessness and serious and complex physical and mental health conditions.

Three years later

In just three years, Way2Home and our partners have supported 183 of Sydney's longest-term homeless individuals into permanent housing and a further 8 are currently in transitional housing awaiting permanent options. More than that, we have been able to provide mental health support for those who need it to make that housing sustainable using our existing case management model.

Of those surveyed, 85% reported an improvement in their quality of life since engaging with Way2Home with housing the primary area remarked on. Many participants also commented on the other positive life changes such physical and mental health, safety, social connections and wellbeing that were enabled as a result of having a safe, secure and affordable place to call home and ongoing support for their mental health recovery.

Way2Home was then invited to deliver Sydney's Aboriginal Intensive Assertive Outreach Service and to a successful tender for the Victorian Indigenous homelessness program, Breaking the Cycle.

As the University of Queensland research reveals, long-term primary homelessness and mental illness are highly correlated. This means we need multidisciplinary experts

working together in teams, a greater use of secondary consulting arrangements and more work to break down the largely artificial administrative barriers that can prevent effective responses.

The bottom line is that no service or system can ever hope to meet the holistic needs of the most complex and disadvantaged members of our community – and significantly improve the quality of their life – without genuinely holistic service responses.

Finding a home

Amal is 66 and was born in Lebanon, coming to Australia when he was 17. During his life he has raised a family of seven children, owned and operated a fruit store and worked as a builder. Due to divorce and relationship's breakdown he lost all contact with his ex-wife and children.

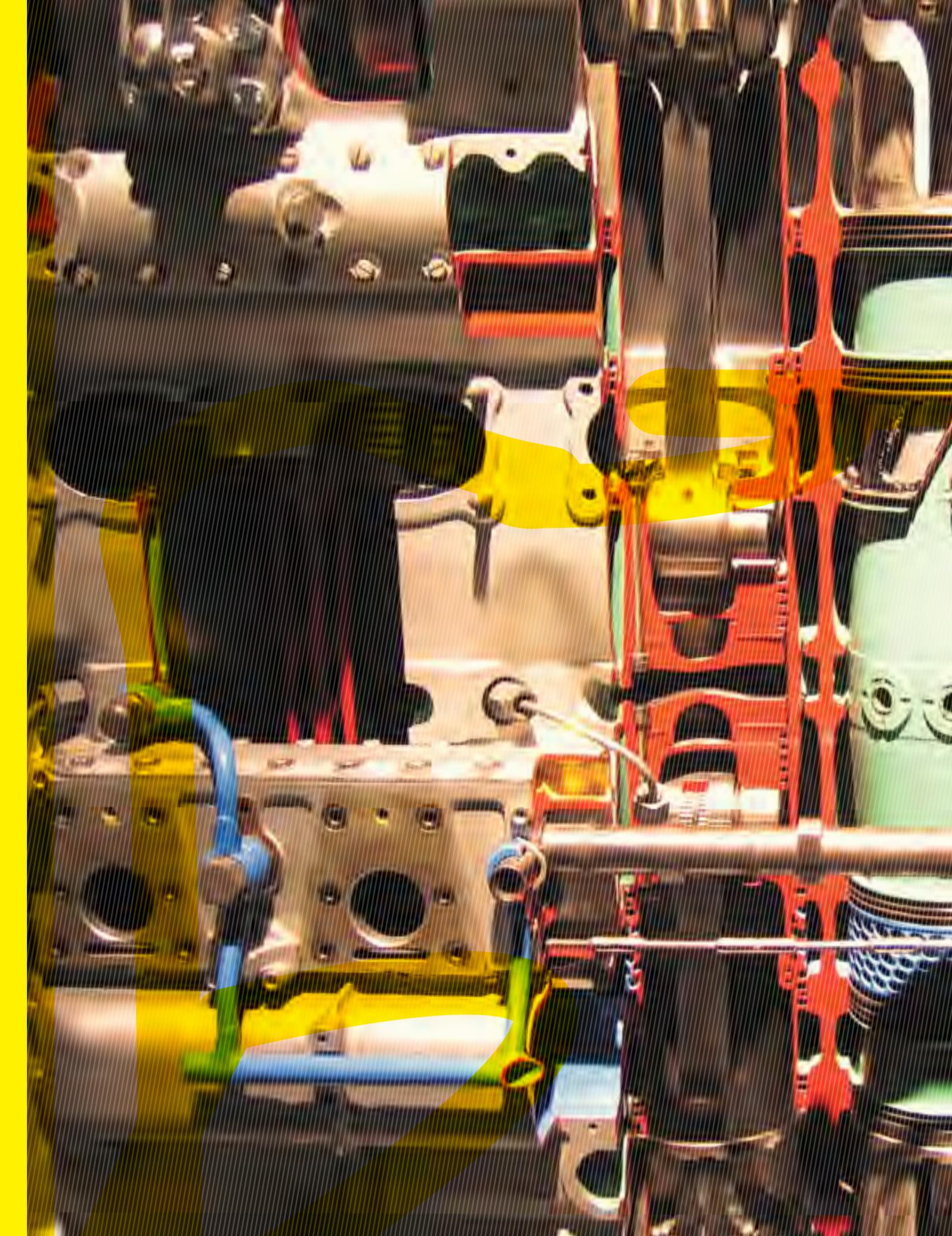
When Way2Home's outreach workers first met Amal he had been sleeping rough in Sydney and Melbourne on and off for about 10 years. He had been diagnosed with diabetes, emphysema, heart disease, kidney disease, schizophrenia and depression. He used alcohol and cannabis daily and occasionally had run-ins with the police for anti-social behaviour.

After meeting him in Sydney's Woolloomooloo a number of times during early morning outreach trips, we were able to establish trust and refer him in to the Way2Home clinical team at St Vincent's Hospital.

After securing transitional housing through Housing NSW, Amal was assisted to look at his permanent housing options and underwent an Aged Care Assessment Team assessment. He then secured community housing in February this year and has continued to receive daily outreach support.

Speaking to Amal it is clear he wants to build on his now stable mental health and to begin to address his poor physical health and his alcohol and drug use issues, which he acknowledges are impacting negatively on his life.

Way2Home will continue to support Amal in his housing and on his recovery until he is able to transition to live independently and rely on his own support networks.



by Sally Sinclair

Chief Executive Officer, National Employment Services Association

MAINTAINING SUPPORT FOR PREFERRED EMPLOYMENT



Employment matters. When you reach working age, what you do for a living is part of defining who you are. When you meet someone for the first time invariably one of the first questions you will be asked is 'what do you do?'

It is why employment has long been one of the most significant markers of success in rehabilitation. It not only gives people a job, but also a connection to community and a sense of self-worth.



We know that the vast majority of people living with mental illness want to, and are able to, work. Ensuring that people impacted by mental ill-health are able to gain and maintain their preferred employment is not only central to their ongoing health and wellbeing, but is important in ensuring that communities are as productive as they can be, and that we as a nation are able to meet our future workforce needs.

Breaking down isolation from the labour market, building opportunities and encouraging people with mental ill-health into, or to re-enter, the workforce can only be achieved by a whole-of-government and partnership-based approach.

We know that employment services can greatly assist and support those wanting to work. There are a number of specialist service providers targeted at ensuring individuals with mental health conditions have the right supports to help them succeed. At any given time, there are over 930,000 individuals accessing employment assistance and support through both mainstream and disability-specific employment services across Australia. There are Job Services Australia for the first and Disability Management Services and Employment Support Services for the second. Conservative estimates suggest that at least 30% of those accessing employment services have a mental illness that is a primary barrier to participation. However, many more are likely to suffer from mental ill-health.

To effectively and positively improve the level of workforce participation and inclusion of people with mental ill-health we need to develop a more holistic assessment framework at the front end of the social security and employment services system. We need a framework to service clients who have undiagnosed and/or undisclosed mental ill-health issues, as well as those with diagnosed conditions. The system needs to identify not only barriers quickly and accurately, but also necessary supports, and where they can be accessed.

Policy silos

In Australia, mental health spans government portfolios and social policy areas. We are lucky – we have a dedicated Federal Minister for Mental Health but while some areas of policy designed at supporting people will fall under the area of health policy, other aspects and support services come from the umbrella of families and community services.

Then you have the issues that cut across education, employment and workforce participation. Unfortunately, while each policy silo might create wonderful programs and provide access to much needed supports, they often fail to talk to, and interact with, each other. These approaches tend to hinder a person's progress rather than provide interconnected supports and services.

Holistic and place-based

If we are going to make better progress in assisting and supporting people to gain and maintain their preferred employment opportunities, we need to be flexible and innovative to work across policy silos and provide holistic services, which address all aspects of the individual's barriers to participation, and place-based solutions, which address local needs. We need to consider communities, as well as individuals, and connect services. If we can concentrate resources at the earliest points of contact with support services, including employment services, that comprehensively assess a person's individual circumstances at the centre of any plans, we can increase engagement and better target supports. From our experience in employment services, we can say improved employment participation and inclusion can, and will be, achieved through service models that incorporate medical, social, educational, and employment interventions to assist people with mental ill-health.

Ongoing support

We must also remember not to limit supports to simply gaining employment – it is one thing to gain a job, but it is often another to keep it, particularly when dealing with the episodes of mental illness. Better mechanisms for ongoing support for people once in employment will improve their work experience and increase long-term connections to the labour market, which should be the ultimate goal. Services and supports must provide assistance and skills to help people navigate employment throughout their lives, and not just when they may be in crisis. We must also better equip employers and business to support people with barriers to participation, and increasing the employment participation rates of people with mental illness is one way of doing this. There is no more powerful way to break down such barriers than first-hand experience.

The future

Recent policy initiatives such as the Partners in Recovery program, which is designed to coordinate and connect all the services and sectors that an individual may need, are examples of working collaboratively across policy silos. We can expect place-based models such as these will lead to more people participating in life and the community than ever before. It is still early days but I believe all relevant policy makers will be watching closely.

GOOD MENTAL HEALTH IN THE WORK-PLACE

by Jack Heath
Chief Executive Officer, SANE Australia

& Kate Carnell AO
Chief Executive Officer, beyondblue

SANE Australia and beyondblue acknowledge the contribution to this article of Carolyn Nikolski, Nick Arvanitis, Paul Morgan and Clare Shann

'I think employers are reluctant. It's very hard if you have any sort of disability, let alone a mental illness that you're open about, to then be able to get employment.'

Person living with a mental illness

Mental health and wellbeing is a key issue for all Australian workplaces. Untreated mental health problems are costly – research findings (for example, Andrews et al: [1999] and Hilton: [2004]) suggest that the financial and productivity costs associated with untreated depression alone include:

- Three to four days off work per month for each person.
- Over six million working days lost each year in Australia.
- 12 Million days of reduced productivity each year.
- \$9,660 In absenteeism and lost productivity costs per full-time employee with untreated depression each year.

Creating mentally-healthy workplaces benefits both employers and employees within a workplace, from frontline staff to business owners and leaders. Businesses that promote good mental health can increase productivity, performance, creativity and staff retention, and can be perceived as an employer of choice. By going beyond meeting minimum legislative requirements for workplace health and safety, and integrating mental health into all relevant business decision-making and organisational policies, business can realise the benefits of creating such workplaces.

Promoting good mental health at work is important for individuals and their families. Participating in meaningful work can contribute to good mental health, and be an important part of recovering from a mental illness – helping people to manage symptoms better, as well as feeling valued members of the community.

'One of the biggest parts of recovery is getting work again. That's how you can pay for stuff that's going to help you have social inclusion. You can pay to have quality of lifestyle. But unless you can get a job, that's a real barrier for people with mental illness.'

Person living with a mental illness

'Last time I got employed, within a week of doing that, I said 'Why didn't I do this before?' Really got my confidence up – and my bank balance!'

Person living with a mental illness

Business practices that promote good mental health (and help reduce the incidence and duration of people's symptoms (whether anxiety, depression or psychosis-related symptoms) can result in improved wellbeing and performance both for people with, and without, a mental health problem. The broader community also benefits from having workplaces that support good mental health, as improvements in job quality and conditions have the potential to improve significantly Australia's mental health and wellbeing, social inclusion and the national economy.

The importance of good mental health at work was documented in the National Mental Health Commission's inaugural A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention. This report pointed out that to create mentally-healthy workplaces, and achieve real improvements in workplace mental health, government and different industries and sectors need to work together. To lead this collaboration, the Commission established the Mentally Healthy Workplace Alliance in late 2012. beyondblue and SANE Australia are founding members of the Alliance.

Mentally Healthy Workplace Alliance

The Alliance brings together government and the mental health sector to work collaboratively with the business sector to provide practical guidance to businesses on how to create mentally-healthy workplaces. The Alliance is guided by a set of shared principles, which include:

- Working collaboratively across business and the mental health sector to benefit from shared expertise, resources and networks.
- Acknowledging and promoting existing good business practices as a means of communicating the benefits of good mental health to all workplaces.
- Drawing on the best available research and practice-based evidence to promote effective interventions.
- Drawing on the experience of individuals in the workplace who have had a mental illness.
- Recognising that the wide variation in the culture and size of businesses and organisations will require a flexible and scalable approach.

The Alliance is targeting all mental illnesses; all individuals within a workplace (from frontline staff to business owners and senior organisational leaders working full-time, part-time, casual and in contract employment); and workplaces across all industries, geographical locations, and of all sizes.

Its projects promote the benefits of good mental health at work and support businesses and organisations to provide mentally-healthy workplaces. These include:

- Identifying the return on investment for businesses as a result of creating mentally healthy workplaces.

- Identifying the best available research evidence relating to effective strategies to create mentally healthy workplaces.
- Identifying good practices adopted by Australian businesses to create mentally healthy workplaces.
- Developing case studies to assist businesses to create mentally healthy workplaces.
- Developing videos featuring business owners and leaders speaking about how they have created mentally healthy workplaces.

Evidence-based programs

Two examples of existing evidence-based programs that have been demonstrated to promote awareness of mental health problems within the workplace, and provide people with the skills to manage these problems successfully are the beyondblue National Workplace Program, and the SANE Mindful Employer Program.

The beyondblue National Workplace Program is an educational program that has been developed to help workplaces manage common mental health problems, such as depression and anxiety. The program can be tailored to the needs of specific organisations, and it targets staff, managers, human resource professionals and executives. It has been demonstrated to:

- Increase awareness and understanding about the most common mental health problems in the workplace.
- Promote a greater understanding of the impact of these problems on the lives of people affected, including their work performance.
- Improve attitudes towards a colleague with depression or a related disorder and decrease stigma.

- Increase people's willingness and confidence to assist and/or manage a person who may be experiencing depression or a related disorder.
- Promote a greater understanding of the responsibilities of staff and the organisation as they relate to these issues.
- Increase awareness of support services available for staff to seek help.

The SANE Australia Mindful Employer program is a training solution that provides managers and employees with the skills and confidence to respond effectively to signs of mental health problems at work. Mindful Employer is both an e-learning and face-to-face solution using workshops.

The program aims to:

- Increase the awareness and understanding of mental illness, understand the stigma towards mental illness and impacts of stigma in the workplace.
- Improve awareness of supports available to workplaces, managers and employees in the workplace.
- Provide the right information and skills so that managers and employees have the skills to respond to the early signs of mental health problems.
- Help employees access the medical assistance they need while providing appropriate workplace supports to manage effectively any possible impacts to productivity.

Through the work of the Alliance, it is hoped that businesses will receive the practical support and advice they need to be high-performing and mentally healthy workplaces. This will help to ensure that the benefits of a mentally healthy workplace are realised, including better business outcomes, and improved mental health and wellbeing for individuals, their families, and the broader community.

**CREATING
MENTALLY
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BENEFITS BOTH
EMPLOYERS
AND EMPLOYEES
WITHIN A
WORKPLACE,
FROM FRONTLINE
STAFF TO
BUSINESS
OWNERS AND
LEADERS.**

Work is good for you, if you can get it.

by David Thompson AO
Chief Executive Officer, Jobs Australia

Employment is the cornerstone of economic and social participation in Australia. Without it, social connectedness is more difficult, networks shrink and both physical and mental health deteriorate. Work structures a day. It provides regular social interaction and a sense of identity. What is more, for people with a mental illness, it can actually assist recovery.

There is strong evidence of the therapeutic benefits of work. Studies on the impact of work for people with mental illness have shown improvements in social skills, reduced symptoms, fewer hospitalisations, increased independence and better self-esteem (Department of Education, Employment and Workplace Relations: 2008).

Given that an analysis by the Nous Group and Medibank Private in 2013 found that, in total, \$28.6 billion is expended by all levels of government in supporting people with mental illness, the government can gain a lot if we can successfully assist more people with mental illness into the workforce and reduce their reliance on government supports.

All told, we could – and should – be doing better.

Unfortunately, data on the prevalence of mental illness among generalist employment services clients is not available. We do, however, have some information about the clients in Disability Employment Services. The data shows that around 31% of people receiving assistance from a Disability Employment Service have a psychiatric condition as their primary disability. That makes people with psychiatric conditions the second biggest group in the caseload, behind people with a physical disability, who make up 43% of the caseload. Of course, many people with other disabilities are also known to suffer mental illness in combination with their primary disability, so even this figure understates the true prevalence. What is most alarming in the statistics, however, is not the high numbers of people with mental illness in the system – it is the poor rate of job outcomes. Job outcome rates for people with psychiatric disabilities are worse than

for every other type of disability, with only 19% of people ending up in a job that lasts more than six months.

There is clearly much room for improvement.

Fortunately, thanks to extensive research, we have a good understanding of what types of services and interventions work. The review by the Department of Education, Employment and Workplace Relations in 2008 identified a number of best practice principles for achieving employment for people with mental illness, including:

- Services focused on competitive employment in the open market – in other words, a regular job – rather than sheltered employment.
- Individualised support based on a person's choices and preferences.
- Stigma and disclosure strategies that counter negative perceptions of mental illness in the workplace and structured counselling around disclosure.

IMPROVING PERFORMANCE AND GETTING MORE PEOPLE INTO JOBS MAY REQUIRE THAT PROVIDERS INVEST MORE IN THEIR STAFF

Ideally, a vibrant employment services market should foster a variety of approaches, including all of those that the research tells us work. Indeed, this is part of the thinking behind Jobs Australia's recommended approach to employment services reform: we believe the system should be re-designed to give service providers greater flexibility, with a payment-by-results model that provides greater funding for people with more severe conditions but also ensures the approaches that work best receive the greatest financial rewards.

If there was a genuine market for employment services, then different approaches would emerge, with some providers choosing to specialise in particular client cohorts, interventions or industries. Some might choose to work collaboratively, partnering with other service providers, while others may develop a complete in-house service. Ultimately, there would be greater choice for service users, ensuring people have access to the personalised services they need.

Importance of funding allocations

Implicit in such a model for reform is also the need for more funding for those who need the most support. While this has been a feature of employment services for some time, in a model increasingly relying on market incentives, funding allocations would become more important than ever. Accurate assessment of individuals' needs and the appropriate level of support would be vital as would selection of the tools used to assess people on entry to the system; these would need to be improved and continually refined.

Finally, a system where service providers have more control over their processes would demand more of the frontline staff. Improving performance and getting more people into jobs may require that providers invest more in their staff.

Re-designing the system to provide more diverse approaches and staff that are better qualified and better equipped to work with their clients can only be an improvement.

While these reforms would improve the employability of people who are unemployed, we can also do more to prevent workers who develop a mental illness from falling out of employment in the first place. One program that has worked well is mental health first aid. Most workplaces have first aid officers, but many workplaces are now seeing the value in having staff trained in mental health first aid as well. The research shows that there is a sound basis for improved support in the workplace, with people who have received this type of training better able to identify mental illness and more likely to recommend appropriate treatments (Kitchener and Jorm: 2002).

Helping people with mental illness find, and maintain, employment has benefits both for the people themselves and for the broader community. We must strive to do better. Improving workplace services that help people into jobs and then improving in-work support would be an excellent start.

A WORKPLACE PREVENTION APPROACH TO EMPLOYEE MENTAL HEALTH

by

Prof
Lyn Littlefield OAM,
Anna Stitzel
& Jill Giese

Australian Psychological Society,
Melbourne

Work is central to the development, expression and maintenance of good mental health and psychological wellbeing. Satisfying work has a positive impact on other aspects of life such as family, personal relationships and feelings of wellbeing. However, work can also bring about job-related stress and negative consequences for the mental health and wellbeing of employees. Occupational stress can cause behavioural, medical and psychological problems including greater alcohol and drug abuse, increased smoking, accident proneness and violence. Psychological consequences of stress can include family disharmony, disturbed sleep, anxiety and depression.

Factors causing stress in the workplace include excessive demands and workload, and poor relationships with colleagues and managers (Hillier, Fewell, Can and Shepherd: 2005, 419-431). Negative workplace experiences such as poor leadership and lack of recognition can also lead to stress, anxiety and other health problems. In addition, the level of control that employees experience over their work situation, and whether or not they feel valued in the workplace, can dramatically affect work performance.

Employers and organisations are becoming increasingly aware of the effect of stress on individual employees and the wider organisation. Stress is the second most common cause of workplace compensation claims after manual handling (Worksafe Victoria, 2013), with substantial costs to employers, employees and the community. Studies on work-related stress highlight the extensive costs of job stress on the individual employee (e.g. medical problems, burnout, substance abuse) and the organisation (e.g. reduced productivity, absenteeism, turnover; see, for example, Mack-Frey; Quick and Nelson: 2007; Giga, Cooper and Faragher: 2003, 280-296).

With increased awareness of the impact of stress at work, organisations can address these challenges through programs promoting health including awareness, education and organisational interventions. Such broad health promotion programs, while of benefit, rarely focus on the impact of work on psychological wellbeing and prevention strategies to maintain the emotional wellbeing of employees.

Psychologically healthy workplaces

Supporting workplaces to be psychologically healthy and foster employee wellbeing represents a huge opportunity to improve mental health and wellbeing across the population, as well as to enhance organisational performance. Organisational psychology research has linked a number of workplace conditions and environments with positive psychological health and wellbeing. Several occupational stress models have identified organisational factors considered to be common causes of stress.

Australian psychologists Peter Cotton and Peter Hart (2003: 118-127) reviewed organisational health research and concluded that the organisational climate greatly influences employee wellbeing. They found that organisational experiences common to all workplaces, such as leadership practices, decision-making styles and goal alignment, can, when they are unfavourable, be more stressful than the impact of adverse aspects of a particular job. Cotton and Hart recommended that, in order to reduce stress, it is very important to develop a supportive organisational climate that helps employees manage their work more effectively.

This organisational health framework provides an evidence-based approach to the management of employee wellbeing and the prevention of occupational stress. It provides useful guidance for employers to establish support for employee wellbeing and address workplace difficulties. Improvements to organisational climate, especially through building supportive leadership capability and fostering more engaging and positive team management, can increase morale and reduce distress more effectively than traditionally-used coping skills, training and other individual stress management approaches for employees. Organisations can thus address broader organisational climate issues that can improve employee health and wellbeing.

Promoting employee mental health

A new prevention program was established by the Australian Psychological Society in 2013 to encourage Australian organisations to focus more on the working environment that is provided to maximise the psychological health and wellbeing of employees. Using Cotton and Hart's organisational health framework and other organisational psychology research, the elements of a psychologically healthy workplace have been identified and conceptualised as five pillars of an organisation's psychological health: supportive leadership; role clarity; staff engagement; development and growth; and morale (see opposite for more details).

The program enables organisations to evaluate whether the elements of a psychologically healthy workplace are present within the culture of the particular organisation and tailor mental health prevention strategies to promote employee wellbeing and good mental health.

Five Pillars of a Psychologically Healthy Workplace

1 SUPPORTIVE LEADERSHIP
The extent to which leaders understand the needs of staff and provide an environment that fosters employee engagement, development and support.

2 ROLE CLARITY
The extent to which staff have a sense of purpose and know what is expected of them.

3 STAFF ENGAGEMENT
The extent to which staff collaborate, share ideas and solve problems together, leading to a shared understanding and alignment of team goals. This includes:

- Teamwork – opportunities for staff to work together.
- Empowerment – opportunities to be involved in decisions that affect day-to-day work.
- Ownership – alignment of staff members' goals with the goals and approach of the team and organisation.

4 DEVELOPMENT AND GROWTH
The extent to which the organisation recognises the efforts of its employees, and provides appropriate learning and development opportunities. This includes:

- Feedback and recognition – enabling staff to receive feedback on their performance, as recognition of their efforts.
- Learning and development – enabling staff to learn and develop in their roles.

5 MORALE
Staff's emotions while at work that underpin their motivation and commitment, including individual morale and work team morale.

SUCH WORKPLACE MENTAL HEALTH PROMOTION AND PREVENTION APPROACHES RAISE AWARENESS OF THE IMPORTANCE AND VALUE OF PSYCHOLOGICALLY HEALTHY WORKPLACE PRACTICES AND POLICIES TO SUPPORT EMPLOYEE HEALTH AND WELLBEING IN AUSTRALIAN ORGANISATIONS, AND PROVIDE YET ANOTHER LEVER TO IMPROVE THE OVERALL MENTAL HEALTH OF THE AUSTRALIAN COMMUNITY.



PARTICIPATION
in Education

CHANGE AHEAD

by Sue Harrison

Learning and Development Unit, Psychiatric Disability Services of Victoria (VICSERV)

The mental health workforce is as wide and as varied as the people that it supports. When many people think about the mental health workforce, they envisage those working with people who are extremely unwell, and accessing hospital-based treatment and care.

In addition to these, the mental health non-governmental organisation sector, known as the community-managed mental health (CMMH) sector, also supports people with mental health issues in the community. These services provide flexible, cost-effective community-based support that is essential to recovery, early intervention and prevention. Services include a mix of psychosocial rehabilitation and support services, such as housing support, individual support, day programs, prevocational training, residential services, outreach and respite care. Service differences have arisen around Australia from past funding decisions, community need and the availability of generic support services.

The National Health Workforce Planning and Research Collaboration (2011) conducted the Landscape Study of the CMMH workforce in 2009-10, asking organisations about their characteristics and the services they offer. There were 268 valid responses from around 34% of the sector. The study estimated that between 4,950 and 9,989 paid employees worked for the responding organisations, which can be extrapolated to an estimate of between around 15,000 and 27,000 paid employees work for CMMH organisations around the country.

These organisations vary in size and budget, as shown in this table:

TABLE 01



An interesting finding regarded the range of funding sources for the responding organisations, with 28% having only one source of funding. Given the rate of change in mental health policy and subsequent funding distributions, this is risky for these organisations. Of the CMMH organisations with only one funding source, half were from their state or territory health department or other state-run department.

Government involvement

So why does receiving just state/territory-based funding expose organisations to significant change? Since 2006, as a result of the Council of Australian Governments' (COAG) National Action Plan for Mental Health, the role for the Commonwealth Government in community mental health funding has increased. The Plan outlined programs that are funded nationally, and provided by CMMH organisations, including:

- Day to Day Living.
- Personal Helpers and Mentors (PHaMs).
- Mental Health Respite and Carer Support.
- Family Mental Health Support Services.

In addition, the new programs of Partners in Recovery and DisabilityCare Australia, (formerly known as the NDIS) are being rolled out. At this stage, the interaction between these programs, and existing state and territory-based community mental health funding is not finalised, but everything points to these programs having a significant impact on how CMMH services will be funded and delivered.

The first stage of DisabilityCare Australia will be launched from July 2013 in four locations across the country:

- Hunter area, New South Wales.
- Barwon area, Victoria.
- South Australia (for children).
- Tasmania (for young people).
- In the ACT from July 2014.

At the time of writing, agreements for the full roll-out of the program have been made between the Commonwealth and all state/territory governments, with the exception of Western Australia. The scheme will be funded through the Commonwealth budget, an increase to the Medicare Levy, and financial and in-kind contributions from the states and territories.

In Victoria, CMMH services are watching the launch site of Barwon closely, in which existing mental health home-based outreach support, day program, and care coordination services will be provided as in-kind contributions as part of DisabilityCare Australia. Current consumers will be able to continue to receive services under the new program, but all new consumers may not meet the eligibility criteria.

Workforce challenges will be significant. Mental health services in Victoria are funded using an input-based block funding model. DisabilityCare Australia is funded on a consumer-based flexible funding model, with consumers able to purchase services of their choice to meet their needs. This provides much needed flexibility and choice to consumers, but sets challenges for service providers.

Organisations will be required to find ways to promote their services to consumers, provide these services at a high standard, and maintain cost efficiencies. With no guaranteed block funding, services will need innovative methods to maintain a well-trained and motivated workforce.

With less predictable income, service providers will still need to prioritise the training and education needs of their workforce. Highly developed skills in supporting recovery, care coordination, managing complexity, and collaboration with a myriad of other services, will become the core skills required of the CMMH workforce. It is generally accepted that the Certificate IV in Mental Health is the base-level qualification expected of this workforce, but service providers are questioning whether the qualification is adequate in this new environment. The critical thinking and analytical skills developed at diploma, degree, and even graduate diploma level are increasingly seen as required of the workforce in the highly complex community-managed mental health environment. There needs to be a significant investment in workforce training and education for existing and new staff to cater for future consumers.

What next?

Details of future funding arrangements for the CMMH sector are being developed but it is clear that the CMMH workforce faces challenges. These include a shift in traditional funding sources, a change in delivery of funding, and less predictable income and expenditure. Workforce development has not been at the forefront of these changes, but without a secure, well-trained workforce, services simply cannot be delivered.

Developing the workforce is crucial to cover:

- Desired characteristics of the CMMH workforce, including key skills and qualifications.
- Availability of training and education to existing and new workforce.
- Strategies for the recruitment and retention of a workforce that can meet the needs of consumers.

In conclusion, there is a significant challenge ahead. Development of the CMMH workforce to enable not just adequate, but best-practice service delivery, will require a significant investment. Many service providers are acutely aware of this need, and are working towards this goal with the limited resources at their disposal. But without a dedicated investment of funding, resources, and expertise at a policy and governmental level, there is a risk that workforce development will not keep up with the rate of change in service delivery, and consumers and carers will miss out.

**HIGHLY DEVELOPED
SKILLS IN
SUPPORTING
RECOVERY,
CARE COORDINATION,
MANAGING
COMPLEXITY, AND
COLLABORATION
WITH A MYRIAD OF
OTHER SERVICES,
WILL BECOME
THE CORE SKILLS
REQUIRED OF THE
CMMH WORKFORCE.**

EDUCATIONAL SUCCESS

for People with Mental Illness

by Laura Collister

General Manager, Mental Illness Fellowship Victoria

.....
'The supported education course was a significant part of my recovery. Not only is it meaningful activity, including work, study, training and volunteering essential for self-esteem, finances and lifestyle, it is also important to make a contribution to society, keep a routine and do purposeful and enjoyable things. It has certainly been a pathway to social inclusion for me where I discovered a new world of possibility' (Ennals, Cartwright and Rinaudo: 2010, 2-16).
.....

Education is crucial for many people with a mental illness as a positive contributor to recovery and enabling them to gain employment. As a facilitator of recovery, participation in education gives individuals a socially valued role (Best, Still and Cameron: 2008, 65-68; Soydan: 2004, 227-248), builds self-esteem and overcomes some of the cognitive barriers that might result from mental illness (Rinaudo and Ennals: 2012, 114-120). Low levels of educational attainment have also been associated with poor employment outcomes (Waghorn, Still, Chant and Whiteford: 2004, 343-358).

It is reasonable to expect, then, that successful participation in education may have a powerful, positive effect on the lives of many people with a mental illness.

International psychiatric rehabilitation literature recognises this, for example, Mowbray, Collins, Bellay, Migivern, Bybee and Szilvagy (2005, 7-20) and Soydan (2004, 227-248), and yet apparently there are few descriptions or rigorous evaluations of programs designed to support people to enter into education in Australia. Equally, return-to-education programs do not seem to figure prominently in the national mental health landscape for reasons which are unclear.

Certainly, numerous barriers to educational achievement have been described by the international literature – barriers relating to symptoms of mental illness and its episodic nature, barriers relating to the inflexibility of course demands and to the overwhelming social demands of mainstream educational settings. Fear – and experienced – stigma in educational settings are other key barriers.

Mental health professionals also can sometimes stigmatise people with mental illness and this can prevent them from achieving their employment goals. The professionals might view getting, and keeping, a job as unrealistic and likely to exacerbate illness.

This factor may also possibly influence considerations of a return to learning, with mental health professionals unintentionally curtailing an individual's educational aspirations.

People with a mental illness, including low prevalence disorders, however can be successful in education. The literature describes several approaches, some that can be broadly thought of as supporting people to return to mainstream settings and others that create specific supported learning settings as a stepping-stone to the mainstream.

.....
Mainstream support
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Supporting students to return to mainstream settings has numerous advantages over a more sheltered approach. Mainstream settings are more highly valued, less stigmatised, offer numerous course options and enable students to move out of the mental health world into a mainstream student role. It has been suggested that approaches paralleling the Individual Placement and Support Model will be most effective in assisting people to return to mainstream study (Waghorn et al: 2004,

As Australia builds a mental health system centred on recovery, it is essential the mental health community embraces the educational aspirations of the people it serves and develops models that enable choice and support success.

343-358) and there has been some success in adopting this approach in Australia, particularly with young people (Kilacky, Jackson & M^cGorry: 2008, 114-120). This approach responds to individual preferences, rapidly engages the individual in mainstream education and provides on-site, ongoing support.

Demands of the mainstream setting can, however, be high and, perhaps in response to this, a self-contained classroom model has been developed. With this model, described by Best et al (2008) and implemented in New South Wales, students attended supported education classes in a self-contained classroom in a mainstream setting. Teaching was delivered by mainstream teachers and mental health professionals offered support. The program reported high rates of students completing the course. While this approach familiarises students with the mainstream setting and provides opportunities to socialise out of the classroom with the general student population, it is unlikely to provide enough – and varied – courses to respond to student preferences and may be experienced as stigmatising.

Tailored education program

Another approach, described by Ennals et al (2010) and delivered by Mental Illness Fellowship in Victoria, has an education program tailored to the needs of people with a mental illness. This approach, while requiring students to meet nationally recognised standards, has a very flexible pace of learning. The course runs for more weeks with fewer hours per day and range of teaching methods. In addition, it has individualised mental health support and volunteer tutoring. Although this approach has few of the advantages of a mainstream setting, it does enable a high degree of mental health support. For instance, Ben, a student in this program, described how:

'In the course I had two important learning streams. I was learning more about mental illness and how to manage it from others in the class and from the teacher... I was also re-learning the skills in literacy, goal setting and regaining hope for my future' (Rinaudo and Ennals: 2012, 99-104).

In this quote, Ben refers to the importance of peers in his return to learning. Both Ennals and Best acknowledge the importance of peer learning and support. Peers not only provide valuable insights into managing mental illness and recovery, but also practical problem solving and support in overcoming educational challenges. Peer support is also increasingly being recognised as a particularly effective enabler of recovery.

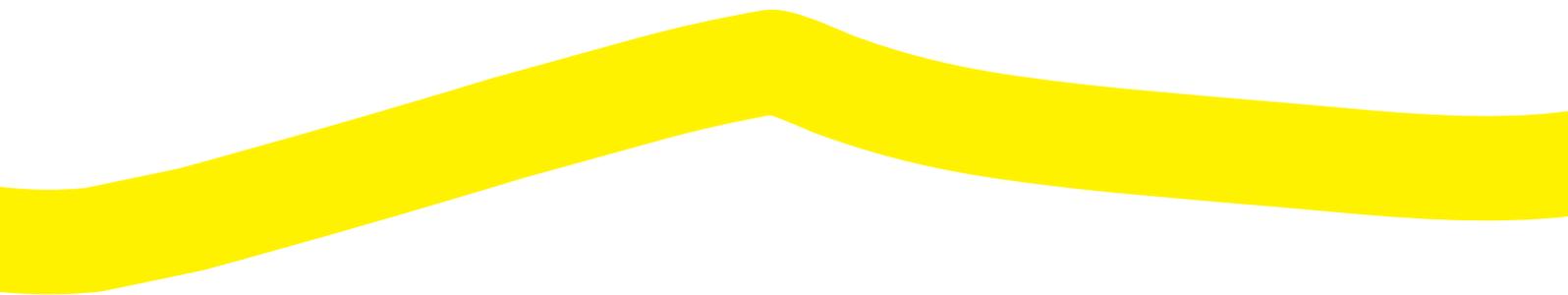
Recovery Colleges in the United Kingdom take this approach even further. As learning centres, they offer a curriculum incorporating traditional education, such as literacy and numeracy lessons, with recovery education. Peer learning is fundamental to the colleges, with all courses being co-designed and co-led by peers and teachers or professionals. The colleges are open to people with a mental illness, the community, staff and their family.

Recovery Colleges are relatively recent developments in the UK and are yet to be established in Australia. This combination of peer approaches and education may well offer a highly

effective model for some, but like the other sheltered settings, will be unlikely to have the range of opportunities for students as in a mainstream setting and may be stigmatising.

It is likely that different approaches will suit different individuals, at different times. Young people may well value a rapid return to mainstream education, while people who have been disengaged from education and struggling in their recovery journey may choose a more sheltered approach, which incorporates more chances to learn from peers and to learn about illness self-management and recovery.

As Australia builds a mental health system centred on recovery, it is essential the mental health community embraces the educational aspirations of the people it serves and develops models that enable choice and support success.



**ECONOMIC
INDEPENDENCE**
& Income Support

LACK of SUPPORT for INCOME SUPPORT

from conversations with
Dr Tessa Boyd-Caine

Deputy Chief Executive Officer Australian Council of Social Service
at the inaugural Australian Council of Non-Government Organisations
on mental health, October 9, 2012

The fragmentation of mental health and allied services affects the continuum of care available to people using those services. Critical services include employment, housing, legal, family and health services.

The House of Representatives Standing Committee on Education and Employment Inquiry in 2012 resulted in the Work Wanted: Mental Health and Workforce Participation report (House of Representatives Standing Committee on Education and Employment: 2012). The committee summed up the key issue as: 'increasing numbers of people with a mental health condition being on income support'.

This includes 800,000 people receiving employment-related allowance payments including the unemployment benefit Newstart Allowance (NSA) and Youth Allowance – Other (for jobseekers). Most are living in poverty, especially those on the \$35 per day of NSA for a single person.

The single rate of Newstart has fallen in proportion to the minimum wage from 52% to 45% since 1994, when it was last increased. Compared to wages, the single rate of Newstart is the lowest unemployment payment in the Organisation for Economic Co-operation and Development at 40% of a low full-time wage after tax – and that includes rent assistance.

From the Work Wanted report, we know that in the 2007 Australian Bureau of Statistics National Survey of Mental Health and Wellbeing, 45% of Australians aged 16-85 years reported experiencing at least one, or a combination of, mental illnesses at some point in their lifetime. And 20% of Australians reported experiencing one or a combination of mental disorders in the previous 12 months.

Mental illness is the single largest cause of disability in Australia. According to the Australian Institute of Health and Welfare (AIHW), mental disorders account for 13.1% of Australia's total burden of disease and injury and are estimated to cost the Australian economy \$20 billion annually in lost productivity and labour participation (Begg, Vos, Barker, Stevenson, Stanley and Lopez: 2007).



We know this has a particular impact on ability to gain and retain paid work, as does the lack of unskilled jobs for low-qualified workers, which ACOSS members see as one of the reasons for increasing numbers of people on NSA.

The Australian Council of Trade Unions (ACTU) partners in an international report (IndustriALL Global Union: 2012) on secure work points to growth in agency or contracted labour as a significant factor in increasing job insecurity. The report was completed by IndustriALL, a new international organisation made up by unions representing 50 million workers in 140 countries across the mining, energy and manufacturing sectors. It showed that between 1996 and 2009 the number of workers in labour hire and contract work had doubled. Labour hire agencies' revenue has increased from \$105 billion to \$257 billion in the same period.

The Productivity Commission has estimated that a quarter of a million Australian workers are employed through labour hire (Productivity Commission: 2013); ACTU reports Australia

has the second highest rate of insecure work in the developed world, at 40% of the workforce (ACTU Australia: 2013).

In October 2012 SANE talked about more Australians calling for help, with enquiries to the national helpline rising 27% from July 2011 to June 2012, as compared with the same period in the previous year. Women seeking help outnumbered men, three to one.

Just under half the callers were enquiring about support in the community, while a further third were asking about treatment. Analysis of SANE Helpline's statistics show Australians are concerned about their loved ones' health, with almost half (42%) of all enquiries coming from people worried about the mental health of someone they know or care for (SANE Australia: 2012).

One in five enquiries are related to undiagnosed symptoms. 'Often there has been no diagnosis and people are seeking information, advice or encouragement to take the first and most important step of contacting a general practitioner for help or assessment,' SANE Chief Executive Officer Jack Heath explains. 'Others need help to navigate the healthcare system, while some

people require assistance to access housing or jobs, or require financial or legal advice.'

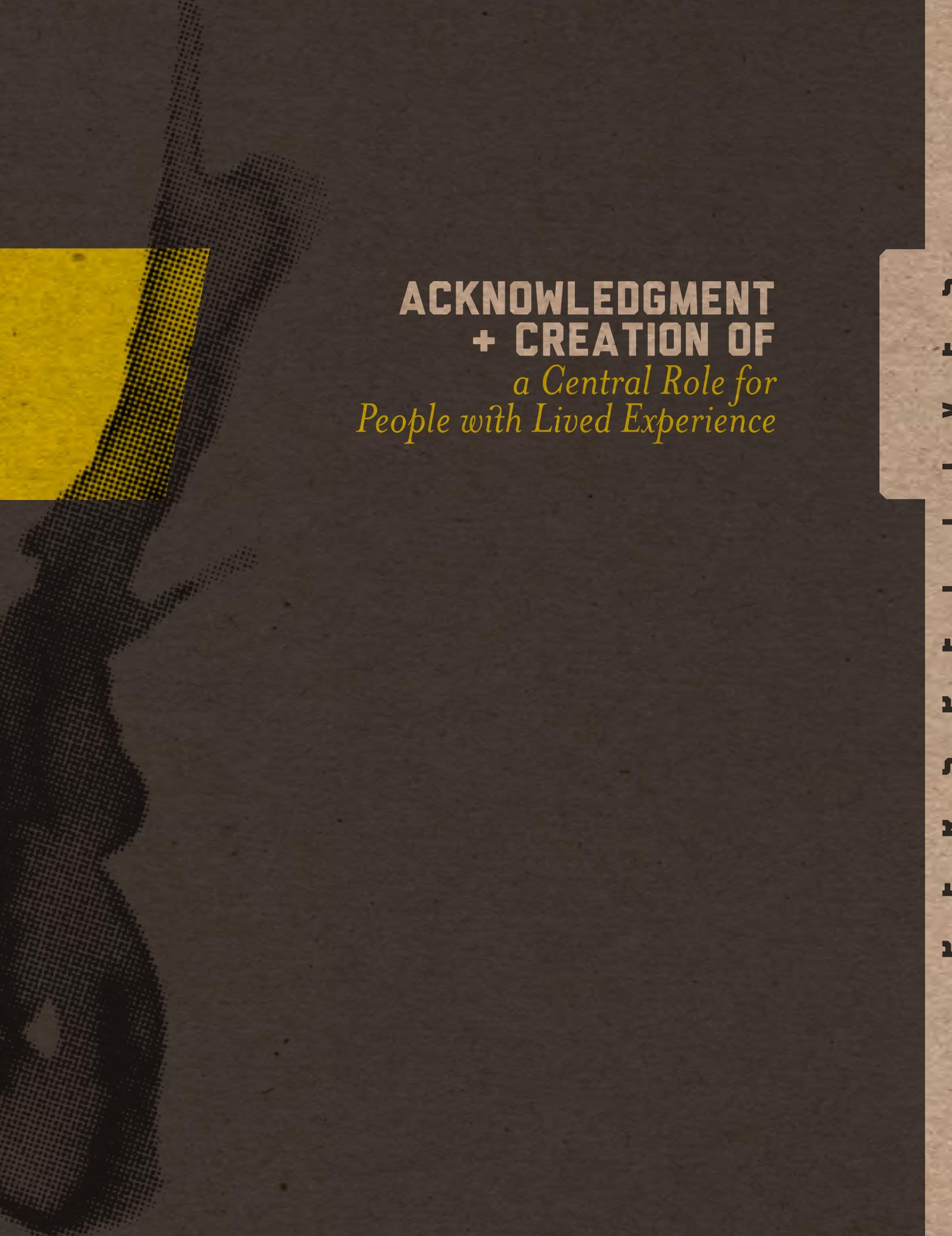
There are also particular challenges for people seeking legal services. The Australia Institute has conservatively estimated that 490,000 Australians each year miss out on legal help for financial reasons or lack of knowledge. Furthermore, over 80% of the people helped by community legal centres earn under \$26,000 a year.

The National Association of Community Legal Centres shows the most common issues community legal centres help people with are tenancy, debt, employment issues, family violence, family law issues about children, divorce, consumer issues, family law issues about property, wills, powers of attorney and guardianship, minor crime and fines, car accidents and social security. About 60% of the work is in civil law, 35% in family law and 5% in crime.

Yet, Australian Government funding for legal assistance services has failed to keep pace with demand, inflation and population growth, and budget figures show falls in real terms in per capita funding for the next three years.

The reality is that while demand for community services is growing, the complexity of the needs of people seeking services is also growing. While an employment service may secure a job interview for someone, their capacity to maintain paid work is going to be undermined if they cannot at the same time fill a prescription, secure the housing they need, and meet the costs of their child's schooling. We need holistic services that support people's overall health and wellbeing, not just a particular condition, if we are to truly support people living with mental illness to maintain socially and economically participating lives.





**ACKNOWLEDGMENT
+ CREATION OF**
*a Central Role for
People with Lived Experience*

People with

SEVERE, ENDURING MENTAL HEALTH AND PSYCHOSOCIAL DISABILITIES

The mental health system urgently needs to redirect its attention to whole-of-life needs and not just medication and crisis-driven service delivery.

DESPITE YEARS OF NATIONAL AND STATE MENTAL HEALTH REFORMS ACROSS AUSTRALIA, MANY INDIVIDUALS WHO EXPERIENCE PSYCHOSOCIAL DISABILITIES AS A CONSEQUENCE OF SEVERE AND ENDURING MENTAL ILLNESS STILL DO NOT RECEIVE THE SUPPORTS THEY SO DESPERATELY NEED. THIS OFTEN RESULTS IN TRAGIC CONSEQUENCES, INCLUDING A HIGH PROPORTION OF THOSE WITH A SEVERE MENTAL ILLNESS BECOMING HOMELESS OR INCARCERATED FOR MINOR CRIMES, AND WORSE.

There is a dearth of research from among this cohort. Their number has been estimated to be anywhere between 60,000 and 200,000. What we do know is that they are among the most socially and medically marginalised members of the Australian community.

We also know that, despite the fact that many who have a psychosocial disability are monitored and treated by qualified health professionals for their mental health problems, their physical health issues are often not addressed (see Janet Meagher's article).

According to the World Health Organization and SANE Australia, the average life expectancy of people with schizophrenia, for example, is at least 25 years less than that of the general population.

This appalling situation is substantiated in many recent reports, including the report card presented to the Prime Minister by the National Mental Health Commission in September 2012.

Seventy eight percent of persons living with a mental illness are still living with their families because housing options are so limited. Across Australia, there are very few good examples of supported accommodation. Often, the only alternative is living in privately-owned, substandard facilities. Family carers have serious concerns about the lack of appropriately supported accommodation and what will happen to their

loved ones when they are no longer around to support them, and the reports reveal that this is impacting significantly on the health and wellbeing of family and friends, as evidenced in recent reports.

Family mental health carers across Australia are repeatedly reporting that support agencies refuse to assist their loved ones, who are expected to have 'goals', to 'lead their own recovery' and to 'drive their own care and support', leaving carers at a loss as to how they fit into 'care'.

National Mental Health Consumer and Carer Forum

The National Mental Health Consumer and Carer Forum (NMHCCF) was developed collaboratively in 2002 by peak consumer and carer groups and the Australian Health Ministers' Advisory Council. The NMHCCF is the combined, national voice for mental health consumers and carers participating in the development of mental health policy and sector development in Australia. Our membership includes one representative consumer and one representative carer from each Australian state and territory and representatives from six national health consumer and carer organisations. The Forum aims to improve the wellbeing and quality of life of mental health consumers and carers throughout Australia

MENTAL ILLNESS, DISABILITIES & THEIR CARERS

by the National Mental Health Consumer and Carer Forum

The National Mental Health Consumer and Carer Forum is the combined, national voice for mental health consumers and carers participating in the development of mental health policy and sector development in Australia.

through promoting their rights; creating a responsive, recovery-focused service system; and through supporting innovation in service delivery appropriate to different life stages.

To do this the Forum:

- Provides a strong, united voice for mental health consumers and carers focused on influencing national, state and territory policy and discussion about service development.
- Draws on our members' lived experience and expertise in mental health to identify what does and does not work in mental health, as well as key human service policies and practice.
- Promotes approaches that support individual recovery and contribute to an improved mental health and human services system at all levels.

The NMHCCF members use their lived experience, understandings of the mental health system and communications skills in systemic advocacy to promote the issues and concerns of Australian mental health consumers and carers. NMHCCF members represent consumers and carers on national and state committees including working groups, expert reference groups, forums and summits. The NMHCCF provides a tangible opportunity for mental health consumers and carers to play a positive role in reforming the mental health sector to improve the lives of millions of Australians.

The NMHCCF has six priority work areas:

- National mental health reforms.
- Psychosocial disability issues and disability sector linkages.
- Workforce development and education.
- Forum partnerships and alliances.
- Accountability and promotion.
- Consumer and carer research.

We produce submissions, advocacy briefs and position statements on issues that are important to consumers and carers, including seclusion and restraint, peer workforce, stigma, confidentiality and psychosocial disability. Focusing on the latter, the NMHCCF publication, *Unravelling Psychosocial Disability*, outlines our position on this controversial issue that is rarely discussed openly.

To identify individual needs and look clearly at how everyone with severe and enduring mental illness and psychosocial disabilities can make their way in the world, it is critical that there is a comprehensive assessment of an individual's functional capacity by people who well understand mental illness and psychosocial disabilities and have the high-level skills to conduct appropriate assessments. Families and carers must be included in this assessment, where appropriate to do so, particularly when the

individual experiences anosognosia, a condition which affects approximately 60% of those with schizophrenia. Having this condition means that they are unaware that they have an illness, and this impacts significantly on their capacity to lead their own recovery.

It is essential that governments take the lead in providing policy - and direction - and adequate funding for the wide range of supported accommodation options that are needed by persons with psychosocial disabilities in order to make a positive difference to their lives and that of carers. People with psychosocial disabilities, like anyone else in our community, are entitled to the full rights of citizenship and this means that they have a right to safe and adequate housing, and a right to be adequately supported to achieve the highest level of function they possibly can.

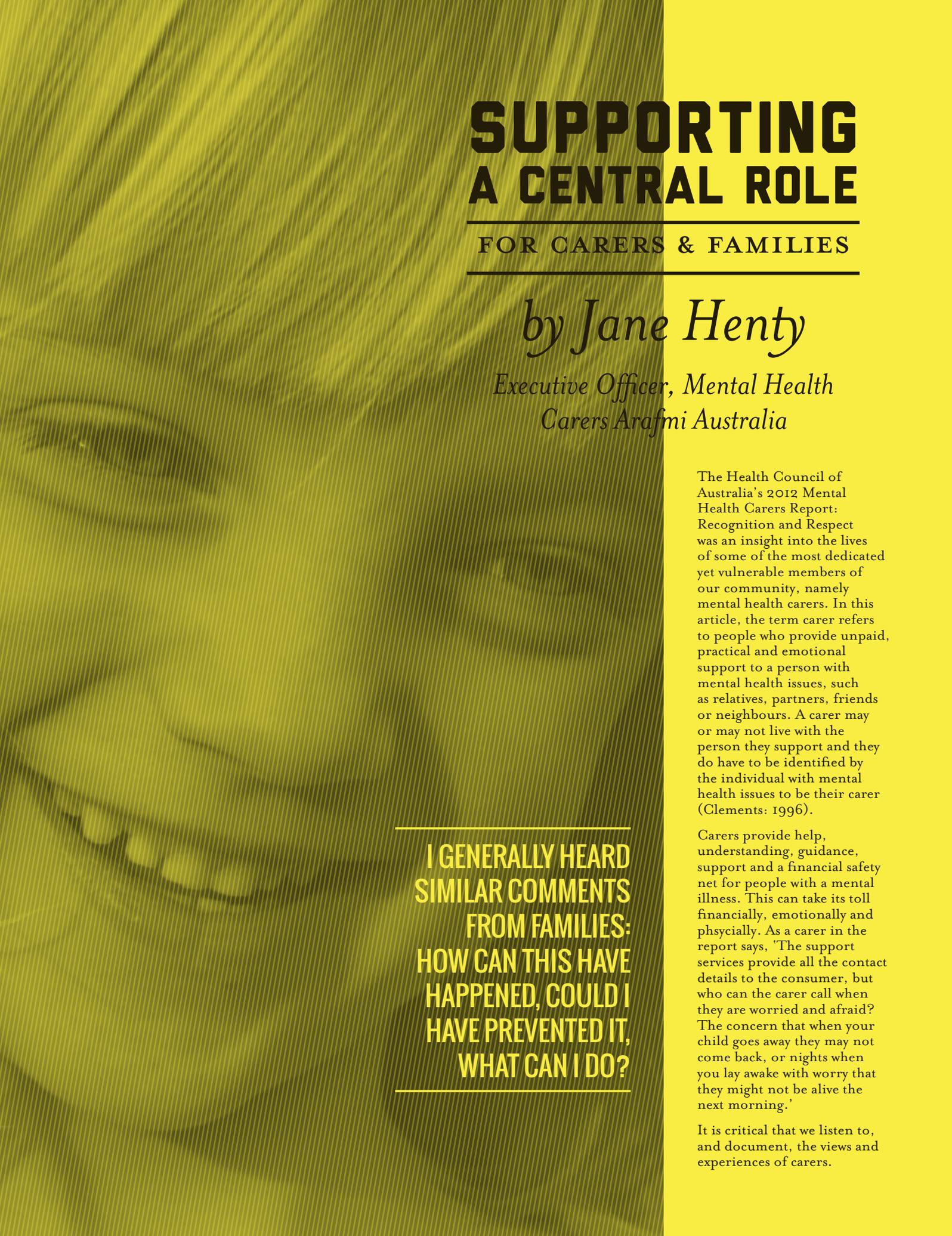
Anyone unable to live independently requires appropriately supported accommodation where they can be properly cared for, where their physical and mental health is properly monitored, and they receive decent meals and assistance with their physical and mental health needs and everyday activities. Worldwide research indicates very strongly that there are huge economic gains for the community when its members are adequately supported in this way.

The mental health system urgently needs to redirect its attention to whole-of-life needs and not just medication and crisis-driven service delivery.

We force people into hospital, transported by police, force them to take huge amounts of antipsychotic medications against their will, ignore their physical health and take away control of their money. We cannot continue to do these inhuman and discriminatory things and yet, at the same time, fail to provide the support that aims to help them to live a decent life and become contributing members of society - something everyone wants and deserves whether they have a mental illness or not.

Australia is working on ways to restore varying degrees of health, wellbeing and dignity to the lives of its citizens, including those who have physical disabilities. We need to do the same for those with psychosocial disabilities.

.....
To identify individual needs and look clearly at how everyone with severe and enduring mental illness and psychosocial disabilities can make their way in the world, it is critical that there is a comprehensive assessment of an individual's functional capacity by people who well understand mental illness and psychosocial disabilities and have the high-level skills to conduct appropriate assessments.
.....



SUPPORTING A CENTRAL ROLE

FOR CARERS & FAMILIES

by Jane Henty

*Executive Officer, Mental Health
Carers Arafmi Australia*

**I GENERALLY HEARD
SIMILAR COMMENTS
FROM FAMILIES:
HOW CAN THIS HAVE
HAPPENED, COULD I
HAVE PREVENTED IT,
WHAT CAN I DO?**

The Health Council of Australia's 2012 Mental Health Carers Report: Recognition and Respect was an insight into the lives of some of the most dedicated yet vulnerable members of our community, namely mental health carers. In this article, the term carer refers to people who provide unpaid, practical and emotional support to a person with mental health issues, such as relatives, partners, friends or neighbours. A carer may or may not live with the person they support and they do not have to be identified by the individual with mental health issues to be their carer (Clements: 1996).

Carers provide help, understanding, guidance, support and a financial safety net for people with a mental illness. This can take its toll financially, emotionally and physically. As a carer in the report says, 'The support services provide all the contact details to the consumer, but who can the carer call when they are worried and afraid? The concern that when your child goes away they may not come back, or nights when you lay awake with worry that they might not be alive the next morning.'

It is critical that we listen to, and document, the views and experiences of carers.

Shift in emphasis

Asylums have been closed for 30 years. Subsequently the emphasis of mental healthcare has shifted to home-based and community care, with families and carers taking increased responsibility in caring roles, often with minimal support from communities or services. This can lead to carers feeling (and being) swamped in a pattern of day-to-day survival, with little hope for the future.

Supporting someone with a mental illness has a negative impact on the health and wellbeing of carers. In 2007, carers were found to have the lowest wellbeing of any large group recorded by the Australian Unity Wellbeing Index (Cummins and Hughes: 2007). The National Mental Health Carer and Consumer Forum in 2011 linked poor carer wellbeing to: the episodic nature of mental illness; the behaviours that can be associated with mental illness; the lack of community recovery-based services and supports for people with mental illness; and lack of appropriate accommodation for people with a mental illness.

Advocates have therefore been calling for improved community support for family members caring for their loved ones with a mental illness. It is crucial that carers receive knowledge and moral and peer support. A carer has emphasised the importance of carer support: 'Mental illness was completely new to me and I had to learn as much as I could whilst (sic) dealing with my sick son. Education and support was provided at a time of despair and bewilderment' (ARAFEMI: 2007).

However, there is still inadequate support for carers. Sharing my professional journey illustrates some of the typical barriers and shifts across the sector.

My experience

Commencing as a graduate psychiatric nurse in 2005 in a Melbourne hospital, I completed four rotations in the acute psychiatric wards, which was a comprehensive crash course in psychiatric nursing. The psychiatric wards were always full. There were always patient admissions, patient discharges and forms to fill out.

Families entered and left the wards at the periphery of our vision. As a nurse, the focus was on a timetable of medications, meals and risk assessments, which would be periodically interrupted by difficult situations, such as a patient absconding or creating a disturbance.

As a nurse, I was sympathetic and concerned for families' needs. However, timetables and processes sometimes got in the way. I think back to how a mother looked at me in concern when I told her she could take her son on leave from the ward. Possibly her concern related to the nature of the illness, or the treatment had not been explained to her, or she was worried that something may happen while he was in her care. However, she could not say anything in front of her son and I did not intervene. His leave papers were signed by the head psychiatrist, so he left. A more family-inclusive approach to the leave arrangements would have supported the mother in her caring role. At the time, the ward culture and work expectations made family inclusion challenging.

Part of the barrier that is often cited within workplaces is whether carer and family involvement in consumers' care and treatment is core business. Since the introduction of the National Standards for Mental Health Services in 1996, it is required to involve consumers and carers in mental health treatment. This imperative has arisen from clear evidence that families, carers and friends are the largest providers of care for people living with mental illness in Australia and that inclusion in care and treatment leads to greater health outcomes for consumers (Falloon: 1998).

However, families have often continued to be marginalised and excluded from participating in their loved ones' care (Lakeman: 2008, 203-11). This is concerning given that 'fifty to ninety per cent of the chronically mentally ill live with their relatives following acute psychiatric treatment' (Lauber et al: 2003, 285-289).

After a couple of years of nursing I turned my attention to mental health community rehabilitation and recovery. I wanted to work in the community where recovery from mental illness was the focus of care. I started working for ARAFEMI Victoria as an outreach worker. In this program, families were more central to the consumer's care. I entered into families' private lives, learnt about their hopes and fears, and heard their stories of coming to terms with their loved one having a mental illness. I generally heard similar comments from families: how can this have happened, could I have prevented it, what can I do?

Physical and emotional exhaustion, chronic stress, depression and grief are not unusual among family members. Social isolation and low self-esteem, economic losses, decreased life opportunities, and difficulties accessing effective treatment and support services add to the pressures that carers and families face. The lack of support and information about the illness, management and services compounds these feelings of powerlessness and frustration.

National representation

A deepening respect and commitment for families and carers has led to my role as Executive Officer of Mental Health Carers Arafmi Australia. This organisation represents at national level the interests of the needs and concerns of its members and constituency – families and others voluntarily caring for people with mental illness.

Attending a Carers Conference held in Perth in 2012, I heard the ABC sports presenter and broadcaster, Karen Tighe, share her story about being a carer. She had cared for her husband, Glenn Mitchell, also a sports broadcaster, during his depressive illness. The pain, stress, anxiety and stigma she described brought the audience to tears. I began to really understand how isolating and painful being a carer can be and that often carers are crying out for help, with no-one listening.

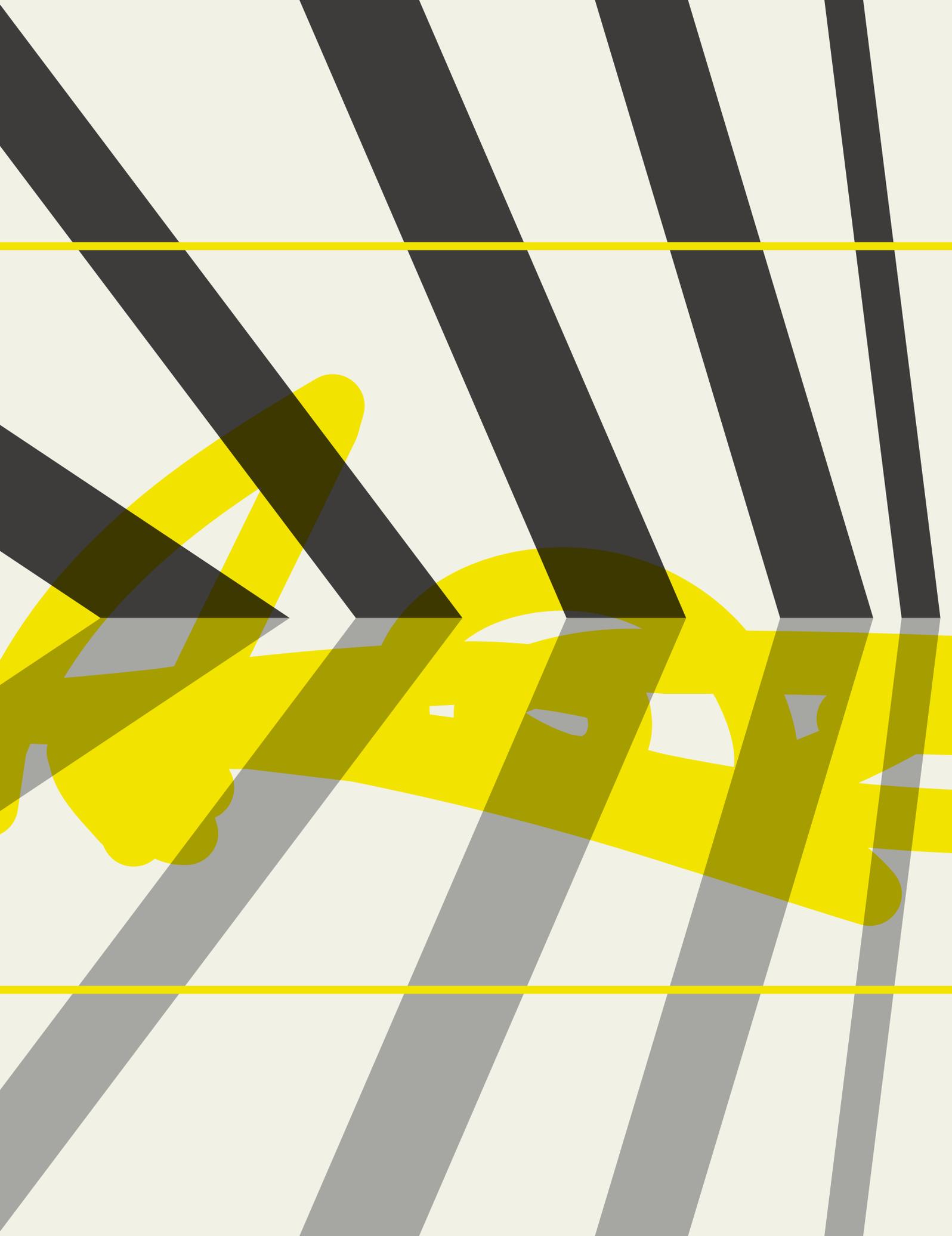
We can decide as a country that we are going to ignore the needs of carers such as Karen, and continue to focus on diverting most government revenue into acute psychiatric beds. The majority of national mental health expenditure in 2010-11 went to public hospital services for admitted consumers, at \$1.8 billion, followed by community mental healthcare services at \$1.6 billion (AIHW: 2012).

Or we can choose to lead the world in mental health treatment and support by:

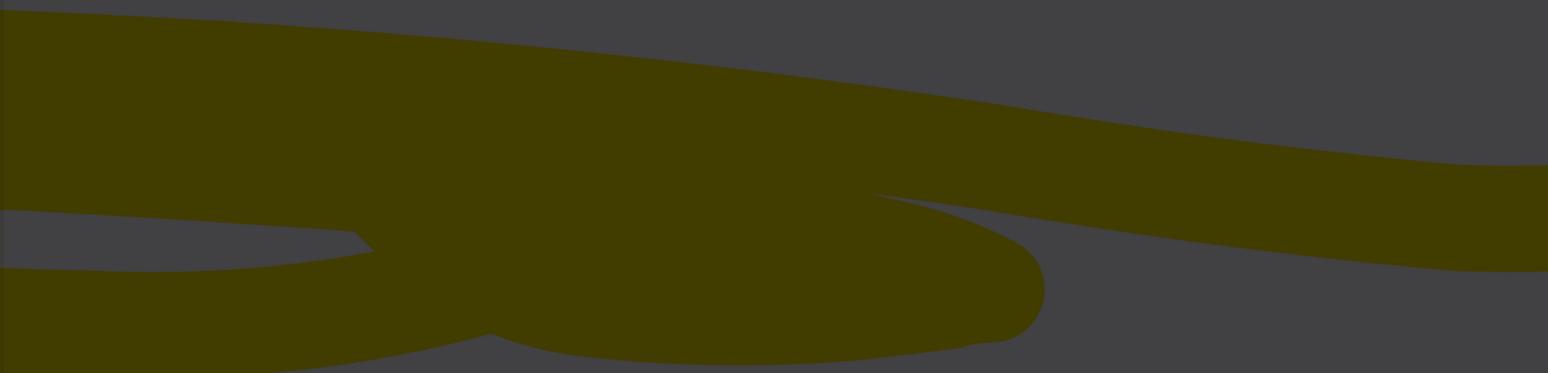
- Connecting and empowering families and the community to be involved in psychiatric services and care.
- Reaching out to other sectors, such as housing and education.
- Improving access to carer services and information for carers and family members.
- Integrating services.

And most importantly, we need to give carers hope. We can do this by using personal experience through peer support, and building carers' skills through information, education and support. A focus on empowerment, hope and self-determination is central to recovery from mental illness for both consumers and carers.

The choice is with the policy makers, the government, individual services and the community. So Australia, what are we going to do?



**RECOVERY
APPROACHES**
*in Principle
& Practice*



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HOW FAR HAVE WE ADOPTED RECOVERY-ORIENTED

by Helen Glover

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Director, Enlightened Consultants
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Although the mental health sector has much literature on moving service delivery towards recovery-oriented practice, we are still struggling to create the changes within service provision that people with a lived experience have told policy makers, funders and services, is helpful in reclaiming a life. Why is this so difficult? There are many reasons, all of them requiring us to re-examine the core principles on which we have built societal and service responses to those who experience episodes of mental ill-health.

This article attempts to highlight some of the opportunities available to re-orientate service frameworks, so that they can be fully used by people as they go about reclaiming their lives beyond the impacts of mental illness.

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**What does
recovery mean?**
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One of the challenges for systemic change is the term recovery in itself. Never has such a term created so much emotion, confusion, anxiety and debate among so many people, including those with a lived experience, family members, service providers, administrators, funders and policy makers. The term has many focal points and prevents more inquiry than it allows. There is no clear direction as to what services should uphold, change or resist. It is then not surprising to hear many mental health workers claim 'we do recovery', or 'this is not new'. On examination their practices remain firmly centred in people's lives, with people heavily relying on them to access their needs. One service leader claimed that because they worked in the community and were not a clinical service, they were, therefore, recovery oriented. Unless we get beneath the term to focus more clearly on the real implications for services, recovery will risk being used in name only.



SERVICE DELIVERY?

To become clearer, we must honour the origins of recovery knowledge, the collective wisdom from those that have struggled and triumphed over the impacts of mental illness. Research and published narratives informed by lived experience include Scottish Recovery Narrative Project (2013); LeCroy and Holschuh (2012), Deegan (2005: 29–35 and 1996: 91–97); Ridgeway (2001); Tooth (2003: 70–77); and Onken et al (2002); repeatedly attest to people's ability to self-right (Glover 2012) over adversity. Their wisdom reinforces and names the internal efforts to overcome the impacts of mental illness, efforts such as:

- Reclaiming identity.
- Taking control.
- Self direction.
- Self management.
- Taking risks.
- Making meaning.
- Finding connection and community.
- Renegotiating a life beyond illness.
- Living a life beyond service participation.

How to eradicate symptoms and attain the goals within the narratives receives little attention with more importance attributed to the people's recognition of their own self-capacity, role and mastery in creating the shifts, changes and reclaiming a sense of citizenship?

We are in an era of mental health service delivery where it appears that every clinical and non-clinical service has whitewashed programs intimating recovery, giving the impression that merely attending the programs will lead to recovery. Recovery is not a concept that can be owned and delivered by professionals, it is not a model of treatment, cannot be programmed, manufactured or even measured as a service outcome. The role of services, as Chris Munt (2009) states, is to 'have opportunities to avail myself of, in order to recognise my potential'. Services must stretch beyond eradicating and managing illness alone, to offer service environments and opportunities that are conducive for people to exercise and reclaim their capacity to self-right.

Paradigm shift in service delivery

Shifting mental health service delivery to align to a recovery orientation has been described by many as a paradigm shift, if not a revolutionary one. (See Barker: 2003, 6–102; Davidson: 2005 b, 5–26, and 2008); and Glover: 2003 and 2012.) Zucconi (2008) suggests that a genuine paradigm shift occurs only when the current way of understanding or responding to a problem is considered to be no longer useful or valid. It is difficult, if not impossible, for a new paradigm to uphold existing ways while adopting new ones.

Recovery-oriented service transformation requires us to challenge the very premise that mental health service provision has historically been organised around. If the premise underpinning service frameworks considers mental illness as permanent, life defeating, where people cannot reclaim their life from the impacts of mental illness, then services will be compelled to treat, shift, monitor, manage,

We recognise people live within social and political context where inequality exists, and therefore we work with people to advocate for social change.

We are a learning culture that works in ways that encourages and create opportunities for curiosity and innovation. We work in ways that recognise all people and situations are unique, and therefore our approach must be unique.

We understand that to discover, people may need to take risks, and have opportunities for these to be taken. We will resist limiting actions or interventions that prevent this.

We believe each person is the expert and change-agent in their own life. We work in ways to support people to act on this expertise and lead and direct the process.

We intentionally support people to live, love, work, and playing their own community and not within our service.

We will not abandon someone because of the complexity of the issues faced, and that an inability to provide useful support is a problem of the agency and not the individual.

Proactive Proposition developed by Anglicare Tasmania's
Community Services Team, 2012

and ultimately adopt responsibility for fixing this as a problem. Despite naming our services as recovery-oriented, the service experience will remain one of managed care, ultimately inviting a person to remain passive at the feet of service providers.

Much of our current mental health and social policies name programs associated with recovery. Yet on closer examination some of these programs may not be aligned to a true recovery orientation, especially if programs are designed to support people for life, require increasing amounts of support, and where others are expected to manage and monitor people's lives as a core focus.

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Recovery orientation
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A whole-system commitment, starting with a major policy shift and program focus, is required to fully realise a recovery-oriented paradigm shift. Funded programs that dare to name a recovery focus, need to commit to their understanding of working this way, such as following the statements below, developed by a team of community services managers.

Recovery-oriented service transformation is as much an active learning process for services, as individual recovery is for people who experience mental illness. I have been privileged to contribute to, struggle with, and learn from a number of organisations, committed to transforming their service frameworks to a recovery orientation.

Service transformation towards a recovery orientation does not come easily and requires constant vigilance. Workforce training alone is not enough to sustain the required paradigm shift. It requires a multi-dimensional organisational-change approach driven by leadership, ensuring policies, processes and programs align to the service commitment. Reflective practice, supervision and learning circles are helpful in supporting this transformation.

Programs and services that are committed to supporting people to reclaim a life beyond mental illness and beyond services:

- Recognise that working from a recovery orientation can happen at all times in all places with all people and does not refer to specific therapies, models, treatments or programs.

UNLESS WE GET BENEATH THE TERM TO FOCUS ON THE REAL IMPLICATIONS FOR SERVICES, RECOVERY WILL RISK BEING USED IN NAME ONLY.

Recovery is not considered a program within itself or tacked onto to the end of 'treatment'. Services acknowledge they have the potential to both enable and disable and do not just assume their relevance in people's lives. They are vigilant and reflective as to where service structures and processes may impede a person's self-righting, determination and management.

- Recognise the person as the expert on their life and resist inhibiting this by making decisions for people. Workers collaborate with people upholding the principle 'not about me without me'. Services work to resist having conversations about people, complete planning, reviews, or even make telephone calls on behalf of a person, without the person present.
- Value the importance of forming relationships that see a person beyond the experience of illness. They are prepared to go beyond, sometimes outside the square, to meet the person where they are at and resist responding to people through an illness relationship. Working from a recovery orientation does not wait for readiness but relates as if people are

already active in trying to meet their needs. Workers adopt an adult–adult relationship and resist parent–child interactions at all times.

- Acknowledge that services hold positions of power and are mindful not to exercise this power to coerce or manipulate people to their agenda. Such services recognise that while they cannot empower people, they can disempower through their actions. They acknowledge the importance of supporting people to recognise and exercise their own power and active sense of self in creating their desired shifts.
- Develop mechanisms that invite people into an active learning recovery space. Workers recognise the right time to do for, do with, do without and when to challenge. They understand that to do for people, because it makes them feel good, is easier; and that not believing the person can accomplish things themselves, erodes opportunities for learning and mastery. They adopt the role of coach, facilitator, educator (Roberts and Wolfson: 2004, 37-48), as opposed to being a care worker.

Creating a learning environment takes precedent over providing service interventions alone.

- Believe that each of us is responsible for our lives, despite a mental illness, but at times we may need support to hold that responsibility well. Services extend their focus beyond a risk management focus to support a person to master risk-taking behaviour as a key focus when working from a recovery orientation.
- Support people to live, work, love and play in their own community and resist replacing natural relationships with illness saturated/ service relationships and environments.
- Recognise the difference between service plans and personal recovery/ life plans, with life plans belonging to the person covering many things outside the scope of mental health service provision. Services may assist the person to determine a life plan, but resist taking ownership or copies of such plans. A service plan is built from what the person has requested help to master and what a service has the resources to commit to.

- Acknowledge that they are only one of many resources available to people in their recovery processes and do not invite people to meet all their needs within their environment.

In conclusion, as I have said previously (Glover: 2012, 31:)

'To hold space for a new paradigm to fully emerge will be uncomfortable, and from time to time systems of care will lose sight of their intent and retreat to what is more familiar within the existing paradigm. To not be seduced into this lull, services will be required to be constantly vigilant about questioning and testing whether the way in which services are being provided, ultimately enables or disables people's ability to reclaim a full life outside of the context of illness and service responses.'

THE PEER WORKFORCE – HOPE AND CONTAGIOUS RECOVERY

By Keith Mahar

*Peer Support Worker, Mental Health Advocate,
Activist and Social Worker*

Seventeen years ago, I came close to ending my own life in Toronto at the age of 33. I was experiencing symptoms of major depression and had recently been diagnosed with bipolar disorder.

I remember being curled in the foetal position on my bedroom floor in absolute despair, tears rolling across my face. Everything felt utterly hopeless. In this state of mind, I was absolutely convinced that I was never going to work or enjoy life again.

I was wrong.

At the end of 2007, I conducted a presentation on my experience of severe mental illness and recovery at the World Psychiatric Association International Congress in Melbourne.

Today, I am a mental health advocate, political activist and qualified social worker. For the last four years I have been employed as a peer support worker by Woden Community Service in the Personal Helpers and Mentors Program (PHaMs), a recovery-oriented psychosocial outreach support program funded by the Australian Government. To be honest, I am enjoying a more satisfying and productive life than ever before.

There is a certain irony respecting my career choice. When I first emigrated to Australia in 2001 with my Canberra-born partner Gail, I originally wanted to hide my experience of anxiety, depression and psychosis from as many people as possible. However, my plans fundamentally changed after coming across Mental Illness Education ACT and learning that sharing personal stories is an effective way to reduce stigma in the community and help others with mental health issues. Coming out of the psychiatric closet as a volunteer educator with the organisation proved to be empowering. It also gave me the opportunity to get to know a number of other

people diagnosed with mental illness and hear their stories. My understanding of mental illness and my perception of myself changed in the process.

The Mental Health Community Coalition of the ACT says that 'a peer recovery worker is someone who draws on and shares his or her own lived experience of mental illness and recovery to inspire hope and support others in their recovery journey'. This acknowledges the importance of hope and peer support, which are identified as two of the 10 Fundamental Components of Recovery in the 2006 National Consensus Statement on Mental Health Recovery, issued by the Substance Abuse and Mental Health Services Administration in the United States.

Hope is described in that consensus statement as 'the catalyst of the recovery process' and in the vernacular is defined as 'a feeling of desire for something and confidence in the possibility of its fulfilment'.

The transformative influence of hope and peer support is not an abstract concept to me, and I strongly advocate resources being targeted to further develop the peer workforce in mental health.

In a society where the dominant narrative of mental illness is distorted and overwhelmingly negative, raising awareness of recovery to individuals experiencing mental health issues and emotional distress is critically important for better outcomes. Studies clearly indicate that the news and entertainment media are generally not good at generating hope in this area. Queen's University Professor Heather Stuart, who is also Bell Canada Mental Health and Anti-Stigma Research Chair, has said, 'the media create and perpetuate mental health stigma and discrimination through repeated use of negative and inaccurate images' and this

results in significant negative consequences to individuals with mental health issues, including to their 'self-esteem, help-seeking behaviours, medication adherence and overall recovery' (2006: 99-106).

Lived experience counts

As a result, people with a lived experience of mental illness and recovery are in a unique position to inspire hope by sharing aspects of their own stories, helping others in their recovery process. I like to describe this dynamic as 'contagious recovery'.

According to a literature review by the University of Nottingham's Associate Professor Julie Repper and Research Assistant Tim Carter, a broad range of studies appears to suggest that peer support workers are able to increase self-efficacy and 'promote hope and belief in the possibility of recovery' more effectively than professionally qualified workers (2011: 392-411). This seems logical and is compatible with the human learning process offered by one of the most influential psychologists in history, Albert Bandura. In his work on self-efficacy, the David Starr Jordan Professor Emeritus of Social Science in Psychology at Stanford University writes: 'Unless people believe they can produce desired effects by their activities, they have little incentive to undertake activities or to persevere in the face of difficulties' (2010: 1-3). Bandura contends that 'social models' serve as a highly valuable source of information that can increase the self-efficacy of others. 'Seeing people similar to oneself succeed by perseverant effort raises observers' beliefs in their own capabilities,' he states.

While lived experience is the foundation for peer support work, individuals employed

in this role require a range of skills and knowledge. As a result, it is necessary for jurisdictions and organisations to specifically plan how to develop this specialist workforce. For example, the Mental Health Community Coalition of the ACT has formally recognised the valuable role of peer workers and is developing a framework to effectively develop and support this workforce. As part of this commitment, a Certificate IV in Mental Health Peer Support has been developed and pilot course trialled in the territory.

I encourage the Mental Health Council of Australia to progress the further development of the peer workforce nationally, in part by informing governments and organisations of the benefits of peer support and advocating for resources in this area.

In addition, it would be beneficial to help peer support workers develop facilitation skills. There are a number of excellent opportunities for peer-led groups, including the following, which I openly admit to being associated with in one way or another. These are:

- Coming Out Proud: a three-session group program focusing on the issue of disclosure for people with mental health issues. (For the manual and workbook, go to the resource page from the National Consortium on Stigma and Empowerment at www.stigmaandempowerment.org).
- Ending Self Stigma: a nine-session small group course to help people reduce and avoid internalised stigma related to mental health problems. (For more information, contact Alicia Lucksted, University of Maryland Medical School at aluckste@psych.umaryland.edu).

- PeerZone: 'a series of three-hour, peer-led workshops in mental health and addiction where people explore recovery and whole of life wellbeing' (as explained at www.peerzone.info).

Clearly, peer support workers do not have a monopoly on inspiring hope for people experiencing mental health problems. It is possible for every Australian to help by raising awareness of the reality of recovery. One way to do this is by sharing the personal stories of individuals whose experiences are in the public domain, such as Janet Meagher (see Janet Meagher's article), Ron Coleman, Dr Daniel Fisher and Patricia Deegan. All were diagnosed with schizophrenia. In addition, Mental Illness Education ACT's website includes stories at www.mieact.org.au.

One key feature of peer support is reciprocity. Although I share aspects of my lived experience to support others in their recovery, inevitably people I support end up inspiring me.

SHARING PERSONAL STORIES IS AN EFFECTIVE WAY TO REDUCE STIGMA IN THE COMMUNITY AND HELP OTHERS WITH MENTAL HEALTH ISSUES.

FUNDED PSYCHO- LOGICAL TREATMENT *in* PRIMARY CARE

by Prof Lyn Littlefield OAM
& Jill Giese

Australian Psychological Society,
Melbourne

Over the last decade, mental health reforms in primary care have enabled people with high prevalence mood and anxiety disorders to access funded psychological treatment. The huge community uptake of psychology services under these reforms has indicated a previously unmet need and has had a substantial impact on mental health within the community.

Better Access to Mental Health Care (Better Access), introduced by the Australian Government in 2006, has been the major program that has increased community access to psychological treatment for mental health disorders. The precursor program, the 2001 Better Outcomes in Mental Health Care (Better Outcomes), showed the success of providing funded psychological treatment in primary care settings.

Better Outcomes provided access to psychological services for people with high prevalence mental health disorders funded through the Australia-wide network of Divisions of General Practice (DGPs). The program enabled general practitioners to refer individuals to psychologists and appropriately-credentialed social workers and occupational therapists for evidence-based psychological treatment. Evaluation of the program showed a positive impact on consumers' functioning, symptom severity and/or quality of life (Morley et al, 2007). As a result of this success, community demand for psychological services increasingly exceeded the available funding provided to DGPs under the program.

Mental health in the 21st century

During the early to mid-2000s, the effectiveness of the Better Outcomes program increased interest in psychological treatment for high prevalence mental

health disorders in primary care. Around this time the release of a number of important reports also significantly raised the profile of mental health in Australia, including the Not for Service report (Mental Health Council of Australia: 2005) and the report from the Senate inquiry into the nation's mental health system, A national approach to mental health – from crisis to community (Commonwealth of Australia, 2006). In 2006, the Productivity Commission's report Australia's Health Workforce was released, identifying major community healthcare access problems and recommending an extension of Medicare rebates to make better use of non-medical health professionals in delivering health services (Productivity Commission: 2005). The publication of these influential reports led to the Council of Australian Governments (COAG) identifying mental health as an issue of national significance in 2006, and the Australian Government announcing a \$1.9 billion increase in funding for the mental health system.

Introducing Better Access

As a result of this new level of interest in the mental health needs of the community alongside the success of Better Outcomes, the Australian Government introduced mental health reforms in November 2006 under Better Access that included psychological services under Australia's Medicare system for the first time. Better Access was based on Better Outcomes, with services targeted to mental health consumers on referral from a medical practitioner for evidence-based psychological treatments delivered by psychologists and eligible social workers and occupational therapists. Mental health disorders that can be treated under Better Access cover clinically

diagnosable disorders based on the ICD-10 Primary Health Care version (World Health Organization: 2004).

When Better Access was first introduced, consumers were eligible to receive up to 12 individual Medicare-funded psychological services per calendar year. The referring medical practitioner could also consider exceptional circumstances in which the consumer required an additional six services, for a maximum of 18 individual services per consumer per calendar year. Consumers were also eligible to receive 12 group Medicare-funded psychological services per calendar year for treatment in a group. Funding cuts in 2013 have meant that a consumer can now only receive a maximum of 10 psychological services per calendar year under Better Access with no provision for exceptional circumstances.

Medicare-funded psychological services

There has been a huge community uptake of Medicare items for psychological treatment since Better Access was introduced in November 2006, with psychologists providing the vast majority of the services (over three million services per annum over the last three years (Medicare Australia: 2013). Millions of consumers have benefited from Medicare-funded access to psychological treatment since its introduction.

The Australian Government's 2011 evaluation of the Medicare-funded mental health program showed very favourable results (Pirkis et al: 2011). The evaluation confirmed consumers receiving services were those with moderate or severe symptoms and debilitating levels of distress mostly associated with anxiety and depressive disorders. With the psychological treatment, these moderate or severe levels of depression, anxiety and stress decreased to normal or mild

levels of these symptoms. Better Access was also found to be a cost-effective way of delivering mental health care.

The evaluation of Better Access also showed that it was reaching large numbers of people who had not accessed mental healthcare in the past. Modelling and surveys quoted in the evaluation report demonstrated that prior to Better Access, 35% of people with mental health disorders in Australia sought treatment and that this previously stable rate had increased to 46% since the introduction of the Medicare-funded psychological services (Pirkis et al: 2011).

The availability of psychological services through Australia's Medicare scheme has possibly contributed to a destigmatisation of help-seeking for mental health problems. The inclusion of mental health psychological services under Medicare has begun to promote mental health interventions to a similar standing as those for physical health services, which is an extremely important development.

The success of Better Access in providing effective, cost-efficient and accessible psychological services for Australians with common mental health disorders is clear. However, this effectiveness has required increased mental health funding and in 2013 under fiscal constraints the Australian Government cut spending by reducing the number of allowable services per consumer. Based on the Government's own figures, these cuts to psychological treatment services affect 87,000 Better Access consumers per annum (including 33,000 per annum who would have required additional psychological treatment under exceptional circumstances), who are no longer able to access the appropriate length of effective and cost-effective psychological treatment.

Conclusion

The Australian Government's mental health reforms over the last decade, and in particular the introduction of Better Access, have enabled millions of Australians with common mental disorders to access affordable, effective and cost-efficient psychological interventions in a non-stigmatising way through the nation's universal Medicare health scheme. This has been a huge advance for mental health within the Australian community and it is imperative that government funding continues to be provided to maintain these gains.

THE INCLUSION OF MENTAL HEALTH PSYCHOLOGICAL SERVICES UNDER MEDICARE HAS BEGUN TO PROMOTE MENTAL HEALTH INTERVENTIONS TO A SIMILAR STANDING AS THOSE FOR PHYSICAL HEALTH SERVICES, WHICH IS AN EXTREMELY IMPORTANT DEVELOPMENT.



FINDING A SUSTAINABLE FUNDING MODEL

by David Meldrum
Mental Illness Fellowship of Australia

Sources of funding for people affected by mental illness, including families and carers, were described in Australia in the May 2013 Medibank publication, *The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design*. The report highlights a major disparity between the Australian Institute of Health and Welfare (AIHW) estimate of \$6.3 billion per annum, based on the costs of specialised mental health services, Medical Benefit and Pharmaceutical Benefit Schemes, and real world whole-of-system costs estimated to be \$28.6 billion. While the report considered funding in several areas of government that support people living with mental illness, we would suggest there were still other costs not included.

Neither the current public and policy based discussion, nor the literature have addressed the need for Australia to adopt a model that sustainably funds the overall support required by people affected by mental illness and the people who care for them. There are some models across federal and state governments, but in general each acts in isolation, addressing one or more aspects of support; there is no whole-person model or even whole-of-life model.

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The 80:20 principle
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It is now widely accepted that about 20% of the necessary overall response to mental illness is of a mental health clinical nature, and the other 80% should be available through the physical health and recovery sectors plus a variety of housing, education, employment, family and other supports.

The WHO (World Health Organization) Pyramid of Optimal Mix of Services and our best current knowledge about recovery from mental illness tell us that long-term support should roughly align with this 80:20 principle, so that mental health clinical services are not left to be the main basis of ongoing support, and that people affected by mental illness are offered the same broader opportunities as those people with other types of need, from experts in those fields.

This is particularly true of other parts of the health system. People with severe and persistent mental illness experience extremely poor physical health compared to the general population, but lack equitable access to key services addressing such issues as obesity, tobacco use, diabetes, respiratory health and cardiovascular diseases.

In 2001 the Western Australian report, *Duty to Care –Physical illness in people with mental illness*, stated that people affected by mental illness had higher death rates than others in the community including in cancer, stroke and respiratory disease and there is a growing interest in the poor physical health of people with severe mental illness, and the reduced life expectancy they can expect of up to 25 years. Sustainable models to achieve better outcomes for people with mental illness must include the additional costs of providing these health services, along with other costs of re-alignment in housing, education, employment, family support and other service systems.

Several commentators have quoted that mental health receives about 8% of the health budget, as the Royal Australian and New Zealand College of Psychiatrists indicates in its 2010 *Mental Health Deserves a Better Deal* blueprint for improving the lives of people affected by mental illness. The AIHW estimated in 2007 the total burden of disease for people with mental illness was 13%. The need for increased investment is obvious, but it is important to remember that much of this should not be in the mental health sector of health, and that this figure does not include any non-health costs.

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Better understanding and funding

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The current development of the National Mental Health Services Planning Framework will lead to a comprehensive map of the health sector service types that a person living with mental illness, and those who care about them, might require across a lifetime. The exercise has highlighted those services delivered in the hospital or outpatient environment and those outside of this, in the predominantly non-government recovery sector. Most importantly, the framework identifies the level of skill and training required to ensure adequate numbers of well-prepared workers to offer this support, including the role of peers, which will lead to a better understanding of the key driver of cost – that is, the workforce.

The FaHCSIA (Families, Housing, Community Services and Indigenous Affairs) funded Peer Helpers and Mentors Service (PHaMS) is a good example of a service that seeks to support people as they set and attain their personal recovery goals encompassing social as well as education and employment outcomes and to be as active in their communities as they wish. Uniquely, the program does not require a clinical

standard of diagnosis to enter, and in fact works with people that had previously been considered hard to reach due to their mental illness, their living conditions or their distrust of conventional clinical care. Its costs are modest (about \$8000 per participant) and its outcomes appear to deliver good value for money with people with moderate to severe mental illness.

For people with severe and persistent mental illness, some relief will arrive as the National Disability Insurance Scheme – now called DisabilityCare Australia (DCA) – is gradually rolled out across the country over the next several years. This will be restricted to non-health matters, but will be most welcome nonetheless. However, the emerging eligibility criteria suggest that only those with the most severe and persistent mental illnesses will have access to the scheme, which is some fraction of the total need. For people who are not eligible, the sources of assistance will be as complex and unsustainable as ever, in some cases almost impossible to access given regional inequities, and major gaps in service, especially regarding the largely unmet needs of minority groups.

A major new service, Partners in Recovery (PIR), is about to begin operating across

Australia. Many regions, delineated by the Medicare Local boundaries, have formed consortia of agencies to assist the people most in need of support when living with a severe and persistent mental illness, with complex multi-agency needs. Rather than replacing existing services, PIR will focus on breakthrough collaborations across all the sectors that bear on each individual's chances of building a pathway to a better quality of life—recovery in that sense – including clinical mental health and physical health, family support, welfare, justice, education, employment and others as required.

The total costs attributable to each individual's package of services will be difficult to track across so many agencies, but capturing this data from PIR will be an important aspect of working toward a better understanding of the overall resources required.

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Crisis, coordination and navigation

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The state mental health systems are continually characterised as overburdened in supporting people with severe and persistent mental illness. State systems and the hospital sector tend to be the resources sought first at times of intense need, when people

with severe and persistent mental illness are at high risk. All sectors, including a well-resourced community recovery sector, must contribute to supporting people during periods of acute illness, and in finding the way back to a recovery-oriented life. The National Mental Health Services Planning Framework has grappled with these issues to ensure that, despite acute illness, choices can be offered to reduce the need for inpatient and/or intensive clinical supervision. Their work is beginning to map out those choices, and their likely costs.

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Research and prevention

These examples of on-the-ground practical support for adults with moderate to severe mental illness do not address the need for evidence-based good practice, and prevention strategies that may in time reduce the number of people who are severely disabled by mental illness, both initially, and through the course of their life. The sector requires a greater emphasis on researching prevention strategies that will limit the downstream effects of mental illness but also show a commitment to more thorough investigation of what works now.

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Conclusion

Working towards a sustainable response to mental illness in Australia involves two main elements:

- Understanding the components that make up the whole range of supports required.
- Understanding their costs.

Some of that costing can be done well now; some needs a much better coordinated collection of relevant data.

Key attributes of a sustainable system that can begin to understand its costs will be:

- Accessible and well-resourced crisis services that respond to urgent mental and physical health needs.
- Intensive resourcing of coordination strategies like pir, to join up the dots for the highest-need individuals, and lead to a better understanding of the total cost of support required.
- Further development of the publicly-funded recovery sector, with a remit to work with moderate to severe mental illness as well as severe and persistent mental illness requiring complex multi-agency responses.
- Full inclusion of people with mental illness, especially severe and persistent mental illness, in all the targeted resources aimed at high need/risk

groups for all relevant health, welfare, social services, employment, justice and education services.

- Evidence-based good practice and prevention strategies to reduce the future burden on individuals, families and the community.

The mental health sector, the general health sector and the community care and research communities all appear to agree that people affected by mental illness, particularly those experiencing severe and persistent mental illness, need more support than that currently available. Several new initiatives, including PIR and DCA, go some way to ensuring a more equitable distribution of health and other dollars. However, advocates for people affected by mental illness must continue to highlight the much broader funding and policy priorities that still leave in place widespread barriers to attaining good mental and physical health. Mental health dollars will never be more than a partial response to the need.

We know that many people with mental illness and/or emotional distress are the people most likely to fall between the gaps in Australia's complex human service systems. People with intricate, diverse health and social problems, including high levels of psychosocial disability, can become more disadvantaged and even traumatised and re-traumatised by the very treatment, rehabilitation and support services intended to help them recover.

It is clear that the increasingly complex and disjointed mix of health and community services seeking to respond to the needs of people with mental illness or distress is poorly coordinated. Consumers and carers often describe how difficult it is to access the care that they need and consistently navigate the mental health system when they need it (Durbin, J, Goering, P, Streiner, DL and Pink, G: 2004, 279). They report that they often feel overwhelmed and disempowered and that services are 'fragmented' (Ehrlich, C E; Kendall, E; Muenchberger, H and Armstrong, K: 2009, 619-627; Bodenheimer, T: 2008, 1064-71).

One consumer said, 'The agencies are out there – you just wouldn't believe how many are out there – but they are not working together! There is no hub for the spokes of the wheel' (MHCC: 2012, 16).

A service provider said, 'I think there is a lot of skill involved in care coordination. I think it is sort of one of those aerosol [throw out] terms that everyone is expected to know what it means and know how it is done but just to work alone, that takes skill, but to work with other people takes a lot of skill and to work with different people,

different organisations with philosophies, different backgrounds ...' (MHCC: 2012, 16 Interviewee 9).

In discussing the four priority areas for action for achieving 'a contributing life', the National Mental Health Commission (NMHC) states that: 'we need to see where

living with a mental health difficulty, there needs to be an integrated and co-ordinated mental health service system in place' (2012: 81).

The revised National Statement on Mental Health Rights and Responsibilities states that service providers

The mental health sector in Australia consists of public/government, private for-profit and not-for-profit non-government community-managed organisation (NGO/CMO) service providers with multiple layers of Commonwealth and state/territory government policy, planning, and funding levers. The emergence in mental health service delivery of the new primary healthcare Medicare Locals, including as population health planners, will also bring an additional – but much needed – layer. This is the result of past and current ad hoc mental health planning despite 20 years of a national mental health strategy, and of a failure to effectively support the implementation of policy to practice.

The diversity of workers in public, private and community sectors across primary, secondary and tertiary levels of care is a challenge in itself. Each of these workers has been trained in different disciplines often with opposing philosophies and practice methods (Norman, I J and Peck, E: 1999, 217-230; National Health Workforce Planning Research Collaboration: 2011). The resulting knowledge, skills and attitudes are so different their impact on practice can lead to conflict and other barriers to collaborative care.

Contemporary concepts of coordinated and integrated mental healthcare and related actions were first introduced in the Council of Australian Government's National Action Plan for Mental Health 2006-11, specifically, Strategic area 5 – Care coordination (COAG: 2006) and Fourth National Mental Health Plan 2009-14, Priority area 3 – Service access, coordination and continuity of care (Commonwealth of Australia: 2009).

PRACTICE SKILLS FOR COORDINATED + INTEGRATED SERVICES

by Jenna Bateman

Chief Executive Officer

& Tina Smith

Senior Policy Officer

MENTAL HEALTH COORDINATING COUNCIL

the gaps are ... to see mental health as a coordinated and integrated system' (NHMC: 2012, 14). In considering 'What we know' about achieving a contributing life, the Commission goes on to say that it: ... 'believes that to ensure effective support, care and treatment for people

should 'expect that social, health and mental health services will be integrated and coordinated while retaining their specialised focus, identity and funding' (2012, p21). However, this is far from what is happening (Commonwealth of Australia: 2012).

Unfunded, they are also still largely unrealised. While the changes and activities to coordinate are now better understood at a systems and structural level, the practice skills for such coordination are not.

In 2012, the Mental Health Coordinating Council (MHCC) researched how to better understand service fragmentation from the consumers, carers and service providers' point of view. This research focused on the workforce competencies, skills and attitudes to support both client self-directed care coordination and work coordinated with other service providers. Through this research, and also an earlier literature review by the MHCC, it is clear that the structural aspects of integrated service delivery (i.e. Service Agreements, Memorandum of Understanding and so on) are better understood than practice skills and the workforce developments required to achieve those skills (MHCC: 2011).

'A common assumption is that workers already have the skills needed to deliver the specified outcomes, and there is a lack of understanding of the support and training workers require', the Australian Health Workforce Advisory Committee (2005) has argued.

In addition to identifying the skills, knowledge and attitudes for good service and care coordination, MHCC's research also identified important reasons why such attempts have often failed to better support consumers and carers. Interviewees identified:

- Lack of recognition that service coordination takes resources, time and skill.
- Job descriptions and funding formulas failing to recognise that service coordination is a practice.

- Too large caseloads and lack of clarity about who is responsible for coordinating care.
- Ineffective relationships between community, hospital and primary healthcare providers including not speaking the same language and not appreciating what other services contribute.

education and training – must embed and teach not just the skills required for recovery-oriented and trauma-informed practice but also those for effective service coordination. Professional development opportunities within – and across – all mental health settings and work roles,

enough to change the way they operate (Battersby, Lawn, Wells, Morris, Wong, Lindner, Mathews, Reed and Litt: 2008). There also need to be changes at systems, organisational and individual levels (Productivity Commission: 2005; Battersby et al: 2008); these factors will impact how training can go on to become practice (Battersby: 2008).

The government's 2011 commitment to fund the new national Partners in Recovery (PIR) mental healthcare coordination initiative is commendable and programs commence in July this year. The planned PIR evaluation strategy provides an important opportunity to explore and further develop understanding of the practice skills needed for effective service coordination. Likewise, DisabilityCare Australia will open the way to explore the interface between complex health and psychosocial disability programs and services that encourage the consumer to navigate and coordinate their service needs and options.

Mental health (and other complex health and social issues, including substance misuse) service delivery sits squarely at the interface of the health and disability and community service sectors. Failure to address the enormous and growing gap between these sectors will result in our most vulnerable Australians continuing to fall between the cracks. The development of the respective health and community and disability workforces needs to follow the same direction; including better recognition and focus on the practice skills of individual workers and teams to more effectively coordinate services across service settings.

should be informed by the competencies and capabilities required for coordinated delivery of human services.

It must, however, be reiterated that while worker education and training is important to improving delivery of services, it is only one level of the system and in itself will not be

IT IS INCREASINGLY EVIDENT THAT HIGHER EDUCATION PROVIDERS IN BOTH UNIVERSITY AND VOCATIONAL EDUCATION AND TRAINING SETTINGS MUST EMBED AND TEACH NOT JUST THE SKILLS REQUIRED FOR RECOVERY-ORIENTED AND TRAUMA-INFORMED PRACTICE BUT ALSO THOSE FOR EFFECTIVE SERVICE COORDINATION.

- Obstructive approaches to confidentiality and privacy specific to the mental health sector.
- Misconceptions about the nature of recovery and the principles of self-directed care (MHCC: 2012, 45).

It is increasingly evident that higher education providers – both university and vocational



STRENGTHENING THE INFORMAL COMMUNITY CARE NETWORK

By Dawn O'Neil AO

*Social and health policy consultant,
specialising in governance, strategic
and organisational development
and change management*

AN UNWELCOMING OR HIGHLY BUREAUCRATIC FIRST ENCOUNTER WITH FORMAL SERVICES MAY DISCOURAGE FAMILIES FROM FURTHER ATTEMPTS, LEAVING THEM ISOLATED AND VULNERABLE.

PEOPLE WITH A MENTAL ILLNESS OR SUICIDAL CRISIS DO NOT LIVE IN VACUUMS. THEY ARE USUALLY PART OF FAMILIES, FRIENDSHIP NETWORKS AND COMMUNITIES AND THESE CAN BE ASTONISHINGLY HELPFUL AND OFTEN CRUCIAL TO RECOVERY.

Yet, policy makers have long underestimated the work of informal and community-based mental health and wellbeing activities. Further, service design can overlook the seemingly obvious task of considering what is needed for good mental health.

Although this is beginning to shift, formal recognition in government policy remains limited and there is minimal investment in community engagement and informal community care compared to the billions of dollars invested in direct services, such as hospitals and acute care.

We speak of the mental health system but no coherent system is in place. It is noted that the National Mental Health Commission's A Contributing Life: the 2012 National Report Card, does not talk about the mental health system. Yet there is growing recognition that deficiencies in system design are critical, especially as there has been little serious work to remedy this.

In addition, it is clear that national and state and territory policies need a clearer understanding of how the informal and formal sectors can more effectively cooperate. This requires recognising the crucial roles families, friends and community organisations play and what further investment at these grassroots levels could achieve, rather than implying services alone can meet Australia's growing mental health needs.

For example, we know that by changing thinking and behaviour (e.g. Cognitive Behavioural Therapy) we can greatly improve mental health and wellbeing and prevent mental illness. Yet these therapies often remain available only to those with the funds and networks to access them. Much could be done to make this knowledge more available, through investment in new technologies or by democratising the science, and no longer restricting it to professionals. These skills should be practised and shared in the community.

Despite knowing that trauma, abuse and neglect, particularly in the early years, can contribute to later mental illness, most investment has gone into treatment, rather than prevention or early intervention. We spend more than \$28 billion in direct health and non-health expenditure to support people with mental illnesses. This does not include indirect costs, such as lost productivity, a very real burden that many businesses are just beginning to come to grips with. This staggering figure is unlikely to diminish without drastic change.

Shift in spending required

If Australia were to spend just one of those billions on building on the strengths of families, neighbourhoods and communities, much progress could be made towards meeting a widespread need. Those working in the informal sector know much more investment in community-based care, in addition to mental health and wellbeing services, is needed.

There is much untapped potential. Families often wish to contribute, but either feel helpless or that the system does not allow them a role and sometimes shuts them out deliberately. An unwelcoming or highly bureaucratic first encounter with formal services may discourage families from further attempts, leaving them isolated and vulnerable.

This pattern is repeated for community groups, which are often extensions of family support networks, but are not well integrated into a complicated sector that is dismissive of informal care.

In 2009 the World Health Organization (WHO) produced as a part of a mental health and service

THE GAP IN OUR SERVICE DELIVERY SYSTEM, WHERE THE BURDEN OF CARE MOST HEAVILY FALLS, IS ACROSS THE ENTIRE LOWER PORTION OF THE SERVICE PYRAMID, WHERE HUNDREDS OF THOUSANDS OF AUSTRALIANS STRUGGLE TO CARE FOR THEMSELVES AND EACH OTHER, WITHOUT FORMAL SUPPORT.

guidance package a document entitled Improving Health Systems and Services for Mental Health (WHO: 2009). It defined self-care and informal community care as parts of the services system:

'Most people manage their mental health problems themselves, or with support from family or friends. Self-care is thus the base of the service pyramid, upon which all other care is based. Self-care is most effective when it is supported by formal health services. The formal sector has an essential role in providing information such as how to deal more effectively with stress, the importance of physical activity in staying mentally well, effective ways of dealing with relationships and conflict management, and the dangers of hazardous alcohol and drug use. Self-care should be facilitated through all services and at all levels of the WHO service pyramid.'

Australian policy is largely silent on what an optimal service mix should look like. The National Mental Health Commission adapted the WHO framework to combine self-care and informal family and community care, while spreading community mental health services among primary care and family counselling and support services, as well as within the informal group. This, however, does not truly

clarify a useful service mix and the role of self-care, informal supports and other community wellbeing efforts. A more serious analysis of system design is needed.

Most mental health and suicide prevention policy over the past decade or more has referenced the Mrazek and Haggerty spectrum of mental health interventions, but this has not been translated into any kind of service system design. In recent years there has been a shift in understanding about the importance of community-based care and in government policy and spending towards youth, with the establishment of the headspace consortiums. These resulted from Dr Patrick McGorry's work (see his chapter in the book), among other place-based policy and funding changes, such as the establishment of Medicare Locals.

There is also general agreement by the sector and government that acute care investment is unsustainable. This alone necessitates a shift towards the community, though what such a service system should look like has not been articulated or agreed on.

Australia's mental health, suicide prevention and other support services have emerged in an environment of funding silos and in the absence of a clearly articulated service design. Therefore, there is no clear logic or basis for estimating the size of each service response and the required scale.

To meet immediate and future needs and encourage policy shifts and consequent funding decisions, we must rethink an optimal system design for Australia.

In October 2012, the first ever Council of Non-Government Organisations on Mental Health (CONGO) brought together organisations in the mental health and associated sectors to pursue shared outcomes and system-wide improvement. A range of key agreements were reached and summarised below in the briefing paper sent to all participants in December 2012:

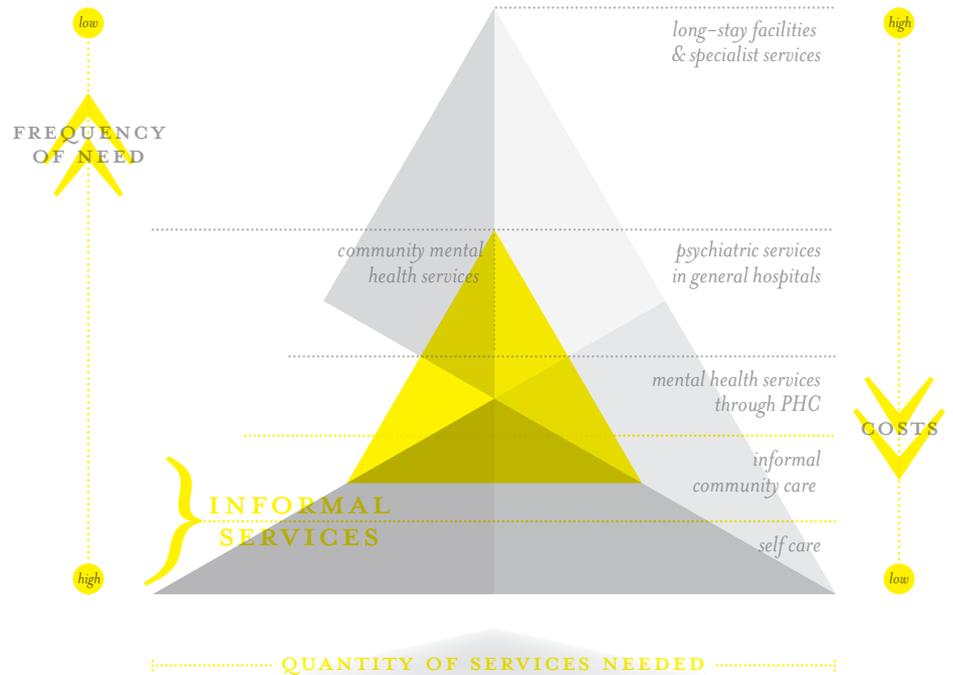
'The gathering committed to establishing a national vision for Australia to lead the world in mental health by 2022, so that within 10 years Australia is acknowledged internationally as a world leader in mental health services, programs, and outcomes.'

CONGO members overwhelmingly agree that gains in new spending and the re-prioritisation of mental health by governments has not, as yet, resulted in lasting improvements for people affected by mental illness or their carers. The change is still too slow and the demand for services still significantly more than we can provide for people who need them. Fragmentation and a lack of coordination across the many systems that people need are uppermost in the range of factors impeding potential gains in new spending and slowing momentum towards successful outcomes for people with lived experience.

A lack of coordination between NGOs, businesses, governments and within jurisdictions is leading to fragmented decision making and lack of clarity regarding respective roles and responsibilities. As a result, service delivery remains uneven and inequitably spread across Australia. In this environment, the need to address socioeconomic factors in health and social care is an aspiration as yet unrealized' (CONGO: 2012, 11).

In Australia, the vast majority of our national spend on mental health is invested in the specialist psychiatric and inpatient services that sit at the top of our pyramidal system. Yet we know that only a fraction of people who experience mental illness ever use these services.

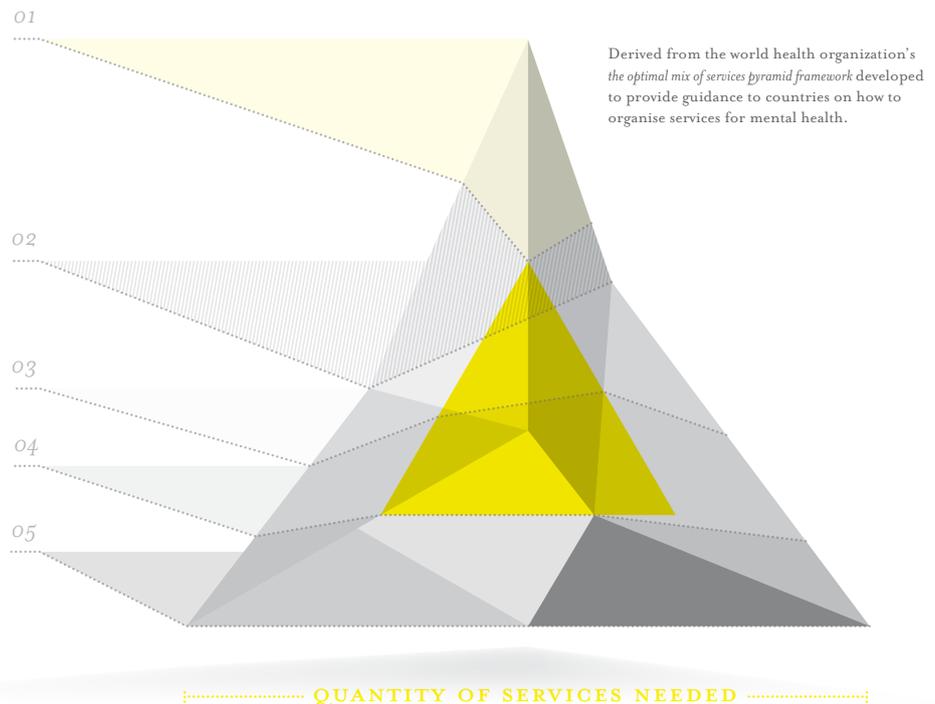
Current gap in Australian service design & policy



Most, if they receive any specialist support at all, will do so through the doors of general practice, or else find connections with those under-funded community organisations who struggle to meet demand across the middle of the service pyramid.

The gap in our service delivery system, where the burden of care most heavily falls, is across the entire lower portion of the service pyramid, where hundreds of thousands of Australians struggle to care for themselves and each other, without formal support. There are almost no resources being invested in this informal system of care. This disparity is shown in the accompanying diagrams.

The challenge ahead is to shift our efforts to where services and supports are most needed and for better collaboration between informal and formal activities to maximise our current and future effectiveness. Poor mental health and wellbeing in an increasingly complex world is going to place enormous demands on our current public health systems if we do not have a clear system design in place, which draws on all its resources.



- 01 forensic/intensive care
- 02 specialist services
- 03 community mental health services GPs, primary care, early intervention
- 04 professional non-clinical care, counselling personal support, housing support, family support
- 05 ourselves, family, friends, community employers, co-workers, promotion & prevention

STIGMA/ DISCRIMINATION /AWARENESS

by Jack Heath

Chief Executive Officer, SANE Australia

& Kate Carnell AO

Chief Executive Officer, beyondblue

SANE Australia and beyondblue acknowledge
the contribution to this article of Carolyn Nikolski,
Nick Arvanitis, Paul Morgan and Clare Shann

.....
'The stigma of mental illness is, in some ways, worse than the illness itself. Unless the stigma can be removed to such a degree that it does not become a barrier to acknowledgement, treatment and hope for the future, the reduction of [the impact of] some mental illnesses will be nothing but a pipe dream.'
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People living with a mental illness

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Stigma and discrimination are major barriers to recovery for many people affected by mental illness and their carers.

The relationship between the two is close: stigma is a primary cause of discrimination. It is the perception that a group of people is less worthy of respect than others and shares characteristics with other forms of prejudice, such as racism and homophobia.

Stigma against people with a mental illness may involve inaccurate and hurtful representations – for example, being perceived as violent, comical or incompetent, and being feared or ridiculed. It may be associated with social or cultural stereotypes; it may also be unintentional and result from a genuine lack of understanding about mental illness.

Inaccurate and negative attitudes and discriminatory behaviours towards people affected by mental illness inhibit social inclusion. As the person living with a mental illness suggests, many people report that the experiences of stigma and discrimination associated with mental illness can be as bad as, or worse than, the symptoms of the illnesses themselves.

Stigmatising attitudes cross all facets of life – people with a mental illness, and their carers, report that stigma can prevent them using health services; limit their access to employment, housing and insurance; and impact on

personal relationships. There are many different types of stigma, which include:

- Personal stigma – a person's stigmatising attitudes and beliefs about other people ('people with depression should snap out of it').
- Perceived stigma – a person's beliefs about the negative and stigmatising views that other people hold ('most people believe that a person with depression should snap out of it').
- Self-stigma – the stigmatising views that individuals hold about themselves ('I should be able to snap out of my depression').
- Structural stigma – the policies of private and governmental institutions that restrict the opportunities of people with mental illness ('mental health services and research don't deserve as much funding as other health problems').

Efforts to reduce the stigma and discrimination affecting people with a mental illness should support broader anti-discrimination strategies. This is an important part of acknowledging and responding to the complexity of stigma and discrimination, and the impact that multiple forms of stigma and discrimination can have on people's mental health and wellbeing.

Working to reduce stigma

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Evidence suggests there are two major strategies to reduce stigma:

- Educational approach, which provides people with information resources that challenges inaccurate stereotypes and replaces them with factual information.
- Contact-based approach, which facilitates personal contact with people with a mental illness.

Community attitudes towards people affected by mental illness have certainly improved in recent years. The work of beyondblue has changed social attitudes towards depression, and encouraged high-profile people with depression to speak publicly about their condition and how they manage it. This has contributed to a growing normalisation of depression as part of the everyday human experience, rather than something which is kept quiet and is seen as shameful.

Portrayal of mental illness in the media also plays a major role in determining public attitudes towards mental illness. Therefore, to influence public attitudes it is important to improve the way the issue is reported and represented in the media. The Australian Government's Mindframe initiative has a comprehensive approach to this challenge. The SANE Media Centre and StigmaWatch program are integral to it, taking a positive approach to educating and working with the media – filmmakers, scriptwriters, TV, radio and online producers/journalists, as well as staff working on magazines and newspapers. Much of SANE's work in this area is conducted behind the scenes, ensuring that stigmatising attitudes do not appear in the media in the first place.

Limitations of legislation

Direct discrimination towards an individual because that person has a disability (including mental illness) is unlawful under the Disability Discrimination Act 1992. This relates to the equal access of provision of services such as employment and education. In employment especially, many people report they have been treated unfairly and even sacked or forced to resign after an episode of mental illness.

However, widespread lack of knowledge and understanding about the Act, and the difficulty of proving a case, as well as the stress involved, mean that this legislation has been of limited use to people with mental illness. The provisions of the Act are also limited in that there is no protection for people who have experienced stigmatising practices, behaviour or attitudes. While it is unlawful to vilify or publicly invite contempt for people on the basis of religion, gender, culture, or sexual preference, it remains legal in most states to do this on the basis of someone having a mental illness or disability.

A long way to go

Reducing the stigma and discrimination associated with mental illness is one of the key aims of Australia's national mental health policy and reform agenda and of organisations like SANE Australia and beyondblue. Yet despite this, and despite significant improvements in awareness of common mental illnesses such as depression and anxiety, we have not seen commensurate changes in stigmatising or discriminatory behaviours. Public attitudes towards people affected by mental illness remain complex, and there is still widespread misunderstanding regarding many mental health conditions. Stigma towards people affected by conditions such as schizophrenia is particularly resistant to change, and improves only slowly.

Charting the direction

To reduce stigma effectively, research has shown that a comprehensive, long-term, collaborative and multi-sectoral approach incorporating the two major strategies is needed. This approach should be based on the reported experiences of people with a mental illness,

and their carers, and include:

- Conducting research to determine the best way to deliver stigma-reduction strategies that include contact and educational approaches, in a sustainable and ongoing manner.
- Continuing to work with traditional and new media to promote accurate and positive reporting and portrayals of people living with depression and anxiety, with a particular focus on personal stories.
- Facilitating personal contact between people who have experienced mental illness, and others who have not – in line with recommendations that contact is targeted, local, credible and continuous.
- Developing and delivering educational approaches, which promote attitudinal change, challenge inaccurate stereotypes, and replace them with factual information.
- Delivering interventions that reduce stigma and discrimination in multiple settings – for example, workplaces, schools, housing/accommodation services and healthcare centres.

In summary, a combination of well-funded, sustained, nationally-led (top down) and locally-driven (bottom-up) contact-based approaches, which are targeted to key groups and settings, seem to offer the most promising way forward in stigma reduction.

**IN SUMMARY,
A COMBINATION
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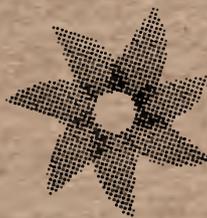
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