



The peak organisation representing the non-government mental health sector in Tasmania at a state and national level

Response

Referral to community sector mental health services Discussion paper

25th August 2010



The Mental Health Council of Tasmania has a vision for a vibrant and effective mental health sector in Tasmania.

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The Mental Health Council of Tasmania (MHCT) is the peak body representing the interests of consumer, carer and community mental health sector organisations, providing a public voice for people affected by mental illness and the organisations in the community sector that work with them.

The MHCT advocates for effective public policy on mental health for the benefit of the Tasmanian community as a whole and has a strong commitment to participating in processes that contribute to the effective provision of mental health services in Tasmania.

The MHCT welcomes the opportunity to provide comment on the discussion paper “Referral to community sector mental health services”. The paper outlines five options in referring people wishing to access supported accommodation, residential rehabilitation and recovery programs, as provided by Richmond Fellowship of Tasmania Inc, Anglicare, Aspire, Caroline House and Langford Support Services, via the Maximising Recovery Panel (MRP) process.

It will be an imperative to consider the recommendation from the MHCT and its members in line with Australian Government Health Reforms.

Option one – maintain the status quo – current system of referral continues to operate without amendment.

Option two – amend the current system of referral to address primary issues of concern.

Option three – dedicated co-ordination of referral to mental health community sector services by a responsible person within Mental Health Services (MHS).

Option four – direct referral to community sector organisations with system for monitoring and reviewing referral outcomes.

Option five – referral via an assessment team process.

From the five options outlined above the MHCT **endorses option four** to be utilised for referral to the community mental health sector services.

This referral pathway would allow all consumers of mental health services and potential consumers of mental health services to directly refer themselves. Consumers are the experts in identifying their own needs which need to be met. This option would also allow for consumers outside of the MHS to access the community mental health sector services. It would enable those consumers who have not had an admission to a psychiatric facility to access the community mental health sector services.

This option follows the principles of prevention and early intervention, whereby the consumers of mental health services are able to identify when they require access to recovery based community mental health sector services. It would also allow for flexibility for consumers to move between supported accommodation, residential rehabilitation and recovery programs. The MHCT supports the concept that consumers do not always require case management involvement in their recovery process. Consumers are able to self determine and this option would allow this to happen.

The MHCT cannot support option one (maintain the status quo) due to the issues which currently exist with the process. These include the consumer has to be receiving a service from MHS and have a case manager; lack of consistency in operations of MRPs across the regions; uncertainty of criteria for referral to MRP; consumers not having their needs met and community mental health sector services are not able to assist consumers in their journey; consumers have to have had admission to a psychiatric facility before being considered by MRP for assessment; no provision for early intervention; time delay for consumers when referred to MRP and then assessed by MRP for suitability for service; consumers left out of the process – no consumer and carer representatives on MRP, despite a commitment from MHS; community mental health sector services experience lack of communication from MRP.

Option two outlines amending the current system of referral to address primary issues of concern. The MHCT cannot support this option because it still excludes consumers outside of the MHS and still includes all consumers requiring a case manager from MHS.

Option three suggests the co-ordination of referral to community mental health sector services by a responsible person within MHS. The MHCT cannot support this option because there is a risk management issue with one person from each region taking on this responsibility. There is no point of accountability or grievance process outlined. This option still excludes consumers outside of the MHS and still includes all consumers requiring a case manager from MHS. The perceived power still sits with MHS, whereby MHS maintains control of the referral process.

Option five outlines a referral to MRP via a team assessment process. Assessment teams would operate within each region and would comprise of existing staff of MHS. The MHCT cannot support this option because it again excludes consumers outside of the MHS and again stipulates all consumers require a case manager from MHS.