Whole-Of-Person, Whole-Of-Life
Submission

Rethink Mental Health Project:
A long-term plan for mental health in Tasmania

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PREFACE

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

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.

Mental illness continues to be a significant public health concern. In recognition of this, over the past decade, both the Tasmanian and Australian Governments have increased the level of funding to the mental health sector. However, with ongoing workforce problems, persistent stigma and inadequate provision for early intervention and prevention, combined with an ad hoc approach to the funding of programs in the community, the extent to which the increased investment has yielded improved health outcomes is questionable. According to the National Mental Health Commission Chair, Allan Fels, in his address to the National Press Club on 1 August 2012:

> … while I believe that Australia has a good health system by international standards, it has two profound weaknesses: mental health and Indigenous health, to which mental health is a very significant component. Mental health needs to be a higher priority for governments and the community at all levels.[1]

Professor Allan Fels is right and part of this work of bringing mental health services provision into the 21st century must be the development of effective public policy and its implementation to foster wellbeing and pathways to a connected and participating life for those living with mental illness.

For this reason, MHCT welcomes the Tasmanian Government's commitment to the Rethink Mental Health process with the objective of the development of a long term plan for mental health in this state. We applaud the Government's highly consultative approach across the spectrum of stakeholders, including consultations with consumers, their families and carers, clinicians, service providers and other key stakeholders. We also welcome our role in this project, working in partnership with the Mental Health, Alcohol and Drug Directorate and thank all of those we have consulted with, consumers, carers and the community mental health sector.

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[1] Website: http://theconversation.edu.au/national-press-club-address-allan-fels-on-mental-health-and-suicide-prevention-8567

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Introduction

It is with some consternation that we note that the same issues have been repeatedly identified as priorities for action in the provision of mental health services across Australia time and time again. There have been many reviews and reports at both federal and state levels and again and again we are left with 'available data point to policy implementation failure, or partial or inconsistent implementation.'[2]

The Tasmanian community is still waiting for the level of community mental health support which was promised with the closure of the Royal Derwent Hospital in New Norfolk 15 years ago. It has been shown that 15 per cent of the Tasmanian population experience mental health issues in any given year which is 2.6 per cent more than the Australian average.[3] In addition to this Tasmanians experiencing complex psychosocial disability make up approximately 3 per cent of the total population.[4] Evidence suggests that the social determinants of health including poverty have a huge impact on people's mental health and in turn their ability to access treatment[5] and over half the population of Tasmania is categorised as having lower socio-economic status, nearly double the percentage of the Northern Territory.[6]

MHCT is particularly concerned at the fragmented approach to the mental health of children and adolescents and in particular, the lack of sufficient early intervention programs. This includes the under-resourcing and staffing concerns of Child and Adolescent Mental Health Services (CaMHS).[7] Recent industrial action from the staff of Clare House in Hobart is of particular concern as are reports from state-wide consultations demonstrating a significant lack of child specific treatment and supports for all areas of Tasmania.

Education and training opportunities have been shown to protect against mental health problems. Global report cards continue to find a disturbing underperformance of Tasmanian children in meeting educational benchmarks. In 2014, more than half of the state's students fell below the national baseline for maths, compared to 42 per cent nationally. Forty-seven per cent failed the minimum standard of English, compared to 36 per cent nationally. Education is critical to maintaining a young person's trajectory towards a fulfilling life and some strategic planning is needed to encourage education providers to come up with new ways to keep vulnerable youth on the path of learning.

The importance of early intervention cannot be stressed enough. Young people who miss out on care typically struggle at school, and are then excluded from the labour market – with profound,

[2] J Mendoza, *et al*. (2013), *Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future*. Summary Report. ConNetica, Caloundra, QLD, p. 18.
[3] Tasmania Department of Health and Human Services Population Health, State of Public Health 2013, p.9.
[4] Tasmania DHHS, (2006),*Mental Health Services Strategic Plan,* 2006-2011, p. 2
[5] World Health Organisation (2008), *Commission on Social Determinants of Health, 2005–2008*.
[6] AIHW (2007), *The Burden of Disease and Injury in Australia 2003*
[7] Jennifer Crawley, 'Clare House Woes Worsen,' *The Mercury*, 10 February 2015, p. 8.

lifelong implications for those individuals, their families, the community and Tasmania's economic future.

It is important to note that patterns of mental illness vary with age, culture and life experience. Therefore mental health programs and policies require a whole-of-life approach to recovery, and the consideration of all aspects of life, including family and social support, culture and spirituality, financial, employment, education, housing and accommodation, access to resources, social inclusion, and connection to the community. Critically, along with providing social support, the system needs to respond to the physical and mental health of consumers.

In a recent article on the mental health situation in the United States, Thomas Insel, director of the National Institute of Mental Health noted that

> Mental illness costs Americans under 70 more years of healthy life than any other illness ... That's because mental illness, unlike cancer or heart disease, is not a disease of aging. It often develops when people are in the prime of life, arising during adolescence or young adulthood. Left untreated, mental illness can rob people of decades of health.[8]

The situation is similar in Australia. What's more, as the article points out, 'The mentally ill who have nowhere to go and find little sympathy from those around them often land hard in emergency rooms, county jails and city streets. The lucky ones find homes with family. The unlucky ones show up in the morgue.[9] In Tasmania, we are aware of high numbers of people in prisons having a mental health issue and we are certainly aware of the high prevalence of people with mental illness who have co-occurring alcohol or drug problem or a co-occurring physical disorder. Indeed, people with mental illness have significantly higher risks of cardiovascular disease, diabetes, respiratory disease and infectious diseases and it is diseases such as these that reduce life expectancy to 25 years lower than the general population.

MHCT recognises that shifting the approach from the hospital medication-centric system to community-based and recovery oriented care is not an easy task. Innovation in the area of healthcare is notoriously difficult and there is still much to do to achieve this change in focus and this must begin with a change in culture. Stigma does not only occur in the community, it is still a feature of clinical and community mental health provision. The system must move away from a negative focus on stabilisation and medication to a positive one focusing on empowerment and recovery. An integrated system which has as its main principle the centrality of the consumer is the first step towards services that meet mental health and social goals of consumers, improve their quality of life, and enhance their recovery journey, connecting people to their community, and strengthening people's natural supports. In other words, a modern, caring, recovery-focused system that will reap benefits for all, not least a health ministry that seeks to save money in the long run.

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[8] Liz Szabo, Cost of not caring: Nowhere to go - The financial and human toll for neglecting the mentally ill, *USA Today*, http://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535/

[9] Liz Szabo, ibid.

A. Underlying Principles

1. Recognition of fundamental human rights and freedoms

Australia is a signatory to the UN Convention on the Rights of Persons with Disabilities (2006) which promotes full inclusion and participation in community life and access to quality health care services as close as possible to people's own communities (Article 19 - Living independently and being included in the community). This has important implications in terms of deinstitutionalisation and the development of community based mental health and social services (Article 12 Equal recognition before the law).

People with psychosocial disability are often assumed to lack capacity to take charge and make decisions concerning their own lives. The Convention counters this assumption by promoting key rights such as the right to own property, to enter into contracts, to manage one's own financial affairs, to marry, work, and retain custody of one's children. Furthermore the Convention states that people with mental disabilities should retain their legal capacity, and, when required, should be provided with support in exercising their legal capacity and their rights (Article 12 Equal recognition before the law).

The Convention refers to participation as a principle and a right. It refers to the paramount importance of inclusion which aims to engage persons with disabilities in the wider society and in making decisions that will affect them, encouraging them to be active in their own lives and within the community. Inclusion is a two-way process: persons who have no disabilities should be open to the participation of persons with disabilities.

The general principles provide guidance on the interpretation and implementation of the Convention. The eight general principles are:

- Respect for the inherent dignity, autonomy, including the freedom to make one's own decisions, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion in society;
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- Equality of opportunity;
- Accessibility;
- Equality between men and women; and
- Respect for the evolving capacities of children with disabilities and for the right of children with disabilities to preserve their identities.

Stigma associated to mental disabilities results in people being denied a wide variety of economic, social, cultural, civil and political rights afforded to others. By promoting the right of participation

in political and public life, to education, employment, health and habilitation/rehabilitation services, work and employment and other rights, the Convention provides a legal framework for putting an end to discrimination experienced on a daily basis by people with mental disabilities.[10]

2. Recovery oriented practice

Recovery is grounded in the principles of the empowerment and involvement in their own recovery journey of the individual. In the mental health lexicon, recovery does not mean cure but refers to a person living the best life possible within the context of his/her mental illness. The following basic components of a recovery framework are:

- There is an individualised, strengths-based approach to care, respecting each person's expertise in and capacity to manage his/her own health;
- focus is on whole-of-person, not just on symptoms;
- self-direction, with consumer and family / carers having direct and ongoing input into interventions;
- trust that someone is there at times of need, e.g., that a helpline is really a helpline;
- hope is encouraged and supported and no consumer or his/her family / carer is made to feel that their situation is hopeless;
- recovery can occur even when symptoms re-occur;
- recovery is often episodic, not necessarily linear; and
- recovery is both a process and an outcome.[11]

3. Person-centred – whole-of-person, whole-of-life

Because patterns of mental illness vary with age, culture and life experience, mental health services must address a whole-of-life approach to recovery, and consider all aspects of life, including age, family and social support, sexual orientation and gender identity, trauma history, culture and spirituality, financial, employment, education, housing and accommodation, access to resources, social inclusion, and connection to the community. They need to be flexible, personalised, and delivered in a way that is accessible for all people, whether that might be, as far as is possible, in a centralised facility, the home or choice of location.

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[10] Information on the Convention sourced at UN Convention on the rights of persons with disabilities - a major step forward in promoting and protecting rights.(2007), Geneva, World Health Organization, (http://www.who.int/mental_health/policy/services/en/index.html, accessed 28 November 2008; Mental Health, Human rights and Legislation Information Sheet, Sheet5); and http://www.un.org/disabilities/default.asp?id=224

[11] Information on recovery principles accessed at Office of the Public Advocate Queensland (2004), *Annual Report 2003-04,* p. 30; US Department of Health and Human Services (undated); Australian Health Ministers' Advisory Council (2013), A National framework for recovery-oriented mental health services: guide for practitioners and providers, Canberra at www.health.gov.au/mentalhealth; *National Consensus Statement on Mental Health Recovery*, accessed at www.samhsa.gov

A person-centred approach has at its heart the goals and aspirations of the individual and operates flexibly and responsively to the individual needs and circumstances of the person with mental illness. A person centred approach involves:

- A 'focus' on the person and their goals, aspirations, capacities, strengths and concerns;
- listening, understanding, exploring and addressing what the person sees as 'core' issues for them; how they would like their life, situation and circumstances to change; and what is needed to do that and identifying who will support them;
- identifying and exploring options with the person inclusive of not only 'what currently' exists as specialist or mainstream services but what 'could exist' or be created;
- mobilising and drawing on those 'key' allies - family, carer, friend, service representatives that are willing to help and support the person, advocate and facilitate changes for them;
- building on the person's strengths, gifts, skills and abilities, goals, objectives and aspirations;
- supporting personal empowerment through choice and control,
- providing meaningful options for the person to express preferences and make informed choices (assisted and supported as needed to do this) in order to identify and achieve their hopes, goals and aspirations;
- the unique needs and circumstances of people from diverse backgrounds are acknowledged, including people from Aboriginal or from culturally and linguistically diverse (CALD) backgrounds, people with disability and people of diverse sexual and gender orientation, and responsive approaches developed to meet their needs; and
- by developing personal resilience and optimism, maintaining meaningful relationships, having access to housing and employment, opportunities to contribute and engage within the community and access to high quality mental health services when needed, individuals can build a good and satisfying life despite experiencing mental health problems and/or mental illness.

4. Recognition of the lived experience of consumers and carers

Consumers and carers are experts in their own health care needs and there should be no program or policy developed without their input. It has to be acknowledged that the major reforms of the past few decades have been driven by the consumer movement. The participation of people with mental illness and their families /carers continues to achieve cultural change and systemic reform leading to improved policies and services. For consumers and carers themselves, participation enhances recovery and well-being.

Consumer and carer participation is about greater, meaningful involvement of people who use mental health services and their carers. This includes participation in policy-making and planning, delivery and implementation, and the evaluation of all mental health programs. In short, it is based on the principle expressed by the consumer movement – 'nothing about us without us'.

5. Consumers and carers are treated with dignity and respect

All users of mental health services must be listened to and treated with respect and dignity. All services, supports and interventions must not only meet the person's needs, but must honour the person's goals and aspirations for a lifestyle that promotes dignity, respect, independence, mastery and competence.

The person must be seen in the context of their age, culture, ethnicity, language, religion, sexuality, gender identity and all of the elements that compose the person's individuality and their family's uniqueness. All the facets of a person and their families/carers need to be acknowledged, respected and valued in the planning process. It is essential that the mental health system supports mutually respectful partnerships between the person, their family/friends and service providers/professionals and recognises the legitimate contribution of the person with the lived experience to their own care plan.

6. Mental health programs are community focused

As we shift our emphasis away from acute hospital treatment towards prevention and community care, we must meaningfully address the links between a person's social circumstances and their physical and mental health by ensuring they have access to housing, employment, education and community services. We need to acknowledge that circumstances and needs will change through different phases of life, and that culture and background are critical influences. An emphasis on psychosocial supports is critical to these goals. The current system is heavily weighted to the acute phase of mental illness and tends to fragment when people leave acute care and discharged into the community.

There needs to be a better communication strategy between the acute and the community sectors to build better collaboration to support the transition process and find the right match between the client and the community placement. Discharge planning and transitioning processes are more successful when tailored to the needs of the individual, carefully planned, inclusive of family, appropriately timed, and collaborative in nature. This can only fully work if the community sector is adequately funded to provide the services required.

MHCT believes that there is a need for an improved, well-resourced and innovative, community-focused model of service delivery for adult mental health. Such a model will provide early access to treatment and more effective treatment options, potentially reducing the burden of illness on individuals and families. It will also take the pressure off the acute / hospital sector and provide the whole-of-person, whole-of-life emphasis which has been demonstrated to work in other jurisdictions (see section O. How Should We Balance Investment in Mental Health and Mental Health Services in Tasmania?)

7. The social determinants of health are addressed

It is not an exaggeration to state that the drivers of good mental health lie outside the health sector and in our social environments. More broadly, health is dependent on issues arising from housing, town planning, education, employment and transport. More specifically, social contexts which impact on mental health include the care and nurturing children receive; interactions with others throughout life; experiences of violence, discrimination and racism; the sense of inclusion a person experiences and its impact on our mental health and emotional wellbeing. These environments impact not only mental health but also education and employment outcomes, whether a person develops addiction and alcohol problems, perpetuation of domestic violence, run-ins with the juvenile and criminal justice system, homelessness and gaol time.

Social factors related to poverty, unemployment, conflict, war and strife, and technological change have had significant mental health consequences for populations, with differential effects based on economic status, gender and race which all have a role to play in determining mental health among populations Therefore, addressing the social determinants of health and significantly funding early intervention and prevention programs will have a greater positive impact on a raft of social outcomes for Tasmanians beyond mental health and wellbeing alone.

The prevention challenge is in identifying ways of promoting mental health and wellbeing in order to prevent problems before they occur. The only way this work can be effective is if the determinants of mental health are understood and acted upon.

8. Integrated and collaborative service provision

An integrated and collaborative mental health system means one that provides services across the spectrum ranging from prevention to early intervention, clinical to community supports. The following quote from Rosenberg and Hickie of the Brain and Mind Research Institute, University of Sydney says it all:

> There is also an emerging range of new service models from both within government and without that are designed specifically to meet the holistic needs of people with a mental illness. This includes new individualised packages of support such as those to be offered through the National Disability Insurance Scheme. These approaches do not pass the buck or shift responsibility to other organisations once their role in care has been completed. They take responsibility for all facets of care, and provide this in an enduring rather than desultory engagement with the person. They link and provide services hitherto separated: mental health care, physical health care, employment, housing, psychosocial support and beyond. These new organisations and services are consistent with the evidence about the power of coordinated care, and represent Australia's best bet in relation to driving mental health reform.[12]

[12] Sebastian Rosenberg and Ian Hickie (2013), Managing Madness: Mental Health and Complexity in Public Policy, *Evidence Base*, issue 3, p. 17.<journal.anzsog.edu.au>

9. Natural supports

Flexible personal support for people living with mental illness to meet their mental health and social goals, improve their quality of life, and enhance their recovery journey involves face-to-face contact in the home or choice of location, connecting people to their community, and strengthening people's natural supports.

A recent report from Anglicare on the role of natural supports in recovery from mental illness described the role of mental health support programs in helping to connect people to natural supports. The report stated that,

> They must aim at creating appropriate community connections (i.e. social inclusion and citizenship) and encourage the use of all natural/informal supports as well as those from specialist and mainstream services to assist in ending isolation, disconnection and disenfranchisement by better engaging the person with their community and their community with the person.[13]

The researchers for this project talked to people recovering from mental illness across Tasmania and to ascertain what helped them to reclaim their lives and enable them to lead full and rewarding lives in their community. The research identified the range of natural supports used by people recovering from mental illness and explores their experiences of accessing, using and maintaining them. These are mainly based on relationships with family members, friends, co-workers, neighbours and acquaintances, and are of a reciprocal nature. These are the supports which help people to develop a sense of social belonging, dignity and self-esteem, making a significant difference in a person's life. Studies have shown that individuals with a greater diversity of relationships and/or involvement in a broad range of social activities have healthier lives and live longer than those who lack such supports. Unfortunately, according to research, people with mental illnesses may have social networks half the size of the networks among the general population.

10. Sustainability

At the very heart of the issue of sustainability is the attraction and retention of a suitably qualified mental health workforce. Attracting mental health professionals to work in Tasmania is a major concern for service providers, policy-makers and rural/regional communities. In this state, we struggle to attract and retain suitably qualified professionals and support workers and not only in the rural and regional areas as is the case for the rest of the country.

A 2011 Victorian report stresses 'the important role leadership has in developing organisational attributes that promote the area and organisation to prospective employees, and also the critical

[13] Naomi Sidebotham (2014), *Building a Good Life: The role of natural supports in recovery from mental illness*, Anglicare Tasmania.

need for leaders to be able to collaborate with other organisations and sectors.' This report highlighted the importance of management flexibility which it describes as 'necessary so organisations can adapt to meet the personal and professional needs and aspirations of current and potential employees and their families.' Critically, the report demonstrates that organisational adaptability needs to extend to a collaboration and inter-sectoral partnership approach which requires 'building collaborative relationships with other organisations, establishing linkages with training, and research institutions, and forging links to local professional and social support networks.' This approach helps to meet individual needs, and facilitate access to ongoing professional development.[14]

Mental health services that meet the needs of the community must be funded in a way that is not only adequate and viable but also fair. The Rethink Mental Health project is taking a broad approach to the review of the Tasmanian mental health system, including an analysis of key inefficiencies in the mental health system (including the hospital /community service balance). MHCT would like to emphasise that the importance of directing funding to programs that provide the right services at the right time with regular and consistent evaluation to ensure that these programs are producing the intended results. This evaluation must include review by the end users of services.

[14] K P Sutton, D Maybery and T Moore (2011), Creating a sustainable and effective mental health workforce for Gippsland, Victoria: solutions and directions for strategic planning, *Rural and Remote Health*, 11: 1585, http://www.rrh.org.au

B. Current Mental Health Services

1. What range of clinical services should be provided around the state?
2. What range of Community Sector Organisations (CSOs) should be provided around the state?
3. What are the gaps and what are the opportunities for the future?
4. How can we best organise our mental health services to achieve better outcomes for consumers, their families and carers across the life span?
5. What should the community expect from a mental health service system?

Despite the rhetoric around moving mental health services from hospital to community, this has not been planned or adequately resourced. Decades of de-institutionalisation has not been backed up with nearly enough community services and the prevalence of mental illness among homeless and prisoner populations is often cited as a tragic outcome of this phenomenon with many people referring to prisons as the new asylums. Another outcome is the "revolving door" phenomenon, where people are treated in hospital, discharged with inadequate support, sometimes into homelessness, become unwell largely due to lack of support, and return to hospital again, in an ongoing cycle. Meanwhile, their families and carers are under pressure to fill the gaps in necessary care while becoming increasingly stressed and unwell themselves.

However, MHCT believes that community-based support is the right approach and it needs to be better planned and resourced, with more ready access to community services and better links to the hospital system and other necessary services. It is clear that acute facilities are for acute conditions and should not be used as long-stay solutions. This should be reserved for psychosocial supports in the community.

In a 2007 report the Mental Health Coordinating Council noted that:

> Consistently, studies show that people living with mental illness who are provided with well-planned, comprehensive support in the community have a better quality of life, develop an improved level of functioning and social contact, and have fewer relapses. People living with mental illness must have the opportunity to be not just patients, but individuals with complex lives and needs. Participation in society improves mental health, self-determination, and general functioning. On a broader social level, it reduces discrimination and stigmatisation, both essential to achieving and maintaining good mental health.[15]

What this means in practice is a network of services in the community to address each person's whole-of-life needs, which vary considerably. These include supported residential services, vocational rehabilitation agencies, community centres providing social and recreational activities and linking people to other services, respite and other support for carers, information and education. We currently have this in place to some degree in Tasmania, but there are nowhere near enough resources to meet demand.

[15] Mental Health Coordinating Council (2007). *Social Inclusion: Its importance to mental health*, Mental Health Coordinating Council Inc., Rozelle, p. 2.

Carers are at risk of mental health problems, as they experience anxiety, guilt, helplessness, and at times, fear for their own safety or that of those around them. Respite for carers is limited but a highly effective way of helping people who, in the final analysis, save the government a great deal of money.

Timely intervention and support should provide carers with time, space, and peace of mind. Enough community-based supported accommodation places should be available for consumers who cannot live at home, either for a short or extended time; places where they can feel welcome and safe, and where realistic linkages to the community may be achieved.

The non-government (NGO) sector in Tasmania is ideally placed to provide comprehensive community-based support for consumers and carers, but it requires greater resourcing. In New Zealand three quarters of all funded services are community-based, and 31% of total expenditure is on NGOs. Emphasis is on planned, coordinated care, focusing on social inclusion, active involvement of people in their recovery, and personalisation of services to meet need.[16]

More sustainable rehabilitation, recovery and recreational programs are needed, including mentoring programs like Red Cross MATES and PHaMs which should not just be for people eligible for NDIS. The MHCT Isolation study[17], among others, has demonstrated that there is a clear deficit of appropriate and accessible support and rehabilitation services in the community. People interviewed for the Isolation project reported the concerns they have experienced with particular services, reinforcing the need for a variety of service options and activities to meet the wide range of needs and expectations of people with mental illness.

There were also many comments about issues of vulnerability of people living with mental illness, including: living in poverty and disadvantage, unemployment, family dysfunction and stresses, other health issues and comorbidity, and little opportunity for appropriate and secure accommodation. As a result of their illness, they often lack life skills, including social and occupational skills and all of these issues can exacerbate the symptoms of their illness and social isolation.

In examining the literature available on isolation it is apparent that it is an issue of great impact on the recovery and wellbeing of consumers and their carers. We would go so far as to say that after safe secure and appropriate accommodation social connection is the next most important element in the ability to live the best possible life and begin and continue a journey of recovery.

Consumers and their families in Tasmania should expect to have access to personalised, modern and high quality services that are close to their homes and available when needed. This system would include:

[16] Mental Health Coordinating Council (2007). *Social Inclusion: Its importance to mental health*, Mental Health Coordinating Council Inc., Rozelle, p. 3.
[17] *"Stuck in myself" isolation and mental health consumers* (214), mental Health Council of Tasmania.

- The development of a high quality, personalised, effective and efficient community support service sector that provides people with support to create or rebuild a satisfying, hopeful and contributing life. Such a system would provide support for carers, and families for their own well-being.
- A high quality, efficient and effective community based system that offers evidence based services, in the right locations.
- Community support programs include peer support, personalised support programs, home in-reach, family and carer support and respite (including young carers), recovery programs and harm reduction programs.). Personalised support programs in the alcohol and other drug sector which are a relatively new concept but recognised internationally as important in the delivery of positive outcomes for people with co-occurring disorders.
- Wrap-around, personalised support for people to identify and meet personal goals (which may be in the area of housing, employment, education and so on).
- The adoption of recovery-based practice by mental health staff and practitioners. This will support consumers and their families to decide on the services they access and contribute to the creation or rebuilding of a satisfying, hopeful and contributing life.

There is ample evidence to demonstrate that strengthening community support services alongside community treatment and community bed based services, and improving the ability of consumers to navigate the system is critical. The Tasmanian community should expect that through building the capacity of the system, developing an interactive model which will improve coordination and inter-sectorial collaboration, individuals will be supported to stay at lower risk of harm and to obtain recovery-focused support earlier in an environment best suited to their needs.

Improving the availability of timely, accurate and reliable information is essential for carers and families, as is their inclusion in the care, support and treatment of individuals with mental health issues.

C. How Do We Put Consumers, Their Families and Carers At the Centre of Our System?

1. How can we improve the consumer journey through our mental health service system?
2. How can we develop a stronger focus on consumers, their families and carers in the Tasmanian mental health system?
3. How can we develop a person-centred approach and further develop a recovery focussed service system?
4. How can we create a stronger focus on respecting the rights of consumers and supporting consumers to maintain their responsibilities?
5. How can we enable participation of consumers and carers at all levels?

An effective mental health strategy must be based on the engagement of people with lived experience of mental illness, their families, carers and supporters in designing reforms that meet their needs and aspirations. They must be part of the decision-making process. People who require mental health care deserve to be treated with dignity and respect, to have choice about the type of care they receive, and to be able to find high quality services when they need them. Families and carers must be supported in the vital role they play, and their own needs must also be met.

The culture of a new mental health system will have at its heart respect for and engagement with the expertise and priorities of consumers and carers. Consumer and carer participation will be actively integrated across service planning, development and service delivery with priority given to increasing the capacity for individual and group input. A recovery model will ensure the development of a consumer and carer oriented service. Person centred approaches to planning, connected services and community education are of key importance to help people build better lives. This would involve:

- Direct consumer and carer participation within mental health services must include involvement in treatment and care, and the planning, development and evaluation of local mental health services.
- Consumers of mental health services and their carers have a great deal of experience and expertise that clinicians, mental health service providers and policy makers (including all levels of Government) are able to draw upon.
- Consumer and carer participation is increasingly regarded as a valuable facet of the Australian health care system.
- There is a great deal of evidence to suggest that active consumer participation in decision making in individual care leads to better health outcomes.
- Literature shows that there is a significant reduction of stress for the carer and/or family of someone with a mental illness if they are involved in the treatment and support of the person for whom they are caring.
- Considerable evidence has been identified that innovative consumer participation projects, including use of trained peers in the workforce, have had a marked influence on processes

of systemic change and quality improvement in mental health services -- despite the "shoestring" resourcing and often difficult conditions under which these projects often take place.

As NSW Mental Health Commissioner John Fenely, has asserted, 'Services and programs need to clearly demonstrate their capacity to collaborate with clients rather than act as their caretakers. Approaches such as Trauma Informed Care and Practice offer new guidance to service providers about how to build more respectful therapeutic relationships.'[18]

In the wake of the roll-out of the National Disability Insurance Scheme (NDIS), increasing individualised control may be the right direction for all mental health consumers. Individualised funding is an expression of a people-centred approach to service delivery already in operation. The application of individualised funding is likely to expand dramatically with the introduction of the NDIS. At the core of the NDIS' design and operation is the value of greater service user choice and control over services received. Resourcing client-directed individualised support packages which put the needs of individual consumers at the centre of service provision and will give service providers the flexibility and capacity to 'package' support for individual clients according to their support needs would include, in the words of Peter Shergold:

- A client-directed recovery plan;
- building capacity for self-management and self-care;
- supported referrals to health, human services and social support services;
- information, advice and individual advocacy;
- liaison and coordination with mental health treatment and other key services; and
- carer and family support to assist them in their role as caregivers.[19]

Access to independent advocacy for mental health consumers

Tasmania has a long history of provision of independent advocacy for mental health consumers. Any redesigned mental health system needs to include independent mental health advocacy services as a core service. Advocacy plays a vital role in assisting consumers to access and use the whole range of mental health services from acute, clinical to community based recovery services and to mainstream services, such as housing.

The recognition of fundamental human rights and freedom is a key principle underpinning the mental health service system. A range of safeguards need to be in place to ensure that the rights of consumers are protected. This includes access to independent advocacy, official visitors and the Mental Health Tribunal Representation Scheme.

[18] John Feneley (2013), *Living well in our community : Towards a Strategic Plan for Mental Health in NSW*, Gladesville, NSW, Mental Health Commission of New South Wales, pp. 6-7.

[19] Peter Shergold (20130, *Service Sector Reform: A roadmap for community and human services reform Final report*, Victoria Dept Community Services Service Sector Reform project, p.13.

Independent advocacy is an important recovery orientated service. It assists people living with mental illness to exercise choice and make decisions in order to maximise their autonomy. It helps people to speak up and voice their concerns when things are not working for them and ensures that their views and wishes are expressed and heard.

Early referral to advocacy services means that consumers' concerns can be addressed at an early stage, before problems escalate. In this way it is an early intervention service.

Proactive advocacy supports consumers to engage in treatment and service planning processes, thus maximising the likelihood that consumers will have their needs clearly articulated and plans will be responsive to these needs. In this way it is a preventative service.

The Mental Health Tribunal Representation Scheme has provided vital representations to people appearing before the Mental Health Tribunal for over 11 years. It needs to continue to be part of any redesigned mental health system.

D. How Can We Improve Access to Mental Health Services and Streamline Referral Pathways?

1. What are the barriers for consumers, families and carers to accessing the services and support they need?
2. What are the barriers for clinicians, GPs and service providers to accessing services and support for their clients?
3. What is working well and why?
4. How can we have appropriate access to mental health services across the state?

One of the biggest barriers to access services is the lack of knowledge of what is available. This needs to be addressed in a variety of ways to meet the needs of a variety of consumers and carers and, indeed, service providers and referral agencies. Current pathways into care are haphazard and too often rely on luck or the knowledge of individual general practitioners, social workers or others. Or simply word of mouth. This is inefficient and inequitable. The community needs clearer signposts about where to get help and how.

A central portal that can be accessed by GPs, clinicians, CSO staff and consumers and carers is sorely needed. This could be in the form of a gateway service like the Partners in Recovery model but for the broader groups of people seeking information and referral in the mental health environment. MHCT would be a logical place to host a user friendly directory on its website and through other mediums, but would need adequate resourcing to keep this up-to-date, relevant and useful. This kind of resource would help to ensure a 'No wrong door policy' for organisations where if people enquire about their service and it's not suitable, staff will know where to refer them on to and can guide them in that process.

The current Mental Health Services Helpline is an issue for many consumers and carers who find it frustrating and unhelpful. They would like it to provide not only assessment but also support and, if required, referral to other services.

This service is used by people involved in a mental health emergency in the community, which includes:

- individuals who feel that they require urgent assistance
- families or carers of those with a mental illness
- members of the general public who witness a mental health crisis and require assistance
- health professionals
- community welfare service providers

Currently, the Mental Health Helpline does not appear to be effectively any stakeholder. In order to manage callers' expectations, the Helpline should promote its purpose with a clearer message of the services it provides. It should aim to be staffed 24/7 as it often rings through to an

answering machine which can be a problem for some callers, one of whom has told us that, 'Sometimes I get through straightaway but I don't like answer machines so I'll either try again later or not bother.'

Many people have told us about the lack of case managers to help people with referral pathways which is also a model that demonstrates good results in assisting in keeping people out of hospital. Community coordination models are shown to reduce the negative impact of mental illness for people within their local community. Community coordinators focus on building partnerships with individuals, families, carers and communities that are strengths-based and relationship driven. People are supported to live full and productive lives and have access to a complete range of supports and services including primary care, community support and comprehensive hospital discharge planning. Emphasis is placed on reconnecting people with their communities, increasing social connections and building lasting relationships.

Gateway models like Partners in Recovery (PIR) also work to ensure a streamlined approach to the needs of consumers. This is a federally-funded program that is slated to go across to the NDIS which will provide services to a small number of mental health consumers. MHCT can see a similar model working state-wide as the gateway in Tasmania for all people who require mental health services in the community. The Tasmanian model could include community coordinators to deliver the desired outcomes.

Improving the availability of timely, accurate and reliable information is also essential for carers and families, as is their inclusion in the care, support and treatment of individuals. Carers and families are often left out of the loop and have no idea what is happening or how they should proceed. This is an issue that arises again and again. It is essential to develop a protocol for including carers and family in information sharing (within the boundaries of privacy legislation), especially information about mental illness and treatments.

E. How Can We Further Integrate Our Mental Health Service System?

1. How do we provide a continuum of care that includes clinical services, community sector organisations and primary health care services?
2. How do we strengthen the interface between clinical community mental health services and inpatient services?
3. How do we strengthen the interface between primary care and acute mental health services?
4. How do we strengthen the interface between clinical mental health services and community sector organisations?
5. How do we strengthen the interface between mental health services and other services such as disability services, alcohol and drug services, child and youth services, housing and education?
6. What do we need to do to deliver a seamless and integrated mental health system that provides end to end care, provides support in the right place and at the right time and achieves better outcomes for consumers, their families and carers?

MHCT believes that the focus of future service delivery must involve the development of more community based services to better integrate specialised clinical services with a greater range of rehabilitation and support options. The overall service structure will cover the range from acute care services, community treatment, rehabilitation services to ongoing support for individual recovery. Dedicated mental health services will be complemented by other health and social services to promote the best outcome for individuals. In other words, we are stressing the importance to the future of mental health provision in this state of a partnership between the community and government sector and far more integration with other services, particularly in the areas of housing, justice and alcohol and drug services.

To ensure the development and success of an integration plan for mental health care in Tasmania would require the formation of an implementation committee with a diverse membership across key relevant services and sectors and include consumers and carers to manage this fundamental change in system and culture. MHCT would like to see the development of specific intergovernmental service agreements between health, education, housing, employment and education, youth and family support, justice, homelessness and mental health sectors. This system of cross-departmental, cross-sectorial cooperation will ensure that:

- Working relationships across different sectors will improve referral pathways and coordinate service provision for people who live with mental health conditions.
- Consumers are not compromised by inadequate interagency cooperation.
- It is recognised that a number of government agencies have a role to play in responding to the needs of people affected by mental illness and sets out a coordinated approach to managing these needs.
- Discharge and care plans are recognised as playing an important role in the assessment and coordination of treatment and support needs. While these plans have tended to focus on health needs, they can be an important step in linking community and primary health

care and rehabilitation with broader social needs such as housing, education and caring responsibilities.

The sectors and communities concerned with mental illness, drug and alcohol addiction, and disability often distance themselves from each other due to stigma across these sectors even though there are a great number of people with co-occurring disability or drug and alcohol disorders. Greater coordination and collaboration of these sectors is important, but again, working to reduce stigma generally is an approach that can have excellent results.

A report from the US Agency for Healthcare Research and Quality claims that integrated care saves money. It refers to data which suggests that 'integrating primary care and mental health care saves 20 percent in health care costs.'[20] This is hardly surprising since we know that primary healthcare is much cheaper than hospital care. The current system in Tasmania is fragmented and doesn't promulgate successful models of team-based care at the community level. There is growing recognition that many physical health problems are affected by mental health problems. GPS see a significant proportion of common symptoms such as fatigue, abdominal pain, and back pain for which they don't find a cause. If GPs were supported to better understood psychosocial stressors, the impact of adverse childhood experiences, and were better at identifying common mental and behavioural conditions such as depression, anxiety, and substance use, then there would be a greater understanding about what's driving those symptoms. Mental health cannot be divorced from physical health. Embedding mental health professionals in primary care could enhance a more patient-centred approach to care.

A good model for integrated care, as already flagged in this submission, is a care coordination model which emphasises the need for cross-sector collaboration between government agencies, NGOs, primary care and the private sector in providing support services to individuals with severe mental illness and complex care needs. This model aims to improve care planning and increase the continuity of care across service boundaries. The model also aims to improve service provision by reducing gaps and duplication of services. The Mental Health Alcohol and Drug Directorate currently provides packages of care to organisations like Baptcare and these have a care coordination component. MHCT believes that this system works well but there needs to be systemic care coordination in place. Such a system would ensure that services are provided across sectors and the mental health needs of the Tasmanian community will be met by a comprehensive network of services.

International models of integrated systems:

1. Lille Model

An innovative program developed in Lille, France over the past 30 years has been the progressive development of set up in community psychiatry. This innovative set up conforms to WHO

[20] Evidence for integrated mental health and primary care models Experts call for integrating mental health into primary care, Research Activities, January 2012, No. 377, US Department for Health and Human Services ,Agency for Healthcare Research and Quality, Rockville, MDhttp://archive.ahrq.gov/news/newsletters/research-activities/jan12/0112RA1.html

recommendations. The essential priority is to avoid resorting to traditional hospitalisation, and integrating the entire health system into the city, via a network involving all interested partners: users, carers, families and elected representatives. The ambition of this socially inclusive service is to ensure the adaptation and non-exclusion of persons requiring mental health care and to tackle stigma and discrimination.

Centres of therapeutic activities are called services of inclusion and care activities and are integrated in the city. A devoted team organises inclusion and care activities in all artistic, sport and cultural places in the 6 towns of the sector …. Altogether, 48 different activities are offered per week, with 60% of them taking place in 21 places outside the service (association, social centre, media library, retirement home, sports facilities, etc.). In this system, activities are made upon medical prescription and reviewed regularly with users. They are all carried out in municipal structures, in conjunction with the local associative network, and are led by professional artists, sports professors.[21] The integration of the mental health services into the city at the proximity of citizens work is also a powerful anti-stigma strategy.

'This is 21st century psychiatry … a psychiatry in favour of users, integrated in the community, that is to say, for the people. '[22]

2. Andalucía Model

In Andalucía, one of the 17 regions of Spain, a profound change in the public mental health system was initiated in the 1980s with de-institutionalisation . This involved the creation of a new network of specialised mental health services based in the community and integrated in the general health system. This network is organised in sectors, called Mental Health Areas, and includes: community mental health teams which work in close liaison with primary care services; inpatient units in general hospitals, outpatient child mental health units, day centres, rehabilitation units and therapeutic communities (medium- term units for mental patients requiring a structured therapeutic setting). Creation of a new public organisation, the Andalucía Foundation for the Social Integration of People with Mental Disorders (FAISEM), which manages a network of social support services.

This network includes residential, occupational and vocational facilities and programmes and the formulation of an intersectoral policy that promotes the collaboration of the health sector with services of other sectors (social affairs, justice, education) as well as with users and family associations. The strategy adopted in Andalucía to create the network of social services to support mental patients in the community, is one of the most original and creative aspects of this reform. Basically, the strategy consisted in the government creating a public foundation, jointly funded by the four government departments most closely related to the provision of social support for

[21] Jean Luc Roelandt *et al* (2014), Community Mental Health Service: An Experience from the East Lille, *Journal of Mental Health and Human Behaviour*, Vol. 19, no. 1, p. 12 http://www.salutmental.org/wp-content/uploads/2014/11/Community-Mental-Health-Service.pdf

[22] Ibid, p. 17.

mental patients (health, social affairs, employment and technological development, and economy and finance). An additional agreement was subsequently signed with education.

This strategy proved very successful in ensuring:

- Public intersectoral funding;
- coordinated planning and management of social support services in close contact with health services;
- flexible and efficient administration of the resources; and
- participation of local organisations, as well as staff, users and family associations in the development and monitoring of the programmes.

Currently, the Foundation provides housing support to more than 2,000 users, occupational activities to more than 2,500 users, vocational training to 200 users each year, employment in social firms to around 300 people with mental disorders, and develops many other activities (supported employment, social clubs, support to users and family associations, research, among others). Recent initiatives of the Foundation include programmes for health promotion and prevention of physical illnesses for residential facilities users, as well as of programmes for homeless people and the mentally ill in prisons. The access to the services provided by the Foundation is always made in coordination with the mental health services through coordination committees in each area, involving also the general social services of the area (CALDas de Almeida & Torres, 2005).[23]

[23] Jose Miguel CALDas de Almeida and Helen Killaspy (2011), *Long-Term Mental Health Care for People with Severe Mental Disorders*, European Union, p. 12

What Are Some Other Important Considerations?

F. Promotion Prevention and Early Intervention

1. How can we maintain a focus on mental health promotion, prevention and early intervention in our mental health service system?

> Investing in mental health promotion and prevention helps to reduce demand for more resource intensive services, thus also reducing workforce pressure and overall health costs. In spite of this, and the endorsement by the Council of Australian Governments of the *Roadmap for National Mental Health Reform 2012-22* that prioritised prevention and early intervention, the majority of State and Federal mental health spending continues to be disproportionately concentrated in downstream mental health interventions: in treating problems once they have become serious and complicated. This must change.[24]

Understanding the prevention model from an early intervention perspective is crucial. Supportive environments where parents and children have adequate access to support, health care and education is the best possible way to prevent issues later in life for all members of the family.[25] A key recommendation from the Tasmanian State-wide and Mental Health Service 2009 *Strategic Framework* was to, 'Ensure that nurses working in infant, child and perinatal health care services and family centres have skills in promoting mental health and wellbeing, particularly in relation to building parent/child attachment.'[26] With the rates of perinatal depression, mental health and behavioural issues in children increasing across the country it would appear that more needs to be done in this area.[27]

The evidence suggests that we need to amend our approach so as to focus on childhood early intervention from as young as birth to 3 years of age. [28] This is due to the fact that, 'Trauma history or adverse childhood experience significantly contributes to adult issues. Not just mental health but, overall emotional wellbeing and life outcomes (crime, violence, teen pregnancy, drug abuse).'[29] Investments in areas that directly address the social determinants of health have a flow

[24] Aram Hosie (2014), Crossroads: Rethinking the Australian Mental Health System Reach Out Foundation, [Camperdown, New South Wales]: ReachOut.com by Inspire Foundation and EY, p. 2.
[25] Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p.24.
[26] Statewide & Mental Health Services Department of Health and Human Services (2009), *Building the Foundations for Mental Health and Wellbeing: A Strategic Framework and Action Plan for Implementing Promotion*, Prevention and Early Intervention (PPEI) Approaches in Tasmania Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) in collaboration with Professor Debra Rickwood, University Of Canberra. p.12.
[27] beyondblue, 'Perinatal Depression and Anxiety: A guide for primary health care professionals,' https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&prodid=BL/0162&type=file
[28] Centre for Social Justice and Smith Institute (2008), Graham Allen MP & Rt Hon Iain Duncan Smith MP, *Early Intervention: Good Parents, Great Kids, Better Citizens*, United Kingdom, p.45
[29] ibid.

on effect to all facets of life. For example, according to recent reports around domestic violence the cost to Tasmania will be around 300 million this year.[30]According to Jacqui Petrusma MP, Minister for Human Services, these costs include housing, child protection and counselling,[31] which are all areas integral to maintaining the health and wellbeing of everyone in the community.

Presently in Tasmania the only real provider of early intervention in mental health is the Child and Adolescent Mental Health Services (CAMHS). Currently this service is inadequate in terms of the scope for real impact across the entire state. Recent reports have suggested that youth mental health services in Tasmania are the most poorly resourced in Australia.[32] Early intervention needs to begin at the GP or community health clinic level for all Tasmanians. Placing adequate education and resources in place as you would for a physical health crisis is imperative. Perhaps the best analogy for the need for early intervention is this: 'If people keep falling off a cliff, don't worry about where you put the ambulance at the bottom. Build a fence at the top and stop them falling off in the first place.'[33]

- Evidence clearly shows that it is far better to intervene early to prevent problems from occurring, or escalating, than to try to address them once they have become entrenched.
- Early interventions not only lead to more positive outcomes for individuals and society, they are also cost effective.
- Intervening during the prenatal and early childhood periods offers a unique window of opportunity to shift children's life trajectories.
- The benefits of intervening early are far-reaching and range from reduced contact with juvenile and adult justice systems, reduced notifications of child abuse and neglect, less acute incidence of mental illness, through to improved school performance and better employment outcomes.
- Long-term planning and increased investment in early intervention is needed to break the cycle of disadvantage.

Essential to the prevention of illness or the onset of more complex and severe illness is a whole of community approach to mental health promotion. What works well in other states of Australia and internationally are inclusive programs that steer away from focusing on illness but rather promoting the idea that everyone has mental health and it is important to be mentally healthy.[34] Not to take away from suicide prevention initiatives that are key PPEI strategies, it is necessary to distinguish mental health promotion as being a positive and integrated part of health and wellbeing.

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[30] Sally Glaetzer (2015),'Campaign aim to Break the Silence, *The Mercury*, 8 February, pg. 5
[31] ibid
[32] Ellen Coulter, ABC News Online, 'Youth mental health services in Tasmania most poorly resources in Australia, inquest told,' http://www.abc.net.au/news/2015-01-28/mental-health-services-for-children-and-adolescents-in-tasmania/6051480, January 28 2015.
[33] Graham Allen MP & Rt Hon Iain Duncan Smith MP, op.cit., p.47.
[34] National Mental Health Commission 2013, *A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention,* http://www.mentalhealthcommission.gov.au/media/94339/06_Something_meaningful_to_do.pdf

Tasmanian efforts in this area to date are minimal. It is not due to a lack of enthusiasm or ideas, but rather the sustainability of mental health promotion through a lack of funding and dedicated resources. MHCT employs a Promotions Officer; however, there is a distinct lack of similar roles across the community mental health sector. Integral to this role is the development and initiation of the Western Australian successful program, Act-Belong-Commit. Currently the program in Tasmania has been limited to some grass roots community engagement and participation. It is the hope of MHCT to expand this in a similar way as has been achieved in WA. However, currently, limited resourcing for MHCT will prevent this from occurring in the future.

Organisations such as Red Cross have mental health promotion operating in schools and the wider youth community through their Save A Mate 'Talk Out Loud' program. Headspace has a significant role to play in mental health promotion and increasing help seeking behaviour. The Kids Matters and Mind Matters curriculum run in schools around the country by beyondblue and this is a long established way for children and teenagers to learn about mental health and wellbeing through a managed structured environment.

Increasingly, social media and online mediums utilised by Reach Out, beyondblue and Headspace are vital to providing assistance, information and advice around how to find coping mechanisms and build resilience that will in turn prevent illness. These initiatives need to be complemented, enhanced and expanded into the wider community and they need to be evaluated in order to improve their outcomes.

The National Mental Health Commission acknowledges these gaps in evaluation and accessibility:

> A common theme which does emerge from existing evaluations of school-based emotional wellbeing programs is the challenge of involving parents and families. Some disadvantaged groups are often seen by services as 'hard to reach'. But it could be that services are 'hard to access.'[35]

That same theme of access and reach for services echoes in aspects of all PPEI initiatives in all demographics. Tasmania is a small and diverse community, however, it is also a community whereby many are isolated and live in areas that do not have adequate access to services including health promotion activities and programs that would directly improve mental health and prevent the onset of illness. This is not about diverting existing funding from primary health care but rather about recognising that PPEI and health care are not mutually exclusive. In order to have a whole-of-person and whole-of-life health care system we need to address systemic change across every aspect of the social determinants of health.

One way the Tasmanian community can show cohesion around PPEI for mental health is through initiatives such as Mental Health Week. As MHCT coordinates the small grants program for events

[35] National Mental Health Commission (2013), *A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention,*
http://www.mentalhealthcommission.gov.au/media/94339/06_Something_meaningful_to_do.pdf

and promotes activities around the state, we are well placed to expand upon the existing public awareness for the week and leading up to it. This is not an easy task as many are seemingly unable to see the benefit of not only promoting the service they provide to the community but using the week as chance to raise awareness around mental health as an issue for everyone regardless of illness or wellbeing. MHCT sees this as a challenge worth pursuing and is well placed to work with the community sector and the state government in order to put PPEI at the forefront of mental health initiatives.

Whilst the Mental Health Week itself is a concentration of activities limited to a short time frame, it could be seen as the culmination and focus of a number of PPEI activities and projects in the lead up to it. Funding for Mental Health Week activities has not increased for 6 years with an annual allocation of $20,000. As the only significant state-wide mental health promotion series of events in the state, we recommend an annual increase of $20,000.

Based on extensive evidence:

- Prevention and promotion programs represent value for money, many can be are seen to be outstandingly good value for money.
- Many prevention and promotion programs have a broad range of pay-offs, both within the public sector and more widely (such as through better educational performance, improved employment/earnings and reduced crime).
- In some cases the pay-offs are spread over many years. Most obviously this is the case for programs dealing with childhood mental health problems, which in the absence of intervention have a strong tendency to persist throughout childhood and adolescence into adult life.
- Prevention and promotion programs cover a wide range, from the prevention of childhood conduct disorder to early intervention for psychosis, practical measures to reduce the number of suicides and well-being programmes provided in the workplace.
- The overall scale of economic pay-offs from these interventions is generally such that their costs are fully recovered within a relatively short period of time.
- Economic analyses shows that, over and above the gains in health and quality of life, prevention and promotion programs also generate very significant economic benefits including savings in public expenditure.

A Comprehensive Anti-Stigma Campaign

Mental illness is still associated with negative stereotypes in the wider community that discourage people living with a mental illness from being fully connected to their own communities. As with other chronic conditions, people with mental illness should have the same access to work opportunities, community activities and live a life free of discrimination. Stigma is often one of the biggest barriers to living a contributing life for those experiencing mental health issues.

In 2011 a study by Mental Health Australia (then MHCA) revealed that 71 per cent of participants with a mental illness had been treated as less competent once disclosing their illness to their colleagues.[36]

Renewed efforts are needed to improve understanding of, and attitudes towards, people affected by mental illness. Whilst there are some efforts around the reduction in stigma for those experiencing depression and to some extent anxiety, there is still a lack of understanding, compassion and even a perception of fear around those who have at times far more complex experiences such as schizophrenia, bipolar and other disorders. 'Australian research among people living with a psychotic illness, such as schizophrenia, found that almost 40% reported experiencing stigma or discrimination in the past year alone. The proportion was higher in females, with almost a half reporting stigma or discrimination in the past year compared with a third of males.'[37]

Public awareness campaigns utilising real people living with mental illness have been found to improve knowledge of mental illness; as well as acceptance. Internationally, social marketing campaigns have also been found to deliver both a social and financial return on investment to the government when considering downstream service provision.

The *Like Minds, Like Mine* campaign in New Zealand is a particularly good example that has managed to demonstrate proven results in reducing stigma and improving public perception of those with mental health issues. The New Zealand campaign also evaluated the effect of the de-stigmatisation project through a cost benefit analysis. The results were that it cost a total of $21.05 in advertising per every mind changed in terms of their attitudes toward people living with a mental illness.[38] When taking into account the value of campaign in increasing employment opportunities for people experiencing mental health issues, the cost is further decreased. Other campaigns worth noting are the *See Me* campaign from Scotland and the *Time to Change* campaign in England.

MHCT and its members strongly support the development of and allocation of funding for a prominent and sustained social marketing campaign. We believe ongoing mental health anti-stigma campaigns should ideally be fully funded by government, as is the case for other public health campaigns such as those targeting smoking and road safety. However, MHCT is also proposing Tasmania create a grassroots campaign working from the ground up with youth in order to provide education, community engagement and therefore more targeted and achievable results. Our recommendation is to increase resourcing and targeted funding around PPEI programs including specific initiatives around stigma reduction. Whilst each aspect goes hand in hand it would be remiss to presume that funding should be targeted to one area alone as this would be insufficient.

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[36] Mental Health Council of Australia 2011, *Consumer and carer experiences of stigma from mental health and other health professionals.* Canberra: MHCA.
[37] Barbara Hocking, (2013) *Life Without Stigma: A SANE Report*, SANE Australia.
[38] Phoenix Research, Ministry for Health (2010) *Cost Benefit Analysis of the New Zealand National Mental Health De-stigmatisation Programme*, 'Like Minds Programme'.

G. Whole of Government, Whole of Community

1.	How do we get a whole of government and whole of community approach to mental health and mental ill-health?

Alignment of Commonwealth and State in mental health provision and strong connections forged across Commonwealth, state and local governments, professional bodies, peak organisations, private and community sector organisations are fundamental to implementing lasting and effective change. One of the biggest problems with mental health provision all over Australia has been this lack of cohesion with all stakeholders working together to tackle mental health priorities at policy, program and service delivery levels. It is critical that this level of collaboration is critical to the fostering of the range supports and services required for prevention, early intervention, treatment and recovery.

What a modern, effective and equitable mental health system needs, as the Western Australia 10 year mental health plan puts it, is:

- Key stakeholders working together at policy, funding, program and service delivery levels to achieve common outcomes for mental health including prevention, early intervention, treatment and recovery initiatives.
- Collaborative partnerships between funding bodies across local, state and Commonwealth departments to commission integrated services and assist in effective service planning.
- Agencies and community sector organisations working with each other and with individuals, families and communities to mobilise unique combinations of informal and formal supports which meet individual, family and carer needs.
- People with exceptionally complex needs having access to cross-agency planning and wraparound approaches overseen by senior agency staff
- Emergency clinical services working with primary care and community based services to support people with acute mental illness within the community in place of seeking hospitalisation.
- Improved access to employment, educational, and vocational training to support community participation and economic security.
- Increased focus from mental health service providers on the physical health needs of people with mental health problems through improved linkages to services, and access to information, guidelines, protocols and workforce development.[39]

Again, MHCT would like to emphasise the need for an implementation committee to oversee the important work of building these partnerships, with the political, planning, service, consumer and carer support required to establish a truly integrated mental health system in Tasmania. (see E. How Can We Further Integrate Our Mental Health Service System?)

[39] WA Mental Health Commission (2014), *Mental Health 2020: Making it personal and everybody's business Reforming Western Australia's mental health system*, p. 19.

H. Physical Health

1. What can we do to improve the physical health of people with mental illness?

> The association between mental ill-health and physical illness is intimate and real. People with schizophrenia suffer coronary heart disease at close to twice the rate of the general population under the age of 55. Rates of diabetes and stroke are significantly higher too, contributing to a situation in which the life expectancy of people with schizophrenia is reduced by a shocking 18 to 25 years compared to the general population. Mental health reform must consider people as a whole, rather than just body parts or illnesses.[40]

Mental and physical health is fundamentally linked. There are multiple associations between mental health and chronic physical conditions that significantly impact people's quality of life, demands on health care and other publicly funded services, and generate consequences to society. The World Health Organization (WHO) defines: health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The WHO states that "there is no health without mental health."[41]

People with a mental illness have the right to expect health care that's in line with the care provided to the general population. Yet we have heard that people who present with mental health issues are rarely given a physical health assessment. Mental health services have an important responsibility to ensure that the consumers involved with their service have access to such health care by:

- Supporting consumers to receive a physical health examination
- Ruling out any physical causes for their mental illness or disorder
- Carefully considering how any treatment the consumer receives for their mental illness will affect their physical health, and vice versa
- Putting consumers in contact with a GP or other health providers for health reviews or tests
- Ensuring care plans for consumers address mental as well as physical health needs and any ongoing health issues
- Providing consumers with opportunities to improve their physical health, helping them to attend activities and giving them information that will improve their physical health and wellbeing

The life expectancy of people with a severe mental illness is estimated in some international studies to be as much as 25 years less than the general population The aim is to reduce the

[40] NMHCCF (2010), Advocacy Brief Issue: Physical Health Impacts of Mental Illness http://www.nmhccf.org.au/documents/Physical%20Health%20Impacts.pdf

[41] *Promoting mental health : concepts, emerging evidence, practice : summary report* (2004) World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne, p. 1.

premature mortality rate and the prevalence of comorbid physical health problems, particularly cardiovascular disease, diabetes and oral health problems. Risks associated with poor health that are common to this population group include side-effects of medication, obesity, smoking, poor nutrition, low levels of physical activity and drug and alcohol misuse. The level of physical health inequality experienced by people with severe mental illness is also driven by complex, inter-related factors including poverty, homelessness and poor living conditions.[42]

Again, this is an area that can be improved by early detection and intervention, through physical health assessment and supported referral, and a focus on prevention, through health promotion, education activities and targeted health interventions. Furthermore, sustained action must be undertaken to address the social and economic determinants of good physical health, with particular attention to improving access to affordable housing, employment and adequate and nutritious food.

Specific ways in which to ensure that the physical health needs of people with mental illness are taken care of are:

- Ensuring that people who present with a mental health problem receive a physical health assessment at the outset. This includes presentations at the GP and the Emergency Department.
- A care coordinator approach would ensure that the physical health of mental health consumers is monitored and any co-occurring disorders are appropriately treated by:
- Improving continuity of care achieved through strengthened coordination and collaboration at the local level between specialist mental health, GP and Community Health services.
- Providing access to allied health services such as dieticians, podiatrists, diabetes educators and oral health (dentistry) services in the private, community health and other relevant service sectors.
- Providing access to local mainstream providers of healthy lifestyle services such as exercise groups, gyms and recreational activities.
- Providing health promotion education, advice and information with a particular focus on smoking cessation, reducing alcohol consumption, weight management and nutrition, sexual health and physical activity.
- Providing access to targeted interventions such as healthy lifestyle counselling and physical activity programs.

Above all, the mental health system must ensure that initial assessments of all new clients identifies their known physical and oral health needs and embed physical health in the client's Individual Support Plans. Based on the critical need to address the physical health and low life expectancy of people with severe mental illness the Victorian Ministerial Advisory Committee on

[42] Based on data provided by Australian Institute of Health and Welfare (2012), *Comorbidity of mental disorders and physical conditions 2007*. Cat. no. PHE 155. Canberra: AIHW.

Mental Health made the following recommendations to their government in a 2012 report, and MHCT believes that this work provides a good direction for Tasmania to take as well. These recommendations are:

1. Develop a clear mental health and physical health policy … to drive the structural, practice and cultural change required within the specialist mental health service system.
2. Invest in the necessary infrastructure and capacity building required to support the specialist mental health service system to embed physical health into core practice and work collaboratively with local GP and Community Health services.
3. Establish a state-wide physical health advisory body to oversee the system reform and development needed to drive outcomes in this area, including research and the development of clinical guidelines, heath promotion resources and targeted health promotion strategies and interventions.
4. Ensure policy and operational frameworks and funding guidelines for current and planned investment in public primary health and acute health services prioritise and optimise physical health outcomes for people with severe mental illness.
5. Develop physical health outcome measures and performance indicators for inclusion in existing reporting and accountability frameworks for specialist mental health services.
6. Invest in research and evaluation to ensure evidence based physical health best practice, assess impact of investment and support continued improvement in service provision.[43]

There are and have been many small programs which were developed to address the physical health of people with mental illness in Tasmania but there is an inconsistent approach in supporting these programs. One example is the Mental Health Carers Tasmania (MHCTas) Tobacco and Mental Illness project (July 2013-July 2014) which was originally funded through Mental Illness Fellowship Australia (MIFA). They received funds through DOHA (now DOH). The project operates in other states and is centralised in the Mental Illness Fellowship South Australia. With an increase in funding MIFA was able to begin operations in Tasmania (southern) in July 2013. MHCTas employed a 20hr per week project officer.

The change in the Federal Government had slowed down the negotiations and consequently ceased the funding. MHCTas was able to obtain funding from DHHS to continue the project from the 1 January to 30 June 2014. During September 2013 meetings were held with all Tasmanian parties and there was consistent support from all those discussions. Commitments were made to support the project but these would not be realised until the outcome of the state election.

The primary aim of the Project is to work together with mental health, drug and alcohol and tobacco control services to significantly improve the health and well-being of people with mental illness, and reduce the harm caused by tobacco use across the community by working in three key areas:

[43] Victorian Ministerial Advisory Committee on Mental Health (2012), *Improving the physical health of people with severe mental illness No mental health without physical health* Report.

1. Staff Information Sessions (42 during the 12 months) were held to provide information about the program and its content and encourage staff to make contact (referral) to the project for mental health workers, drug and alcohol workers, general practitioners, psychiatrists and other health workers in hospital inpatient units, rehabilitation centres, activity or drop-in centres, health centres and supported accommodation facilities.

2. "Talking about Tobacco" awareness-raising sessions (32 during the 12 months) provided an opportunity to encourage smokers to think about their tobacco use, to receive information and to consider what they would like to do about it. These explored the likes and dislikes of tobacco smoking, getting information and support, addressing tobacco and mental illness and sharing personal experiences.

3. The Tobacco FREE course was tailored for people living with mental ill health, their family, friends, carers and work colleagues. Approximately 58 people have participated in it from a background of a number of different mental illnesses and included people with a number of other addictions. This course helped participants to think about tackling tobacco use and make their own decision about it; build on their personal strengths and skills to address their tobacco use; and achieve their goals for better health and quality of life.

This program has achieved significant results with participants reporting:

- "Feeling happy to be able to breathe better!"
- More confidence now and improved self-esteem, e.g. Able to maintain unstained teeth.
- The cravings are now gone and I can feel my appetite coming back.
- More understanding around smoking behaviour.
- Improvement in mental health has improved and reduction in medication.
- Development of skills to help me cope better with stress and not go back to smoking.
- Having more energy as a non-smoker.
- More money for things like camping and other activities.
- Saving money for things like a car, "I have been smoke free for 191 days now, have not smoked 3834 cigarettes and saved $ 3163.00."

Overwhelming the participants agreed that support and encouragement by others in the group helped them stay focused.

The CEO of MHCTas has continued to try and secure a funding agreement for three years to continue this very successful project which not been able to operate as no funds were secured post June 2014.

I. Quality and Safety

1. How can we maintain and improve the safety and quality of our services?

Accountability mechanisms should be developed and implemented across the mental health system to ensure that the policies and programs contained in a future mental health plan informed by the Rethink Mental Health Project are actually delivered in practice.

Accountability goes both ways. All too often there are no reports from the responsible government departments, or agencies on the implementation, or progress reports, following the statutory office review. It is abundantly clear that the accountability requirements on governments, Ministers, departments and agencies are inadequate given the frequent reoccurrences of the same recommendations. Repeatedly, statutory authorities are finding the same systemic problems.

The National Mental Health Commission is currently working with the Australian Commission on Safety and Quality in Health Care (ACSQHC) to improve the uptake of national mental health standards. The ACSQHC has conducted a scoping study on the implementation of national standards in mental health services to provide a better understanding of the enablers, barriers and challenges to the implementation of the current National Standards in Mental Health Services, in particular, from the perspective of people with a mental health difficulty and their families and supporters. It also aims to identify gaps in the standards concerning safety and quality in mental health service delivery. The report is being finalised and will be ready for release soon.[44]

Evaluation of programs and services are critical to ensuring quality and safety. Importantly, policies and programs should be evaluated by the end users of services – consumers and carers.

Consistent with the purchaser / provider model, there is a growing trend internationally and nationally towards commissioning for outcomes. This approach assumes that there is less of a focus on measuring inputs and activities, and more of a focus on measuring the client outcomes resulting from those inputs and activities. MHCT believes that this would be a more meaningful and appropriate way to evaluate the impacts of services. This is notoriously difficult to do. Nonetheless, it must be appropriately resourced and properly done. TasCOSS has also noted in a recent report that this does require resourcing. The report asks:

- What resources will be available to enable the sector to improve its data collection and information management systems?
- What resources will be available to help the sector acquire the skills it needs in data collection, outcomes measurement and evaluation?

[44] http://www.mentalhealthcommission.gov.au/our-reports/national-standards-in-mental-health-services.aspx

- What will the process be for identifying which organisations will take part in the development of program-level outcome measures and indicators?
- The framework document says that DHHS Program Managers will manage the decision-making about program-level outcome measures and indicators. How will we, and DHHS, evaluate whether the decisions made have been a genuine collaboration between DHHS and the community sector?
- The Framework document is about reporting on outcomes, but it is called an 'Outcomes Purchasing' framework, and there are references throughout it of 'commissioning for outcomes'. The document says that this is an approach with less emphasis on reporting on resources and activities, and more emphasis on reporting on client outcomes. Commissioning can mean much more than this though. More discussions need to be had to clarify what the Department means by 'purchasing outcomes' or 'commissioning for outcomes'.[45]

MHCT believes that these issues must be addressed if the community mental health sector in Tasmania is asked to report against outcome measurements.

[45] Tascoss (2014), *Measuring and reporting outcomes of Community Sector grants A Plain English resource to use with the DHHS Community Sector Outcomes Purchasing Framework*, p. 17

J. Supporting Infrastructures

1. Do we have adequate facilities for providing mental health services around the state now and into the future?
2. Is our IT infrastructure adequate for providing mental health services around the state now and into the future?

Currently Tasmania has Adult Community Mental Health facilities in the regions of Hobart and Southern Districts, Glenorchy and Northern Districts, Clarence and Eastern Districts, Launceston and Northern Districts and limited North West outreach services and facilities. Throughout the consultation process MHCT heard that in particular the North West region needs to increase the level of community mental health services to ensure all members of the community have adequate access to treatment. Existing community facilities would be well placed to work in partnership with the NGO community mental health services in order to provide consistent and comprehensive care across all stages of each individual's recovery pathway. Such collaboration and effective communication between the sectors would ensure that people are not likely to fall through the cracks due to a lack of continuity of care. In 2013 mental health nurse, Ros Gorrie claimed that, 'We've slashed our community mental health teams considerably across the state due to budget cuts, so people are unfortunately just not accessing appropriate levels of care.'[46]The focus needs to shift away from looking to decrease services but rather ensure that all levels of mental health care are adequately resourced.

This does not appear to be the case when the consistent message from consultations is that throughout Tasmania there is significant need to provide acute care in the community therefore eliminating the 'revolving door' in and out of hospitals emergency departments and psychiatric wards. The plan for the redevelopment of the Royal Hobart Hospital is for bed numbers to be reduced without providing alternatives within the community.[47]This is a narrow-sighted decision that will see many people back in emergency without appropriate places in the community to treat them.

Current facilities in all areas of the sector need to expand their provision for youth. As previously mentioned in other sections it is often inappropriate to place young people in adult facilities and our current Child and Adolescent Mental Health Service is understaffed and poorly resourced. It is necessary for there to be designated beds for young people that directly accommodate their needs. This extends into the need for dedicated beds for those with eating disorders that need not only hospitalisation at times but appropriate treatment in the community. Currently people with eating disorders have to seek treatment interstate and youth are placed in either the paediatric ward or on the adult mental health wards - both more than likely inappropriate for the unique care needs required.

[46] Carol Raabus and Ryk Goddard, ABC, http://www.abc.net.au/local/stories/2013/09/11/3846311.html, 11 September 2013

[47] ABC, 'Nurses warn against closing mental health beds at Royal Hobart Hospital,' http://www.abc.net.au/news/2015-01-28/plan-to-close-acute-mental-health-beds-illogical/6050954, 28 January 2015

K. Workforce Development and Planning

1. How can we build a sustainable workforce into the future?
2. How do we grow and develop a mental health peer workforce in Tasmania?

In 2008 The Tasmanian Catholic Justice and Peace Commission reported that 'statistics on mental health in Tasmania are incomplete and do little to shed light on the woeful fragmentation of the current system. Despite the goals set out in the *Tasmanian Mental Health Services Strategic Plan 2006-2011: Towards Recovery* report, Tasmania is far behind other states and territories in its implementation of the National Mental Health Service Standards . The number of FTE staff in mental health services has decreased in number since 1993. Whilst the number of clinical psychiatrists and psychiatric registrars in Tasmania is not insignificant, the majority of those doctors work in the private sector. This leaves a small number of psychiatrists working in the public sector with a majority of the caseloads in the state.'[48]

The situation is almost exactly the same today and according to extensive research, by 2027, the current system will require at least 8,800 additional mental health professionals at a cumulative cost of $9 billion to Australia.[49]

The mental health workforce needs to be well resourced and have the right characteristics to meet a diverse need for services which are grounded in a recovery focused approach. The workforce will also need to reflect the needs of the population and this includes peer workers as an essential part of all facets of the mental health sector. The implementation of any structural and service delivery reforms identified though the Rethink Mental Health project can only be realised if the structures established have sufficient numbers of staff; with appropriate capabilities, to deliver the services that meet the demands of service users and their families.

By 30 June 2014 the Tasmanian state government provided $16.3 million to 22 Community based organisations for, 'mental health treatment, support and management of mental disorders to maximise mental health, wellbeing and quality of life.'[50] However, due to a significant lack of current workforce data in the community-managed mental health sector, there is limited ability to plan this sector's services capabilities and workforce capacity.

In addition to the Rethinking Mental Health Project, there are workforce planning implications of policy, structural and funding changes being introduced nationally. Specifically these include:

[48] Tasmanian Catholic Justice and Peace Commission (2008), *Bringing about change by actively challenging injustice and promoting peace: A Submission to the New Royal Project Department of Health and Human Services*, Submitted by The Tasmanian Catholic Justice and Peace Commission.
[49] Aram Hosie (2014), *Crossroads: Rethinking the Australian Mental Health System Reach Out Foundation*, [Camperdown, New South Wales]: ReachOut.com by Inspire Foundation and EY, p. 2.
[50] Department of Health and Human services, 2014, p. 58.

- The implementation of the NDIS;
- The revision of the National Practice Standards for the Mental Health Workforce completed in 2013;
- National Review of Mental Health Programmes and Services by the National Mental Health Commission;
- Reform of the Federation White Paper: Roles and Responsibilities in Health Issues Paper 3, released in December 2014.

The implementation of the National Disability Insurance Scheme, in particular, has highlighted a number of workforce challenges which have emerged as services move to consumer driven service delivery models. Whilst it is clear that many people with a lived experience of mental illness will not be eligible for the NDIS, it is anticipated that existing service delivery models will also change to consumer driven models. The Council of Australian Governments has committed to the development of a National Disability Workforce Strategy. In early 2014, the Australian Government (Department of Social Services) contracted NDS to provide advice on this strategy.

The workforce implications for the changing mental health environment that have been far identified include the need for a 20 to 50 percent increase in support staff and the types of employment available.

Building Workforce Capacity

The following principles should guide the structural models for service delivery and the way in which services are purchased by consumers.

- Roles need to be defined, resources allocated, and achievements monitored.
- Increased consumer and carer participation and choice, including a strong peer work force.
- Services matched to need, through co-ordination, collaboration and partnerships.
- Provide the right incentives to drive better outcomes; including innovative procurement models; improvements, flexibility and innovation in service delivery models; and continuous review.
- Ensuring Government and services are accountable, through structured reporting and outcome measurement.

The starting point for this change is the development of a Tasmanian state-wide mental health workforce development plan. Workforce development plans provide an analysis of projected future demand and supply; potential gaps and strategies to balance supply and demand; employee attraction, retention and work organisation.

The development of this plan will involve a wide range of stakeholders from the government (including Skills Tasmania), private and not for profit sectors; as well as consumers and carers. This plan in turn will guide the mental health sector to identifying, recruiting and developing the workforce needed to implement the structural changes identified. This will also inform the budget for the implementation project. The implementation will require leadership and commitment to

implementing the changes, and guided by an adequately resourced team, with excellent change management skills.

The project could be led by the Workforce Development Officer of the Mental Health Council of Tasmania supported by the Workforce development Officer at MHADD, Skills Tasmania representative, and three representatives from MHCT Member organisations.

The priority tasks for this group would be to:

- Deliver a project plan, complete with resources, cost estimates and timeframes.
- Complete a submission to Skills Tasmania for a budget allocation for the project from the Skills Fund, or any other appropriate Tasmanian Government budget item.

A peer workforce

Peer workers have legitimate roles to play in the mental health workforce, therefore the Council recommends that this should be government and employer policy. However there are a number of conditions that need to be addressed to make this workforce change effective.

Firstly it is necessary for government and employers to ensure that a policy of peer worker participation and employment is genuinely acted on; that participation in the workforce is taken seriously, and that the employment offered to peer workers is meaningful. Peer workers must be treated as equal partners in the mental health workforce.

The design of peer worker jobs needs to provide a career path, supported by equal access to training and educational qualification opportunities. The workplace needs to provide a flexible and supportive environment; providing appropriate supervision to ensure that peer workers are able to perform their duties as detailed in their position description. This includes realistic workloads and access to an equipped work station and amenities.

Importantly other colleagues need to be provided with awareness training about the role and need for peer workers, to ensure that peer workers are regarded as equals in the workplace and safe from disparaging attitudes and comments. Recognising that peer workers have a lived experience of mental illness, co-workers need to have an understanding about mental illness so they can be aware of any signs of ill health presented by a peer worker.

The roles in mental health service organisations for peer workers can include advocates, researchers, educators, managers and supervisors, policy officers, support workers and personal helpers and mentors. Peer workers roles in a clinical environment can include:

- Crisis assessment and treatment teams;
- Continuing care teams;
- Acute in-patient units;
- Secure extended care units;
- Prevention and recovery units; and

- Emergency departments.

In non-clinical environments, peer workers can take roles in:

- Home based outreach staff;
- Rehabilitation staff; and,
- Advocates employed in peak organisations to undertake advocacy in both the clinical and non-clinical sectors.

However the Council also supports the placement of mental health peer workers in non-mental health environments such as government agencies and businesses where services are delivered directly to the community; in guardianship and estate administration; police fire and ambulance services; employment agencies and services; and in public and community housing services. It is also appropriate to have peer workers in hospitals, medical practices, and in universities, schools and colleges.

L. Supported Accommodation

1. What are the supported accommodation needs of consumers in Tasmania?
2. What are the gaps in the current residential programs and supported accommodation options available across Tasmania?
3. What are the opportunities for future development?

The MHCT, Shelter Tasmania and Advocacy Tasmania paper on long-term supported accommodation[51] found that there is currently not the capacity to provide sufficient, and timely, support due to lack of suitable and sufficient accommodation options. The paper emphasised that:

- There is a critical shortage of suitable supported accommodation in the community for people with mental illness – particularly long-term and 24/7 supported housing options.
- This may be a major reason why people remain in mental health facilities longer than necessary.
- There is a clear need for an increased supply and range of supported housing options that provide on-site support for 16 to 24 hours per day, and for services and support for people with psychosocial disability to be driven by flexible, person-centred and individualised approaches.
- Models like the NSW Housing and Accommodation Support Initiative (HASI) or Queensland's HASP are effective examples of supported accommodation and agency partnership for people with severe mental illness and associated disability in those states.
- The disability sector has a much larger number of long-term and highly supported accommodation options. However, current policy in the disability sector excludes people with psychosocial disability who have a primary diagnosis of mental illness from most of this accommodation.

There are a number of supported housing models described in the paper including the NSW Housing and Accommodation Support Initiative (HASI), which is a good example of such a partnership. Under HASI, tenancy management is provided by community housing providers and in the public housing system, support services by specialist mental health non-government organisations and clinical care by the public mental health sector.

[51] *Long-term Supported Housing for Mental Health Consumers in Tasmania: Advocacy Paper* (2014), http://www.advocacytasmania.org.au/publications/ATI_Long-term_Supported_Accommodation_Briefing_Paper.pdf

M. Older People

1. What are the mental health needs of older people?
2. What is working well with our current services for older people with mental illness and why?
3. Are there any gaps in current services for older people with mental illness?
4. What are the opportunities for the future?

Tasmania's population is the oldest of all states and territories, and the state has the most rapidly increasing number of people aged 65 years and over. In 2011, 16.1% (over 80 000 people) were aged 65 years and over, compared with 14.9% (71 161 people) in 2008, 13.8% in 2001 and 12.8% in 1996. Of this older population in 2011, 10 300 were aged 85 years and over compared to 535 in 2008. The Australian Bureau of Statistics predicts by 2057, the 65 years and over cohort will represent around 30 per cent of the Tasmanian population, which is a substantial increase from the 8% of the early 1970s.[52]

In terms of mental health, there will be more people living longer with mental health problems, more people developing mental health problems in old age and more people with chronic diseases and mental health concerns. Older people with mental disorders are doubly disadvantaged. They are disadvantaged by being older and they are disadvantaged by having a mental disorder. Older person's mental health care is fragmented and sometimes it's non-existent. There is no consistent system for the delivery of mental health services to older people. The quality and accessibility of existing services varies enormously from place to place. Rural and remote locations are particularly poorly served.

Mental health disorders: Around 10-15% of older Australians experience anxiety and depression; this rises to 34.7% for persons living in residential aged care facilities. Less common conditions, like schizophrenia and related disorders are more common in older people (2.3%) than in younger adults (1.3%). Dementia is a specific and significant concern for Australia. Today 245,400 Australians have dementia; by 2050, 1.3 million Australians will have dementia. 5% of 65 year olds, 20% of 80 year olds and 30% of 90 year olds have dementia. The complex nature of behavioural and psychological symptoms often causes stress in carers and can lead to the breakdown of community care and institutionalisation.[53]

Developmental researchers discuss the older age group beginning processes of disengagement, making adjustments to the loss of a vocational role, and changes in social status and self-definition. People within this age group also face transition experiences, including retirement, birth of a grandchild, physical, social and cognitive ageing, and the death of a spouse or other close family and friends.

[52] *Health Indicators Tasmania* (2013), Tasmanian Department of Health and Human Services, Population Health, p. 164. http://www.dhhs.tas.gov.au/pophealth/epidemiology

[53] The Royal Australian and New Zealand College of Psychiatrists (2010), *Older Australians Deserve a Better Deal in Mental Health*, p. 1, https://www.ranzcp.org/Files/Resources/Older_Australians_Deserve_a_Better_Deal_in_Mental_.aspx

First onset serious mental illnesses increase after middle adulthood, and continue into older age. Serious depression and early stage dementias can present with similar symptoms. Medication taken for physical conditions may cause mental disorders, as can alcohol and other drug use. Suicide becomes a significant issue for older people, especially for those with mental or physical health problems or following significant loss. Post-traumatic stress disorder has also been shown in those who have suffered early trauma, or have served in armed forces, despite no symptoms obvious in their adult life.

Older Tasmanians require access to seamless services that meet their physical and mental health needs and their social and welfare needs. Mental health funding and services must be integral to planning and delivering aged care services. Mental disorders in older people frequently accompany general health problem, the two must be managed together. It does not make sense to have two separate health care systems for older people, one managing mental health problems and the other managing physical health problems. It is essential that there is a whole of sector approach and a whole of government approach to care for older Australians. We must have services that are tailored to the particular needs of older Australians. This would improve service availability, accessibility and navigability.

Prevention and early intervention can occur at any age and a tiered aged health care system will include prevention, early intervention, treatment, care and rehabilitation components. The tiered model should inform a redeveloped model. It is important to notes that less common conditions, such as schizophrenia, are more common in older people. Mental disorders in older people frequently accompany general health problems, and the two must be managed together.

Psychiatrists have a critical role in providing care and treatment, supporting and advising other health professionals and advocating for service improvement. An older persons' mental health care system needs to provide community based psychiatric assessment and treatment to persons over the age of 65 years who are generally not covered by many mental health care services. This model involves assessment taking place within the person's environment, which may be at home, in a residential facility or hospital. All treatment takes place in a shared care arrangement with the treating General Practitioner, and family or carers.

In our consultations with seniors, we were told that older people don't know how to raise mental health concerns with their families, friends or even their GPs. We also heard about the importance of recreational programs like Eating with Friends and Birds in the Bush to end isolation and enhance wellbeing. The biggest problem in rural areas is transport and programs which provide this, like Eating with Friends, are sorely needed.

N. Other Groups

1. Are there other groups that we should consider?
2. What are the particular needs of these and other groups that should be considered when designing an integrated mental health system for Tasmania?

1. Rural, regional and poorly resourced areas
2. Aboriginal people
3. People from Culturally and Linguistically Diverse Backgrounds
4. LGBTI
5. People with Borderline Personality Disorders
6. People with eating disorders
7. People with co-occurring disorders
8. People with mental illness in the prison system

1. Rural, regional and poorly resourced areas

Tasmania's population is dispersed across small towns and rural area, often difficult to access. It is calculated that about 25 per cent (108,000) of the State's population can be considered rural. This is a small rural population by general Australian standards, but it is thinly dispersed across areas which, though not great by mainland norms, have considerable access difficulties with mountainous country on winding, often treacherous and sometimes impassable roads. This makes access a significant factor in distributing services and challenges the provision of health and community services to meet current and emerging needs.

In terms of mental health needs, the Australian Bureau of Statistics informs us that people living in rural and remote settings have greater ill health than those living in urban areas do. In the case of suicide, for instance, Tasmanian rates are consistently higher than the national rate. In Tasmania, though by no means singular to this state, there exists

- a paucity of services in rural areas relative to urban areas of the State;
- poor communication between health services only a few kilometres apart;
- difficulty accessing services; and
- difficulty in recruiting and retaining health professionals in rural areas. [54]

There is a need to identify more appropriate integrated models of non-inpatient care in rural and remote areas but this is often difficult to implement because of viability and sustainability problems. Some ideas for improved services that have been trialled in other jurisdictions in rural and regional areas are:

[54] Christopher Moorhouse, Gerald Farrell (1999), Navigating Mental Health Services in the Island State 5th National Rural Health Conference Adelaide, South Australia, 14-17th March 1999 Proceedings http://www.ruralhealth.org.au/PAPERS/5_island.pdf

- Multipurpose Services have been particularly successful in small rural communities, providing they effectively link with regional centres for the more complex services.
- The development of regional mobile medical and nursing services to address critical gaps at smaller sites.
- The development of new types of practitioners to support the introduction of contemporary models of care.
- Develop new models of primary and community care
- Develop the capacity of general health services to provide non-specialist mental healthcare
- Increase the focus on services that maintain the health and independence of older people
- Enhance access to clinical services via telehealth technologies, e.g. GP2U which provides a service by which that patient anywhere in Tasmania can see a psychiatrist online. This is a bulk billed service and all Tasmanians are eligible for consultations.

Some things we heard at our rural consultations:

- It is often necessary to catch a 9am bus to attend a 4pm appointment in a main city, simply because services are so limited.
- Bus services for students do not meet their needs; college students miss the first and last hour of class daily because of bus times.
- The bus operating to enable kids to undertake recreational activities in other towns does not run during the holidays.
- The only respite offered for one carer was located in the North West, without support in getting the consumer there. This meant that in order to have a week off, she first had to transport a resistant consumer three hours to the respite centre and leave him when he had made it clear that he did not want to leave home.
- One man tried to attend a community art group but was not provided with the necessary introduction and support. This meant that the community was scared and uncertain about him, and he was unable to integrate into the group.

2. Aboriginal people

From a consultation with the Aboriginal community at the Tasmanian Aboriginal Centre 08/01/2015

Reliable data for the reporting of Aboriginal health status are generally limited in Tasmania due to under-reporting and other gaps in monitoring and reporting on Aboriginal health issues. It is clear, however that there are significant health inequities between the Aboriginal and non-Aboriginal populations. Aboriginal people have higher prevalence rates of many health conditions, particularly circulatory diseases (including heart disease), diabetes, respiratory diseases, and kidney disease. They also have a lower life expectancy and more disability. Many of these inequities find their origin in greater socio-economic disadvantage, with Aboriginal people generally being worse off than non-Aboriginal people when it comes to the social determinants of

health. On average Aboriginal people report having lower incomes, higher rates of unemployment, lower educational attainment, and more overcrowded households than other Australians. For Aboriginal people, issues such as cultural connectedness, colonisation, and racism have also been identified as having a unique influence on mental health and social and emotional wellbeing. The self-assessed health of Aborigines in Tasmania continues to compare unfavourably with that of non-Aboriginal Tasmanians, with Tasmanian Aboriginal people being significantly more likely than non-Aboriginal Tasmanians to rate their health as only fair or poor.[55]

There are many factors which contribute to poor social and emotional wellbeing in Aboriginal communities. These include colonisation, dispossession and cultural dislocation; dislocation of families through removal; marginalisation as a minority; unemployment; welfare dependency; past history of abuse; destructive coping behaviours; health and mental health issues, low self-esteem and a sense of powerlessness.

The participants at this consultation noted that they are seeing an increased number of people with complex needs and that this will continue with the unaddressed problems of inter-generational trauma. For this reason, they identified that child/adolescent care should be a priority. Although Tasmanian Aboriginal people have a strong culture of family and community connectedness, they continue to experience far greater inequities in terms of health and wellbeing status. This does not, however, counter the effects of racism and dispossession. It is clear from the experience of Aboriginal Health Services and the people present at the consultation, that any consideration for the improvement of the mental health and wellbeing of Tasmanian Aboriginal people and providing services that will work for them must be under-pinned by knowledge of the history and culture of the people themselves.

Clinical Services

Clinical services are of particular concern to the Aboriginal community. Issues raised included:

- There is great value in providing mental health care within an Aboriginal community controlled health service.
- Restraint in clinical services continues to be used, with no attempt at de-escalation prior to an episode or debriefing following one. It was emphasised that if restraint is necessary, it needs to be undertaken with clear explanation, and debriefing of the consumers afterwards is critical to ensure the episode is the least traumatic it can be for the consumer.
- Cultural barriers can also be problematic in the Department of Emergency Medicine. A lack of understanding and respect around Aboriginal culture can deter patients from seeking help. Lack of cultural awareness extends outside of emergency services. Tasmania has a

[55] Tasmania, Department of Health and Human Services, Population Health (2013), *State of Public Health*, p. 23. This report refers to data from the following publications: Australian Institute of Health and Welfare (2010), *Australia's Health: Aboriginal and Torres Strait Islanders,* and Statewide and Mental Health Services, Tasmania (2013), *Submission to the Joint Select Committee on Preventative Health Care.*

severe lack of psychologists with an appropriate understanding of Aboriginal culture. While this lack can be mitigated by better use of technology, utilising the relationships that Tasmanian Aboriginal Centre (TAC)has built with their clients can also assist. However, the only way to appropriately address the issue is to increase the number of psychologists with the appropriate knowledge.

- Recognising the value of clear communication and cultural understanding, cultural training of clinicians in Aboriginal culture would improve the experience for consumers from Aboriginal communities, and would encourage them to seek help in the future.
- Lack of information and education within clinical services is an ongoing problem. Consumers should be made aware of their personal rights while within mental health facilities, and given access to the Mental Health Act. They should remain informed and engaged throughout their treatment. Aboriginal people need to have access to advocates from within their community and staff of TAC could fill this role.
- GPs need to be properly educated on mental health and mental health services generally. GPs also need to be properly educated on Aboriginal culture.
- Lack of appropriate discharge procedure is a problem for Aboriginal people as well as the broader community. Clinical services are not contacting family or friends before discharge. While there are services in place to ensure people have support upon discharge, such as at TAC, these are not being utilised by clinical services. This leaves people vulnerable following time in hospital, and places them at risk of homelessness and further episodes of severe mental ill health.

Although the group believed that there is more acceptance of people with mental health issues within Aboriginal families and community, they nonetheless noted that stigma does exist within the Aboriginal community. This could be addressed by changing the focus of mental health provision from an alienating medical model to a community-centric one. The participants at this consultation stated that they would like to see a shift away from medical models to a community-based model of care such as provided at TAC. The current model is still too disease-centric and does not align with the need for a holistic consideration of social and emotional wellbeing which is closer to the Aboriginal concept of mental health. For Aboriginal people this concept is not just related psychological distress and behaviour problems, includes mental health and acknowledges the importance of factors beyond the individual, such as cultural identification, spirituality and the community – factors that promote social and emotional wellbeing.

Children and families

It was emphasised that there needs to be a particular focus on Aboriginal families, and in particular, on Aboriginal children. With large numbers of children in out-of-home care – most in kinship or foster care and a small number in institutional care – the needs of the children must be directly addressed. Resourcing Aboriginal community-controlled services to enable the assignment of a social worker or Aboriginal health worker to each child at the commencement of their interaction with the department would alleviate many problems that currently exist. While foster carers need to be provided with the appropriate support and education to care for the children, there also needs to

be a focus on increased advocacy for the children themselves, as the current system focuses on guardians rather than charges. This advocacy would include relevant education of foster carers, such as provision of information about inter-generational trauma.

Children should have a case worker as soon as they are brought to the attention of the department. Current services are directed at working with the parents or guardians, but not with the children. It should also be a priority that carers are informed about the children's needs, especially in terms of the effects of trauma.

When possible, there should be a priority on keeping families together and children in the home. While some services presently exist to provide support to struggling families, they are often 'band-aid' solutions, assisting with the running of the home but not providing any long term solutions. Services need to be put in place to address underlying issues such as addiction, directly addressing the problems rather than just provide home support.

Having greater impact than tinkering around the edges of a child protection system that does not work for Aboriginal children and their families would be transferring responsibility for this work to the Aboriginal community. As recommended in the report *Keeping our Children with Us*[56] the Department of Health and Human Services should enter into immediate negotiations with the Tasmanian Aboriginal Centre for the transfer of responsibility for out of home care for Aboriginal children to the TAC with an accompanying transfer of finances currently available for those children. This would then alleviate the need to educate foster carers and case workers within the Department about Aboriginal history and culture.

For those children not in care, the value of Aboriginal children's Centre and the AHS in providing activities that promote mental health, screen for mental health problems, offer early intervention, work with families/parents, refer to specialist services, cannot be overstated. It is clear that services grounded within the Aboriginal community itself provide the best outcomes for social and mental wellbeing.

Services, referrals and pilot programs

Tokenism continues to be an ongoing problem in the provision and resourcing of services for the Aboriginal community. Services will often advertise that they provide for the Aboriginal community and be funded as such, without appropriate consultation and consideration of which services are actually needed. This often leads to a decrease in funding of services that actually address Aboriginal needs in a way that works for the community.

There is also a need for appropriate assessment of pilot programs, and approved funding to continue those that are working. Often, programs are funded for a short trial period, and discontinued even if they are working well, leaving people without services they have come to rely on.

[56] Heather Sculthorpe (2014), *Keeping our Children with Us*, Tasmanian Aboriginal Centre.

There are ongoing concerns with referral of clients to the Tasmanian Aboriginal Centre. Aboriginal Health Services sees a large proportion of Aboriginal people, but is not adequately funded to cover all services. Individuals tend to be referred to the Tasmanian Aboriginal Centre because they are Aboriginal without recognition that the Centre does not have the specialised services that are needed for appropriate treatment. The Tasmanian Aboriginal Centre could fulfil client needs with adequate funding, improved recognition of the services of the Tasmanian Aboriginal Centre and better referral pathways.

If it is recognised, as it should be, that in most cases services for Aboriginal people are best provided by Aboriginal organisations like the Tasmanian Aboriginal Centre, then Aboriginal organisations must be adequately resourced to provide these services. However, there are services that would still need to be provided by mainstream providers if only due to economies of scale.

There is no doubt that the provision of regional Aboriginal case managers based within the Tasmanian Health Service would build relationships across regions. Currently, there are insufficient resources, and not enough consistency in staff to build the necessary relationships, but a dedicated, adequately funded position would ensure greater connectivity and integration across the state.

3. People from Culturally and Linguistically Diverse (CALD) backgrounds

Appropriate services must also be available to meet the needs of individuals from culturally and linguistically diverse groups. Beyond the particular influences of cultural practice and beliefs, migrants and refugees settling in Australia are subject to unique and sometimes traumatic experiences. Language barriers, history of torture and isolation/integration problems are just a few of the common issues relevant to this group [57], and associated with this are numerous and complex mental health disorders.

There is a need to:

- Raise awareness and understanding of mental health and cultural issues in both cultural and service environments.
- Fund to reduce stigma associated with having a mental illness, which the CALD community also experiences.
- Ensure the provision of mentoring services even after funding for PHaMS moves across to the NDIS. New entrants with mental illness who are not eligible for NDIS will still benefit

[57] See, for example, Keller, A.S. et al, 2003, Mental Health needs of asylum seekers, Lancet, 362 (9397), 1721-1272; Newman, L.K., Dudley, M., & Steel, Z, 2009, Asylum, detention, and mental health in Australia, Refugee Survey Quarterly, 27(3) 110-127; The National Inquiry into Children in Immigration Detention, 2004, Australian Human Rights Commission.

from this service. It will help them connect to the community in general and help them adapt to the Tasmanian culture.

- Employ designated CALD mental health workers in all mental health services.
- Provide training for interpreters in the area of mental health.
- Ensure that all mental health services use interpreters and not family members or friends.
- Expand funding for natural therapies including massage, acupuncture and other evidenced based natural therapies for newly arrived refugee and humanitarian entrants.

At the CALD consultations we heard:

- One suicidal young man was discharged six times in a period of two weeks, into the care of other young people.
- There have been instances of patients being involuntarily admitted to hospital, but not being provided with an interpreter until days after their admission.
- The high school with the largest CALD youth population in Tasmania has not accessed an interpreter in 5 years.
- There is need for 10 teacher education sessions in southern Tasmania alone, but the Phoenix Centre is only funded to run 2.

4. LGBTI

The mental issues for people from LGBTI communities need to be highlighted because this is a group which is at increased risk of very negative mental health outcomes. As William Leonard and Atari Metcalf put it, in a recent report:

> Australian data suggest that LGBTI people experience the same range of mental health disorders as the population as a whole. However, the data also show significant variations in the prevalence and patterns of mental ill health between these two populations. While LGBTI and mainstream communities experience similar rates of low prevalence, high impact mental health disorders such as schizophrenia and bi-polar disorder, the data indicates that LGBTI people are at increased risk of a number of mental health problems, including anxiety disorders, depression, substance use disorders, self-harm and suicide.[58]

There are a range of initiatives that must be undertaken in order to address the mental health issues faced by LGBTI Australians. The success of these initiatives is dependent upon commitment from the Government to work with mental health service providers and LGBTI health organisations to ensure that LGBTI people are accessing and receiving proper care and support.

These initiatives include:

[58] William Leonard and Atari Metcalf (2014), *Going Upstream: A Framework for Promoting the mental health of LGBTI people*, Sydney, National LGBTI Health Alliance, p. 12.

- Supporting and funding prevention and early intervention programs that seek to address LGBTI mental health issues, particularly for young people;
- supporting and funding programs that address the issue of dual diagnosis among LGBTI people (i.e. mental health and problematic drug/alcohol use);
- ensuring that LGBTI people with mental health issues are able to properly access existing mental health services; and
- supporting a strengths-based, holistic approach that promotes the resilience of LGBTI people.

During our consultation with members of the LGTBI community, the issue of stigma was raised in reference to clinicians and GPs. In particular it was noted that some GPs have very dismissive, impersonal attitudes that demonstrate a lack of respect for the dignity of the person they are seeing. One participant noted, "GPs need to respond beyond handing a number over a desk when they're faced with something they're not qualified to deal with."

We were also told of one young person who has a friend relying entirely on her peers for support because she cannot be assured that the school counsellor will keep her sexuality confidential. This fear of disclosure of personal information is not uncommon with young people from the LGBTI who are subjected to significant stigma and bullying.

5. People with Borderline Personality Disorder

Currently in Tasmania there are no dedicated services for BPD and during our consultations state-wide, we heard many distressing stories from carers and consumers about the negative outcomes of this neglect. MHCT believes that the Department could rectify this situation by purchasing consultations from Spectrum in Victoria. Nonetheless the situation could be improved with a more coordinated approach.

Diagnosis is generally made by a psychiatrist, with ongoing treatment managed by a psychiatrist, clinical psychologist or other mental health professional.

- The most effective treatment usually involves a combination of, psychological therapy, medication and support.
- Psychological therapies that have been found to be effective in the treatment of BPD are Interpersonal Psychotherapy (IPT) and Dialectical Behavioural Therapy (DBT). During IPT, a person learns new and effective ways to relate to significant people in their lives. DBT helps people learn to handle their emotions better and re-learn the way they typically respond to situations and other people.
- Medication alone does not 'fix' BPD. It can be helpful, however, in the management of some symptoms, such as depression, anxiety and mood swings.

- Longer term psychiatric treatment may be provided by a GP or community mental health services – a clinic with specialist health workers treating people in their local area.
- Community support programs may include help with finding suitable work, accommodation, training and education, psychosocial rehabilitation and mutual support groups.
- Family and friends of people with BPD can often feel confused, angry and alone. Education and support for family and other carers is an important part of treatment, as is understanding from the community.
- With appropriate treatment and support, most people with BPD can lead full and productive lives.[59]

6. People with Eating Disorders

Eating disorders are serious health conditions that can be both physically and emotionally destructive. People with eating disorders need to seek professional help. Early diagnosis and intervention may enhance recovery. Eating disorders can become chronic, debilitating, and even life-threatening conditions.

The most effective and long-lasting treatment for an eating disorder is some form of psychotherapy or counselling, coupled with careful attention to medical and nutritional needs. Care should be coordinated and provided by a health professional with expertise and experience in dealing with eating disorders. Tasmania lacks the clinicians trained in eating disorders and general training of psychologists and general practitioners is minimal. People with eating disorders often present firstly to their GP and in many cases are not properly diagnosed due to this minimal understanding of eating disorder conditions.

When someone is very seriously affected, it may be necessary for them to be treated in hospital for a time. Information and mutual support are also important for the person affected and for family and friends. In Tasmania we have no dedicated provision for adults with eating disorders in acute facilities. There is also a lack of community support for this group apart from Tasmania Recovery from Eating Disorders (TRED). TRED provides information and support groups for people experiencing an eating disorder in Hobart, Launceston and the north-west of the state as well as family and friends support groups in Hobart and Launceston.

In 2011, a report from the Hobart Women's Health Centre noted that:

> Eating disorders are extremely complex mental illnesses accompanied by substantial physical impairment and medical complications. An eating disorder is a potentially fatal mental illness, frequently requiring both psychological and physical intervention to promote recovery. In particular, Anorexia Nervosa has the highest rate of mortality of

[59] Sane Australia (2014), *Borderline Personality Disorder Factsheet*, http://www.sane.org/information/factsheets-podcasts/160-borderline-personality-disorder

all psychiatric disorders. In fact, anorexia nervosa has a standardised mortality rate 12 times higher than the annual death rate from all causes in females aged 15 to 24 years. All forms of eating disorders are also linked to considerably higher rates of completed suicides than the general population.[60]

This same report estimated that in Tasmania 'approximately 12,000 people are living with an eating disorder which is also impacting on the lives of their family and friends. In addition 2.9% of females met the criteria for binge eating disorder and 2.4% for partial anorexia nervosa.'[61] Despite the fact that the report made several recommendations, four years down the track, things remain as they were. What's more, the Paediatric Eating Disorder unit in the Royal Hobart Hospital is under-resourced; there are no dedicated beds in acute facilities for adults with eating disorders and resourcing for prevention and early intervention is negligible.

7. People with co-occurring disorders

MHCT believes that the government should be aware of the disastrous state of services for people with co-occurring disorders, or comorbidities. In particular:

- Individuals, families and primary health care workers who make referrals need to be confident that, regardless of which service they contact – drug and alcohol services or mental health – a timely and effective response to both issues will be coordinated.
- Given the common occurrence of drug and alcohol issues coexisting with mental health problems, protocols between agencies that specify how to connect and facilitate a collaborative response are required.
- Innovative funding models are needed which foster a coordinated approach between mental health and drug and alcohol services.
- The development and implementation of shared approaches between mental health and services are needed for people with disability and acquired brain injury.
- Ultimately, what is needed is better outcomes for people with co-occurring problems and complex needs, through joint planning and protocols, common assessment frameworks, community brokers, case management and joint programs.

Given the common occurrence of drug and alcohol issues coexisting with mental health problems, protocols between agencies that specify how to connect and facilitate a collaborative response are required. However, there are many people who have mental health related needs who also have co-occurring physical health or disability related needs. People who have a disability, a drug and alcohol problem, an acquired brain injury or physical health problems also have significantly greater likelihood of experiencing mental health problems and/or mental illness. People with coexisting needs often face discrimination from neighbours and communities due to facing

[60] Jen Van-Achteren (2011), Sprouting Seeds: Tasmanian Eating Disorders Information Line Project Hobart Women's Health Centre, p. 8.
[61] Ibid., p. 11.

multiple life challenges. They can also face discrimination when accessing housing, further education, employment and justice services.

Ways in which services need to work together effectively to improve mental health outcomes and sustain people with coexisting needs:

- Innovative funding models which foster a coordinated approach between mental health and drug and alcohol services.
- Development and implementation of shared approaches between mental health and services for people with disability and acquired brain injury.
- Better outcomes for people with co-occurring problems and complex needs, through joint planning and protocols, common assessment frameworks, community brokers, case management and joint programs.

8. People with mental illness in the prison system

People with a mental illness are over-represented in the prison system. This is a group that does not seem to receive appropriate treatment due to their incarceration; they are not eligible for ATAPs and as a result cycle in and out of prison and hospital. These interventions cost far more than the initial mental health treatment that may have prevented their imprisonment in the first place. [62]

An adult corrections health plan should ensure that prisoners who need some form of mental health intervention receive it. The following are key mental health service requirements for a correctional facility:

- Ensure that every prisoner with a diagnosed or diagnosable mental illness has a care plan through the service that includes a release plan that allows for the successful engagement with services in the community;
- Have an emphasis and support for mental health promotion, prevention and early intervention;
- Have an emphasis on access, quality and coordination of services both during and post incarceration;
- Adopt a recovery orientated treatment service that includes improved links between the correctional facility and community based services such as supported training and rehabilitative services; and
- Include enhanced data collection, monitoring and planning.

[62] http://www.justice.tas.gov.au/correctiveservices/breaking_the_cycle/documents/Breaking_the_Cycle_Discussion_Paper.pdf

O. How Should We Balance Investment in Mental Health and Mental Health Services in Tasmania?

1. What are the priority areas for investment and reform?
2. How should we balance investment across clinical bed based services and community teams, and community sector organisations (non-government)?
3. How should we balance investment across services for mental ill health and mental health promotion, prevention and early intervention?

MHCT would like to see resourcing of the mental health sector that is proportionate to the growing number of people experiencing a mental illness. This requires long-term development of community-based care and real alternatives to acute hospitalisation which is the most expensive intervention. Instead of focusing on optimising hospital-centric services, 'new funding mechanisms and genuine innovations in health (step-up and step-down beds) and secure housing, backed by clinical supports, need to lead the way.'[63]

New organisations and new structures are attempting more holistic management approaches, combining clinical care, community support, housing, employment and other services. The best option for consumers, carers and funders is the development of a wider spectrum of acute and community-based care settings to deliver both acute and psychosocial interventions with an increase in the number of community-based programs that contribute to reducing the demand for inpatient services. This may take a number of years to roll-out but on every level this is the way into a less expensive, more responsive, recovery-driven solution. Furthermore, 'the key challenge facing continued reform in mental health is not uncertainty regarding programs or services, but rather how to drive coordinated care for consumers across departments, governments and providers.'[64]

Trieste Model

MHCT would like to draw the attention of the Government to the mental health system in Trieste, Italy, which has been recognised internationally as achieving successful de-institutionalisation of mental health services, and where the gap is filled by strong community mental health organisations. Evidence of the achievements of the Trieste model include:

- Substantial population coverage –70% of the Trieste population now have access to a local, 24 hour, 7 days a week mental health service [population 250,00]
- Decreased suicide – suicide rates have been reduced by 30%
- Lower rates of involuntary treatment– only seven Trieste residents per 100,000 residents are subject to involuntary treatment, compared with 30 per 100,000 for Italy overall

[63] Getting mental health reform back on track: a leadership challenge for the new Australian Government, (2014), *MJA* 200 (8), pp 445-448

[64] The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design (2013), Medibank Private Limited and Nous Group, p. 1.

- No homelessness and little incarceration – no one with mental illness is homeless in the region and only one mentally ill person is in a forensic hospital
- Employment opportunities – 400 people with mental illness are employed on award wages in social co-operatives and a further 200 people are employed in private firms.[65]

Senator Lynn Alison, Chair Senate Select Committee on Mental Health in 2006 noted that: 'While Australia's demographics and the development of its health system is different from that of Italy there are some lessons to be learned from the mental health services in the Trieste region … Some of these are:

- Early, easily accessible, community-based intervention is successful in reducing serious episodes of illness that require acute care and therefore cost
- Mental health services must provide or be closely linked with housing, employment and social reintegration provision for minimising psychiatric disability
- It is possible to treat the vast majority of people with mental illness in an environment free of physical or chemical restraint if their human rights and their experiences are respected and services readily accessible
- That families and carers can be relieved of the most onerous caring tasks if they are engaged with and informed by service providers in the care provided.'[66]

While this model may not translate exactly to Australia, or indeed Tasmania, there is much to be learned from it. There is sufficient evidence that a community-based model does make a great difference to creating a successful mental health system, is less expensive than our current model which is weighted towards acute hospital care and has other benefits including the reduction of stigma. This is enough reason for a thorough investigation of how such a system, with local modifications, could work here. Earlier in this submission, we also referred to community-centred models in Lille, France (p. 19) and Andalucia Spain (p. 20). There are many more community-based models from other jurisdictions that could provide some direction to our own mental health system.

One further example is the Canada Greater Vancouver Mental Health Service Society a community-based non-institutional mental health service which has been running from the 1970's. This service has been offering community-based mental health services to persons with schizophrenia and other major mental disorders over the past 40 years. In 1993, a review of this service found that:

> The key to its success lies in a decentralized, relatively non hierarchical organizational structure which allows committed and skilled multidisciplinary teams to work with patients and their

[65] *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*, (2013) Medibank Private Limited and Nous Group, p.82.

[66] Lyn Allison, *A national approach to mental health from crisis to community: Appendix 3 - Report of mental health services observed in Trieste, Italy* (2006), Senate Select Committee on Mental Health, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/e03

> families in their community. The resulting services are fully integrated within the fabric of the community and are responsive to local needs. Partnerships among professionals, patients, families and community agencies result in work that is creative, productive and effective.[67]

At MHCT, we know that people with mental illness can fare better with appropriate and timely care, and we also believe, based on a mound of evidence, that prevention and early intervention plays a significant role in preventing further and more acute mental health issues and other negative outcomes in the future. This cannot be accomplished on a shoe-string budget. Every objective review of the mental health system indicates that the system has been significantly under-resourced over a long period of time. MHCT accepts that streamlining the system is a good objective, and agrees that structural change to support people in accessing a modern, person-centred service is sorely needed. However, our organisation and stakeholders will not accept any reforms that leave people with mental illness, one of the most disadvantaged groups in society, with further disadvantage.

At the outset, the MHCT would like it noted that saving money, though not a bad end in itself, cannot be the primary basis for reform. Furthermore, if people with mental illness are placed in stressful environment and are unable to access the support they need or experience a continuity of care, they are likely to relapse and require yet more costly clinical interventions. This is not a solution that can help people or the economy ultimately.

MHCT believes that the primary goal of reform of the mental health system should not be to save money in the short term. The government must look at the impacts on people of any reform and choose options that are proven to prevent mental illness, reduce hospitalisation and deliver a life based on basic human rights and dignity for all Tasmanians. Only this can promote the general wellbeing of the Tasmanian community, improve quality of life for mental health consumers and deliver long-term savings to the Tasmanian economy.

According to Professor Peter Shergold:

> The evidence is categorical. Patterns of disadvantage established in childhood and adolescence continue into adulthood: poverty, family instability or abuse lead to behavioural and mental health problems, poor educational attainment, lower job prospects and more likelihood of welfare dependence in later life. Investing in prevention may be more costly up-front but, over the longer term, it reduces expenditure significantly. Strategic service interventions on a planned basis are likely to be far more effective over time than episodic care based around a recurring series of discrete crises.[68]

In 2012 consultations were held by the Commission on Delivery of Health Services in Tasmania. Participants 'were fairly unified in the opinion that a single point of funding, managed

[67] N Sladen-Dew, DA Bigelow, R Buckley, S Bornemann (1993), The Greater Vancouver Mental Health Service Society: 20 years' experience in urban community mental health, Canadian Journal of Psychiatry, vol. 38, no. 5, pp. 308-14.
[68] Peter Shergold (2013), *Service Sector Reform: A roadmap for community and human services reform. Final report*, Victoria Department Community Services Service Sector Reform project, p. 39.

cooperatively by both federal and state governments, would ensure a greater level of accountability and collaboration. The need for greater cooperation between state and federal governments was emphasised, although many expressed the view that the Commonwealth should take sole responsibility for management of the state health system. That said, there was also a call for a single governance structure; an independent agency with authority to build integration between the Tasmanian Health Organisations and the Tasmania Medicare Local.'[69] It is now clear that the three Tasmanian Health Organisations will now be integrated into one state-wide THO and the Medicare Local will be replaced by a Primary Health Network but that does not change the intention of the recommendation.

The mental health system is costly and all indications are that that the high personal, social and financial costs associated with mental illness will not be reduced significantly by treatment interventions alone. Interventions that impact earlier in the development of a mental illness are also required. We need a new direction for mental health, one that encapsulates a better balance between promotion, prevention and early intervention (PPEI) and clinical interventions at the other end of service provision. An effective mental health PPEI program must be developed based on strong partnerships with all branches of the Tasmanian Health and Human Services Department, GPs, NGOs, consumers, families and carers and including a range of other key stakeholders.

PPEI strategies will not provide a quick fix and will take time to achieve better outcomes. However, the right balance of investment and the right type of services can result in improved mental health and wellbeing, and are critical to long-term and sustainable reform. To make a positive difference and achieve lasting change, we must balance our focus, investment and resources to include strategies that help people maintain their mental health and wellbeing, prevent problems from developing, and aid early identification and intervention when problems do arise, to minimise their duration and severity. We must focus on returning people to wellness at every opportunity.

The Royal Australian and New Zealand College of Psychiatrists has noted that:

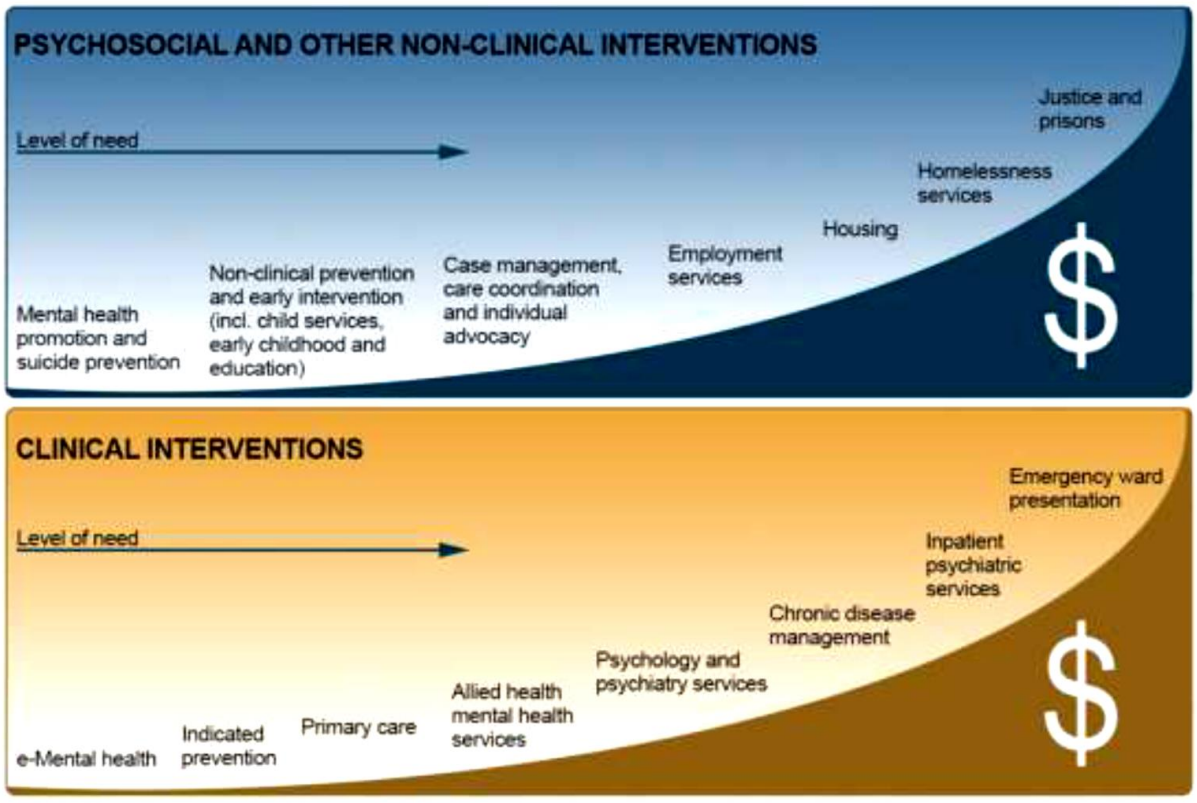
> Few studies have reported economic evaluations for early intervention programs and the few that have do not use comparable assessment metrics. It is therefore difficult to directly compare the cost of one program with another. However, overall, considering the available cost data, for high-risk families, there seems to be a good return on investment although further research is needed. The limited amount and non-comparability of cost data across studies of preventative measures highlights the need for all future trials of preventative programs to build in formal economic evaluation procedures from the outset.[70]

[69] The Commission on Delivery of Health Services in Tasmania (2012), Summary of issues raised at the 13-15 November 2012 consultation forums http://www.tasmaniahealthcommission.gov.au/internet/tascomm/publishing.nsf/Content/forumsynopsis#.VOmhfnyUeSo

[70] The Royal Australian and New Zealand College of Psychiatrists (2010) Report from the Faculty of Child and Adolescent Psychiatry. Prevention and early intervention of mental illness in infants, children and adolescents: Planning strategies for Australia and New Zealand, p. 23.

It is clear from a mountain of evidence that good social skills, adequate nutrition, positive school experience, good physical health, strong cultural identity and economic security improve resistance to risk factors and the development of mental illness. Risk factors such as poor health in infancy, low parental involvement in a child's activities, family violence and disharmony, parental substance misuse, bullying, school failure, problematic school transitions, physical, sexual and emotional abuse, poverty/economic insecurity and a lack of support services are associated with increased probability of onset, greater severity and longer duration of mental health problems. These factors are also related to an increased probability for the continuation of cycles of abuse, violence, poverty and other negative outcomes. Early intervention models which include across sectorial input are ways of addressing a range of social disadvantage. By this logic early intervention has the possibility of saving significant costs, financial and social, to government and community.

What is therefore also becoming increasingly clear is that the way we pay for mental health today is the most expensive way possible. Thomas Insel, Director of the National Institute of Mental Health in the US says, 'We don't provide support early, so we end up paying for lifelong support.' That, in a nutshell, is the point of view of the MHCT.[71]



[71] Liz Szabo, Cost of not caring: Nowhere to go - The financial and human toll for neglecting the mentally ill, *USA Today*, http://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535/