COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

SENATE SELECT COMMITTEE ON HEALTH

Health policy, administration and expenditure

(Public)

WEDNESDAY, 26 AUGUST 2015

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

EXHIBIT 974

EXHIBIT 974

SENATE

SENATE SELECT COMMITTEE ON HEALTH

Wednesday, 26 August 2015

Members in attendance: Senators McLucas, Muir, Williams.

Terms of Reference for the Inquiry:

To inquire into and report on:

a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;

b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;

c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;

d. the interaction between elements of the health system, including between aged care and health care;

e. improvements in the provision of health services, including Indigenous health and rural health;

f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;

g. health workforce planning; and

h. any related matters.

WITNESSES

BUTT, Mr David, Chief Executive Officer and Commissioner, National Mental Health Commission

CROWE, Ms Jacqueline, Commissioner, National Mental Health Commission

FELS, Professor Allan, Commissioner, National Mental Health Commission

GOODSPEED, Ms Sally, Executive Director, National Mental Health Commission

HICKIE, Professor Ian, Commissioner, National Mental Health Commission

Committee met at 09:11

ACTING CHAIR (Senator Muir): Welcome. On behalf of the committee, I acknowledge the traditional owners of the lands on which we meet and pay my respects to the elders both past and present. I also extend that respect to Aboriginal and Torres Strait Islander people present today. This is a public hearing, and a *Hansard* transcript of the proceedings is being made. The hearing is also being broadcast via the Australian Parliament House website. Before the committee starts taking evidence, I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to the committee. Such action may be treated by the Senate as contempt. It is also a contempt to give false or misleading evidence to a committee. The committee generally prefers evidence to be given in public but, under the Senate's resolutions, witnesses have the right to request to be heard in a private session. If a witness objects to answering a question, the witness should state the ground upon which the objection is taken, and the committee will determine whether it insists on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, the witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time. I welcome the witnesses from the National Mental Health Commission and invite you to make a brief opening statement, and then the committee will ask questions.

Prof. Fels: Thank you, Acting Chair, and I thank the whole committee for giving time to mental health. We appreciate the fact that you see it as an important topic. I would like to talk for 10 to 15 minutes mainly about our report on the mental health system, which we provided to the government last December. I will also, when I have finished, ask Commissioner Jacqui Crowe, Professor Hickie and David Butt, our CEO, to comment on some further issues. The approach in our review—we call it 'contributing lives, thriving communities'—is a whole-of-person, whole-of-life, whole-of-government approach to mental health and wellbeing. It is not just a narrow health issue—fixing people's health up at the doctor's or in a hospital. We think you start with the person and the challenges they have. These include not only their need in certain cases for treatment at the medical level but also their needs for accommodation that is safe, secure and to a degree comfortable; participation in education and particularly in the workforce; and participation in the community more broadly. That implies a whole-of life approach to a person—every dimension of it. We need to look at every aspect of people from their youth, from their childhood, right through to old age, because mental health problems are omnipresent. It also means for governments that they have to look at not only what is looked at in health departments but at just about every department. Talking about the Commonwealth, for example, I cannot think of a department where mental health is not relevant. Take veterans, immigration, foreign affairs, the AFP, Treasury and finance, social welfare, social security, human services and so on—just everywhere there are mental health questions.

I want to stress one particular point today, which is mentioned in the report. It so happens that this hearing coincides with the National Reform Summit being held. We have provided all delegates to that summit with a submission about mental health reform. That is not so much because we think it will be a key issue for discussion today—I had a quick look over the draft communique this morning and I do not think it was even mentioned, but I could be wrong—but because we are urging the summit to recognise mental health and suicide prevention as key economic reform priorities that could lead to better productivity and growth in Australia. We have a copy of that submission and we seek your approval to table it.

Senator McLUCAS: I move that we approve that.

Senator WILLIAMS: Seconded.

Prof. Fels: Thank you. On the economics point for two or three minutes—because I am an economist. I know that that may earn me pluses or minuses from some.

Senator WILLIAMS: Many pluses.

Prof. Fels: Thank you, Senator. I was not expecting that accolade but I accept it with great pleasure. The fact is that mental health is a significant problem for the economy—as significant as or more significant than tax or microeconomic reform. Many people do not get the support they need, and governments get poor returns on substantial investment. The economic or GDP gains from better mental health would dwarf most of the gains, often modest economic ones, being talked about in current economic reform debates. You take one tax off here and you put it somewhere else; the net gain is not that big. A lot of the arguments for tax reform are actually about equity: it would be fairer to do this than that, and so on. But once again the equity benefits from improving mental health absolutely trump the equity and fairness benefits from redistributing taxes. That is starting to be recognised internationally. For example, Martin Wolf, who is often called the world's leading economics commentator, said, 'Mental health is the developed world's most pressing health problem.' And further:

> Given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves.

The OECD estimates that the GDP cost of mental health is four per cent. That is a huge number. In Australia that would be $60 billion or over $10,000 per family per year. The costs are the direct costs of treatment; the indirect costs, disability support pensions, imprisonment, accommodation and so on; the costs of lost output and income; and, finally, the big costs and direct costs, as I am sure all members of parliament would know, to carers and families. Also, there is now a lot of data about their reduced participation in the workforce due to the fact that they have to spend their time caring for ones who are close to them.

If we could improve the mental health system by 25 per cent, and we believe there is big scope for improving the system, both by reorganising it and by further investments in it, we could in fact deliver a one per cent improvement in GDP. That would be a huge contribution. For every 10 per cent gain in mental health, GDP would rise by 0.4 per cent. So if you think of some of the other reforms we have had—for example, the national competition reforms—they took 10 years of pretty hard work and they got a 1½ to two per cent boost to GDP. I believe you can have similar impacts through tackling the health system as a whole but particularly the weak part of it, which is mental health. There are two weak parts of the health system, in my view—mental health and Indigenous health, of which a significant part is mental health.

I might just mention that in our report on the Indigenous dimension we have made a number of recommendations, but one I particularly emphasise is that mental health should be part of Closing the Gap targets.

Just dwelling a little bit longer on the economic side, Treasury is always emphasising the three Ps that are key to better performance—population, participation and productivity. If we get all of them right we get good results. The mental health population is, as you all know, very big. One in five Australians experience some form of serious mental illness per year. If we could do something about that big block of the population, that will have a significant effect on the economy. The number of measures of the burden of mental health all show that it is quite a high proportion of the burden of illness in our economy. It is about 13 per cent on the main measure and it attracts only about eight per cent of the health budget. So there is a big population story.

The second factor is participation. If you can get labour force participation up, that is almost the best way of improving productivity and I am sure at this reform summit today we will hear a lot about measures, tinkering here and there, that will get participation up. People with mental health problems have a 38 per cent non-participation rate versus 22 per cent in the general population. Our participation rate is low by the standards of good OECD countries. We are at the bottom of the top good 10, 12, 13 OECD countries. Most people with mental illness are at the mild to moderate end. The scope for their better participation in the workforce is very large. The World Economic Forum estimates the cost of lost output and income at about 1.75 per cent of GDP. Most people with mental illness want to work but find it difficult to get a job and then to hold it.

The third variable is productivity. There is no doubt that mental health problems generate considerable absenteeism and so-called presenteeism—that is, people at work not being productive. Mental health conditions result in about 12 million days of reduced productivity for Australian businesses each year, according to Pricewaterhouse. A lot can be done. We are doing some work with businesspeople such as BCA, ACII, AiG and COSBOA, as well as with mental health institutions such as Black Dog, beyondblue and so on, to get a better handling of mental health problems at work. The direct budgetary cost of mental health to the Commonwealth is about $10 billion a year. Is that money being spent effectively and efficiently? Are we using that limited amount of money well and to best effect? Our view is that much of the funding from the Commonwealth is neither particularly effective nor efficient. Eighty-seven and a half per cent of the spending is downstream on income support and crisis response, basically—the Disability Support Pension, carer's payments, payments to states for hospitals, Medicare and pharmaceutical benefits. So, much of the Commonwealth spending is for failure to treat the problems early and cost effectively. It is payment for failure. We have made recommendations about how that heavy expenditure could be reduced with a much greater emphasis on and investment in prevention, early detection, recovery for mental ill health and the prevention of suicide.

I want to mention rural suicide. I used to think rural suicide was almost exclusively about the fact that farmers have a tough time and their pride is at stake—I have heard Senator Williams say that from time to time—and that is all true. But it is also about the poor services—the poor service availability for mental health in rural, regional and remote Australia. The fact is that the availability of psychiatrists, psychologists and mental health workers is about one-third what it is in the cities. Putting it lightly: if I live in a well-off area in Melbourne or Sydney and have a headache, I can walk out the front door and there are five psychiatrists ready to treat me; if I have got a serious mental health problem and I live in an area of low socioeconomic disadvantage, often a GP, despite their commitment, will not even think of referring me to a psychiatric service because there are none nearby—and it is even worse in the bush. This is despite the fact that we know that a lot of mental health can be dealt with, can be treated and that people can make a considerable improvement in their lives, if they are treated.

We did a review. We have of course emphasised that mental health is not just a problem for governments; it touches every industry, every workplace and the vast majority of families—it is everyone's responsibility. We consulted widely. We heard a huge amount from people with lived experience, their families, supporters and people who work in the sector. I would like to say that there is a strong consensus in the sector that the recommendations made by the commission are the right ones. There is a general consensus that the broad recommendations we have made are the right ones. Remember, we made those recommendations in the context of the government effectively saying: 'Do a report that does not recommend spending increases. We want you to come up with a way of doing it better, within the spending envelope.' Of course, I believe we should be doing more for mental health. There are a number of really important investments that would pay it, but we work within that fiscal envelope, as they call it. We also note that there are a lot of great things being done in mental health—a lot of wonderful innovations—but the system needs to be realigned from a focus on the service provider to people with lived experiences, their families and support people. They should be involved a lot more. 'Nothing about us, without us' is the slogan of that vast mental health community. I think there are about three or four million people who are touched by mental illness directly, and typically for their families and carers it is an all-consuming thing in their lives. As I am sure members of parliament know, when you meet these families, it is the only issue that counts for them.

We believe that you start with the person and what their problems are, and then you think of the range of solutions that are required—a kind of socioeconomic approach. Health is not just a disease. There are a set of broader drivers and all of them need to be tackled. So we need to have a broad approach to people and to the role of government. We need to shift the focus from downstream to upstream, from income support and crisis response to prevention, to early intervention and to recovery. The fact is that recovery is possible for mental health; it is not necessarily a perfect cure but you can greatly improve the lives of people with treatment—we know that much—and with broader based support through giving them proper accommodation, job opportunities, better education and transition from education to employment.

They are just a number of the things we have recommended, and we could go into them in more detail. There is also what is called a stepped care approach. It means that a person is in hospital—I know a lot of cases like this: people have a really serious mental illness attack and they end up in hospital—and when they step out there is nothing there in the community for them. The next night they might sleep under a bridge. They are going to relapse and go back into hospital. What we need is a stepped approach. True, we need the very, very costly hospital to deal with these people, but when they come out of hospital a number of them can receive less expensive treatment by getting accommodation that provides less intense treatment and is so much cheaper. Personally, I am involved in a project where most of the people have been in and out of hospital all their life. We now provide them accommodation and a degree of care and support. It is about one-third the cost of them being in hospital, and most of them do not go back in there because they get adequate support. When they start to recover, we can get them into the community. We can get them jobs. We need to do a lot more on jobs.

We also know that at the other end of the spectrum there are a lot of people whose needs are much less severe and that we need to have a step-care approach at that level. Sometimes there is just self-help. If we have good resources on the internet, some of them can go to that. Others need a degree of counselling and therapy. They may need light medical treatment. They need good attention in the primary healthcare system. We believe there should be a step-care approach. But the emphasis in the system now is just at the hospital end. We need a more balanced approach and if there are no more resources we need to shift resources carefully into community mental health under that range of other measures that I have talked about.

Another important point is the design of the system, the kind of architecture that is organised, needs improvement. By the way, we also think that the issue of children in the first three years is really important. I want to talk about Primary Health Networks. Two or three things need to be said about them. Firstly, they are one way of bringing about greater regional parity in the treatment of mental health. If you have regions and they are the primary dealer, with mental health at primary level and also at treatment level, you are going to get a more 'evening out' of the clear inequities in regional terms that exist in mental health. Also, we believe that they should be renamed Primary and Mental Health Networks. There are a couple of reasons for that. It would be a really important sign from the government and the parliament that mental health is taken seriously. It remains a rather low priority, I am sorry to say, all over Australia—at a federal and state level and in the community. But also of concern is the physical health connection. The life expectancy of people with serious mental illness, those with schizophrenia or those three or four per cent with bipolar et cetera, is about 15 to 25 years less than the rest of the population. They have a worse life expectancy than the Indigenous population. That is not only in Australia; it is pretty worldwide. That is because, above all, they have poor physical health. It is not their mental health that causes the early death; suicide is quite a small contributor to that statistic. They have very poor physical health. The mental health system does not give proper treatment to physical health. It just concentrates on mental health. There is a vast amount of research showing a so-called 'overshadowing effect'—that means if you go to a doctor and you say that you have a mental health problem, your physical health problems get discounted. If you say you have a pain, they tend to think that it is just a mental health thing and not a real pain. What we need to do, in any case, is to integrate the treatment of physical and mental health much better. A strong sign of that would be if we renamed them Primary and Mental Health Networks. Suicide is a very big problem. It is not an entirely mental health problem. We believe there should be a bigger regional and local community emphasis on that matter.

In our report we mention Aboriginal and Torres Strait Islander problems. There are very high rates of psychological distress and suicide. We have made a number of recommendations, including not only making it a Closing the Gap target but also a number of proposals, largely coming from the Aboriginal community about making the treatment more culturally sensitive and having more Indigenous workers. So there we are. We have produced a big report. There is enormous support from the whole mental health community, the families and the carers who are associated with it. As I have said, it also turns out that there is a pretty strong economic case for doing something about it. We have put in the report to government. It is public. We are hoping for the report to be adopted and for it to be seriously implemented. Thank you. I would ask Jacqui Crowe to make some comments.

ACTING CHAIR: Ms Crowe.

Ms Crowe: Thank you very much for letting us appear here today. It is a pleasure to be here. I agree with everything my fellow commissioner Professor Allan Fels has outlined. I would also like to state that the key to all change initiatives is that, when we ensure change, we do better. Our report has a lot of change in it. There has been a lot of change in mental health over the years, but I think now is the time to actually see that we do that better and that we get better outcomes both economically and, more importantly, for people themselves.

With regard to adding to the inquiry into and report on health policy, administration and expenditure I would like to add a few comments from the perspective of myself and family members living with mental illness, and from also spending many years talking with people, families and communities that are affected by mental ill health. That goes from mild mental illness to quite severe mental illness. Some of those people I come across are thriving in our communities, but the majority are just surviving. That is not acceptable to me or to my fellow commissioners.

Our people with mental ill health are over-represented in hospital emergency departments, often because they are forced to seek help in crisis as a result of early intervention services. We talk about the blockage in ED departments, but if we are forced to go to ED departments because we cannot get early intervention there is an issue there. The severely mentally ill carry a grave burden of physical health problems, as Professor Allan Fels spoke about. This includes diabetes and cardiovascular problems. These health problems are often not adequately managed and thus there is increased hospital related care and, tragically, premature mortality. For the severely unwell, that is actually up to 30 per cent. It is extraordinarily high, but it is an extraordinarily high cost to our health system as well.

An issue that Australia very often discounts is that of our frequently unseen and unheard champions: families and carers. Their roles and efforts are often unsupported and are becoming increasingly unsustainable. A report on mental health care was done by Mental Health Australia and then, I think, by the Mental Health Council of Australia, in 2012: *Recognition and respect: mental health carers report 2012*. It showed the experience of caring for a person with a mental illness can have major negative health impacts on family members and carers, especially as the report found they frequently neglect their own health requirements. A staggering number of carers end up in our public health system as well.

The report also found that the focus of carers and health professionals is often entirely centred around the mentally ill person's health, while family and carers needs are often not considered and their health needs are not considered. Neither are they being effectively supported. It is costing their health and wellbeing and it is also costing the health and welfare systems as well. In the report, carers were asked whether their mental or physical health had been affected as a result of being a mental health care. Seventy-one per cent of respondents reported a deterioration in their health as a direct result of caring for someone with a mental illness.

We often hear of young people with mental health worries—and with good reason: it is very important that we ensure they have contributing lives all the time—but we rarely hear of young carers. Young carers are very unheard and very silent. But these young carers state that they feel alone, stressed and distressed. The mental Health Australia survey showed that 70 per cent of respondents felt alone in their role and a staggering 81 per cent felt stressed and distressed as a result of being a young carer.

Family and carers provide understanding, guidance, support and, often, financial safety for people they care about and care for—and Allan alluded before to a housing initiative that many family members have started in Victoria. Unfortunately, the role of carers and families is not always appropriately recognised or supported by service providers, workplaces, government agencies or the broader community.

I would like to end where I began by stating again that the key to all change initiatives is to ensure that change means we do better—and we must do better for the people who are caring and our families. To do this, Australia must consistently and rigorously be monitoring and reporting publicly on outcomes. We do not currently do that well—and not just outputs but outcomes for people, which includes human rights issues, the effectiveness and quality of services, service system impacts, immigration, performance and coordination, the reform process and, importantly, what people, families and communities think of those systems.

ACTING CHAIR: Thank you. Would anyone else like to add to that?

Prof. Hickie: Yes. I would like to start by thanking the Senate for its ongoing interest in mental health. I recognise the role that the Senate has played through its committees, particularly over the last two decades, in monitoring Australia's national mental health and leading inquiries itself. In my own career, over the last 20 years I have participated in a whole series of national health inquiries, human rights inquiries and other independent inquiries into mental health. I would like to say what is different about the situation relating to this particular report. Most of those previous inquiries documented the many failures in our levels of health and relevant social services systems. They have generally led to programmatic approaches by government—a new program by either the federal or state to deal with one or another particularly identified problem from many of those previous reports. This report is really different. It was commissioned by the current government to look systemically at what the national government could do and the style of change that it could lead to result in a fundamentally different system over time. It is fundamentally a different type of work from that which has previously been done in national inquiries. It is an incredibly serious piece of work. Most of the Australian mental health community made significant contributions to the problem-solving exercise—not to just document the problem again but to arrive at agreed solutions to those problems in the short and longer term. There were over 2,000 submissions to the inquiry. The commission itself commissioned work from experts in the field to deal with many of the specific issues that needed to be dealt with.

As a consequence of that, the commission has produced a report which is a template for action for this government or any future government—on the options in the short term, the options in the longer term and on the way in which all expenditure needs to focus on delivering better outcomes, not simply an increase in programmatic activity in the area. As a consequence of the seriousness of the report, it is extremely challenging to many people who are currently funded and active in the field—and I am sure you will hear reports from many of the health providers, social service providers, non-government organisations and representatives of government about what they currently do. In truth, the report is challenging to all of those agencies in terms of the way they do those activities and whether those activities are linked with outcomes.

That is the challenge that I think governments face in responding to this particular report. It fundamentally says there is a need to redesign the system architecture, to develop regionalisation of care. So I think both the Australian government and state governments face a challenge: can they actually back local leadership? Can they provide the resources to the 60-plus regions in Australia to bring together the relevant health and social services in a way that is relevant to those particular communities to provide the range of health and social supports that are necessary for people to live a contributing life? That is a fundamental shift in the way we have understood Commonwealth-state relationships and in particular the way that we have organised that set of funding and service priorities.

I think it is important to say that it appears that there is consensus not only among providers but also among a number of the states—and, notably, from the Premier of New South Wales. In New South Wales, Queensland and WA in particular, there is a real appetite for implementation of this regionally focused approach that is backed by the resources of both the federal government and the state government. What we want to see is the implementation of locally led programs that are nationally significant, evidence based and accountable at the local level. That runs across the key areas of health and social services and suicide prevention and with a shift to a fundamental focus on resourcing the community, not necessarily the hospitals, the institutions or the traditional providers.

In the health sector this is particularly challenging because of the way that we fundamentally back fee-for-service based systems, particularly under our Commonwealth funding models. The report, at its heart, talks about funding models that are team based. It does not matter whether you are a doctor, a nurse, a psychologist or somebody else who works in that field—what is your capacity to work in a team in an organised way to meet the individual needs of a person and their family? In that spirit, it therefore resembles the spirit between the National Disability Insurance Scheme and National Disability Insurance Australia to put the person and their family and their needs at the centre of health and social service organisation. It encourages innovation, it encourages local testing, it encourages the use of new technologies to enable people to monitor their own health care and access better health care no matter which part of Australia they live in.

I think what has happened here is very unusual. The whole Australian mental health community, through both its lived experience and its technical experts, has combined to say to our respective governments that there is a fundamental need to move away from a programmatic funding approach in response to each crisis and towards locally led and organised services that work in regional Australia. We have models of that, we have ways of doing that. What we have never done before is shift our funding and our actual intention to say that is the intention, there is a consensus in the community. Quite unfairly, the mental health community is often painted as divided and in dispute in this area. It is therefore fundamentally blamed for a lack of service development. I think it is very clear that in this report they have come together and said: 'This is the way forward; we are in agreement.' It is challenging to the way governments currently do business—through the micromanagement of individual contracts. It is challenging to the traditional service providers, particularly in the mental health industries, and also in a number of our other non-government and social services areas. It is therefore challenging in its implementation. Fundamentally, the future should be about investing the money that we have, which is not small. It is $10 billion of Commonwealth money at this current point. It costs the nation $60 billion. We should invest it in a way that delivers better outcomes for those individuals and families who live with mental illness.

ACTING CHAIR: Thank you. If nobody else has anything to add, we will move to questions. Senator McLucas.

Senator McLUCAS: Can I start by congratulating the commission on this report. Professor Hickie, I think you are right: it is a different response from other inquiries that have happened in the past. I think back to the Senate select committee inquiry into mental health. That resulted in PhaMs and PIR really, which was a programmatic response to an analysis of a situation. So this is a blueprint, it is a way forward, but it is complex; and that is part of the reason why this committee has decided to undertake these three days of focus on mental health. We want to do two things: we want to better inform parliamentarians and the Senate about what you have said and also, hopefully, encourage community engagement around mental health. Professor Fels, congratulations to you and your co-commissioners. I know it was 12 months of hard work and talking to people.

Before we finish today, I want to go to the question of the independence of the commission. But that is not the fundamental reason why we are here. Professor Fels, you said that the government said that you were to stay within the current funding envelope. Your letter to the national reform summit today talks about an increased investment. If you were to give this committee advice about what areas you would focus increased investment into, where would that be?

Prof. Fels: I suppose there are two things that are needed—and, to a degree, I am speaking individually. Firstly, there is a great deal of scope for reorganising the system. I am sure there are some smaller costs involved in what we have recommended, and I hope you will not blanch from them. But, turning to investments, the fact is that every part of the mental health sector is crying out for additional support. Just to complicate that, we said that, over time, there should be a redistribution away from the acute end. That is not to say that there are not desperate problems at the acute end; it is just that there is scope to carefully manage a reorientation of the spending to keep people out of hospitals, which is expensive and is a sign that people are terribly unwell. And some of them do not need to be in there but some of them do. So we would generally say that the additional investments need to go to the front end of the system.

To put into context the question you asked, I have to mention that it is not just health—and you know that yourself—there is a range of things that make people better and keep them out of hospital. From that perspective, it is housing and whatever can be done about employment and also people's health in schools and education and their transition to the workforce. If someone has a mental health problem at school, there are things that can be done to help them get back on track and help them with employment where they might otherwise be struggling. So I have to give you a slightly broad answer by mentioning those other dimensions.

There is another dimension—and I am sorry to spend a bit of time answering your question, but the needs are pretty universal. There is the whole of life question—that is, children, the young and adolescents, the next group and then older people. The needs are all quite high there. We have particularly emphasised young children. What happens in the first three or four years of life is crucial, so that would have to be a priority.

Senator WILLIAMS: I am very intrigued about what the first three or four years of life have to do with mental health later on. We are always learning. Can you expand on that please? I think that is very important as far as parenting goes and preventing problems later on.

Prof. Fels: The evidence is fairly clear that what happens in those early years is extremely important, whether it is the inherited position of a young person, the surrounding family or the abuse question, and I would like my colleague Jackie Crowe to comment on that in a minute.

Senator WILLIAMS: Are you referring to physical, mental or sexual abuse, or to all of the above?

Prof. Fels: Yes, as one driver of that, but I think that there are a number of other things. There are a lot of cases where young children have a terrible time because their family has problems. The family itself may have mental illness and be not functioning very well. It may be not functioning well for other reasons. There may be some genetic factors at work, which need to be tackled early on.

There is quite a lot of research led by Professor Heckman, who actually got a Nobel prize for this, showing that an investment in the first three or four years of life pays off a huge amount more than an investment a bit later in life. In fact, not only that: if you get to people early, then later investments will pay off a great deal rather than if you leave them undealt with and start doing some work in adolescence. When I am talking about this, what I have in mind, anyway, are severe problems in early childhood. You know, there are challenges and stresses for young children, but there are a pretty big group that have severe problems and they are all mixed up with family dysfunction and other sorts of problems. They are the ones that I have in mind as a priority in that area.

There are some other areas where more needs to be done. It is really the stepped care approach that I was referring to. There need to be better step down arrangements from hospitals. I believe that that would be another area of priority, and that is wider than just mental health treatment. Support is being withdrawn somewhat from community mental health, and I think that we need to watch that. I wonder if any of my colleagues have comments on priorities.

Ms Crowe: Can I answer some of the questions around childhood mental health issues or preventing mental health issues later on in life? We know, from many research studies that have been done across the world, that 80 per cent of people that end up in a mental health service in the severe end have come from backgrounds of abuse and neglect. We also know from—

Senator WILLIAMS: Eighty per cent?

Ms Crowe: Eighty per cent.

Senator WILLIAMS: So you are telling me that, of people who have some sort of mental illness as adults, 80 per cent had problems as juniors?

Ms Crowe: Eighty per cent of them have come from abuse and neglect backgrounds as children, yes. That does not mean that their families were the abusers or the neglecters, but they come from that background. Professor Ian Hickie can talk more to this, but neuroscientists are coming up with a lot of evidence, and a lot of very interesting and fantastic research, on how the structures of the brain form in unborn and young children that live in environments of abuse and neglect, and on how that leads to mental health issues early on and later on in life. So, for me, investment into research that combines all of the brain research is hugely important—to understand that, to come together and talk about that. They are quite siloed in their research; not a lot of them come together. Investment in how to be emotionally healthy is extremely crucial. We do not invest a lot in that when we are talking about early intervention. We do not invest in our children about how to be emotionally healthy or mentally healthy.

Even if children are living in abusive and neglectful families—there is a huge amount of them in Australia it is not an uncommon phenomena and it crosses all socioeconomic boundaries as well—families must be supported to ensure that their children grow up healthy, both mentally and physically healthy, and not just blamed. My worry is when we talk about—

Senator WILLIAMS: Isn't that a basic responsibility of parents?

Ms Crowe: Absolutely, but there are reasons for—

Senator WILLIAMS: Sorry for interjecting, Senator McLucas, I am just intrigued by this statistic.

Ms Crowe: There are reasons for neglect and abuse. And, when we talk about neglect and abuse, it does not have to be the top end. You can be living in a perfectly wonderful family, from the outside, but if you are neglected within that family that will cause massive implications for your mental health down the track. So it is not as simple as removing the children or doing something quite invasive. It is about supporting families to be able to give the children the support that they need to thrive. And that is a whole other conversation. It is in our report. Our report is quite—

ACTING CHAIR: I might head back down that path a little later.

Senator McLUCAS: I think you recommend the three-year-old check-up that includes the mental health component. I think that is a very doable thing to do. My fear, though, is that we do the check up, and the GP says 'there's something here', then where do we refer to? And that is where we need to grow the system so that there is a pathway for that family to be supported in caring for their child in those circumstances.

Ms Crowe: Absolutely.

Mr Butt: I would just like to comment on that. We recommend in fact that it start earlier than that. We talk about the first four years of a child's life as the most important ones in terms of development. It goes down by the age of three, so it goes before that. You raised the funding issue and, to get back to that: yes, we do talk about prevention, early intervention and reducing the incidence of mental ill-health in society and starting at a very young age. That can realise savings down the track in relation to hospitalisations and so forth.

The issue that we have is that it is a whole-of-government issue but traditionally governments have not taken a whole-of-government approach in relation to the funding bucket. So we would be saying, for example, that if there are reductions in use of the disability support pension or carers' payments, because we are getting people into employment and maintaining them in employment, then any savings realised there should not just go back into Treasury but should be used, for example, by the department of social services to invest in early childhood programs and the like.

Senator McLUCAS: I totally agree with you, but you will know from your experience that central agencies do not necessarily think that way. But let's make the argument.

Prof. Hickie: Just on the priorities issue, you have raised a really important question. What this commission has said is that, if there were immediately more money available, investments in accommodation and employment are much more likely to deliver better health, social and economic outcomes than further investments in health. It is still the case that about 30 per cent of our hospital beds on any given day are occupied by people who have an accommodation crisis not a clinical crisis. Investments in employment, particularly at the age when people move from school into the early employment period—youth employment support for those who have mental health and substance abuse—is a high priority. In the health area, funding teams—teams of Indigenous workers, teams of mental health nurses, teams of psychologists—organised regionally is a sound investment, as distinct from the poor return on investment for fee-for-services systems where the providers determine the location and the outcome. So there are some high priorities.

The other is in the 12 regional trials of suicide prevention. There would be immediate implementation trials in Australia—not piloting but implementation trials—of organising suicide prevention regionally and effectively for suicide attempts, along with completed suicide. So there are some stand-out issues the commission has highlighted. Within the next two years or within the term of this particular government, particular investments could be made, if the monies were made available, that would have an immediate effect to signal where we need to go.

ACTING CHAIR: On that note, you were pointing out the lack of affordable housing and employment opportunities. For the record, are you essentially saying that, particularly for those wedged in a bit of a situation, it would actually help reduce the incidence of mental health issues?

Prof. Hickie: Yes. There is a lot of evidence from specific trials. We love to trial things here in Australia. We have done trials of all of these things. We never move from the trials to the systematic implementation. So you not only have a reduction in cost; if you have somewhere to live, you do not come back into hospital. In Sydney a hospital bed is $800 to $1,000 a day. You could be at a very nice hotel for $800 to $1,000 a day. Currently we are using hospital beds for that. Not only will you offset the cost, you will be well. You will stay well if you have a home, and you will be less likely to have a relapse in your clinical problems. If you have a job, you do better. We use this expression all the time: 'You don't get well to go to work; you go to work to get well'. We all thrive in environments where we have a home and we have a job and we have social connections. Those things are not simply cost offsets; they deliver better outcomes.

ACTING CHAIR: So essentially we put a lot of effort into the trials, but they have actually worked—

Prof. Hickie: There is constant discussion about the evidence. We have evidence of what works. We have very poor experience in Australia of systematic implementation through our complex federated system of government of effective programs.

ACTING CHAIR: Fantastic.

Prof. Fels: If I could just add to that: there is a movement in the US called Housing First. It really subscribes to the view that, if you fix housing for people with mental illness as the top priority, a lot of improvements will flow simply from that. It does not mean that they do not need other help. There is now a fair bit of data about the effectiveness of Housing First. Also in Canada the government gave $100 million to Housing First experiments, if you like—although that is a fairly big experiment—and there is now reporting and data showing there has been quite a significant improvement in mental health. I mentioned a project like that I am part of in Melbourne. It was independently evaluated by Monash University. Using a number of measures it concluded what everyone who goes there knows, which is that there has been an enormous improvement in the lives of people who are at the severe end.

Senator McLUCAS: Following your whole-of-government theme, if we go the fifth national mental health plan, who should sign off on the plan? 'Should it go to first ministers?' is the question.

Prof. Fels: It is essentially Commonwealth, state and territories that have signed off on the plan.

Senator McLUCAS: As health ministers, is my understanding.

Prof. Fels: I see. Well this is the question. Health ministers have a health focus, and with all the will in the world they tend not to pick up enough on housing and employment questions, in my firm view. There is a case for it being somehow getting a wider endorsement and a wider frame.

Prof. Hickie: I think it is a very strong view within the commission, Senator, that the health plan of the health ministers is the health plan, which may be an important part but it is not a total plan. This commission is really set up under Prime Minister and Cabinet, and we recognise that now under the current government the health minister has responsibility for response to the report, but what we are seeking is a whole-of-government response. And when it comes to implementation we seek a whole-of-government implementation, so in my view a fifth national mental health plan is only likely to address the mental health specific components within the health system.

It is a constant problem for mental health that many of the determinants of the health outcomes are economic and not in the health portfolio. What is happening in the social services area, what is happening in accommodation, what is happening in employment policy and what is happening in participation policy—these are fundamental sets of issues in terms of the way in which you would get a fundamentally different system.

I think the great thing about the national government having commissioned this report was getting a national response. The leadership, as in the agreement between John Howard and Morris Iemma in 2006, was to have a first ministers response. That framework, which we only had for a short period of time, was quite different to the recurring national mental health plans, which is the mechanism by which the health ministers respond to only part of the problem. It is fundamentally the downstream part of the problem that they are responding to.

Senator McLUCAS: So you are recommending to us that the fifth plan should be a first ministers sign-off? Have you been that specific?

Prof. Fels: I think the health plan would be for the health ministers. I am trying to be realistic about it, but you need a wider COAG driven strategy, if you like, for mental health that picks up all of the variables.

Prof. Hickie: I think we have seen a clear response. Premier Baird has made it clear in New South Wales. He has launched the mental health plan and mental health initiative in New South Wales and takes responsibility on behalf of the state government.

Senator McLUCAS: Is that in his office, as Premier?

Prof. Hickie: Yes, and in a sense I think that is what we are looking for across Australian governments—a response from the first ministers.

Ms Crowe: I did quite a lot of work on the third and fourth mental health plans that we have had, and especially the fourth had a lot in it about social issues—housing, employment and participation. It was extremely hard to get traction within the plan on those issues, so I would agree 100 per cent with the suggestion about the first ministers.

Senator McLUCAS: Part of the fourth mental health agreement was the establishment of the National Mental Health Service Planning Framework. I keep asking questions at estimates about where the national mental health planning framework is and departmental people say, 'It's on track, on the way.' New South Wales is leading, is my understanding.

Mr Butt: That is correct.

Senator McLUCAS: Please give the committee an understanding of what it was meant to do. Did the commission have access to the material in the planning framework in writing the report? Would you like it to be published?

Mr Butt: The National Mental Health Service Planning Framework was developed by New South Wales in association with Queensland. We were not provided with a copy of it in undertaking the review and I think—

Senator McLUCAS: You were not?

Mr Butt: No, we were not. I think we have commented previously that it would have been useful to have it, because what it does is model the staffing and the services to respond to particular assessed needs. So that would have been a very useful tool, and it probably is a very useful tool. My understanding—and you really would need to check this with the department again—is that it has been distributed across all the states and territories and they are all looking at the implications and whether it is in fact a good model. It is a planning tool and there have been planning tools used across Australia for a long, long time in a whole range of areas.

I think some concern has been raised by some states—not all states—that the potential implications of implementing that model would be quite expensive, but the resourcing issue is a separate issue from the planning tool, from our perspective. Governments have to make decisions about how much investment they will put into particular services and obviously there are finite resources available. So we would certainly be eager to see that services planning framework finalised and released.

Prof. Fels: I would also like to comment on that important question, because there is an analogy with the National Disability Insurance Scheme.

Senator McLUCAS: That was my next question.

Prof. Fels: I was on the original committee set up by Mr Shorten to establish a disability investment group and we happened to have, very early on, a pretty full specification of what needed to be done, taken right down to the level of individuals, and a costing of it. The costing was very large. We were quite struck by the very heavy cost and we did some frankly preliminary pruning, but it did set it out. It went to the government and they blinked and sent it off to the Productivity Commission. The Productivity Commission in turn did a good job and worked through the costing. As a result of that process, people began to understand the size of the challenge there is for disability and the fact that it is costly. We need to do something like that in mental health.

Senator McLUCAS: But I think you have done that today, Professor Fels. One of the important chapters of the Productivity Commission's work was to identify that, if you invest early, your cost over the lifetime of a person with disability is actually reduced. Your letter today indicates that, if we invest now, we will grow GDP by a proportion commensurate with the level of investment. So, without going to the Productivity Commission, two pages seems to have done the job. PC, do not be troubled.

Prof. Hickie: I think your question is important, because many people contributed to that national services planning framework, including me on a number of advisory committees and in my technical capacity. In my view, there is the great need for that to be in the public domain so that people can understand issues related to hospital beds, styles of investment, step-down care and what the current investment is. When one is talking about the kind of regional planning that we have talked about in this report, that type of tool is essential. One of the good things the Commonwealth has done is invest in this planning framework and have the states lead this issue.

This commission is tied up fundamentally in transparency. Its role is to report to the Australian people on progress in this area, and part of that is having the tools in the public domain so that public discourse can take place. So I think the commission has a strong view not only that those reports should be available to us but that they should be available to the Australian people and the government so that we can have an honest discussion. Where are our current investments? Where are our current resources? Which communities are doing what and who is missing out? Really central to this report is the question: where do future investments need to be? We have said very strongly and clearly that this remains a contentious issue in the community—greater community based rather than hospital based investment.

Senator McLUCAS: We will ask the department those questions this afternoon as well. Can I go to your recommendations in the report about regional services—the PHNs becoming PMHNs—and your somewhat different recommendation about the 12 suicide implementation sites. When we started the NDIS we called them launch sites. I take your point, Professor Hickie. Can you talk to us about regions? We now have larger primary health networks that are fairly embryonic. We have the National Disability Insurance Scheme rolling out and there are a lot of balls in the air. Can you talk to us about regional investment and how the PHNs would work? What would we have to do to ensure the PHNs, which are only a month old, are ready to do the sort of rollout that you are talking about?

Mr Butt: We are not suggesting there be another architecture put out there. We are really saying we should build on what is there. As you say, the PHNs are quite large, both geographically and in population. What we are saying is that, if you are going to take a regional approach, you can achieve greater equity, as Professor Hickie mentioned, because you then divide funding on a weighted population basis between the regions.

There is an issue there about how much capacity they have with existing funds. Obviously, as Medicare Locals and divisions of general practice in the past, they already managed a range of different mental health programs, so they are building on expertise that already exists in most areas. A lot of those programs are relatively small when you look at something like Better Access, which is quite a large program. Hence we go on to make recommendations about Better Access and where you are not achieving regional equity because you basically cannot attract the staff. What do you do about that? First off, we look at alternatives such as e-mental health, where there is great capacity. But we are also looking at potentially cashing out some of the growth in funding that might be going into Better Access by looking at ways of distributing those funds on a regional basis, therefore achieving more equity, so that the primary mental health networks can commission services at a local level.

We are also looking at other ways of distributing services, particularly in relation to psychologists. The spread of psychologists is quite poor due to the fee-for-service nature of what we are dealing with. In fact, we would argue that a better geographic spread of psychologists is probably more important than a better geographic spread of psychiatrists, who are really there as consultants and it can often be done from a distance, which Professor Hickie might want to comment on.

We are not really proposing a different approach in relation to suicide prevention. We are really saying that, if you are going to take a place based approach, even with primary health networks, which are quite large, you are going to have great variation and great diversity between different areas within that primary health network. So you actually need to look at what different communities, which ultimately means that primary health networks need to do their needs assessment—looking at the needs of local communities, not all the things the same.

We have basically said much the same in relation to suicide prevention: What is the response at a local level? We talk about Regional Development Australia areas, where there are 55 of those. You could actually use them as the basis of looking at a more local approach as opposed to across a whole primary health network. We talk about the use of Commonwealth resources as incentives to attract investment from the private sector, from local government and obviously linking in with state governments, local hospital networks, clubs, schools, churches and the whole range of things that would impact in relation to suicide prevention and in relation to better mental health outcomes. It is actually saying that, even within primary health networks, you will have to drill down to a more localised level in terms of your planning, so that you are picking up that regional variation and responding to it.

Prof. Hickie: Senator, I think you have raised an absolutely critical question, and one of current confusion now due to the implementation of this report. We talked about the 55 regions that are Regional Development Australia. They did closely map the 60 previous Medical locals. So at that stage there was some coherence. The Commonwealth has changed the maps and the names, but the regions of Australia still exist in the same way. The PHNs can manage that because they know what those regions are. They have just been accumulated for efficiency purposes into larger 30 groups. But if anything is to work it has to work in the 55 local regions, not to a map made up by Health this week or Education next week or Social Services the following week. There are 55 functional regions in Australia, and they are the communities that we are focused on. It is the challenge for the agencies to respond appropriately. We are talking about suicide prevention in 12 of those 55 regions, which is very much community participation along with the service structures in those areas. The PHNs can manage the primary care.

David's point about managing the equity in healthcare distribution is important. The original Better Outcomes, which had a tiny amount of money to distribute, did that much more effectively through the divisions of general practice at that time throughout regional Australia, led by people like Julie Thompson in Gippsland and people in Orange, Bathurst and throughout many areas of rural and regional Australia. They did that very effectively to contract locally the psychological service and develop new partners. They developed partners through the university sector and through the nongovernment sector to get the workforces to those areas. Since we have moved to the simplistic fee-for-service Better Access system, we have returned to the traditional inequities associated with those specialised services.

Senator McLUCAS: So is the model we introduced with Partners in Recovery, which tried to be more flexible and tried to allow a group of people who were not necessarily health people, a model that you would recommend we continue with and grow to do the suicide prevention work?

Mr Butt: Whether you call it Partners in Recovery or whatever, we are basically saying yes to those sorts of models where you actually have a larger bucket of funding at a regional or local level and you engage a whole range of partners. Australia does not invest highly in the nongovernment sector compared to, for example, New Zealand. I think identified seven per cent of Commonwealth and state expenditure going into the NGO sector, with a lot of it into the non-clinical areas—psychosocial support housing et cetera. We have actually said that that area really needs to be boosted over time. We would be saying that, with the Partners in Recovery model or whatever you call it at a local level, there should be a larger bucket of funds available at a local level to bring in a range of partners that can then respond according to local need.

Prof. Hickie: And we think the health sector really needs to look at it. The two current reviews, the Medicare review and the primary healthcare review, need to look at models like Partners in Recovery which are led by organisations, rather than doctor or provider organisations leading the design of those services. There are excellent examples of community partnerships. It is that style of partnership which can take responsibility. If enabled by national funding—combined state and federal—and national technical expertise, these things can be done well at the local level.

Senator WILLIAMS: Professor Fels, is it possible for the federal government to spend less but get better results? We are talking about a $10 billion package.

Prof. Fels: I think so. That is not to say that we in anyway support that. We just say that at the moment it is not well spent. The current amount could be spent to get much better results. So I suppose the logic of what you say—

Senator WILLIAMS: That is fair enough: don't spend less but spend it better.

Prof. Fels: Yes.

Senator WILLIAMS: I am very concerned about a comment from, I think, Ms Crowe—or it might have been Professor Fels—that GPs will often not refer to specialist help. How do we solve that problem?

Prof. Fels: I will try to analyse the problem as I understand it. Basically, it relates to the distribution of the workforce and their immediate availability. That stems from the Medicare system, under which, if you are a professional, you go and get a provider number and then you can live wherever you want. They tend to live less and therefore to provide less service in these areas where you do not get access. Then the doctors, knowing that, do not bother to refer to available professional services in the area.

We in this country do not permit conscription of the workforce. The issue I am raising is a fairly well-known one about Medicare in general, but it bites quite strongly in mental health. We did suggest some things that could be done about it. We have said that psychologists, who can play a pretty useful role, particularly at the mild to medium end, could be in various ways made to devote more of their activity to rural and regional and to disadvantaged areas. As you would know, there are incentive payments for GPs and some others in rural and remote, but they do not apply to mental health services in general. That is a start on answering your question. I do not know if any others would like to add to that.

Mr Butt: The discussion paper put out by the Primary Healthcare Advisory Group, chaired by Dr Steve Hambleton, echoes a number of recommendations we have made here about how you deal with those chronic complex cases in terms of looking at severe mental health issues coming along with a lot of physical health issues but those issues not necessarily being identified or dealt with properly. We recommend, for example, things such as voluntary enrolment with a general practice so that a general practice takes responsibility for all of your health needs. We also recommend changed payment arrangements, such as bundled-up payments, population based payments, performance payments—basically blended payment arrangements that free up the time of GPs and practice nurses and mental health nurses and allied health professionals to spend more time with those people with more complex needs. That is what we have recommended and that has been echoed in that discussion paper.

Prof. Hickie: It is an issue we have dealt with in cancer care and other specialised areas. So it is a problem in all specialised areas. We do not want just primary care in rural and regional Australia; we want access to specialised care, particularly at the more specialised end—psychiatrists, clinical psychologists backed by other workforces. You have to put in the serious team based structures, payment structures and support structures with the right kinds of enduring partnerships to do that. We have found in other areas that, if you put the right partnerships in place with the right payment systems, you will get those workforces. If you leave it up to the individuals, they will be working in Sydney and Melbourne.

ACTING CHAIR: I very much support those comments, and I might put some questions to you on notice. Thanks very much for appearing before the committee today.

Proceedings suspended from 10:34 to 10:50

FRKOVIC, Mr Ivan, Deputy Chief Executive Officer, National Operations, Aftercare

HOPWOOD, Professor Malcolm, President, The Royal Australian and New Zealand College of Psychiatrists

MELDRUM, Mr David Macmillan, Executive Director, Mental Illness Fellowship of Australia

PETERS, Mr Andrew, Chief Executive Officer, The Royal Australian and New Zealand College of Psychiatrists

QUINLAN, Mr Frank, Chief Executive Officer, Mental Health Australia

ROSENBERG, Mr Sebastian, Senior Lecturer, Brain and Mind Centre, University of Sydney

RUTLEDGE, Ms Pamela, Chief Executive Officer, RichmondPRA

ACTING CHAIR: I now welcome everybody to our first round table of mental health peak bodies and service providers. Thank you all for making the time to talk to us today. Do any of you have any additional comments to make on the capacity in which you appear today?

Ms Rutledge: I am also the chair of the national Partners in Recovery organisation reference group. I do not formally represent the reference group, but I am here and able to speak from the perspective of Partners in Recovery, as I understand there is an interest in that.

Mr Frkovic: I am here as part of the MIFA group.

ACTING CHAIR: Thank you very much. I definitely feel like I am in good hands. I invite you to make a brief opening statement, and then the committee will ask questions.

Ms Rutledge: Thank you very much, Senator. The organisation that I primarily represent is a large mental health community organisation operating primarily in New South Wales and south-east Queensland. We provide a whole range of services to help people with a mental health issue stay well, stay independent in the community, learn new skills and get employment. One of the key programs that we are involved in is the Partners in Recovery initiative. This was an initiative of the Commonwealth government in 2012, and it is important for its capacity to provide ongoing infrastructure and support to people with a serious and persistent mental health issue. We hope to be able to evolve into a role in the National Disability Insurance Scheme.

We wanted to particularly draw the program to the senators' attention because it has been somewhat misunderstood historically. It is a large program funding consortia across Australia to deliver what is called 'support facilitation' to people with a severe and persistent mental health issue. It has had the impact of bringing together a very wide range of organisations, not only specialist mental health providers but primary care organisations and other organisations working in the community in a different way to reach out to people who have fallen through the cracks and who have missed out on services or have been poorly treated by services in the past. The Commonwealth has invested significant money in this infrastructure, and there is an opportunity to enable it to evolve—with some modifications, of course, and potentially some different use of money—into a role in the National Disability Insurance Scheme as a special supporting arrangement for people with a severe and persistent mental health issue. As service providers on the ground, our plea to government—through you, Senators—is that we do not throw away the investment that has gone into creating these consortia, which bring together organisations that are now in a position to provide ongoing support to people who have historically missed out on mental health support. Thank you.

ACTING CHAIR: Thank you.

Mr Quinlan: I have tabled an opening statement and, with your indulgence, I will just speak to it rather than bore you by reading the details. I think the main interest from Mental Health Australia is really that there are a number of processes happening at once that are affecting the mental health space. The National Mental Health Commission have produced their comprehensive Review of Mental Health Programs and Services, and we are awaiting the government's response to that review, but at the same time we have the government in multilateral negotiations with state governments over the Fifth National Mental Health Plan—with the end of the Fourth National Mental Health Plan, we are coming into the Fifth National Mental Health Plan. At the same time, the government is in bilateral negotiations with each state and territory on arrangements for the National Disability Insurance Scheme, which, as Pam has just indicated, has implications for the sorts of services and programs that are transferred into the NDIS and the programs and services that remain outside the NDIS. At the same time, the government is reviewing primary healthcare arrangements, which are currently under review, but also, at a macro level, reviewing arrangements around the Federation in the Federation white paper process.

So I do not think we have ever experienced a time when there were so many wheels turning all at once, but I guess the great irony—the bitter irony—of all of that is that that has resulted in a great deal of inaction in the mental health space. We have really been on hold, largely, in terms of major policy decisions since the government commenced their Review of Mental Health Programs and Services. Beyond the temporary extension of certain programs just to keep the doors open a couple of times during that period, there have not been substantial reform measures undertaken—this at a time when, I think it is fair to say, there has never been greater unity or clarity from a very broad and diverse sector about the need for reform and, in large measure, about the steps that are required in order to undertake that reform. I am sure we will explore that a bit more as we go on.

The key points of our concern are, though, that I think we need to ensure that there is a true partnership between government and non-government providers, because I think it is fair to say that non-government providers do not yet feel especially engaged in the reform process, and ultimately they will be the ones that are required to implement it. We need to have some clarity about why it is that the mental health system continues to be outside the NDIS, and I suspect my colleague David Meldrum from the Mental Illness Fellowship will touch more on some of the details about our concerns about who is in the NDIS and who is outside the NDIS. We have some concerns also about the primary architecture of Primary Health Networks. There is a large measure of agreement about the need for us to localise programs and to pool programs, but there are some concerns that the arrangements for Primary Health Networks do not yet give us confidence that they are going to be the best channel to undertake all of the work that has to be done in the non-medical, non-clinical space if we are going to address mental health properly.

Finally, I will just say that, through all of this, I think we need to be doing a much better job of ensuring transitional arrangements. This is not a problem for the future. As at today, if one of our agencies loses a staff member in, say, the Partners in Recovery Program, it can only offer a replacement staff member an eight-month contract with an uncertain future beyond that. That means that, as at today, the sorts of programs and services that we are delivering to people on the ground are starting to deteriorate again, because of the uncertainty of the arrangements beyond June next year. That is something that I think we need to be doing much more work on, and we stand ready to assist government and other interested parties to develop that work. I am happy to take further questions as we go on.

ACTING CHAIR: Thank you, Mr Quinlan. Before we go any further, does the committee agree to receive Mr Quinlan's opening statement as a tabled document?

Senator WILLIAMS: Yes, certainly.

Mr Rosenberg: Thanks, Senator. Thanks again for the opportunity. I also want to acknowledge the role of this parliament and its enduring interest in mental health, particularly the Senate. The Senate has inquired into mental health previously, as you would know. The sector really appreciates the level of interest and accountability and scrutiny and concern for the issue of mental health that the Australian Senate in particular has shown to mental illness and people with mental illness over many years. Thank you. I also thought it was worth reflecting, as people talk about a fifth mental health plan, about where we got to and what we have received, if you like, in the ensuing 20 years since 1992 when we had our first mental health plan—so this may be slightly controversial.

Despite four national plans and two national policies, one road map, two report cards and one action plan, genuine mental health reform seems as far away as ever. There is a sense that things have changed and that the asylums have closed in Australia. Well, there are still 1,831 beds in asylums across Australia costing about half a billion dollars per year. Large elements of the old system are still very much in place in our current system.

The initial plans were looking for national fairness and consistency, but in fact the experience of care varies wildly depending on where you live. The seven day community follow-up rate on discharge is 72 per cent in Victoria and 48 per cent in New South Wales.

People in the sector were really hoping that the policies would reflect the interests of clinicians and consumers and carers and service providers, but in fact the policies have been led by health bureaucrats in each of the nine departments and have become less relevant to the interests of the sector.

There was a very strong emphasis at the start on clear accountability—and I know Senator Williams has already asked about how we know certain things. The answer is: we largely do not know about the impact of the $7.6 billion we spend on mental illness in Australia. Prime Minister Howard, Premier Iemma and then subsequently Prime Minister Gillard all promised some long-term, organised reform around mental health in order to try and establish some accountability, and that has not occurred. Instead what we have had are some piecemeal and sporadic changes with some good ideas and some good programs, some of which people are now anxious not to lose as other changes arise.

People were interested in not separating this part of the body from that part of the body and in having holistic care, but instead we still very much have care by body parts or disease types.

People were interested in consumer-carer feedback in driving system quality improvement, but instead we have clinician-rated arrangements which fail to really impact on service quality improvement.

One of the main things that was through all the history of Australian mental health policies and plans has been the desire to establish community-based mental health care, but in fact what we have is an extremely hospital-focused system of care. Even when the National Mental Health Commission suggested a very small change to those arrangements, Minister Ley unfortunately seemed to indicate that that would not be pursued.

People were interested very much in joined-up services, but in fact we have a Commonwealth-state split based very much on who pays and not what works—and that moves beyond health care to include social services and housing and community services and other areas.

We were interested very much in promotion, prevention and early intervention, but in fact we have a system which really is about postvention and crisis management.

We were very much interested in e-mental health technologies, some of which Australia has led in, but in fact what we have is a continued dependence on face-to-face care and fee-for-service type approaches.

There were 32 separate inquiries into mental health between 2006 and 2012. Here is the Senate's recommendations from 2006. They were excellent. The reform of mental health care really depends on filling the gap between the GP and the hospital. There needs to be an establishment of good community mental health services, and this was a key recommendation that the Senate made in 2006. The issue here is that nobody owns community mental health. It falls between the federal government and the state government in terms of responsibility .Nobody has a leadership role, so I am putting up a 'position vacant' sign.

It is also worth mentioning that, despite recent changes to funding arrangements and so on, the mental health share of the health budget is in decline. The mental health system remains in crisis. New funding into existing failed systems is a terrible idea. What we need is a new approach based on genuine community access to mental health care which combines both clinical and non-clinical elements of support.

Mr Peters: Professor Hopwood will explain the broader view from the college perspective, but I thought I would speak about one of the largest investments made in psychiatry that this government and the previous government made and the need for this to continue. I commend the governments for investing in the shortage of psychiatrists that currently exists.

The Specialist Training Program is a highly valued initiative within the college of psychiatrists that is significant and essential to psychiatry training. It aims to match the nature of demand and reflect the way health services are delivered in Australia. The training program currently funds posts that otherwise would not exist. These posts provide an expanded training environment and also contribute to mental health service provision. The college has also received funding for sustainable support projects that aim to support trainees and specialist international medical graduates on their pathways towards fellowship. The project commenced in June 2009, and the college is currently in the process of finalising the latest deed. The total funding payable in relation to training of psychiatrists is somewhere in the vicinity of $100 million over that period. It finishes in February 2017.

We currently have contracts with over 80 health services and practices across Australia to achieve the target of 160 full-time employees. It offers a salary contribution to these full-time employees. Approximately 30 per cent of these posts have a component of their work that is done in a rural or a remote area, which is critical. These posts attract a rural loading so that we can provide some incentive. Approximately 50 per cent of these posts have a component of work that is done in a private setting, and private settings attract a private infrastructure and clinical supervision allowance. The posts range across a variety of subspecialty areas, in particular Aboriginal and Torres Strait Islander mental health, drug and alcohol addiction, child and adolescent, consultation liaison, general adult and perinatal and infant.

We have also implemented a number of support projects, and these are critical. These include a recruitment into psychiatry initiative, which is targeting student membership in a category which has somewhere in the vicinity of 1,300 to 1,400 members already, a rural psychiatry project, which has educational grants to support rural trainees in attainment of fellowship, a mentoring program for over 25 rural trainees to receive support from fellows and mentors, peer support groups for rural trainees for networking and exam preparation. We also have specialist international medical graduates support, which offers one-on-one coaching grants to support these individuals on their pathway to fellowship. Without going further into it, I and we as a college commend the governments. This is an enormous investment that hopefully will continue to be a good news story. We do have a shortage of psychiatrists. This is one particular, large investment by this government and previous governments and, we hope, future governments to achieve what needs to be achieved in this sector.

Prof. Hopwood: I will bring some broader comments from the college, if I may. The college of psychiatrists is an organisation of about 5½ thousand members and represents over 95 per cent of psychiatrists in Australia and New Zealand. It is responsible for the training and continuing professional development of psychiatrists across Australia.

I want to start my remarks by acknowledging the work of the Mental Health Commission in their review and to indicate our overall support for the directions in that review document. There are a few items from it that we think are particularly worth highlighting. The mental health system continues to experience both great stress and great difficulty in meeting the needs of the population. Twenty per cent of the population suffer from mental health disorders in any 12-month period, and, at the very best estimate, we are providing some sort of service to under half of those. Clearly, the kind of service required varies greatly, depending on the nature of the problem, and does not always involve psychiatrists—please, do not get me wrong!—but we are way short of the target. We are particularly way short of the target in rural and remote areas and, I think we should note, in the Indigenous population, where the suicide rate is twice that of the rest of the population and is amongst some of the most concerning aspects, I dare say, of health care across the nation.

We support strongly the commission's focus on not just integrating clinical services across the spectrum, as has already been highlighted, but linking them to services like housing. It is very difficult to improve mental health in the face of inadequate housing. We particularly support the review's and other commentators' focus on bringing things together across the sector. Mental health funding is diverse in its origin, and that is a significant barrier to improving mental health care. By this, I mean not just governmental boundaries but also boundaries across the primary, secondary and tertiary sectors. We support strongly the idea that it is an important focus within the Primary Health Networks that they act to facilitate a smooth transition and the delivery of the right care for the right person.

We would particularly like to draw the committee's attention to the issues of physical health in relation to that junction, noting that individuals with mental illnesses like bipolar disorder and schizophrenia in Australia die, on average, 14 to 23 years younger than the rest of the population. That is something that is not acceptable. The majority of that premature mortality is due to poor physical health—a proportion due to suicide, but the majority due to poor physical health. We feel that a significant contribution to that is the failure to take that issue seriously and to meld together the different layers of the system in being responsible for that outcome.

The role of clinical services remains very important. As we have diversified what we do in mental health, the role of community mental health, which was the key platform in the early mental health plans, has actually fallen back, in our view, over the last decade. Part of that is about the funding division and who is responsible for community mental health. But, if we are to achieve what was hoped for with community health reform, committee mental health will continue to require support.

We also feel that in-patient care remains an important component of the mental health system and we see little or no evidence that current in-patient services are quiet, lacking in work or lacking in demand by people with difficult problems. We perceive that, if our early intervention and community services improve the situation, over time it may be possible to further reduce the numbers of beds, noting there has been a very significant reduction over the last two decades. But we are concerned that if we move too quickly we will exacerbate an existing problem.

I would like to draw attention to two aspects of the Medicare system. We see the Medicare review as a very important opportunity, although we suspect that mental health has not been the primary focus or instigator of the Medicare review. We acknowledge that the current Medicare structure does not necessarily facilitate interchange between the primary and specialist sectors and that the range of item numbers available for both consultant psychiatrists and GPs, as well as allied health professionals, may not necessarily mean that we are best using those resources, and we would like the review to give serious thought to that area. As a subset of that review, some recent changes that have been tabled in relation to the Medicare safety net do cause us some concern. In particular, they involve those people who require intensive treatment that currently may only be available for some disorders within the private sector. A relatively small number of individuals will be affected, those who are seen many times in one year. They are usually people with very high needs, and the changes will result in a significantly greater out-of-pocket cost. A submission is available on that, if required.

Finally, in closing, we have already heard about the fifth National Mental Health Plan. We very much support the need for a new national mental health plan but very much more support a new national mental health plan that achieves something. The creation of a national mental health plan that perhaps says the same things but is not associated with some of the structural reforms we think are required is probably not, we think, ultimately of much value as perhaps suggested previously. We would really like the National Mental Health Plan to help address some of these structural issues and to involve broad consultation across the sector, to really lead us further down the path of reform that we are obviously all seeking. Thank you.

Mr Meldrum: I am going to concentrate mainly on the NDIS, as Frank correctly predicted. Just briefly, the Mental Illness Fellowship of Australia at the moment is 10 organisations, with about 2,200 staff, operating out of about 150 locations across Australia. Our core strength is our work with people with severe and persistent mental illness, although we do much more in a whole variety of areas. For instance, Aftercare have got four headspace centres they run, and we are partners in a lot of those. Although our reach is reasonably broad, our core strength is severe and persistent mental illness, which is why, with the Partners in Recovery program that Pam was talking about, we are on the consortium of, I think, 28 of the 48 Partners in Recovery programs across Australia.

I want to talk about the NDIS. First of all, when in 2011-12 the debate was going on about whether psychiatric or psychosocial disability would be included in the scheme, there was a lot of unanimity across our sector that we had an unfinished job that this offered a chance to finish, which was in relation to the final group of people who, through deinstitutionalisation, have both enduring mental illness and complex, severe disabilities which are largely continuous. We have never done a good enough job in Australia of providing the comprehensive, ongoing—lifelong if necessary—support that they need. We all know that. A variety of state governments have made efforts. Probably New South Wales and Victoria are the best in Australia, but every state has done something for some hundreds or even, in a couple of cases, more than 1,000 of such people. But we have not really touched the last 50,000 or so of those people in the way that they need to be with services that are guaranteed for as long as they need them. So we welcomed the scheme, provided that it was workable, and there have been lots of debates about that. There is lots of controversy about the term 'permanent disability' and there is lots of controversy about the insurance model and the funding in arrears and the eligibility processes. That is inevitable with any new scheme, and we are working our way through those, and I think the National Disability Insurance Agency, is, with goodwill, trying to work those things through with the sector to make sure we can work the scheme right.

I want to concentrate, though, not on the 56,000 people who we think will be eligible for that but on the several hundred thousand people who will not be eligible for that scheme. The reason I want to concentrate on them is that a lot of the money that is going to those several hundred thousand people is actually being rolled into the scheme to look after 56,000 people. How many hundred thousand people have severe and persistent mental illness in Australia? You could get an argument going between any two people who study this. The most conservative estimate was from PricewaterhouseCoopers when advising the Productivity Commission about how many people might be eligible for the NDIS, back about three years ago. They said they were 480,000 people in Australia with severe mental illness, of whom about half had severe and persistent mental illness and of whom 56,000 fitted that definition of severe and persistent mental illness with profound ongoing disabilities of a complex nature.

So we are talking about well over 400,000 people—by the most conservative estimate; some people would say the figure is something like 600,000—who access services because they need them desperately from time to time, maybe not continuously in the way that that last 56,000 people do, but from time to time they and their families need them desperately. They currently access a range of clinical services, but I am particularly concentrating here on the funding for the services in the non-clinical area—things like Partners in Recovery, Personal Helpers and Mentors, day-to-day living programs, respite care for carers, a whole range of programs that are funded by the Commonwealth and a whole range of programs that are funded by every state and territory. In the case of the Commonwealth, all of the dollars for all of the programs I just mentioned have been rolled into the NDIS. The problem is that the majority of the clients of all of those programs will not get a service under the NDIS, so we are effecting a sort of two-card trick here, in which a lot of people are going to find there are a lot of wrong doors for them from next 1 July.

For the people we are trying to assist—and across our MIFA membership we are dealing with about 10,000 people at any given time—we think about 8,000 of those 10,000 will find the door closed next 1 July. We can have arguments with the NDIA about that. We do not want them to mission creep. We do not want them to start diverting the funds in the NDIS to people who do not fit that definition of extreme mental illness and extreme disability, because that sort of mission creep has happened time and again in mental health, where money designed for people with the most severe need drifted into a wider target group. So, we do not want them to mission creep, but we also want it to be recognised that if we leave things standing as they are and we do not find some way to maintain the current programs while implementing the NDIS we are actually cutting several hundred thousand people out of the existing services from next 1 July.

Mr Frkovic: I would just like to add to a few of those things from a service delivery perspective. Aftercare is a national mental health organisation operating primarily across New South Wales, Queensland, Western Australia and Victoria. We provide a range of community non-clinical services, as they are called, as well as clinical services through our headspace and early-psychosis services. We are probably one of the largest providers of PHaMs—Personal Helpers and Mentors—across the country. We are also one of the largest players in terms of Partners in Recovery. We are also a lead agency in all of those locations, and we have experience as both a player and a lead. So, we certainly have some interesting learnings from that. We are also one of the largest providers of headspace services, including early psychosis. We have four in Queensland. We also provide a range of residential services, both step-up and step-down, for people needing to exit hospital but also people who need to avoid hospital admission. So, we have a range of those services.

What I am going to say to you today comes from the experiences of particularly consumers, carers and families we are dealing with every day as a result of this changing environment, which I think we have heard all the speakers talk about here this morning. There is a real concern about the introduction of the NDIS around people with psychosocial disability or psychiatric disability—whatever you want to call it. There is a concern because the feeling is—and the analogy that I think has been used around the NDIS—that it is like a plane taking off while we are still building it. In fact, I think it is worse than that: a plane has taken off while we are building it but we are taking parts of a system that has been working relatively well—not perfectly, but relatively well. So, I think there is a real danger that we could have both systems fall over, I suppose, because you are taking parts off one system to build another while you are flying. I think there is a real danger in that, and I think families and consumers and carers feel that on an everyday basis, particularly regarding the uncertainty around the NDIS and how many people will qualify.

People are really concerned that existing services, such as Personal Helpers and Mentors and Partners in Recovery, which are helping them to maintain lives in the community to some level and degree, will disappear. Some of them will qualify for an NDIS package, as I think David and other speakers here have said. Our estimate is that probably between 70 and 80 per cent, particularly Personal Helpers and Mentors, potentially will not qualify. We have heard all sorts of figures, but we can tell you from our experience—and Aftercare is involved partially in the Newcastle pilot and in the Western Australian MyWay pilot, so we have experience across both of those—that they are slightly different, and there are pros and cons in each. But I think from a psychosocial disability perspective there are some real challenges for people who are trying to get into that system and who are existing Personal Helpers and Mentors participants to actually get a package.

This is creating uncertainty at the moment and increasing anxiety and levels of relapse amongst people, because they do not know, as I think has been said. A lot of these programs are due to finish in June next year: 'What happens beyond June? Where do I go?' So, it is creating problems for the participants themselves—the individual consumers—families and carers. They are saying, 'What do we do in this situation?' But also, as was raised earlier, by Frank and others, we have staff who are really struggling in terms of what happens to them. When you think about it, we have 450 staff, and a lot of people are wondering what happens beyond June next year. That whole system that is currently working is being unravelled from a whole range of perspectives, which I think is causing us some major challenges in terms of ongoing support for people with mental illness, and their families.

What we are also seeing—and we have certainly had discussions with the various state governments—is that as a result of this more people are going to emergency departments and more people are ending up in fairly expensive and scarce inpatient beds. I spent most of my life in the public mental health system before I came to Aftercare, so I have the experience of working on the other side. I think there is a real danger that if we unravel the current system and only a certain number of people qualify for the NDIS then the biggest pressure will be felt in the public mental health system, particular the inpatient and ED services. That is certainly the indication so far.

Just to round this off: as I said, I have spent most of my life in the public mental health system. I was involved in some of the national mental health plans and a whole range of things, so I certainly have some background in that. But the biggest experience I had was more recently, when I was involved in Queensland in establishing the Mental Health Commission, and I consulted with over 2,000 people across the state. The fundamental message coming from families and carers—and this is what I think we as a system, as governments and other people need to hear—is: 'More of the same. No, thank you.' We talk about more doctors, more nurses, more beds, more NGOs et cetera, but that is the fundamental message I would like the Senate to hear, as well as colleagues here, and the parliament of Australia. It is not working. If you talk to consumers, families and members, the current system is not working for them. We do not need reform but a fundamental transformation. We need a transformation process. That is always difficult. Having worked all my life in the public system, I know that to shift the public system or the NGO system takes time; it takes a lot of effort. But I think if we put ourselves in the shoes of the consumers and carers they are clearly saying that the current system is not working for them and we need a different approach to mental health.

I will finish by saying that we support the directions that were set in the Mental Health Commission report, particularly, again, from a consumers and carer perspective. Let's have a system that focuses and is incentivised for outcomes, not for maintenance, whether it is the public system, the private system or the NGO system. We should have incentive payments based on outcomes, which means we are helping people move on with their lives rather than continuing to rely on the service delivery system. Thank you.

Senator WILLIAMS: Mr Meldrum, you obviously do a lot of work overseas in your organisation.

Mr Meldrum: Yes.

Senator WILLIAMS: What are they doing better overseas than we are doing in Australia? What have you learnt?

Mr Meldrum: In some areas—say, working in regions and gathering together all the funds that are going into mental health and cashing-out and capitation schemes and so on—there are some pretty exciting initiatives, in parts of Canada and parts of the UK. There is a real attempt to understand what is happening with all the dollars in an area. I think the evidence is that it works best if you can settle on the region, where everybody knows what is there, and try to get over the issues of Commonwealth and state boundaries. That is exciting stuff that I do not think has happened in Australia yet.

In terms of the National Disability Insurance Scheme, the evidence from a number of countries is that we need to be very careful that we do not end up with half a dozen huge for-profit providers in Australia rather than a lot of current organisations because the funding model drives efficiency so hard that only the big ones can do it. That has clearly happened in the United Kingdom. I do not think any country would say that it has solved the issue of the final remaining people who are so severely disabled and mentally ill—the last wave of people we de-institutionalised 20 years ago. I do not think any country would say that they have finished that process well. Most countries you read about still have large homeless populations, of whom about 70 per cent have severe mental illness. Most countries would still say that their jails are full of people with mental illness.

I was looking at the population of jails in Western Australia the other day, and 20 per cent of the women in Western Australian jails have schizophrenia. That is 40 times the community rate. Nearly half of them have had suicidal thoughts in the past month. There are huge numbers of mentally ill people in prisons. I do not think anybody internationally is doing way better than us on that last, most difficult-to-support group.

Mr Rosenberg: If I may add something to that, going back to the numbers I guess the question is, what problem are we trying to address when we are thinking about whether anybody is doing any differently? You can say that about 3.1 per cent of the population has severe and persistent mental illness of the kind for which they are likely to end up in a hospital.

Senator WILLIAMS: Here in Australia?

Mr Rosenberg: In Australia, yes. In 2010-11 the percentage of the population receiving state and territory hospital acute services was 1.6 per cent. Roughly half of the population are able to receive care, so we are already short, if you like, by that factor. But what is interesting is that in 2006-07 the number was the same. So, there has been no rate of change of access to public acute hospital services for people with severe and persistent mental illness. I raise that because—

Senator WILLIAMS: At the same time, a lot more money has been put into the whole—

Mr Rosenberg: Yes, well—over the same period we had 13 per cent fewer inpatient beds and 15 per cent fewer inpatient days but 20 per cent higher costs and a 50 increase in expenditure. I cannot explain that to you. I am an academic; I am supposed to be able to explain things. But I cannot explain that to you. Obviously there are higher wages and so on. I always say that putting new money into old systems or failed systems is a moribund approach.

But the reason I interjected—I am sorry, Senator—was just to say that one of the other contrasting places to look at would be New Zealand. I realise that they are a little bit foreign, but the change that was led by the New Zealand Mental Health Commission in the mid 1990s is worth thinking about. Their mental health commission responded to the views of the sector—psychiatrists and others—to basically say: 'Our system is unsustainable. The revolving door of access to care is spinning too quickly. We're seeing the same people without actually making a big difference to their quality of life. We need a different approach.' In New Zealand that really caused a change in the way they funded. I was here this morning and heard the testimony from the national commission, and they noted that the NGO sector in Australia, which provides psychosocial rehabilitation support, is about seven per cent of the total health budget. That is roughly one-quarter of the amount New Zealand spends on that kind of care.

The last thing I want to say is that I think we need to be careful about splitting things between clinical and non-clinical. We are finding now that a range of community based organisations, including ones like Aftercare and MIFA and so on, are now looking to augment decades of expertise in psychosocial rehabilitation and support with access now to clinical services—psychologist, psychiatrists, general practitioners, nurses and so on—to build new approaches. So, I am saying that New Zealand has chosen to change the pattern of their mental health investment, and it has caused an increase in access to mental health care. They have gone a long way further than we have to lift the rate of access to care, particularly for people who have persistent and severe mental illness.

Ms Rutledge: Coming from a slightly different angle, and from RichmondPRA's perspective—we work in a way that is very strongly led by people with a lived experience of a mental health issue, and we also support the National Mental Health Commission Review and the direction that it proposes—while there are many things that are wrong, I do not think it is fair to say that we do not know what works. We do know many of the things that work, and we have evaluative data about what works. Organisations like Aftercare and ourselves invest in action research—real research, with people who have a lived experience—and can point to significant outcomes for people who have a lived experience of a mental health issue—getting employment, getting long-term housing, staying well, staying out of hospital. So I do not think access to the public system is the best measure, because it is really about wellness and physical health and those sorts of outcomes for people. And we know there are many programs that work. I mentioned Partners in Recovery, and it is working. It is being formally evaluated by Urbis on behalf of the Department of Health, and there is real data that shows already that not only is there a very high level of satisfaction with the service people are receiving—that people feel that for the first time their lives have been supported and that they are receiving ongoing support and staying well and staying independent in the community—but also people are getting housing, they are getting the sort of support they need. That data is coming through from the Urbis research and is demonstrating that Partners in Recovery is reaching many of the people the Productivity Commission talked about and for whom the NDIS is a real way of funding their ongoing support. So again I say that it is really important that we look at the macro system—at the levers and the funding arrangements—and at how to get proper investment in the community setting. As Sebastian has said, the under-investment in community settings is really a major deficit in the Australian system. We do know what works and we have a lot of data about that.

Mr Frkovic: I have done a bit of work around comparing systems—Australia, New Zealand, the US, Italy, Trieste, the UK and I am going to Canada soon as well. No-one has the perfect or the right system; I have not seen it yet. There are some programs in some jurisdictions with some really interesting arrangements which are producing some phenomenal outcomes, but from a systems perspective—and there could be other people around the table who may know more than I do—from what I have seen there is no perfect system around mental health. But I have seen some phenomenal programs producing some phenomenal outcomes for people. I will pick up the point made by Sebastian and Pam. What we do not have right in this country, and the Mental Health Commission report picked this up, is that we do not have the right balance of investment.

I might not have the latest data, but New Zealand got to the stage where they had an investment in the community sector—I talk more broadly about the clinical and non-clinical in the community sector—at such a level that they started to feel the pressure come off their ED departments and their inpatient beds. That was with about 35 per cent of the mental health budget going into the community sector; that was the point where they started to feel it. That could be different for Australia and other jurisdictions, but you get to a point where, if you have supports for people in the community, you will see that translate into pressure on inpatient beds and ED departments. I cannot tell you what that percentage is, but I think it is a bit like New Zealand: we need to keep investing until we see the benefits.

Senator WILLIAMS: On that very issue, I live in rural New South Wales and I think we have a scattergun approach to mental health with money. Let me explain why. I see money go into Centacare, then Anglicare and then we have The Salvation Army contributing. Then we have money coming out of agriculture for mental health because of drought assistance and so on. How do we make it more effective? Ms Rutledge refers to unemployment, and I get very annoyed when we talk about unemployment in rural Australia. I will tell you why. You can go to any abattoir in Australia, and it is half full of foreign workers—the locals will not work there. Why won't they work there? Where I live there are 850 people employed in the abattoir—a heap of people from Brazil and the Philippines. The locals do not show up for work after a couple of days or they fail the grog test or they fail the drug test. There are jobs out there, but we bring in people from Samoa to pick our fruit. You do not need a college education to pick fruit; I did not need a college education to shear sheep. Is there a silver bullet solution to this—unemployment, the flow-on to mental health, the drugs? Ice is a huge worry, and it is out in the shearing sheds now; it is out in the small communities and in the big communities. There are drug busts in country towns where they are manufacturing drugs. We need a holistic approach to put all the pieces together to solve it.

Mr Quinlan: It is not a silver bullet, Senator—

Senator WILLIAMS: No, there is none. If there were, I wish you would bring it forward and we could fire it.

Mr Quinlan: but I could propose some ideas. All of those programs that you listed are purchased by government and each year, in 99.999 per cent of cases, government will sign off on those contracts at the end of each year and say, 'Thank you. You delivered us what we wanted you to.'

Senator WILLIAMS: Government or department?

Mr Quinlan: Department. We would suggest that what is missing from that system is any overarching goal. The national Mental Health Commission in its most recent report—

Senator WILLIAMS: Let me stop you there, if I could. We just heard from the previous witnesses that the problem starts about the abuse of children at three and four years old. That is a huge concern. How do we in government target bad parents who neglect and abuse their children? We cannot have federal police looking in the window of every house, saying 'You're doing it wrong. We're going to lock you up and take your kids from you.' I just shake my head and say, 'Why would anyone neglect or abuse a child?' That is the first question I would ask, as a father of three and a grandfather of three. Where do you start and where does it finish? This is a huge problem.

Mr Quinlan: It is a huge problem. If I can continue, what we fail to do is—

Senator WILLIAMS: Sorry for interrupting.

Mr Quinlan: No, you are welcome. What we continue to fail to do is to set any overarching targets. So we ask those organisations that you listed—we ask Centacare to look at some family services, we ask Anglicare to do some youth counselling and we ask the Salvos to help out with financial support. Nobody ever sets a goal for your area and says, 'Okay, in the area of Inverell, here is what we want to achieve with our families: greater stability, higher employment rates and so forth.' We do not go to that local community of Inverell and say, 'Okay, what are the local assets and resources in terms of the abattoir and the agencies that are working there? Overall, how do we actually target this problem? We will put all of the money into one pool.' At the moment, I can guarantee you that all of those agencies working in your electorate are drawing a pittance of funding from 20 different funding sources each to try to put together a comprehensive program. What I think the commission has done is say, 'We don't want to support a system anymore, we want to look at some outcomes.' They have listed some very solid outcomes that could be agreed in the mental health space, which is to say that we want people to be in more secure and stable housing, we want people to be in employment, we want people to be less engaged with the criminal justice system—

Senator WILLIAMS: You say you want people in employment, but what do you do with the people who will not work—those who have jobs offered to them but who will not show up and who refuse to work? It is great to say that you want people in work, but what do you do with the sector of the community who will not work and who refuse to work? I know they are out there.

Mr Quinlan: I think what you need is a program of job support that extends beyond being a simple job placement program.

Senator WILLIAMS: I think it comes back to the three- and four-year olds, and having a work ethic imbued in your children. That is where I think it stems.

Mr Quinlan: I am sure that is a contributor too. Nonetheless, we have unemployed people who have limited capacity to take up job opportunities.

Senator WILLIAMS: Generations. In one family, three generations that never worked.

Mr Rosenberg: Pam is correct in saying that we know a lot about what works, but that is program by program. So, we know whether this program is quite effective and we know, for example, if there is a program which would effectively deal with drug and alcohol issues as well as mental health. So, there are programs which we know have got some evidence to them. They fail to scale—so they might be available in the region next to you, but not at Inverell. Why is that? That is the way funding has rolled out and it is very unfair.

What I wanted to say was that we do not actually know about the global accountability or measures—if you like—of our success. For example, we do not know about the rate of housing amongst people with mental illness. We use some other data and try to cobble together a picture. It would be good to be able to know about the rate of unemployment for people with mental illness, but we do not know about that. It would be good to know about the rate of social participation by people with mental illness, but we do not know about that. It makes it very difficult for people who are well-intentioned decision makers and funders to be able to say, 'That's working.'

The other thing about the commission and what it was looking to do was to establish regional approaches to accountability so that, for example, in Inverell you would be able to say, 'What's another area that's like us—a similar sort of region with a similar number of centres and similar characteristics? Let's have a look at what they're doing and start to compare'—

Senator WILLIAMS: Dubbo abattoir. They are relying on foreign workers and backpackers to run the abattoir.

Mr Rosenberg: 'Is there is difference from what is happening in Dubbo?' So, if Dubbo has access to—I do not know—service X, a head space, a something-or-other. Is there some difference around the composition between different regions to try and get around the fact that—as I said in my opening statement—the experience of mental health care varies wildly depending on where you live. That is something that could be assisted by trying to put in place consistent outcomes and benchmarks for people to compare from place to place.

Senator WILLIAMS: With local accountabilities.

Mr Rosenberg: With local accountabilities.

Prof. Hopwood: You have highlighted some of the challenges we recognise every day, working in the area. They are, at times, sort of imponderable to calculate how they come about. But the thing we have under our control is how we organise our response. I would support the idea that, both at a regional level and a national-plan level, a national mental-health plan is an opportunity to say: 'What are the kinds of elements that we really need in a service response that are going to give us the best chance of solving these kinds of difficult problems?' Of course, there are going to be local variables within that. One of our challenges, at the minute, is that we need a diverse sector to meet the needs of the people we work with. But that can end up being confusing, difficult to approach and, at times, more competitive than is helpful. A national mental-health plan is a great opportunity for us to say a little bit more clearly how we want these elements to fit together, how we are going to govern that niche region and really tell if it is having the impact for the kinds of things you are talking about in the way we like. We really want to make the best of that opportunity.

Senator WILLIAMS: Mr Frkovic, was it you that mentioned Aboriginal mental health?

Mr Frkovic: Yes.

Senator WILLIAMS: You see, my attitude is that throwing money does not always solve the problem. I can take you back to the seventies when I was driving livestock transport in the Flinders Ranges and there were Aboriginal stockmen there—great stockmen, great blokes, good horsemen, good musterers, good drafters and good at their work. We threw money at them to solve the problem, and all we did was send them to the pub. They got on the alcohol abuse and drug abuse and everything else; there are probably very few working out there today. I learnt from that experience that throwing money to the problem does not always solve the problem. It has got to be spent.

Prof. Hopwood: I do not disagree.

Senator WILLIAMS: Efficiently targeted, as you say, to get the results. And not always money. But every time we have these hearings and everything, all we often get in submissions is more money. All my life we have put more money into everything but I do not think we have got any better results or a better society.

Mr Quinlan: With respect, Senator, I do not think any of the submissions presented so far have asked for more money.

Senator WILLIAMS: We are talking more money to the states for the hospitals et cetera from the federals.

Mr Quinlan: I would just encourage you; I think that the sector is—

Senator WILLIAMS: Mr Hopwood, you suggested more money to the states for hospitals et cetera in your submission.

Prof. Hopwood: I am not quite sure I did. I think what I said is we would be concerned about any reduction in hospital bed numbers currently.

Senator WILLIAMS: When I turn to Senator McLucas or the chair I will do some research.

Prof. Hopwood: I am happy to share that with you. I think Ms Rutledge has a little bit to add to that.

Ms Rutledge: Senator Williams, I absolutely hear your point about our need for community development and community-support interventions. We are needing to look at how issues arise in communities, from very young people right through to older people, especially in rural communities where there have been so many battering impacts on the wellbeing of those communities. I think we are in a position and we would very strongly say that we probably do not need more money. What we need is redistribution of the money—the overall funding that is in the system—long term.

I think that was the point the commission was trying to make in their original submission—unfortunately, it got misunderstood in the media around it—that there is an opportunity here to look at some different approaches. Taking the regional focus that the commission talked about and that we can see can work—working with the Primary Health Networks or some form of regional commissioning body—bringing all the organisations and the people in that community together, to work on community solutions for that community, is the only way to really build the sorts of outcomes that you are talking about. The mental-health sector is really well placed to work in that way—to work very broadly and holistically with housing and employment and local people, with Aboriginal communities, who understand how to build wellbeing in their community, and we can find new solutions with a redistributed way of working. We absolutely take your point about that being the outcome we are looking for.

Senator WILLIAMS: I think a lot comes back to parenting, and I think it starts at a very young age.

Mr Rosenberg: I think the commission pointed to several areas of existing spending where we could make efficiencies through reorganisation. I just pulled up the latest figures about the Better Access program, and last week there were probably just a tick under 150,000 services provided across Australia under the Better Access program, costing $15 million that week. So it is an enormous program and an enormous taxpayer investment of federal government money into this style of care. Only about 50 per cent of the treatment plans which are written by GPs are reviewed, and I would suggest therefore that the model of care is suspect. We also ask almost nothing about what we get for our money, for that expenditure. I guess my basic question is: are people getting any better? Having had their sessions of therapy with a psychologist, registered or clinical, do they get better? So we are making investments already which I think could be much better scrutinised. However, I would also say that, as is well-known, the burden of disease is about 13 per cent from mental illness, and the level of funding is in decline and is five per cent of the health budget. This is not taking into account other areas, but the burden of disease represented by mental illness is 13 per cent and the share of the health budget is five per cent and falling. I guess there is no particular reason that the funding should match the burden of disease, but I would say that surely that gap is telling. So I think we need to be very realistic when we know about the fact that only 13 per cent of young men who said they had a mental illness requiring assistance last year got any care for their illness, and 87 per cent of young men got no care for their illness. I do not think we can deal with that problem just through redistributing existing funding. There are huge service gaps which create enormous costs to the police and to domestic violence services and create a whole range of other community problems that have their root in untreated mental illness. I think we need to be very careful to distribute the money as efficiently as possible, but there is no doubt that mental health is chronically underfunded.

Senator WILLIAMS: Well, Professor Hopwood, your submission says:

> … RANZCP submits that the Commonwealth Government must make an immediate capital investment to increase funding for mental health beds in state and territory public hospitals.

Prof. Hopwood: I am not quite sure which submission. Is this the previous submission from 2014?

Senator WILLIAMS: I am just reading this one here now. It is in our book work provided by the secretary.

Prof. Hopwood: If you read our recent—

Senator WILLIAMS: It is your submission from September 2014. It calls for immediate capital injection for funding for mental health beds in state and territory public hospitals. I just wanted to bring that to your attention.

Prof. Hopwood: In our recent response to the Mental Health Commission review—we heard that the Mental Health Commission were calling for a reduction in funding to beds—we indicated that a maintenance of the current level of beds would be desirable.

Senator WILLIAMS: I just want to make the point that in your submission you sought more money, because you were not sure of that. That's a win to me!

Prof. Hopwood: I was not present at the time. I accept that.

Mr Quinlan: Perhaps I could give you a suggestion as to how you might find some money to fund the sorts of activities that you are talking about in your electorate of Inverell. The National Mental Health Commission pointed out that most of our expenditure in the mental health space is not spent on the sorts of programs and services that we have been talking about. It is spent on the Disability Support Pension, and at the moment the government has changed the arrangements for the Disability Support Pension such that entry into that program is more difficult; entry into that program is controlled by independent doctors rather than people's own doctor. We could argue both ways about the merits of that, but, nonetheless, that is the policy. That policy is resulting in a slowing of entry into the Disability Support Pension such that in our estimate—and I would say it is very much a back-of-the-envelope estimate—somewhere between a quarter of a billion and half a billion dollars of savings will be yielded by the government for people who would otherwise have entered the DSP but will not.

Senator WILLIAMS: That is the problem when you have limited money. If we run out of money, like Greece, we will have none of these services in 20 years time—

Mr Quinlan: But what I am saying is there is a saving that is being made. I would suggest that is an opportunity for government to reinvest that saving into various initiatives in the mental health sector without increasing the overall budget.

Senator McLUCAS: Thank you very much, all of you, for coming along today. We have a lot of things to cover. I have five topics on my list here, so hopefully we will get to the end. Can I get your views about how the governance around the fifth national mental health plan should happen. The commission's very strong advice to everyone is that there is mental health and then there are all of these other things that are affecting people's mental health like their accommodation, their employment and their participation. What is your view about an idea that the fifth national mental health plan should in fact be a whole-of-government plan, not a health department plan, and potentially signed off by first ministers, which would then require engagement across all departments at both Commonwealth and state level?

Mr Quinlan: Mental Health Australia asked its members prior to the last COAG meeting to sign a letter to first ministers asking for precisely that. I cannot necessarily speak for all the colleagues at the table—they will speak for themselves—but more than 80 organisations across the sector signed that letter asking directly for that. The concern to us is that there are so many areas of action that are required that will involve, as we have already heard, housing, employment, family services and other programs, and such high-level funding arrangements and other arrangements between governments, that we think it is absolutely essential for those plans of governments to have not just the sign-off of first ministers but an actual commitment of first ministers. As Mr Rosenberg pointed out, the agreement between Prime Minister Howard and Premier Iemma at the time was critical. It is that sort of level of agreement that, I think, has seen us make the incremental breakthroughs that we have had along the way, and I really think we are at a point where we are unlikely to achieve the sort of substantive reform that we think is required without that sort of high-level agreement.

Mr Rosenberg: As was mentioned, there have been four plans already, and I think they have become decreasingly relevant. The last plan in particular was well written—it had all the nouns and verbs in the right spots and so on; I think it appropriately colonised the term 'recovery'—but it really did not have any money or any implementation or any real support for it to be actioned. Frankly, I would not support a replication of that process. I think it is a moribund process.

I would suggest that first ministers can direct attention beyond health, and that is clearly what is required, but what is mostly required, I maintain, is to fill the gap which exists between the GP and the hospital. That is why, rather than a fifth mental health plan, I would rather see first ministers sign off on a first national community mental health plan. In my mind, there would be appropriate links to primary care in that community mental health plan. You may well be asking at some stage, Senator, about the role of PHNs in fulfilling their role as part of community mental health. I would also like to see, within the community health plan, what the role of hospitals would be in arranging the appropriate discharge and other arrangements to smooth discharge for people back to the community through step-down arrangements, outreach nursing and a whole range of other things. I, for example, did not realise that Hospital in the Home began in mental health.

Senator McLUCAS: Neither did I.

Mr Rosenberg: It is a really good idea. I have used Hospital in the Home for other things, and you think, 'What a lovely thing to be at home and recover rather than in an institution.' We could return to those kinds of arrangements. So my money would be on a community mental health plan which had links to primary care and to acute care. The community part of it—and this is very important—would need to also figure very prominently in discussions around links to housing and employment services and community services and the range of psychosocial support services that are funded, currently, by Commonwealth and state governments. It would appropriately place emphasis exactly where I feel reform for mental health is most necessary.

Mr Meldrum: I strongly endorse what Frank was saying. The First National Mental Health Plan—and, amazingly, I have been around long enough to have been involved in it—had a little bit of bite because of its newness and, in fact, it came out of a fair bit of argument between people on which direction we should be heading. In that sense, it was quite influential.

With the last couple, in my view, you have been able to read them and say, 'That's about right,' but that is about the end of the conversation. There has been nobody made accountable to do something about those, particularly in the Commonwealth-state divide. You have mental-health plans in every state and territory being developed, as we speak. They either have just been released or are about to be released or are starting to be formulated. That is the situation at any given time. Most of them are the same. Most of them do not have any sort of a timetable or accountability for implementation. This one needs state ministers and the Commonwealth minister and key departmental heads not only to be saying, 'This looks like the way mental-health services ought to look' but also 'It contains some specific accountabilities for outcomes that will lead to some implementation.'

The First National Mental Health Plan, in fact, could have been a lot more influential if more people had done what Jeff Kennett did in Victoria. He took the First National Mental Health Plan—whenever he got into power; I think it was '92 or '93—and said, 'This needs an implementation plan.' They wrote a blueprint for what it would look like, to implement this in Victoria, and went ahead and did it. From the mid 1990s until quite recently Victoria had, by far and away, the best range of community mental-health services of anywhere in Australia. That is why. They put an implementation strategy into place. This one needs one.

Senator McLUCAS: The message from the commission, this morning, was very much around building-in an evaluation tool at the front end of anything. I suppose that is where you would start. I want to move from that issue, if that is okay, to the National Mental Health Service Planning Framework. Did any of your organisations have much to do with the development of that? I asked the commission this morning about whether they were given access to it and they advised me they were not. Do you have any comments about that and recommendations to this committee about what should be happening about it? I ask these questions at Senate estimates all the time and I get patted on the head, a bit gently, and am told 'It is all going along swimmingly, Senator.' I think we are getting to the pointy end of getting it out there.

Mr Quinlan: We have all been waiting, I think, for the National Mental Health Service Planning Framework to come out the other end. If I can provide a crude summary, it is fair to say that both the government and the sector invested a couple of years in working through a model for the provision of mental-health services and, as I understand it, some of the people at this table will have been involved in that process. What the process ought to do was say, based on the best evidence we have available: what are the sorts of profile of services you would expect to be available in the community, the sorts of services we might be expected to have available in the electorate of Inverell or anywhere else? Then it mapped that against the populations of people who might have particular illnesses. It also said that realistically we will, perhaps, never provide services to all of the people who have particular illnesses. It made discounts in its process for the fact that not all people will always get access.

We have seen parts of it. It is not yet available for release. It is fair to say that any of the people I have heard talking about it describe it as the best model we have for this sort of provision of care. It runs the risk of locking us into older models of services. It is more of a snapshot than a prediction of future. Nonetheless, it gives us an excellent model for working into the future. It is fair to say that those across the sector who invested a lot of time—and it is true to say that there were some hundreds of people across the sector—in developing that model have been somewhat frustrated by the fact that it has not yet managed to come out the other end of the process. This is because it is likely to give us some of the answers to the questions that David Meldrum alluded to—what are the numbers?—and gives us a platform where we can have a sensible debate about who is in what group and where the sorts of services for them should rest.

Senator McLUCAS: Mr Quinlan, you said a snapshot not a prediction. Does that go to the question of this being a current workforce funded by health rather than a look at a workforce funded by health and others? DSS spends a lot of money in mental-health services. Is that what you meant by that phrase?

Mr Quinlan: What I meant was it modelled particular forms of care. As I understand it, and others might correct me, it certainly focused on health but also extended well beyond that into the sorts of programs that might be available in the community. Any picture like that runs the risk of being a model for us doing what we have always done. I would want to argue that, yes, we need the mental-health service planning framework but we need a framework for ongoing planning of mental-health services. This is because we will innovate; we will learn. Regionalisation of services will teach us new things. What we need is that kind of process to go on marketing and remodelling services into the future.

It will be a helpful snapshot when it is available. It would be even more helpful to have a process where, for those with expertise in the sector, those looking at the best evidence available, those trialling new approaches, those evaluating emerging approaches—like Partners in Recovery and so forth—there is a process for us to engage and feed that into the ongoing development models.

Mr Rosenberg: I fully concur. That should be made public and used and analysed and further developed. What I want to mention with regard to the framework is not only that it would be good to have it revealed but also to go back to the point that Frank raised, at the very start, about the range of different things going on at once.

The framework really is about the best use of limited resources for the population. It is a population based approach, and most states and territories have used resource-allocation formulas of one sort or another. It would be good to make that clear and transparent, so you knew where the money was going and to make sure it was evidence based and so on. I would certainly look to include the community sector in that, as I believe the framework does.

On the other hand, there is also a policy stream that is very clearly pointing us towards individualised packages of care. I do not understand how those two things go together. We have to think about that. We have a very strong emphasis on fee-for-service in our current response, yet a lot of the innovation and so on is pointing to blended payments systems. I do not understand how those two things go together. I would also say there has been a lot of interest and investment in activity based funding as a way of being clearer accountability for the way budgets are put together and spent in mental health. At the moment, we are choosing some dumber historical block funded approach to funding. I do not see how that goes.

The commission talked about regionalisation but our approach to decision making is still largely centralised in the state capitals. There is a lot of talk around commissioning services, yet we still have competition between providers through tendering. There is a range of different policy conflicts embedded in our current approach, which are partly to do with the number of different issues we are dealing with but they do not make it easy.

Prof. Hopwood: The activity based funding has obviously been explored through the Independent Hospital Pricing Authority. The missing element, in that, remains outcome-driven funding. It is a different way of funding things, but it does not necessarily change the outcome. The status of that is at this moment unclear, but we would reserve—if it became more clear as an important consideration, well, that is great, so you fund it on what you do, but does it actually help anyone? It remains central to what I have said about a lot of things.

Senator McLUCAS: Professor, a health economist said to me once: if you build a bed, a doctor will put someone in it.

Prof. Hopwood: And there is no doubt, if we were to increase the number of beds tomorrow, people would fill them, but that is not necessarily the outcome we want. There is no doubt about that.

Just to follow up on something else Frank said: a really important element of any development in the mental health sphere is research to improve what we do. The risk that we continue to do what we do because we do it will be obviated if we measure the outcome better, but common sense says we would still like to improve on what we can do. So the very best we can do at the minute still could do with a lot of improvement. A significant commitment for research is an important factor—and that includes funding we currently receive from organisations like the NHMRC while a specific allocation from potential new funds like the medical research fund would be something we would like to support.

Senator McLUCAS: I think that is a nice little recommendation that we would be able to make.

Mr Rosenberg: It is worth noting that mental health is about as successful at getting NHMRC funding as it is at getting health funding.

Senator McLUCAS: We have covered the planning framework issues now, which leads me neatly into regionalisation and regional services. My next topic is NDIS, so I am not forgetting that—is that okay, Senator Williams; I am not being too greedy?

ACTING CHAIR: I think Senator Williams might still be doing a bit of research over there.

Senator WILLIAMS: No, all good.

Senator McLUCAS: Let us go to the question of regionalisation. There was a very strong recommendation from the commission to move to a regional approach in planning and service design and delivery for mental health services in the broad, but also around suicide prevention—so it is almost in two streams there. Can you talk to us about what your organisations think about those recommendations and what you think the primary and mental health networks might look like? That was one thing that Mr Quinlan forgot to put in his list of balls in the air at the moment. These organisations are one month and 25 days old, so what do we have to do? We are going to have a quite big shift in a short period of time. What do we have to put in place in the networks to make sure that we do what Commissioner Crowe said, 'If we're going to change something, we ought to change it for the better.' It has stuck in my head.

Mr Quinlan: We just had a meeting of our members again, if you do not mind me jumping in. Some 60 of our members had a meeting ahead of consultation with the Department of Health here about the response to the National Mental Health Commission's review and the ERG process, and Primary Health Networks were one of the topics of some heated and considered discussion. It is true to say that there is very broad agreement about the need for regionalisation of our approach, to look at whatever that means, but it is also true to say that there are some reservations, not necessarily terminal ones, about Primary Health Networks just because, as you have rightly pointed out, they are so new. The concern I would summarise as this: if Primary Health Networks are dominated by GP interests and a GP-centric approach in the local community—and this is not to suggest that they are—then that will achieve certain goals but it will not achieve the breadth of engagement that many of our members are keen to see.

If we are going to achieve the breadth of agreement and planning that we need, then we would have to go somewhere to what the commission recommends, which is primary and mental health networks. What would that mean? That would mean that community organisations, consumers and people with a lived experience of mental illness themselves and others were all engaged in those governance structures, on the boards of Primary Health Networks. I think it would also likely mean that Primary Health Networks would also look at their localisation and many of them, I suspect, would say: 'Actually, we're not that local. If there's only one Primary Health Network in this vast area, perhaps we need to have some structures by which we can have sublocalisation, if you like.' So I think there is a lot of anxiety about us investing too much too early in structures that are just emerging, notwithstanding, I think, the broad agreement that we need local structures to steer and govern investment.

Prof. Hopwood: Yes. It was a very useful discussion at Mental Health Australia, and I support those comments. I think that, while we can have discussions in relation to the Primary Health Networks, we need to acknowledge that some of the same issues apply to the governance and administration of the acute health networks that, within the mental health space, control both acute hospital beds and some of the clinical public community services. They too are charged with health care for a region but filtered through the lens of what runs a hospital—the budget and so on and those concerns. We are at the same risk of replicating the same issue with the Primary Health Networks. So there should be cross-governance arrangements such that they share responsibility. They are meant to be looking after the same community, or close to it, usually—with some of them it is not quite. Therefore they should be looking for the same outcomes, but the current governance arrangements and funding streams do not support that; in fact, they tend to—perhaps inadvertently—occasionally produce the opposite outcome, with unhealthy competition for more resources to produce the same outcome with, therefore, inefficiency.

Mr Rosenberg: Here are my two bobs worth about this. I am a 'form follows function' kind of guy, and I would love to have the discussion about what sorts of services you are talking about. I must say I was on the edge of my seat as Allan Fels was talking about stepped care. I think one of the issues that are unresolved is: what is stepped care? What does it look like? What are those different steps? I think we need to be quite clear that at the moment I cannot help but suggest that the system seems to be run for the benefit of the providers, largely—and I would probably discount the community sector from that, because they do not seem to be benefiting much at all. Certainly I think any new system of stepped care is going to change and challenge current ways of working for health professionals and other service providers. And what does that look like? I think we need a very strong emphasis on psychosocial rehabilitation and support, community and living skills, employment and housing support. These are the kinds of things that Pam's, Ivan's and David's group are experts in, with decades of expertise and expert staff who know what works. Allan Fels has talked about step-up step-down services, but they are carefully put together to provide short-term accommodation for people. They are not wards for overflow from acute hospitals; they are a separate service and, I should say, have not been costed as part of activity based funding at the moment, so that is a gap we may wish to return to at some stage.

What we also need is multidisciplinary community mental health teams on the high street, and that would include a crisis capacity. Again, it will not stun senators to know that those sorts of systems, which engage psychologists, psychiatrists and others, were throughout Australia about 15 or 20 years ago and have been thoroughly dismantled since then. Services have withdrawn to the hospital and fee-for-service providers to their own practising rooms and out of the high street.

Senator McLUCAS: Can I just interrupt at that point. Is that because states and territories have reduced investment?

Mr Rosenberg: Yes, there is no doubt of that.

Senator McLUCAS: Is it basically states and territories—the old community health centres that we knew in the olden days?

Mr Rosenberg: As I say, nobody owns community mental health, and I think there has been a withdrawal by the states and territories to the areas they know they control, which are hospital based services. That is why you have some real confusion: when they talk about community based services, they include hospital outpatients, who are by far the largest component of their supposed community spending.

Mr Quinlan: I think the current funding discussions around the NDIS risk exacerbating the point that my colleague is making, because the fear is that there is going to be nothing left in the pool to fund the sorts of services that Sebastian is talking about.

Ms Rutledge: Can I just put in, in parentheses, that I think that that diminution of services is also an outcome of some unanticipated consequences of federal-state funding arrangements. As you said, nobody owns and supports community mental health, and it fell between the cracks of the Commonwealth and the states.

Mr Rosenberg: With respect to mental health community outreach nurses, the Mental Health Nurse Incentive Program is a proven program that adds so much to the armaments of GP practices so that they can follow people into the community and provide care. The cost is only $40 million, which would be less than three weeks worth of the Better Access program. It is a tiny program with massive effectiveness. So, again, Australia has a program which it could scale but has not.

Senator McLUCAS: Is that because we do not have the personnel?

Mr Rosenberg: That is part of the issue and, again, the amount of money that is set aside for workforce development is tiny. Some of our colleagues in the College of Mental Health Nurses have been struggling to build that workforce.

Prof. Hopwood: The Mental Health Nurse Incentive Program is capped, and that limits—I think there is adequate workforce to expand it further and distribute it more evenly. But it is capped.

Senator McLUCAS: I did not know that AMSs are not allowed to have Aboriginal mental health workers.

Mr Quinlan: The Mental Health Nurse Incentive Program is one of those programs on the list that has been extended on a 12-month-by-12-month basis for quite a number of years. It is not unique to this area, but it is one of those areas where clearly if you are a nurse in the community who is thinking, 'Where will I build my career in nursing?' this notion of 12-month-by-12-month funding does not create—

Mr Peters: It is common across a lot of the services.

Mr Quinlan: It does not create a platform for people to say, 'That's where I'm going to invest my future', because you never know—

Mr Peters: The uncertainty of mental health funding is probably causing as much stress as anything else, no matter what it is—if that makes sense.

Mr Rosenberg: The Mental Health Nurse Incentive Program would also assist greatly with managing the physical health needs of people with mental illness in primary care. Senator Williams asked about other places—

Mr Meldrum: I just want to make a comment about Primary Health Networks before we finish on that topic. The notion of mental health planning and strategy and commissioning and so on, and all the money being thrown into them, as Frank said, was controversial. But ultimately, in terms of the final outcome, we can all see that they are the only game in town for a regional structure and that we are going to have to work out a way to do it. I also feel they need a personality transplant in a lot of cases before they can do it, because they are focused specifically on the role of the GP, who has an important role but not all the roles. The key issue is that they do not have a mission. It is going back to the stuff that Seb particularly was talking about. Why suddenly chuck a whole amount of money at an organisation yet again without specifying what we want it to achieve? And while we have a national mental health plan that has not been finished, while any implementation strategy is yet to be dreamt up, while the NDIS arrangement is so unclear et cetera and while we do not have any of those key outcome objectives, there is no mission to give them. I would suggest that we are at least a year away from being able to describe to a Primary Health Network, 'The mission we need to achieve in mental health with this money is this.' That would be the very first step before they get given the job, from my perspective.

Senator McLUCAS: That is a very clear recommendation, I think. I am seeing nodding from other people around the table. It will take 12 months before we can actually start doing something around that.

Ms Rutledge: I just want to reinforce the point Frank made about the governance structures, because the Primary Health Networks really are Medicare Locals reinvented. It is the same people and some of the same attitudes and some of the same values, and I think we really need to think about how we get a stronger mental health presence into the governance of those organisations as well as a stronger sense of the outcomes we are looking for.

Senator McLUCAS: I wonder whether I could ask you to take some homework away on that question, and perhaps you have some specific advice for our committee about what we should do in that next 12 months to ensure that the PHNs or the PMHNs or whatever we are going to call them are transformed to the point where they will really be able to capture the responsibility of primary and mental health care at the same time.

ACTING CHAIR: Is that essentially a question on notice for the whole—

Senator McLUCAS: It is a QON for everybody. You were finishing something off—

Mr Rosenberg: I still have a long list here—a Castro-style monologue! I will just keep going. One of the things Senator Williams asked about in terms of differences to other places was the use of peers. One of the only targets that were set in the fourth national mental health plan was a target of one per cent of the total workforce to be peer workers. It is pathetic. These are proven, efficient ways of delivering support in the community to people with mental illness and again characteristics of community mental health service should have a large role for peers. Again I would be asking Primary Health Networks: 'To what extent do you offer a peer workforce, a nurse outreach workforce?' These are all components of part of a stepped care arrangement. Personal Helpers and Mentors and Partners in Recovery are precious, scarce resources in this area.

Senator McLUCAS: Given you said Partners in Recovery and PHaMs, can we move then to the NDIS and pick up on Mr Meldrum's point? You said that you expect 70 to 80 per cent will not qualify to get a tier 3 package under the NDIS. That is for PHaMs. Why do you say that, Mr Meldrum?

Mr Meldrum: Partly because we know PHaMs well. Just in my organisation, apart from after-care, between us we have something like 40 to 45 PHaMs programs across the country, so we know that population very well. When you look at the definition of severe and persistent mental illness and complex psychosocial disabilities we can clearly see about 20 per cent of them fit that characteristic. That was the way that program was designed. It was not designed to be totally that very challenging group; it was designed to be a wider cohort. So in a sense we are saying it should not be more than 20 per cent of them fitting. That is the way the two programs have been designed. It is a highly contested space. A lot of people in the National Disability Insurance Agency say, 'No, we are enrolling up to 80 per cent of people from some PHaMs programs.' I am yet to see the proof of that but if they were I would be alarmed because that is dramatic mission creep. They should not be going out to people who are coping well most of the time and giving them small packages of care. That is not what the NDIS is about.

All I can say is that we keep on looking at our PHaMs programs and keep on seeing the same results. I am very up to date with what is happening in the Hunter, which is the most advanced area in terms of transition. I was talking to people there only last week and they said it is something like 25 per cent at the moment of people in PHaMs programs are being found eligible, so we know we are in the ballpark.

ACTING CHAIR: Mr Frkovic, do you want to talk about PHaMs?

Mr Frkovic: We need to remember that PHaMs was designed for people with severe, persistent mental illness but the people we are seeing at the moment are people who might need a very small amount of support, even though they have a severe persistent mental illness. They have a whole range of other supports. We provide a little bit of support and they maintain good quality of life in the community. It is that that will be missing. They will not qualify for a NDIS tier 3 package but they will also lose that little bit of support that they currently rely on to be able to live in the community.

PIR is slightly different even though there are elements of that, because we are trying to pick up the group that is falling through the service gaps. We suspect with the PIR group more of those will actually qualify for the NDIS, but PHaMs is the safety net. Potentially we could lose that safety net. We keep hearing about ILC and that the tier 2 level will provide coordination to this and that, but coordination to what when that whole tier 2 level of support will disappear?

Ms Rutledge: As I am sure you are aware, there is a major national systemic issue around the NDIS which is to do with where the money is coming from in each state and territory, so we are experiencing some unanticipated consequences of the fact that in New South Wales the money was historically disability service money, in Victoria it was historically mental health money and it is different in every state. It is part of the bilateral agreements. This puts the National Disability Insurance Agency in a very difficult position in trying to create a national framework of eligibility and support until we can get some greater clarity around that broader issue. The NDIS is intended to fund disability supports for people, including people with a psychosocial disability, but it grew out of the broader disability sector. There is a lack of definition about what is a disability support for a person with a mental health issue compared to what has traditionally been a health support for those people. That is the piece of work that many of us are trying to get engagement with. The agency understands the need for that piece of work to happen, but I think it is sort of clouding and confusing the whole framework about what it is that the NDIS will provide and fund for people with a long-term severe and persistent psychosocial disability and what will remain as a Health funded support. That is where I think we start to get into this confusion about: where will support for all the people who do not get tier 3 packages sit? We do see that the Partners in Recovery model is really well positioned to be reframed to go on being funded as part of the solution, not only for supporting the tier 3 packages but also for trying to fund the level 2 and provide some block funding for ongoing support for people who do not get their tier 3 packages, but it is a very big, clouded picture at the moment, and there is a need for some really detailed and committed work. Many people are involved in it, but it is really hard to see how we are going to get traction in that space. I think the next year is really crucial about getting that traction.

Mr Quinlan: We have made some recommendations around precisely that point. I want to be absolutely clear, because we are often misheard. Mental Health Australia are not making a case for more people to be included in the NDIS. We remain largely agnostic about who delivers the services to the people in need. Some of them will come from the NDIS. Some of them will come from existing or ongoing Commonwealth programs and some of them will come from state government programs. Largely, we are happy for state and federal governments to sort that out amongst themselves. But I think there ought to be mechanisms available—and I could provide you with some more details about this. If Sebastian, who is on the PHaMs program at the moment, comes into my NDIA tomorrow for assessment and is refused—I say, 'Sorry, Sebastian; you can't have the NDIS service and, by the way, your PHaMs service has been enrolled'—he walks out the door entitled, under the current agreement between state and federal governments, to a continuity of service, a guarantee of service. Governments have agreed that Sebastian is entitled, but Sebastian walks out the door with no mechanism to tie him to that guarantee. A very simple process, in my view, would be for the NDIA not to say, 'Good luck, Sebastian; you're on your way,' but to say, 'Here is the state or the Commonwealth program to which you are now entitled.' That would be a very simple mechanism to turn that guarantee of service, which governments have happily committed to, into some sort of concrete action on the ground, because otherwise I fear there are going to be a lot of people falling through the cracks.

Mr Rosenberg: This is another one of those strange conflict policy areas that I was alluding to before. You have now got national recovery standards which are really about trying to encourage and arrange for people to move through a system of care with a view to them getting better, which of course most people with mental illness do. That is the goal. However, the way we fund services often runs counter to that, and I think this comes out of the NDIS and it comes out of other arrangements with our current funding to the NGO sector, in particular, where their funding is dependent on me coming back next Wednesday still being sick. Again, you have just got a conflict here between what we are trying to pursue as an outcome, which is people's recovery, so they can go back to work and resume their lives, have fewer days out of role, as they say, and what we subject service providers to in terms of the way they are funded. Again, this is a policy conflict which makes things very unclear.

Senator McLUCAS: We should pay you if your patient does not turn up!

Mr Rosenberg: It's a deal!

Prof. Hopwood: In trying to link together consequences for various parts of the systems, perhaps this is a somewhat surprising figure. Between 2007-08 and 2011-12, the Institute of Health and Welfare figures show the average length of stay in a public psychiatric hospital went up from 48 days to 69 days, which is very counterintuitive.

Senator McLUCAS: What years were those?

Prof. Hopwood: Between 2007-08 and 2011-12. It has subsequently plateaued. That is counterintuitive, because we all know the pressure on those systems. The corollary is that many hospital directors say, 'I have a number of patients in my inpatient unit at any point in time who I do not think need to be here.' What does that really mean? They are usually talking about people with enduring disability; they are not well. They have enduring disability, but issues around housing and disability support mean that maintaining them outside of hospital, which everyone would desire, is not possible.

Senator McLUCAS: So medication is stabilised but they are still not well?

Prof. Hopwood: We have done as much as we can, if you like; I think that is probably really what we are saying. In terms of the efficient use of that resource, that is a problem, but it is also a very important group of people. One of the issues that we are seeing with NDIA work in other areas of disability is that those people who are currently in a spot, as it were, within the system can sometimes get missed—particularly if they are, for example, a younger person with brain injury in a nursing home. So I promote that as evidence of a need but also of a group that are very important to consider.

Prof. Hopwood: An unpublished national survey of beds carried out by acute ward bed managers in four states—not New South Wales—in 2006 suggested that the number of beds occupied by people who would be better off elsewhere was 43 per cent.

Senator McLUCAS: Has that changed in any way since 2006?

Mr Rosenberg: I do not know; it has not been repeated. I would imagine it would have gotten worse.

Mr Frkovic: I was part of that process when I was in government. Yes, the first survey results were even higher—I think they were just in the 50s; the second repeat survey results were in the 40s—people did not need to be in that bed for clinical reasons, picking up your point. They were stable but the major barrier for them to be discharged and placed in the community was around accommodation. Both clinical and non clinical support in the community was the major issue. We are talking about anywhere between 40 and 50 per cent of the beds.

Senator McLUCAS: What level of government should be responsible for the accommodation for the stepped down care?

Prof. Hopwood: It is a great question, because the solutions are diverse. It is important to acknowledge that, whilst they do not need to be there as in probably the acute hospital is not going to change things, some of them are highly disabled. So some of them are going to need quite specialised accommodation options—in fact, most of them. If it was easy, they would not still be there. Together with that, they are going to need high-level clinical and non-clinical support. Part of the complexity currently is that each of those three things—accommodation, clinical support and non-clinical support—comes from different spots.

Senator McLUCAS: I always say that there were no women involved in Federation.

Mr Peters: If I may say, one of the problems with mental health funding is the confusion about the funding and where it is coming from and then the competition for the funding. So you can see by the number of people that are represented—and the number of parties now that are involved in mental health funding and trying to create a better outcome for everyone—that it is no wonder that the general public and those who need the care are confused and struggling. Those who are involved in it and leading it are confused and struggling. Perhaps, to some degree, with all due respect, parliaments are confused and struggling.

Ms Rutledge: I sound like Pollyanna, but we, again, do know what works. We have some real living examples on the ground of 24/7 supported accommodation in the community for people who have been long-term in hospitals—HASI and HASI Plus. At the moment, those have been state government funded. We had one brief shining moment where there was the national partnership agreement, under COAG, for mental health reform where we did have Commonwealth state funding going to priority programs jointly funded and jointly agreeing on the outcomes. HASI Plus is one of those in New South Wales, providing 24/7 intensive support with good clinical backup—again, three or four pilots across the state with great potential to scale it up.

Mr Rosenberg: I do not think that we should limit ourselves to rethinking or reimagining the system outside of hospital and saying, 'Hospital is hospital, and it will remain so forever.' Again, parts of the reforms in New Zealand are to create hospitals in the community, where it is possible to go for acute care. In other words, these people are—I believe the term is—floridly unwell, and they go to a house in the community where they are provided with care which is led by consumers. Clinical and non-clinical support is provided. The psychiatrist comes to the patient rather than the patient going to the physiatrist. The person does not have to go a traumatic in-patient unit with guards; they have their own room in a nice house in suburban Auckland, and that is acute care and it is cheap. So I think that we need to reimagine mental health at a variety of different levels.

Ms Rutledge: We are running a very similar program in Hervey Bay in Queensland—a peer operated service where we have a house where the clinicians visit and people come and live. It is run by people with a lived experience of mental health issues. For everything that we know we need, we have living examples; it is about how we put them together into the package, scale them up and identify the funding framework. I think it really has to be that—as I think the commission said—the Commonwealth should step back from directly funding services on the ground in this sector. It should put some money in; the money needs to be there, but it needs to be channelled in a way that does not create a Commonwealth state divide on the ground, as we have seen to our peril. I think PhaMs has been a good example of that.

Senator McLUCAS: I have one more topic that I do not want to miss. I am a bit embarrassed about this. It is Indigenous mental health, and it probably should have been at the top of the list. Could we talk more about the recommendations from the commission around Indigenous mental health, what your views of those recommendations were and any recommendations that you would make to this committee about those recommendations?

EXHIBIT 974

Prof. Hopwood: I can talk to a couple of specific things. Certainly, in terms of the commission's highlighting of the issues around Indigenous mental health, we support them wholeheartedly. I do not see how you could possibly not. That is not the challenging bit; it is what to do. Specifically within the profession of psychiatry, we have focused on how we improve access and fit of workforce. New Zealand has reached parity now with medical school intakes of Maori descent compared to population. We have not. We are still about 50 per cent of the way there. If you look at medical specialists, we are considerably lower. We have been able to utilise some of the expanded training setting money that Andrew mentioned recently to encourage, specifically, Indigenous medical students to consider psychiatry, based on the committee that we have of Indigenous community members highlighting that that is what they want. We have had some success. We now identify medical students who are of an Aboriginal and Torres Strait Islander background who are interested in psychiatry. We promote them. That is the workforce that the community tells us that they want.

What will then attract them to go to where the communities are and keep them there is a set of different issues that are not unique to psychiatry, I have to say. Training an appropriate and useful workforce is clearly central, in our view, as one part of the solution. Working in those areas with an inappropriate workforce is perhaps—as Senator Williams previously suggested—not very effective expenditure.

Mr Quinlan: I was going 'hear, hear,' which I think is the parliamentary tradition on those things. Hear, hear.

Senator McLUCAS: Are you after my job, Mr Quinlan!

Mr Peters: The challenge should never be understated. I think that the air gets sucked out of it from time to time. It is certainly pleasing that you raised it, because I think it is still critical. It is still in every discussion we have. We were in the Northern Territory on the weekend. Amongst a number of other topical items you could imagine up there, of course it comes up, and it is just to the floor. We just cannot but support anything that helps that and supports the funding. Training themselves is interesting. That is something they really want to embrace. I probably jump to that STP area, because that is key to this. Where we can get funding to help support that, we see that as a priority of ours—certainly, as a college.

Mr Quinlan: Recently I was fortunate enough to be part of the Garma festival in east Arnhem Land. I think it is fair to say that many of the people I encountered there were baffled that our policies around these issues change as frequently as they do. I would agree with what Malcolm and Andrew have said about workforce being one of the absolutely central issues not just across psychiatry but across all of the disciplines involved in mental health. Having an Indigenous workforce working in those populations is absolutely essential. Professor Pat Dudgeon and Professor Tom Calma have produced strategies through the NSFATSIPMHSEW—or something like that; it is an enormously long acronym—the Indigenous social and emotional wellbeing framework. We need to give some of these frameworks the opportunity to have an impact. Rather than changing our direction mid-flight, there is what I think the doctors would call a dose response. You need to make sure that there is an adequate dose given. It is not just that the program fails. If the program is not delivered often enough and for long enough then it is not going to have a response. I think giving things like the social and emotional wellbeing framework a long enough life and future so that they can actually bed down and engage and start to yield results would be a key recommendation.

Mr Rosenberg: I used to do some work in the Cairns area with their local Aboriginal mental health service, and that was one of the first times where I came across PIR in a very effective way. There was an Aboriginal workforce that was working within that program, and I was blown away. But one of the things that they found very difficult was that the rules preclude PIR from working with kids under 16. It is a classic example of a well-intentioned program that is applied to mainstream health services with rules and so on, but its application to the Aboriginal community was so completely wrong and counter to their whole view about family and about the social and emotional wellbeing of the whole family. I think it was an example of the fact that we have got some things in place, but they need to be tailored appropriately to make the most of those opportunities.

Mr Quinlan: I think supporting the sort of community controlled organisations that are genuinely taking control of their own destiny and delivering programs is important. As part of my trip north I visited the Miwatj health service, where there is a genuine ownership of the local strategies and services that are being delivered in that community. I think those sorts of programs provide an excellent model for what we could be doing in other places too.

Senator McLUCAS: Mr Meldrum, Ms Rutledge and Mr Frkovic, of the services that you are running in PHaMs and PIR, do you have enough Aboriginal and Torres Strait Islander clients to reflect the population that you are serving? Are people enrolling in PIR and PHaMS at the appropriate level?

Ms Rutledge: The preliminary results of the Urbis evaluation of Partners in Recovery nationally are showing that it is reaching a much higher proportion of Aboriginal people than is in the population, so it is touching that central issue about lack of engagement, and the use of the support facilitation model is really enabling people to engage very directly and immediately with people with a mental health issue who may not have been able to engage previously. It is really showing its effect of reaching Aboriginal people. Certainly in the programs that we run that are not PIR, and we run a number of Aboriginal HASI programs, we are working very actively with the Aboriginal community—for example, in Western Sydney with the Aboriginal community controlled service—and I want to reinforce Frank's point about the government: we need to really recommit to Aboriginal community controlled organisations as a way of building community and building wellbeing from the ground up.

Senator McLUCAS: Did you want to add anything, Mr Meldrum?

Mr Meldrum: The PHaMS service is about on par with the percentage of the population. It is highly individualised. It is a service where people go to your home. It seems to work pretty well. I think I have seen figures on respite care services that suggest that does not work as well, that it has rather a group element to it. So the purpose-built ones for Indigenous communities have emerged there and have worked pretty well. My comment on that would be you cannot go any other way but to build and Indigenous workforce for the program. It is slow and difficult.

I have seen a couple of situations in the last couple of years with the federal government has been pushing to set up a service up in the APY lands or Thursday Island, or wherever, and to get on with it: 'We want it on the ground with clients in the next six months.' Our service providers had said that you cannot do it. We are not prepared to say that this program is under way until we have at least half the workforce from the local community and that will take us time.

Mr Frkovic: I can certainly vouch for that. We have taken an interesting strategy both in employing Indigenous people and workforce issues, as people talked about, building of the Indigenous workforce within our organisation across the various programs and investing quite a lot in terms of professional development, orientation and training. We have also offered services in many of the locations like Thursday Island, as you just mentioned, and in the cape, plus in South-East Queensland and in a whole range of areas. We have also looked at where we can add value to local Indigenous services rather than coming in over the top, building some of that capacity and sharing some of that. In fact, in South-West Queensland we took on a DSS contract where part of our agreement was that we would do the PHaMs—it is all Indigenous staff—with the plan to transition after three years to the local primary healthcare organisation, which is an Indigenous organisation. We tried a range of things to do that. I would say that in some of those locations are Indigenous numbers in most of those programs are quite high. There are different ways to do this but again rather than imposing some of the things, like the program guidelines, we should exclude some of these things. For example, I have to be careful what I say in public—we stretched the guidelines to suit the local communities, to be able, with the PHAMs, to have a lot more group interaction, social interaction, rather than the one-to-one model that we use predominantly. You have to make it fit the local community.

Senator McLUCAS: It is really good to have that on the record.

ACTING CHAIR: Time is against us.

Mr Rosenberg: Can I say one last thing. I feel very strongly that, whatever do next, based on one of the most important elements of the national commission's review, is to finally stop the situation where we really do not know the merits of what we are doing and whether we are making a difference to people's lives. What I would suggest and advocate for very strongly, is that instead of the current situation where we have thousands of databases and thousands of indicators which tell us about the numbers of beds, the number of days and whether the person that blue or hair blonde, whatever it is, we need a very limited, rational, practical set of indicators which would provide genuine accountability for mental health region by region, so that we can track whether what we are doing is making a lick of difference to people's lives. Part of that would also be to provide information for service providers to improve the quality of the care they provide. Neither of those systems is in place at the moment.

Senator McLUCAS: Would that be based on consumer satisfaction?

Mr Rosenberg: There is no validated collection of the experience of care for consumers and carers in Australia. It would be one of the key markers which would permit people to know whether the service they provided for that person helped.

Senator McLUCAS: Can I say thank you. That has been a fantastic session and as Australians we can be very proud of the commitment and passion you guys have for the work you do. I love working in this space. Disability people say, 'Don't do say "inspiring"', but I am about to. You do great work, thank you.

ACTING CHAIR: I have to agree, thank you very much.

Proceedings suspended from 12:54 to 13:40

ADAMS, Ms Tracy Joy, Chief Executive Officer, BoysTown

BEWERT, Mr Peter, Executive Manager Care Services, The Salvation Army Aged Care Plus

DALGLEISH, Mr John Roland, Manager, Strategy and Research, BoysTown

HAND, Mrs Narelle Marie, Program Manager, Anglicare

HEATH, Mr Jack, Chief Executive Officer, SANE Australia

JOHN, Mr Christopher, Chief Executive Officer, United Synergies

KING, Ms Susan Elizabeth, Director, Advocacy and Research, Anglicare Sydney

KYRIOS, Professor Mike, President, Australian Psychological Society

LITTLEFIELD, Professor Lyn, Executive Director, Australian Psychological Society

PHILLIPS, Mrs Karen, Manager, National Standby Response Service, United Synergies

PROUDFOOT, Associate Professor Judith, Head of eHealth, Black Dog Institute

ROSENTHAL, Mrs Nicola, Business Development Manager, The Salvation Army Aged Care Plus

ACTING CHAIR: I now welcome everyone to our second roundtable of mental health peak bodies and service providers. Thank you all for making the time to talk to us today. I invite you all to make a brief opening statement, and then the committee will ask questions.

Mr Bewert: Good afternoon, Senators, ladies and gentlemen. The Salvation Army Aged Care Plus is a dynamic provider of social and community services to the Australian people. There are numerous programs focusing on health, wellbeing, mental health, drug and alcohol recovery, and aged-care services which interface with the broader health system. Today we are representing the Salvation Army Aged Care Plus, which operates aged-care residential and community services on the Australian eastern seaboard.

The work of the Salvation Army has shown that many people with mental health difficulties face compounding disadvantage, particularly Aboriginal and Torres Strait Islander people; people living in rural and remote regions; those who are marginalised due to their sexuality, gender, cultural background or job; and people who have difficulties with alcohol or other drugs. People with mental health problems struggle to find acceptance and experience marginalisation. The symptoms of mental health problems can lead to isolation and a lack of sense of belonging.

If placement in an aged-care centre is required, these key elements continue and are often intensified. The reasons for this include lack of residential care places that cater for the specific needs of this client group. People with mental health problems, in our experience, generally do not have access to family members or friends, which can result in extremely high emotional needs once they are in a residential care environment. There is generally a reluctance of the aged-care sector to admit people with mental problems into mainstream residential aged-care services, due to the negative stereotypes that are often associated with that—specifically, behaviour associated with mental health problems, drug and alcohol use, personal hygiene issues and a history of homelessness. Low-care facilities catering for the mentally ill can have up to 90 per cent of residents who have been homeless. Many of these will be assessed as having high and complex needs. The funding tool used by residential aged-care facilities, commonly known as the ACFI or the Aged Care Funding Instrument, does not reflect the level of care and funding required by homeless residents assessed as having high and complex care needs, even at its highest levels, when we specifically look at mental health.

Challenging behaviours in residential care are increasing. Whilst these are usually associated with dementia, older people with long-term mental illness present with behaviours not associated with cognitive decline. One of the things we regularly experience is the difficulty with managing people who have multiple diagnoses. Particularly, those with a diagnosis of dementia and a mental health problem are often neglected with our health system as it currently stands, in that everything is bunched into the dementia diagnosis and often the mental health concerns are ignored.

Many placements fail for older people with mental health problems. The recognition of the need for a sense of place led to the development of some very specific models of care within the Salvation Army Aged Care Plus. My colleague Nicola is going to talk about some of our specialist centres.

Mrs Rosenthal: At Aged Care Plus we offer two specialist residential aged care centres which look after people with specific mental health problems. One is in Balmain. The Montrose men's home is a specialist home for men, the majority of whom—76 per cent, I think, as of today—have a mental illness, a long history of incarceration or institutionalisation, substance abuse and previous failed placements. Our Carpenter Court Aged Care Plus Centre is in Newcastle and up to 98 per cent of our residents up there have long-term mental ill health. As Peter said, the need to find a sense of place led to the development of our person centred behaviour support plan, which was recognised in 2014 with a Better Practice Award by the Aged Care Quality Agency and a Mental Health Services Award in 2015. These homes are specialist in nature and we have further offerings in our aged care portfolio which specialise to a lesser extent in mental health.

We have identified that for the management of older Australians in this environment there need to be specialist resources and living environments available which cannot be accommodated in generalist aged care services. One of those issues is around staffing. The staff in general aged care services have no mental health training, so the person is not able to be managed, they become disconnected from that community and the residential placement fails. We have made a deliberate attempt to specialise in these areas and we have really strong links within the communities to do that.

Further, within our service offering we operate three rural centres in New South Wales and one in Queensland. We will commence the building of a new residential aged care centre in the far north of Queensland in 2016. These issues around mental health and aged care are intensified in those rural areas. Consultation with staff has proven the ongoing challenges regarding access to appropriate and timely mental health services for residents, particularly where this acute. Despite staff accessing the best training we can find, there are times when more highly skilled professional intervention is required. Those challenges can be caused by a lack of local services and mental health professionals—specialist or generalist—support services which are too far away and too expensive to access and the stoic approach of people not seeking help in a timely manner or not wanting to have a stigma attached to them.

The challenge of life in a small community can impact on care. We know that GPs are reluctant to seek hospital care for people who need a mental health admission, particularly where the local multipurpose service cannot cope with that. We also have problems with GPs discharging patients with mental ill health from their books despite their long history of mental health problems. That is particularly pertinent when a GP is the only GP in a town or when they are overwhelmed with people and they need to get some people off their books. The problem then becomes that we need to wait to get the person back onto the GP books when something happens, and that can be very challenging.

We are very passionate about providing care to the marginalised and the vulnerable. This is in our DNA as the Salvation Army and our history. We will advocate strongly for improved services in health to ensure that the issues that we see and will talk about here today do not fall through the gaps in our health system. We deserve a system which is seamless and which provides a holistic approach where the person with mental health problems is central to the health service delivery platform, no matter where they live or who they are.

Mr John: I would like to share why United Synergies is here. A number of years ago we developed a response to a suicide bereavement event that occurred in the hinterland of the Noosa community, in which two family members, on the anniversary of another family member's death, took their own lives. Suicide is a significant issue in our community, and the response we have come up with is really responding to local concerns to address the specific need for the recognition that being bereaved by suicide increases the risk of suicide in communities and particularly among those family members who are bereaved. This response started in 2002 in a formal way to look at addressing those particular needs.

We know that people who are bereaved by suicide have an increased suicide ideation themselves. We know that they have a higher incidence of depression and sadness in their lives. We have been able to develop a program, and the evaluation of it has demonstrated that if we do provide some appropriate intervention—very brief, very early in the process—we can reduce the suicide ideation, the levels of depression and the levels of sadness in those members to below what is occurring in the general population.

In addition to that, what we have found is that when we do respond in a way in which families and members who are bereaved can get that early intervention, then we can improve a number of things in their lives, particularly around presenteeism and absenteeism at work, medical costs and counselling costs—on average in Australia when someone is bereaved it costs about $14,000 to the economy. Our program has been able to demonstrate that it will save approximately $800 per person per year when they have received a brief intervention at the beginning of their bereavement in that space. So not only does it have good social and mental health outcomes for people but it also has an economic benefit for the community in that space.

The program was developed in 2002 and has expanded a number of times. Now we have 16 sites around Australia. The majority of those sites are delivered in regional and remote areas, through local partner organisations who know their communities and are well connected to be able to use the resources effectively in those local communities. Those 16 sites cost approximately $4½ million per year, so it is a very effective, very efficient service for those local communities.

Over the last couple of years we have also seen a significant concern about and vocalisation of communities who are concerned about suicide contagion or suicide clustering. Last year we saw national press around a significant article—a 5,000-word article, which I have made reference to for the senators—on the ripple effect, looking at the suicide clustering contagion concerns in communities. In response to a number of concerns that occurred about four years ago, United Synergies developed an additional response for those communities where there was a significant concern around cluster or contagion in a community and in which we did not have a standby site. It is a program where there is a brief intervention, up to eight weeks, where we can help communities to develop a community 'postvention' plan to respond to concerns around suicide and the number of suicides in a community, and to help them do that in a way that builds capacity, reduces or minimises the harm for potential further contagion of suicide.

We are still very much in the early days around that particular program. We have had about 14 interventions nationally over the last three years from various communities, but the anecdotal evidence we have from working with those communities is that there is a high level of satisfaction and an increased level of confidence for them to be able to respond locally to concerns around cluster and contagion in those areas.

Ms Adams: John Dalgleish and I are representing BoysTown and Kids Helpline this afternoon. We are a major provider of services to children and young people across the country, including many mental health related programs. One such program is the national Kids Helpline service, which is Australia's only 24/7 telephone and online counselling and support service dedicated to children and young people up to the age of 25. Last year we responded to 200,000 contacts from children and young people nationally; approximately 70,000 of those resulted in a young person presenting, which required a formal counselling session with our staff members. Of those counselling contacts, approximately 42 per cent of them were where a young person presented to counsellors with their concerns regarding mental health disorders, suicide and self-harming issues so that number was approximately 28½ thousand contacts—and that is counselling sessions.

In addition to Kids Helpline, we also provide specialist support and counselling to young people participating in the new jobactive program in Queensland, South Australia, New South Wales and Tasmania. Internal research with young people registered with our previous Job Services Australia program indicated high levels of mental illness amongst participants. For example, in one of our previous major offices in the western suburbs of Sydney, 58 per cent of young people who had been classified as belonging to stream 4—that is, young people with high barriers to employment—were experiencing a mental health disorder.

Furthermore, 10 per cent of these young people had also shown suicidal thoughts and/or behaviours and/or self-harming. It is too early to assess but we would maintain it is most likely that the prevalence of mental illness will be at similar levels amongst young people in the newly created Stream C and jobactive programs.

We believe that the mental health service provision to children and young people in Australia could be improved in a number of ways including recognition that young people are not small adults and that the experience of children and young people with mental health, suicide and self-harm is different to that of adults and requires different responses. Policies for the consolidation of mental health service providers should not undermine choice and access to specialist services for children and young people. We believe the resourcing of intensive placement and support interventions within jobactive services for the long-term unemployed young people, predominantly those who are experiencing mental health concerns, would greatly enhance employment outcomes and that the allocation of a proportion of the Commonwealth government's procurement budget to support the establishment of social enterprises employing young people with mental health concerns as a strategy to engage and integrate youth into sustainable employment would achieve great results.

Furthermore, whilst there are elements of integration, we would maintain that there is further opportunity to greater integration and utilisation of specialist providers in the development of safety and recovery plans for those who are identified as high-risk.

Mr Heath: I spent 20 years working in mental health and about the first 15 of those were in the youth area. I would like to reinforce Tracy Adams' comments about the need for youth services to be focused purely on youth. Senators may be aware we circulated a paper to you ahead of this meeting. I do not propose to go in detail through that but what I want to do with your indulgence is just to speak to a couple of highlights of the particular points that are raised there.

In relation to the National Mental Health Commission's review, the sector desperately needs a response this year. We do not want to be in the position where we have funding rolled over for another 12 months. It is just a really terrible way to try and operate services for people with severe needs. When we have seen political leadership in Australia in the past decades—and I would go back to Prime Minister Howard with the work that he did around youth suicide—we have seen significant changes occur. We are not going to see substantial reform in mental health unless we have concerted political leadership around that. I think that at a political level, mental health seems to have dropped off the agenda in the past couple of years. There is an opportunity now for that to be picked up in terms of response to the review. But we need to make sure that those responses are considered and are not done in a simplistic way. At the same time that we have many problems that were identified in the review of the mental health system in Australia, it has been SANE's view for a number of years that we actually believe we have the potential in this country to deliver the best world's best mental health services and programs for a number of reasons but I will not go into that right now.

In terms of the primary health networks, we do support the pushing down of service delivery and coordination to a regional level but we have some major concerns that if you do not design that system right in the first place that we are going to have significant problems down the track in the same way that we had with Medicare Locals. It is not a function of the number of regions that are being applied but the way in which it is being executed. Funding around mental health has to be maintained in real terms. Governments need to understand that how they fund the sector can have particular impacts. We think that government needs to give consideration to what is the right mix of organisations that are funded. For example, in the business community we understand the importance of small business, we celebrate that and that is an engine of growth. But when it comes to mental health, there seems to be an automatic view that fewer is better. So I think this is an issue that people need to take into consideration.

It is critical that the spending on mental health should align with the burden of disease. At the moment, it is tracking at about seven per cent in terms of spending, 14 per cent in terms of burden. We need to have greater investment upstream, especially in the online and digital services. We are still not connecting with around half the people that have mental illnesses and we cannot do that in the ways that we have done in the past. The online world provides an excellent opportunity to do that. Within that environment, there is a huge untapped resource of peer-to-peer support that is available.

In terms of stigma, we have done reasonably well around depression in the past five to 10 years. We have made no progress in the very severe end of the spectrum. SANE Australia earlier this year called for a five-year national stigma reduction campaign. We must have lived experience involved in all aspects of mental health policy formulation, research, system design, promotion, implementation and also evaluation. The life expectancy rates for people with severe mental illness are simply unacceptable, 25 years less than the general public. We need to do much better in terms of combining the work that we do around physical health issues alongside mental health issues. In the past there was an approach which said: let's get your head sorted first and then we will get to your body, and what happened was people never got to the body.

In terms of the National Disability Insurance Scheme, we see this as a highly problematic area when it comes to mental health. We started off in a very well intentioned way. We as a sector accepted an inadequate or improper policy framework that required people to go and plead their disability, which is completely opposite to a recovery model. We did that because we thought there were going to be huge amounts, billions of dollars, that would go to 56,000 people who have got very severe needs and who we desperately want to help. Our concern is that it is now looking like that additional support for those people is going to come off the back of potentially 625,000 people, as identified by the National Mental Health Commission, who themselves have very severe mental health needs. We thought there was going to be a huge bucket of additional funding for NDIS; that bucket seems to be shrinking and potentially disappearing.

In terms of suicide prevention, we have a sector that is united around suicide prevention in a way that has never operated before. We do support the rolling out of programs on a regional basis but that does not mean that we should not be doing anything in those other regions. So we support the continuation of support to national organisations working in that area. We must continue to fund innovation. There is a notion that if something is evidence based that it is the only thing that should get funded. Every single program service that is now evidence based was at one point in time not evidence based. There has to be funding in innovative and promising services.

Finally, this is a little bit of an outlier. SANE Australia is involved next week in hosting a number of events with a former British parliamentarian. He is chair of the all-party parliamentary group on mindfulness. Around half the members of Westminster have actually undertaken mindfulness based training. We are so far behind the UK in Australia. Admittedly there they have the Oxford Mindfulness Centre, which gives legitimacy to it. When I speak to people with lived experience and psychiatrists, mindfulness based practices are being used right across the board. Mindfulness based practices have not yet captured the attention of policy makers or people working in the Department of Health. There is a huge opportunity here around cost saving.

By international standards, we are doing pretty well in Australia but we are so far short of what we could be. We genuinely believe that Australia has the potential to lead the world in mental health services, programs and outcomes as well. We have a sector that is united like never before. We now need political leadership that helps us move forward.

Prof. Proudfoot: I will speak just a little bit about the Black Dog Institute and then I want to concentrate on two areas that we are particularly concerned about. The Black Dog Institute was founded in 2002. We specialise in the diagnosis, treatment and prevention of mental illnesses such as depression, bipolar disorder and anxiety. We work to improve the lives of people affected by mental illness through very rapid translation of research—that is, our own research—plus we also do systematic reviews of research conducted internationally as well. We translate them into improved clinical treatments, increased accessibility to mental-health services and delivery of long-term public-health solutions.

We all know the statistics that one in five Australians experience a mental illness each year, and each day at least six Australians die from suicide. They are horrendous statistics. We at Black Dog Institute focus on incorporating clinical services with cutting-edge research, health, professional training and community-education programs.

I have given you this document so I will not go through it in detail. Just to give you a snapshot, in 2014 we ran 20 clinical trials. We published 136 peer reviewed papers. There were 26,000 people who attended our education program for health professionals for community. We developed, delivered and evaluated e-mental-health programs, which are programs that use technology for developing, delivering and evaluating prevention, early intervention and treatment programs for people with mental-health problems. Our six clinics saw 1,500 patients and we prepared six policy documents. As I said, I will not go through the annual report, because it is all there.

There are two areas of work we do that I want to highlight to you, today. The first is that despite ample evidence suicide is preventable. Suicide prevention is cost-effective and Australia was one of the first countries to develop a national suicide prevention strategy, in 1995. Suicide rates have not declined significantly, in Australia, in the last decade. In fact, in the last 12 months the numbers have increased, particularly in young girls and Aboriginal and Torres Strait Islander men. Progress in this area has been hampered by the lack of integration and poor coordination of suicide-prevention activities and strategies. There has been activity there and a lot of good activity but it has not been integrated or coordinated.

Evidence from overseas shows, very clearly, that successful suicide prevention requires a simultaneous systems based approach that involves multisectoral involvement by all government, non-government, health, business, people with lived experience, and education, research and community agencies and organisations. That is, it needs multiple points of intervention. Within a localised area, having done an audit of what services are available in the localised area, it means implementing evidence based strategies, at the same time, that are effective and demonstrating sustainability and long-term commitment.

The implementation of a systems based approach—looking at overseas results, where the data have been very impressive—being much more conservative than that, we project that a systems based approach to suicide prevention is likely to reduce suicide and suicide attempts by 20 per cent in one to two years. I have put this for you. I have also given you the proposed framework for suicide prevention. The Mental Health Commission of New South Wales launched this two weeks ago. It was developed by the Centre of Research Excellence in Suicide Prevention that Black Dog Institute hosts, and the document is available on our website.

That is the framework. It has now been submitted to the New South Wales ministry, where it is under consideration but has not been adopted or funded yet. The National Mental Health Commission, of New South Wales, has funded Black Dog Institute to develop a detailed implementation and evaluation plan. At the launch, two weeks ago, the participants committed to reducing our suicide rate by 20 per cent within four years, implementing the national suicide based approach and advocating for implementation to begin, immediately, in 12 identified high-risk locations.

The research shows there are nine strategies that are evidence based and effective. The most promising of those is restricting means to suicide, GP education and gatekeeper training but, of course, they need to be fine tuned and tailored to the particular local area. The economic cost, apart from the very traumatic personal cost, is $17.5 billion, annually, to the Australian community. So it is really timely that we do something about suicide and suicide prevention.

The second area that we would like to present today is that of e-mental health—that is, the use of technology, as I said earlier, to develop, deliver and evaluate therapeutic intervention and prevention programs. As we know, less than half of the 4.4 million Australians who experience mental illness each year access formal help—less than half receive treatment. The reasons are varied: stigma, financial limitations, geographic isolation, lack of clinical services, or workforce in particular areas, shiftwork, which makes it difficult to get there. Australia is a world leader in the development and delivery of e-mental health services. They range from interactive websites, apps, online crisis counselling, sensor based monitoring and psychiatry via Skype. There are many advantages; I will not go through all of them because they are outlined in this document I have produced for you. I have also given you the programs that we have developed at the Black Dog Institute.

I would like to say that, apart from it being available 24/7 to enable those in need of support and to assess risk factors in real time, there is a strong body of evidence worldwide demonstrating the clinical and the cost effectiveness of e-mental health programs for mild to moderate depression and anxiety, insomnia, alcohol and drugs, as well as suicide prevention. Controversially, there have been trials which show for these mild to moderate conditions that e-mental health programs are as effective as face-to-face therapy. The other great advantage is that they translate to real world conditions, and research, both ours and international, has shown that they do improve work and social functioning. They do not just reduce symptoms; they improve work and social functioning. This means that fewer people need to be referred to secondary and tertiary services.

We have done some cost effectiveness analyses as well. We considered a fully-automated program—that is, without clinician support—but tailored to individuals, and it was about half the cost of antidepressant medication and about a sixth of the cost of face-to-face CBT. They are available; they are effective, but to date they have not been integrated into a stepped care model or into primary care. That was one of the recommendations from the National Mental Health Commission.

The Black Dog Institute is now implementing a pilot study: we are trialling assessment or screening triage of all patients in GPs' waiting rooms, using tablets and providing real-time feedback to the patients and to the GPs, along with treatment recommendations and a stepped care model so that patients will continue to be monitored every fortnight. If they are not improving, recommendations will go back to the GP to step up the treatment. The first step is e-mental health for very mild symptoms of depression and anxiety. For those with more moderate symptoms, the recommendation would be face-to-face CBT or treatments, and for those who are even more severely depressed or anxious it is going to be medication or seeing a psychiatrist.

Our recommendations are that: it needs to be integrated into a stepped care model; there needs to be multiple access and referral opportunities; and we need to raise community awareness about e-mental health. We have done some modelling to show there are 700,000 Australians who are eligible to receive e-mental health treatments, and that would prevent some of them from going on to require other forms of treatment, thereby freeing up health professionals to treat the more severely ill. We also need a funding mechanism. I will leave it there. Thank you very much.

Ms King: Hi, everybody. Thank you very much for letting us be part of this process. Anglicare Sydney do not have a large number of mental health services but we do have some. We have some in relation to respite services and some early intervention services. We have our Personal Helpers and Mentors program. We have some mental health programs. Narelle is going to speak today from the practitioner's perspective, but I want to say a couple of things.

We are a large provider of a broad range of services, like the Salvos, to the most marginalised and socially excluded people in our society. We are finding through our emergency relief centres that mental health is one of the most significant issues facing people who are really socially excluded. We are finding that people who are on the verge of homelessness or are homeless frequently have a mental health issue. We did discover back in the 1990s that only about 10 per cent of the people coming through our emergency relief services actually had a mental health issue. By about 2002 this had ramped up to more than one-third of our clients coming through. We have about 14,000 clients a year come through our sustainable living services. Mental health, therefore, is a really significant issue for a lot of people coming through our services.

Anglicare Sydney is one of a network of seven Anglicares that operate across New South Wales. The other Anglicares, who I am sort of representing today, are very concerned about the lack of acute mental health services in regional and rural areas. We have spoken to the state government on this issue on a number of occasions. There are very big concerns about the lack of those sorts of services in those areas.

There are two policy areas of concern. We are very concerned—and Mr Heath has spoken about this—about the NDIS and where exactly people with mental health issues fit into the NDIS. I have had some fairly high-level discussions with the New South Wales government on this. There seems to be concern at a number of levels that it is not really clear how mental health is going to come in under the NDIS and what that means. We are very concerned about the people who are going to be perhaps defunded. These services may well be defunded and there may well be no other options.

We have got two or three areas of policy that we would like the government to think about. First and foremost we would like to make sure that no-one gets discharged from hospital, custodial care, mental health or drug and alcohol related services into homelessness, because for many of our clients that is exactly the case. Access to stable and safe places to live actually has to be part of a mental health solution. We are also very concerned that with the growth of the NDIS there may well be defunded mental health services. We want to be assured that national systematic and adequately funded early intervention approaches remain, because we understand the depth of the problem, particularly in the areas in which we operate.

I think that is probably all I really want to say because, as I said, we run a broad range of services and are a $105 million organisation. Mental health issues thread through most of the work we do in terms of emergency relief, sustainable living, family support services and respite services. We also have a large carer population that we look after. There are some significant mental health issues among our carers, particularly among our ageing parent carers. We have five ageing parent carer programs operating across Sydney. We have done a detailed evaluation of that and there are definite signs of anxiety, depression and stress. For carers that is really high. I would be more than happy to speak about that further if anybody is interested.

I will hand over to Narelle, who is going to give a little bit from the practitioner perspective.

Mrs Hand: Thank you, senators, secretary and fellow colleagues. I run three mental health programs for Anglicare and have done for a number of years. The Personal Helpers and Mentors program, which I feel is of such fantastic benefit, is a psychosocial support program. This program is at risk of being defunded and being represented under the NDIS. Our concern is that many people in our program may not be eligible for NDIS packages. We have been attending all of the consultations that have been rolled out in the Hunter region and the evidence that has come back is that at some stage it might be that only 20 per cent of the participants we currently have will be eligible for those packages. Our concerns are that the people who are not eligible will fall through the gaps.

Psychosocial support is an absolutely fantastic recovery based support for people with mental health challenges. We give one-on-one support. We prevent people from engaging in the hospital system. We work very closely with Partners in Recovery, hospital clinicians, psychiatrists and psychologists. I think that at times this particular program has been a little bit undervalued. We prevent people from re-entering the hospital system by working extremely closely with them to ensure that they are working towards recovery and sustainability of health. We are extremely passionate about this. Given the statistics that have already been noted—that one in five people experience a mental illness in one year—this is something that really needs to be supported in the future. We give practical support. We give education support to people.

We have concerns about the rollout of the NDIS. For people who are eligible I think it is an amazing program, but I really fear for people who are not eligible. We have a lot of people with depression, anxiety, eating disorders—with symptoms that may not necessarily be severe and persistent at all times. These are the people who will re-enter the hospital system if these supports are not available.

So I suppose I am here advocating for all of the PHaMs programs. I think this program has perhaps not had as much advocacy as it should have. Personally, I think it is an amazing program and I have seen some amazing results from people we have worked with. I would like to share with you, if I may, one case study that we have permission to disclose today. The participant is a middle-aged single lady. She was admitted to hospital with severe depression and anxiety. Leading up to this she had lost her job. She was not able to pay her rent. She became homeless and lived with different friends. She was discharged from hospital and tried to find support. She found out about our PHaMs program and referred herself. That is another benefit of this program—you can refer yourself.

Her goals were to find stable housing and to finish her university degree. She had been enrolled for some years but, due to her mental health, she was unable to complete the course. During her involvement with PHaMs, she received intensive support in managing her anxiety and depression and addressing issues related to finances and housing. She was able to access stable housing, which was a major breakthrough for her. Our PHaMs workers offered weekly support and later fortnightly support in managing anxiety in relation to social situations and the completion of her university degree. Initially it seemed impossible for this participant to be able to complete her degree and the PHaMs worker employed different strategies to help improve motivation and structure so that she could finish her work.

She experienced regular major depressive episodes, including suicidal ideation, but with the support of the PHaMs worker and her psychiatrist she managed to get through the crisis and did not require any hospital admissions. Her depressive episodes became less regular with time and, in consultation with her doctor, she stopped her medication.

The participant was able to complete her university degree, which improved her confidence, and following on from this she began to reconnect with friends and relatives. PHaMs played a major part in supporting this participant when she was not able to manage most aspects of her life due to severe depression and anxiety. She has achieved a much improved quality of life, which she deserved, and her mental health has been so much more stable. This is just one of, I would imagine, thousands of stories from PHaMs that have been achieved. I would really like the Senate to take note of this today.

Prof. Littlefield: The Australian Psychological Society is the peak national body for psychologists. We have 22,000 members, which is the major proportion of psychologists in Australia, and psychology makes up the largest part of the mental health workforce. We put in a broad submission to you last year, but obviously today we are focusing on mental health. I would like to focus on the systems level, particularly on programs that are funded by the Commonwealth.

People with mental health problems are very varied, but we know from clear data that 80 to 90 per cent have what we call high-prevalence problems, with anxiety and depression as the major ones, whereas 10 to 20 per cent have low-prevalence problems, which are schizophrenia, bipolar disorder et cetera. They are the people that really do have chronic and complex conditions. We need to keep these people out of the acute settings as far as it is possible to do so. It is not always possible, but as far as possible. To do that we need to provide more services in primary care. For these 10 per cent of people, we need in primary care an increase in integrated and coordinated clinical and support systems. That includes more extensive funding for psychological services, which now have a good evidence base of being able to treat these people. We agree with a lot of what the mental health services review has said. In general we believe in a stepped care model—we think that is really important—and to shift funding as far as we can down the spectrum of services from the expensive acute end down to the mental health promotion-prevention end—and, of course, with primary care being the big bulk of things in the middle of that spectrum.

I will talk a little bit about different parts of the spectrum. Our argument is: the earlier you identify people that have symptoms of mental health problems and get them to effective treatment and services before their condition worsens and gets more serious the better it is for them. There is a decrease in suffering and a decrease in cost to the mental health system. We think more money should go into mental health promotion and prevention. That should start at a very early age. You can pick up children in child care and in schools that are showing signs of mental health problems, which will go on to develop. We think it should be in places that are already accessed by the whole population like workplaces. There should be mental health promotion and prevention there—even in aged care. It is really worth doing it in aged care. We are advocating putting more money into that to stop the escalation of mental health problems.

In the primary care system itself, we think that at the point of entry—at the moment it is mainly through GPs—there should be a much more effective assessment process so that you understand when the client comes into the system exactly what their problem is. They are often multifactorial. You might have anxiety, depression or whatever, but it could be due to your own biological vulnerability; it could be due to a family situation, a work situation—a whole range of things. Unless you have a proper assessment, the treatment pathway is not clear. If you want a very effective and efficient system, that is critical to pick up what their most appropriate treatment pathway is.

At the point of entry—let us say it is the GP—what the GP should be able to do is pick up the degree of severity of a disorder. If it is mild, we totally support the idea of e-therapy. We think e-therapy is a very good starting point for someone with a mild disorder. We particularly support therapy-assisted e-therapy, which could be a 15-minute telephone consultation each week, or something of that nature. We think that to be able to pick those people up and get them that form of treatment would save the system a lot of money.

If their disorders are amongst the group we call the high-prevalence disorders, which are largely anxiety and depression, the pathway at the moment that is funded under Medicare is Better Access. We see that as very effective and cost-efficient pathway in that the GPs can refer straight to psychologists and other mental health workers. The evaluation shows very good treatment outcomes. Even people with severe conditions—and we have studies on this and we can give you data—are reduced to mild symptoms or even no symptoms at all. It has good treatment outcomes.

The only problem was that the sessions got cut—I think it was two years ago—and the extra six that were there for people with more difficult-to-treat conditions got cut. I am talking about people with problems such as eating disorders, obsessive-compulsive disorder, or post-traumatic stress disorder. You cannot treat them usually in 10 sessions. You need the extra six. At the time of cutting the sessions, from the Medicare data, 33,000 Australians were left without sufficient treatment and they had nowhere to go. What happens then is they go downhill. You wait for the next year when you can get into the system again and you have to start from a poorer baseline. We think those sessions really do need to come back.

The other system is the ATAPS, Access to Allied Psychological Services, that is now run through the PHNs but was previously run by the Medicare Locals. We think this is a very good complementary system, particularly for people in niche groups like homeless people and Indigenous people, where you need more flexibility in the system, like longer sessions and the ability to do outreach, that a Medicare funded system does not allow. We see the two things as being very complementary and we believe that that should continue as well.

The only problem with ATAPS, and it is a looming problem at the moment, is: should the Medicare Locals have run it? Now we are transferring it over to primary health networks. We found, as the prime deliverers of that service, that there were a lot of problems in the Medicare Locals running it. I can talk more about it, if you wish. They did not manage it properly largely because the staff in them did not have any mental health knowledge, so they did not know who to refer to for what. They were not able to monitor. They were not able to look at the quality of services. They did not consider safety aspects. We are worried that the primary health networks will do exactly the same because they are not particularly well funded. Therefore, what will the quality of their staff be like? Will they make the same sorts of mistakes that the Medicare Locals did?

However, we do see a role clearly for the primary health networks in the coordination and integration of the more complex care that people need. We can definitely see that that is a role they could take where they have to get clinical and support services et cetera together and coordinate them. Our question there is: how do you do it from something that is central when they have huge geographical areas? A system would have to be worked out as to how you get out from a central PHN—a hub-and-spoke model, or something of that nature—because you need to tailor these services to the local community, by and large.

I have given a relatively brief set of points, but I am happy to elaborate on anything that you are interested in.

ACTING CHAIR: I would like to thank all the witnesses for their opening statements. We received three lots of documents—one from the Black Dog Institute, one from the Salvation Army and one from United Synergies—to be tabled. Does the committee accept that?

Senator McLUCAS: Happy to move that.

ACTING CHAIR: Thank you.

Prof. Littlefield: Are we able to give you an adjunct—do you accept that?

ACTING CHAIR: A supplementary submission?

Prof. Littlefield: Yes.

ACTING CHAIR: Yes you can table that if you want.

Mr Heath: Can we ask that our document be tabled as well.

ACTING CHAIR: That document has already been published.

Mr Heath: Okay, sorry.

ACTING CHAIR: I will jump to Senator Williams.

Senator WILLIAMS: Thank you, ladies and gentlemen, for your presence here today. I have had concerns for some time now about our whole approach to funding, financing and addressing mental health. I live in a rural area and I see a lot of people affected by drought. A lot of people who come to my office have financial problems with the banks. I probably do more work with the banks than any other politician in this building. My concern is that we have this scattergun approach where we throw a bit of money out to all these organisations. I look around the room today, and we have about 10 lined up today. That does not include Centacare, SCARF or headspace. Mr Heath, I understand where you are coming from as far as living in limbo is concerned—whether you are going to have finance next year. Is there any push to bring all the groups together and centralise, starting off with the care of our kids at three or four years old—which, we found out earlier this morning, is where the trouble actually starts in many cases? How can we get a better bang for our buck with the taxpayers' dollars or the money we are borrowing to deliver these services and make it more efficient, especially in a case where, according to the Digital Dog pamphlet here, statistics show that less than half of all Australians experiencing the symptoms of mental illness will access formal treatment? We have serious problems: people out in a drought, broken families and kids being neglected. What I am worrying about is that we are just turfing money out here in a scattergun approach and we are not getting the best results. Am I off the money or am I on the money?

Mr Heath: I think your call is correct. In fact, this is what the National Mental Health Commission pointed to in their report. My work in this area started over 20 years ago when I lost a young cousin to suicide on our family farm, so I can certainly empathise with you on the challenges that are faced by people in rural and regional Australia. Some of the organisations here are collaborating in a way that is better than has ever been done before. The sector is probably more united than it has ever been in the past, but you also have to understand the dynamic of how you put money out if you have a whole lot of organisations. You will obviously have witnessed the passion from people in this room and all the other areas where people are working in mental health. If you say that there is only a certain amount of money that is there and you only have it for 12 months, it sets up a dynamic where people are just in survivalist mode. We are thinking: 'How do we get through the next 12 months? Are those people going to have a job?' So, when you set up that sort of funding framework, it actually militates against people being able to sit back, take an overall perspective and then think strategically about how it is that we could work together.

Having said that, at SANE Australia one thing that we have done over the last 12 months is to go and launch an online platform for discussions where people in rural and regional areas across Australia are able to sit down and talk to peers about mental health issues. We have been able to establish that in partnership with 24 mental health organisations around Australia. I think the sector is actually starting to work really well together, but we need some clear political leadership on where the government thinks things should go. I think that you have a more united mental health sector than we have ever had before, and we are very willing to look at ways that we might cooperate together. I am not sure if my colleagues want to add anything.

Mr Dalgleish: I would like to add to that if I may. I come from an organisation that is 70 per cent self funded, so a lot of the work that we do we provide through our own fundraising efforts. I agree with Jack's comment there about the greater collaboration occurring. I think Kids Helpline provides a safety net for children across Australia, at virtually no cost to the government. Agencies in the field can include us in their safety plan or recovery plan for children, and then we can provide that 24/7 support to them. That is just an example of the collaboration that can occur.

But on consolidating the sector, which has been a policy raised in the review, I reiterate our CEO's comments before. We do not want to consolidate and throw out the baby with the bathwater. We cannot consolidate and lose the specialties that are so important for children and young people experiencing mental health problems. We know that children and young people find difficulty accessing help services, but one of the things that enables them to do that is feeling that that service knows them, knows their culture and knows the drivers to their mental health issue and the triggers for their suicidal behaviour and can intervene and provide specialist care and support. So, in consolidating the sector, it would be a backward step to take out all the specialties that already exist.

Prof. Littlefield: I would like to take it from a slightly different point of view. Regarding the point about getting in early in child care and in schools, there is a Commonwealth funded program—I do not know if you have heard about it—called KidsMatter, which is in 2,600 schools. It is to do with health promotion and prevention, getting skills for kids into the curriculum so that they do not develop mental health problems, getting the parents involved, picking the kids up—

Senator WILLIAMS: Isn't that the big issue—getting the parents involved?

Prof. Littlefield: A very big issue.

Senator WILLIAMS: When a baby is born, to me it is the parents' responsibility to rear the child properly. Bring the parents into training courses or whatever, so that they look after the child, would be a good start, wouldn't it?

Prof. Littlefield: And I think it is really good to be in schools and child care because it is non-stigmatising. They go there; part of their daily life is to go to these places. It is about teaching the teachers how to talk to them if the children are showing problems and, if they are seriously in need of some professional help, they can refer straight to a psychologist through ATAPS, without going through the GP. That is important because families do not always like to go to a GP and say, 'My kid's got a problem,' because they feel it reflects on them as parents. So it is about getting in early, destigmatising it and putting things in places where people feel comfortable going.

Senator WILLIAMS: Getting in early is easier said than done. If you start sticking your nose in the door of a young couple rearing a two-year-old and telling them how to rear their child, they are going to tell you where to go, aren't they, unless they ask the help?

Prof. Littlefield: But 90-something per cent of kids now go to child care. In child care, parents are used to talking about their kids and asking the childcare workers what to do for this and that and the third thing. In that context, it does really work.

Senator WILLIAMS: What I am saying is: how do we get the most efficient results? We do not have an unlimited amount of money. We have a budget; we cannot just throw in another $50 billion in the next 12 months and say, 'Here, fix the problem.' What I see we have to do is get your ideas of how to best fix the problem, and some of the statistics coming forward are very concerning.

I have the greatest respect for the Salvation Army. I launched your caravan a few years ago in Inverell. It drives around the farms and stations and talks to the people and does a great job. You said aged-care facilities are reluctant to admit those with mental illnesses.

Mr Bewert: Yes.

Senator WILLIAMS: Why?

Mr Bewert: There is often a complexity that comes with the appropriate management of a person with a significant mental illness, particularly if it is not controlled. The support that is available through the local hospital health networks often is not forthcoming once a person enters into residential aged care, because, unfortunately the attitude is: aged care is funded to look after that person in that context without the specialist knowledge to provide for those individual needs. That links back to what my colleagues were saying. Mental health in Australia is a growing concern, and it affects the generations that we have within Australia. There are very specialist services that need to be provided to best meet the needs of each of those people across the Australian public. No one organisation can truly meet all the needs of what our community requires. Certainly, from an aged-care perspective, I think mental health will become a more complex and challenging issue because we are seeing more and more older Australians diagnosed with mental health problems. The latest stats, which I received before coming here, show that one in three persons in our residential aged care facility has a diagnosis of a mental health problem.

Senator WILLIAMS: I hear so many terrible stories about this drug ice—people going off their brains on it, bashing the ambos, the police and the nurses, and just losing control of themselves. In any of your organisations, are you getting information that this use of illicit drugs is also adding to these problems of mental health?

Mr Bewert: Absolutely.

Mrs Rosenthal: Can I pick that one up?

Senator WILLIAMS: Yes, certainly.

Mrs Rosenthal: Being a residential aged-care provider, I will hold the ice question just for a sec but link back to your question about why other residential aged-care providers cannot cope. We had a man who came into one of our centres who had been diagnosed as a chronic treatment-resistant schizophrenic in 1973. He had been in hospital every year since that time for anything between 18 and 34 weeks of each year. He had multiple failed residential placements. He had failed in dementia-specific locked units. We agreed to take him on. He had multiple delusions, which were that he was a 15-year-old girl; he had period pain; he was in an orphanage; he owned the orphanage; he was in jail; there were people who would beat him up—and those delusions were present four to five times a week with this man. His behaviours could be very aggressive verbal behaviours, physical aggression, physical self-harm—he would be bruised and covered in scratches and bruises and cuts and things. For a generalist aged-care centre which is trying to deal with what I would call the tea-and-toast resident, who is a nice little old lady in her pearls and her pink cardie, that kind of behaviour from somebody like him is not going to win him any friends or influence people or create a connection and community within the area where he lives. So bear that in mind.

In the Montrose Men's Home, which I mentioned before, over 40 per cent of those men have had a long history of substance abuse, drugs and alcohol, coming out of recovery services. As an aged-care provider we are not seeing the ice epidemic, but we are seeing the results of hallucinogenic drugs and long-term cannabis use, and it is something that we manage day to day in our centres.

Mr Bewert: Yes, we manage that every single day in our centres. Just this week we had a case at one of our specialist homes where a person had acquired illicit drugs and was trying to sell them to the cohort of residents within the home. That is something that our staff face on a day-to-day basis in a residential aged-care context. It requires a very specialist knowledge and very strong community links to effectively manage that, because there are very strict guidelines on us about how to manage people. We cannot simply turn around and say: 'Sorry, you're selling drugs. Off you go; you're out.' The legislation in aged care does not allow for that. The complexity of management of those situations is not the norm, but it will become the norm with our ageing population and an increase of people coming into homes like this with mental health problems.

Senator WILLIAMS: So the more drugs today, the more problems later?

Mrs Rosenthal: Yes.

Mr Bewert: Absolutely.

Mrs Hand: Just in reference to people reaching out to services or not reaching out to services, I think that, with the amount of stigma that is associated with mental illness, it can affect your employment; it can affect family; it can enforce isolation. People do not necessarily want to re-enter an acute-care hospital ward if they have already been in one prior, which I think is something that people really identify with. They actually, I think, fear engaging at times with services, in that they will lose their power and they will lose their control.

On the overlap of services: when we have funding going to services like Partners in Recovery for people who fall through the gaps of mental health and then we have Ability Links, which works with people with mental health issues, it is kind of like there is money being spent in areas where there is probably not a service gap. It seems to be a little bit imbalanced.

But, as far as people engaging are concerned, we need to break down the stigma so people reach out. We need to make sure that when people apply for positions, if they have mental health issues, that is not going to affect their not getting employment because of the workers' health and safety risk. They are the kinds of messages that may prevent people from disclosing or reaching out.

Mr Heath: I will just add to that, if I may. In terms of the issues related to ice, we have to be careful and smart in how we communicate messages to the general public. Going to this issue of stigma: we have seen a number of advertisements that have been put out across national media dealing with someone who has an ice issue who is 'psychotic' in a hospital. This actually creates a stigma around people who have an ice issue.

In New Zealand, they were able to halve the ice usage rates by having public messaging which told stories of how people got off ice. When we provide messages of how people deal with problems, rather than focusing on the dramatic consequences or the most extreme examples, that is when we start to see shifts happening. So, in terms of doing things around ice, it is really important that we are focusing on how people actually get help, because if I am taking ice and I do not think that there is any hope, if I do not think that there is any chance of getting to a better place, I am probably more likely to go and be violent. So we need to get our public messaging right around issues like ice. A lot of it is about reducing the stigma so people understand what the situation is and where and how you can go and get help, and that is what will reduce the ice usage rates.

Senator WILLIAMS: And education at the start not to get on it.

Mr Heath: Absolutely.

ACTING CHAIR: What you say about the ice there is really interesting. We touched on a question there—I will get to you very soon, Senator McLucas, by the way.

Senator McLUCAS: No, you are allowed to have some time!

ACTING CHAIR: As far as the ice problem goes, we touched on ice causing mental health problems into the future, especially when it comes to aged-care retirement facilities and so on. I suppose the other part of the question which we did not address was before people end up on ice and mental health issues actually leading to that as well. Does somebody want to have some input on that?

Mrs Hand: Yes. Being a practitioner and engaging with a lot of people that may present to our service with those kinds of situations, I have to say that, in my experience, most people that we have been presented with have had extremely traumatic pasts. There is a history of perhaps child abuse, sexual abuse, trauma. I would be very surprised at someone that would come having some form of addiction without having some kind of a trauma. We have had people present in our program where they have been on eight-hour ice binges and ended up in hospital and actually have been discharged from hospital, still with psychosis symptoms and suicidal ideation, and have not been able to re-enter the hospital system when they really need that high level of care. I think it is a huge, complex issue, but I think it is the early intervention, prevention, education and support and all of the services working together and sticking to what our specialised areas are—Anglicare, PHaMs; we are psychosocial support. We work closely with hospital, clinicians and psychologists to bring that together to make sure that that person has support. If they do not have all the supports in place, how can they succeed in the recovery?

Mr Dalgleish: To add to that: I think also we need to look at the social circumstances of those children and young people, because in our experience, across our services, where we provide services in some of the most disadvantaged areas in Australia, it is the fact that children have lost hope. They are not engaging in school. They fear or they see that there is very little hope for them to get a job, given their educational history and given their lack of employability skills. They are in a hopeless situation where they turn to those drugs and other activities as well. So I think that, as well as personal trauma, we need to look at the social situation of children.

As in our opening address, I think that one of the big areas in Australia where we could make a very practical reduction in the impacts of mental health issues is in the whole area of our jobactive programs. For young people who are often being classified as in stream C with mental health issues, providers do not have the resources to engage those young people in activities that would help them recover from the mental health issue and then get the skills required for them to get a job. We are currently losing a whole generation of young people who are sitting in that system, who have no hope of getting a job unless we provide that support.

We have evidence internationally and nationally. We know how we can engage those young people to get them work. We know that intensive personal support interventions being used in America, being used in New Zealand and being used elsewhere, where you have smaller case loads, where you have a dual case management model—where you have a specialist employment consultant and a specialist youth worker well versed in mental health issues working together in a case management model—produce results with very little investment. I take the senator's point before: government does not have an open purse. We understand that. But if we can look at this in a systemic way, I think you can get more social and economic value by practically intervening with those young people who are currently just sitting idle in our Job Active program because the help is not there and by encouraging their recovery through work rather than what we are currently doing in some other areas. I think having that system overview and looking at priority areas for intervention is the way forward.

ACTING CHAIR: I suppose at this point I had better declare an interest. When I was 15 years old I rang Kids Helpline. I actually gave Kids Helpline a call when I was in my mid-teens.

Senator WILLIAMS: Did it help?

Senator McLUCAS: I thought you said you ran it.

ACTING CHAIR: No, I did not run it; I rang it. Senator Williams raised a point earlier that caught my interest. We have got a lot of different organisations scattered around everywhere. Why can't we centralise them? That helped highlight the point that if you all have your own little specialties it can help you tailor your service to the needs of those certain areas, and I am thinking about rural areas in particular now. With the current way that the mental health system is set up, is it really possible for things to be tailored to certain areas? Out in the west of Victoria it is dry desert and there is a certain type of lifestyle, while in my area in Gippsland it is quite wet, and there are big differences in the issues that people face.

Ms King: I am finding the discussion about trying to have a centralised system—maybe a silver bullet—that is going to solve the whole problem really interesting. I think the issue with mental health is that it is incredibly complex and it is very nuanced. Therefore, it is not easy to have one simple solution. You are talking about mental health across a range of things. You are talking about mental health in the early years. You are talking about early prevention. You are talking about early intervention. You are also talking about managing people who have episodes. You are also talking about people whose illness is chronically severe and who need a whole lot of help. You are talking about people at the other end of the spectrum who may need just social support and some periodic intervention. So you cannot really have one service that is going to meet that spectrum of need. Because it is a complex problem, it needs a multipronged approach, and it does need specialist support, particularly at the local level.

Senator WILLIAMS: You might have 20 organisations. Couldn't we just have one or two where they have all those specific services within their group? Many organisations like the Salvos et cetera are run by volunteers, and the more organisations you have, the more CEOs you have, the more administration officers you have. It appears to me to be just like having five tiers of government in Australia. If we had that it would be just ridiculous. It would be overlapping. This is the point I am getting to: is there a way to make it more efficient with the dollars we have available?

Senator McLUCAS: Can I ask the question differently? I refer to the Mental Health Commission's review and their recommendation around regionalisation of services. Instead of just funding in a scattergun approach, to use Senator Williams's words, we have to think about Australia as a set of regions. We need to think about what the mental health need of each region is, what service array currently exists there and what do we, as a Commonwealth government and as state governments, need to do to serve that population. Then the ability to navigate that system is within a local context. A person with a mental illness does not need to navigate a system; rather, they need to get help and support at the right time. I am trying to pose your question in a different way, if that helps.

Mrs Rosenthal: I think from my perspective there is a need for an understanding of what Susan said about mental health being, for some people, an episodic, one-off event, while for other people it is whole-of-life, chronic ill health. Therein lies the challenge in terms of one centralised provider of services, because if you are looking at everything from your average three- or four-year-old right up to the 97-year-olds that we see the way that we provide care in each stage of life is very different. Children are not small adults, I think you said. The other thing I think is very important is not losing local flavour. Karen and Christopher were mentioning before that local knowledge of how a community works and what the needs are in that community cannot be met by one centralised overarching mental health provider.

Prof. Kyrios: There is a set of outcomes which joins us all. They could be deepening suicide rates, wellbeing, life satisfaction, symptom reduction, jobs—there is a whole range of them. These can be regionally nuanced because in some areas suicide are higher—for particular age groups they are higher and what not. I think the problem is that we do not have an agreed set of outcomes. We do not measure outcomes. We do not have an agreed set of measures of these outcomes. So we do get this scattergun approach and we get policy on the run, as distinct from evidence based policy. We have seen evidence being collected by various organisations and by various research centres. Greater integration with the expertise that academics and research centres offer, greater engagement with professional groups who know what the specific measures are for each of these areas, this is a way forward and a way of bringing it all together. But you can still have this nuanced approach, whether it be regional, whether it be sector or whether it be problem area.

Senator WILLIAMS: And most importantly, not having 20 groups asking whether they are going to be funded next year.

Ms Adams: Could I perhaps put a slightly different perspective. I think there is a need for localised and building up. People know their local communities. They can form linkages and pathways and organisations that are nationally based can be used to support those. Perhaps another framing here does need to be considered and that is the level of integration across government and governments because if we are talking about measures and using these, we actually do not have consistency in the way governments are operating. I even think if we think of mental health, it does not just belong to the department of mental health or to health; it is in employment, it is in education, it is in aged care, but it seems to me that we do not consider it. So integration needs to be considered on both sides of this argument, or investment, because we are linked to a common bond of wanting outcomes that will improve our communities. We are all part of community, as is government.

Senator McLUCAS: Can I ask you a question that follows on from that in recognising that there are already three hands up. Earlier today we heard evidence from the commission and then from another roundtable. In both of those sessions we talked about the fifth national mental health plan, to try to pick up your point, Professor, and yours, Ms Adams, that mental health does not sit in the Department of Health, and the commission's report is very strong on the fact that it is a whole-of-government approach to working collaboratively, where does the fifth national mental health plan fit in our governance arrangements? Does it sit in the Department of Health, as the first four have, or should it be endorsed by COAG, first ministers? I am just throwing that out there as something to think about.

Mr Heath: It has to be picked up by COAG. The only time we have ever seen significant reform of mental health is when there has been political leadership at the prime ministerial level. So the notion that it is going to get stuff happening by being passed off to the health minister or to the mental health minister, when they are having to compete in cabinet to get funding for particular projects, by parking it off in that area you are going to set yourself up to make it much more difficult to get the level of support that you need from your colleagues.

Senator McLUCAS: Hansard does not recognise nodding. So for the purpose of Hansard, I am saying that nearly everyone around this table is nodding. This is called gathering evidence.

Mr Heath: Touching on what Professor Kyrios said, there was an expert reference group formed a number of years ago, of which I was a member, convened by the National Mental Health Commission, which put the case very strongly for setting up specific targets and indicators by which people which be measured. It was people in the sector, organisations like ours saying, 'Let's set some goals and we want to be held accountable.' We were saying to government, 'We want to be held accountable for particular outcomes.' So we need governments to sign up to these targets and indicators, and they need to be long term. If government is prepared to do that, you will find the sector rallying behind, wanting to be accountable and wanting to work together well. But it requires a partnership from political leaders and from the sector as well.

Prof. Proudfoot: And not just activity based measurements but also definite outcome measurements.

Mr Bewert: They need to be measurable outcomes. As Ms Adams said, the issue of mental health is one of those things that crosses all boundaries. It comes across all government departments. It comes across multifacets of everyday life. So, to park the management of a national mental health plan within a specific department such as health, all of a sudden there is an exclusive process that then occurs within other areas. It has to sit with COAG. I cannot see how it cannot. Those measures need to be agreed upon nationally, so the various jurisdictions throughout Australia can then enact those measures through their state government policies and have links. There needs to be those measurable outcomes on both sides of the fence—not just for the provider but also within policy and decision-making frameworks.

ACTING CHAIR: We have identified that children, adults and the elderly have to be catered for differently with respect to their care needs. Is there a link between children at a younger age—and Senator Williams was referring to those up to three years old being key—and either one or both of their parents having mental health issues? Is it a flow-on issue through to the children? Is there a way we can intercept that?

Prof. Littlefield: There are lots of factors that can contribute to someone having a mental health problem. Certainly there are genetic factors that flow down through families, but equally strong are the behavioural factors of parents around parenting and the way they bring up the children. There are social factors to do with the situation in which they live—poverty, no house or whatever. Factors such as family conflict and violence are the big social issues. So it is actually multifactorial. You could draw a diagram with all these factors and we really need to intervene at all levels. Not all things are fixable, but we could do a lot better than we do now.

Mrs Hand: One of the things that really stands out for me is that no-one chooses a mental illness. I think that parents who have symptoms of a mental illness and are managing as parents do the best that they possibly can with what they have at the time. If you have bipolar and you have to get up at 6.30, look after your child, take them to school and stick to a routine and you have a mood disorder that prevents you from leaving the house, that is when the supports need to come into play to support those parents so that they can be good parents. It is not their fault that they have a mental illness. It is a symptom of the illness that they have. We as a society and a community need to wrap around those people so that they do not feel failures as parents and they do not give up and start behaving in a way where they isolate themselves. They are the people who need to connect to get those supports.

ACTING CHAIR: Beautifully said.

Mr Bewert: Again from a Salvation Army perspective, we run multiple programs right across the Australian public. To support Professor Littlefield's comment that it is multifactorial: the Salvation Army is first and foremost a church and there would not be one core ordained Salvation Army officer who would not encounter these issues in their local core environments within their local community in dealing with local families. The issues of poverty, the social demographic, education and learned behaviours from family situations that have been passed on generation to generation all have an impact on a child's sphere of reality, and I think that is something that needs to be considered.

Senator McLUCAS: Can I just contextualise this a little bit. First of all, I want to pass on the apologies of our chair, who is really sick—she has some sort of tummy bug. She is very disappointed she could not be here. In saying so, Senator Muir is doing a fine job of chairing this meeting.

Senator WILLIAMS: Who said that?

Senator McLUCAS: I did and you seconded it, if I remember!

Senator WILLIAMS: I second it, Senator McLucas! He is doing a fine job.

Senator McLUCAS: The Senate Select Committee on Health has decided to focus on mental health in a three-day inquiry—today, on Friday in Sydney and then later on 18 September in Brisbane—because we felt we needed to tease out some of the recommendations in the Mental Health Commission's report, provide a greater community conversation about those recommendations and hopefully even get some of our friends in the media to think a bit more about mental health, which would be a nice thing to do. So are you listening? One of the recommendations which I think has a bit of relevance to this group here is the recommendation that the commission have made around suicide. They have made a recommendation that we need to trial suicide prevention in 12 distinct areas around the country—like their recommendation about primary and mental health networks, we need to regionalise the services. I dare say a lot of you would have had some visibility of that recommendation and might like to talk to us about how you think that would work, and make some recommendations to our committee about that. A few of you are closely engaged in suicide prevention.

Mr John: I might start, if I may. The National StandBy Response Service is actually only in limited communities in the environment. Probably one of the most difficult challenges of expanding the service to those

16 communities is talking to the communities in which we have not been able to allocate the service. United Synergies had the difficulty of actually making decisions around that in that space. I understand that we are limited and we have to do some trials and we have to do that in that space.

This probably comes to the context of the discussion around where our priorities sit as well. Suicide is the leading cause of death for anyone under 44 in our community. If we want to make a difference we have to have a different approach around that. We did it 25 years ago with road deaths, and I am very thankful about that because I think there are a lot of people still living today as a result of a whole range of changes. It involved a large number of communities, non-communities, businesses, legislation, police and engineers—including car manufacturers—to actually make differences in that area of road deaths.

The National Coalition for Suicide Prevention, which is a collaboration of 28 different organisations with many other contributors in different reference groups around that—many around the table here are involved in that process as well—have come together to make a decision about a commitment over the next decade to reduce or to halve the number of suicides in Australia. That will involve not just a collaborative approach with mental health service providers, financial counsellors, emergency counsellors, police and ambulance but a whole-of-community discussion around this and how we actually do that differently. The coalition wants to see how this responds differently. I think the logical approach is to think about that in a 12-site approach. Our personal opinion is that that does need to be done with a level of cohesion between services in those regions. United Synergies has chosen a strategic approach to look at finding the local organisations who can deliver that model for the community. We are not replicating a whole range of circumstances around that; we are actually building on the local networks around that.

To explain a bit of the attributes of what we look for in a site to deliver that: we currently deliver the StandBy Response Service with partners from Lifeline, Anglicare, Centacare, UnitingCare, Mates in Construction, local small organisations, health development boards and the local community. There is no one uniform brand of an organisation. We look for certain attributes in a community organisation that will actually be able to be a point of contact for those areas. What I am trying to get to is that there are levels of specialty in delivering services that need certain attributes. That needs to be found in a local community and needs to be coordinated with the local partners around that community.

Coming back to Jack's comment about where innovation and service improvements happen, there is good evidence and there are good ways in which things develop, but it comes down to the implementation. I think that is really what this 12-site recommendation is about: 'Let's trial it in 12 sites.'

Senator McLUCAS: I think they are calling it staged implementation rather than trial.

Mr John: Okay, staged implementation. The other question is: how do you make the decision about which 12 sites are in that space? There are a whole range of concerns around that. Suicide also has a psychological effect, and I think the question that is probably pertinent there is: how much do we value communities and the support around our communities? Going to 12 sites is probably economical and rational, but I think we also need to think about the impact of exclusion of different communities from available resources in that space.

My final comment would be about linking up with where there are some primary health front-line services around mental health through the states, the Primary Health Networks and the better access program. There needs to be some better coordination of the access to those services and how they are distributed as well.

Senator McLUCAS: And that is outside of the suicide prevention approach? That is more in the primary and mental health?

Mr John: Yes, available resources for ongoing support.

Prof. Proudfoot: In putting together the proposed framework of suicide prevention, we—that is, the Centre of Research Excellence in Suicide Prevention, CRESP—did a lot of consultation with police, ambulance, justice et cetera and talked about this implementation at the local level. There is a great deal of enthusiasm and commitment to it. In particular, though, there is recognition of using not only the evidence based strategies. Some of them are more effective than others, but in other regions strategies are being used that may seem to make sense but are not necessarily evidence based. So we need to stick with the evidence based strategies but also go in, have a look at what is available at the local level and what is needed at the local level as well, and really build on that. We are talking about local organisations too—banks et cetera. There was enormous commitment. It was very heartening to see that. There was a recognition that it would not be easy but that nevertheless this must be the way we go.

Mr Dalgleish: I would like to add that I think that local and regional coordination efforts and face-to-face services can also be supported by telephone and online counselling agencies. We have the capability to provide

24/7 support to back up local services. Also, as we have heard around the table, I think online applications in relation to depression, anxiety and other issues can be integrated into that service delivery.

Prof. Littlefield: I would just like to say that I hope that as part of these trials some extra training and effort would be put into risk assessment to actually stop the suicide from occurring, because there is quite a bit of data about people presenting—not usually saying, 'I'm suicidal,' but with some other problem—to a service or a professional in the month or two before they actually do it. So I think we should look at prevention as part of the trial and skilling up people to do risk assessment if they suspect that is the case.

Prof. Proudfoot: We would also recommend gatekeeper training and also front-line staff training and so forth.

Prof. Littlefield: Yes, that sort of thing.

Prof. Proudfoot: So assessment not just by health professionals but by anyone—schools et cetera.

Prof. Kyrios: Absolutely.

Prof. Proudfoot: These are some of the nine approaches that have been found to be highly effective.

Mr Heath: CRESP does great work in going to particular regions. We need to get a better understanding of what is happening in a particular community with suicide rates going down or not. There are nine different elements to the CRESP proposal, of which some operate at a national level like crisis help lines. If you go into a small country and you have a son with schizophrenia, the first place you will probably go is online or pick up the phone to speak to someone. It is about having the right mix. Across the board people are supportive of these things being done in regions. From a SANE perspective, we would probably say that you would want to look at those regions where there is strong local leadership that is wanting to bring this stuff forward. We heard yesterday that in Mount Druitt there are 57 different government programs because there is a high need. You need to go where there is strong leadership. I will leave it there.

Senator McLUCAS: Can we talk more about this emerging e-mental health work. It seems to be growing like topsy. How do you tell a lay person like me that I should feel comfortable about the quality of the work that is being developed? I would also like to have a better understanding of the pathway. We are told that boys between the ages of 17 and 25 access their e-mental health between eleven o'clock and one o'clock in the morning. Doctors are not available then. So tell us about the pathway and the quality assurance we should be aware of.

Prof. Proudfoot: They are really important questions. The Department of Health did have an expert advisory committee some time back. When we brought all of the e-mental health providers together to develop a series of recommendations, one of those recommendations was that advisory committee be re-established. It did some very important work. One piece of work it did was to establish a portal that people can access, and all of the programs on that portal are secure and evidence based. That is mindhealthconnect. Beacon is a slightly different portal which looks at the evidence, and that is run by the ANU. There are definitely opportunities there for people; there are so many programs out there, but not all of them are good or evidence based.

We also acknowledge that there needs to be a number of pathways into e-mental health. It does have enormous potential, but in Australia we are not using the potential effectively. We know that the programs which have been evaluated are clinically effective and cost effective. It should not only be available through general practice, though we do recognise that should be improved, because many young men, for example, do not a GP. Social media is one way through, but we need to educate and raise awareness in the community that (a) these programs exist and that (b) there are many which are evidence based and they are the ones that people should be using and this is how to get into using them.

Prof. Kyrios: I would like to add to that. I think it needs to be integrated within a staged-care or stepped-care kind of model. There are self-help options and therapist assisted options, and both are effective for different populations. If you have a moderate or severe disorder, then clearly therapist assisted is the better option—they are also cost effective and also more effective. You need to integrate it within the profession. We as psychologists have really been at the forefront of the development of these, and yet very few of our own people use them in their own clinical practice. I think we need to look at our own training models.

I certainly agree with the higher use of social media to promote these. In fact, we have just finished a randomised controlled trial of treatment for OCD, and we got most of our people through social media. It was very effective. These are new referral pathways. But I think we also have to use the traditional referral pathways. GPs need to be able to say to someone: 'Here's a token. Go and use this and see how it works and then come back and tell me. If it hasn't worked then we'll try something else.' This needs to be targeted for appropriate populations. You would not do it for someone who is too severe.

Prof. Proudfoot: One of the other things that the expert advisory group in e-mental health did—and this has been in effect for about 18 months now—was to establish training for general practitioners, and Black Dog is doing that; for allied health practitioners, and ANU is conducting that; and for Aboriginal and Indigenous mental health workers. University of Sydney and Menzies are running that. So there is a recognition—going to Mike's point—that we do need to raise awareness of mental health professionals as well.

Prof. Kyrios: We do have a problem. The review has recommended that we bring commercial partners into this. I think it is imperative that we do, because the bodies that have been funded by the federal government have kind of niche interests and may not have the infrastructure to roll out these programs nationally. There certainly needs to be greater integration. I think that that element of it is actually missing. How do we take what we actually have—which the federal government has already paid for, which is evidence based, which is world's best practice—from these six, seven or eight little groups within various universities to rolling it out nationally? When we do that with commercial partners, how do we make sure that the research-and-development aspect of it is maintained at the level that it is currently working? I think that is a real risk. Commercial entities will not be interested in the research and development in the same way as the researchers are.

Prof. Proudfoot: I do not think we would let them get away with that.

Prof. Kyrios: It is a risk, though, and I just wanted to put that on record.

Ms Adams: I just want to make the point—and perhaps reinforce before—about the risk identification. When we introduced online counselling in 2001, for the Kids Helpline, we introduced it with our clinical team as part of that process. They developed the self-help tools that we have on that website, and we get more than 500,000 young people using those self-help pages. But the online counselling component must maintain the same robustness as any other of the counselling interventions that we have. I think one of the big things that the community has to come to terms with is: who is reputable; where does the trust come from; how do we maintain quality; and how do we make sure that those risk factors are considered when a person is choosing to engage online? Some of the other tools that practitioners can use are not available in the online medium, such as voice identification, or stressors and these sorts of things, so I think there is a need to be very robust in the practice measures as we develop more and more online tools and not lose them in the context of wanting to roll out more and more. I think it is ensuring we have got a balance of quality as well as access, because we need to provide services that add value to the people who want them, not the other way round. It is always a balance to consider.

Mrs Rosenthal: I was just going to make the point that the Salvation Army looks after society's most vulnerable and we always have. I support the development of e-health, but I think we need to recognise that not everybody has access to e-health. Too much of a focus on e-mental health is not going to work for your average homeless person or your average person with a culturally and linguistically diverse background. The other comment that I would make around e-health—and we have come across this as a provider—is that access to reliable networks, in terms of access to the internet, is not always available in our rural and remote locations. It is all very well to have a fantastic app for mindfulness or whatever, but, if you cannot connect, you cannot do it. I think that point needs to be made.

Senator McLUCAS: Good point.

Mr Heath: I absolutely agree in terms of the areas where there is access, but I started work in this area around the internet and youth suicide 20 years ago and, at that stage, maybe three or four per cent of people had access to the internet, and people were saying, 'Don't waste your time doing this.' Now your coverage rate is 90 per cent or whatever. There is the fantastic work Black Dog has been doing for many years around this. When it comes to e-mental health, I believe that Australia may well be there already. It has the capacity to lead the world in this area. We have the world's leading technology companies coming to Australia to test new products and services. We are only 23 million people. We are very technology literate. If you wanted to pick an area where substantial investment by government could have huge returns, I think it is in the e-mental health space, whether it is the work that Young and Well CRC is doing or ReachOut and all that. Also, in terms of usage rates, you will find that pick-up rates of technology by Indigenous communities are as high as they are for the general population.

Senator McLUCAS: Yes, they just jump at technology.

Prof. Kyrios: Yes.

Mr Heath: It is not the answer to everything, and we still need to provide for those people who are very vulnerable and do not have access, but there is a huge opportunity here, because so many groups in Australia are doing phenomenal work. I spent two years working in the States. We are not very good here at celebrating the great things that we are doing. I was staggered by how highly Australia is regarded on mental health and e-mental health in the United States and in other countries. So I think this is an area of huge opportunity, and we need to be celebrating the great work Black Dog and others are doing in this area, because there is an opportunity, when we have a population of 23 million that is pretty well wired and is going to be better wired under the NBN, to do stuff that is going to make a huge difference right across the community.

ACTING CHAIR: That goes hand in hand with what you were saying in relation to ice earlier on, doesn't it? We should perhaps be promoting things in a different way from how we do.

Mr Heath: Yes. The thing that motivates me is when I get a sense that you understand what I am going through and there is a real empathy, and you are creating a sense of hope that there is a possibility of something beyond my immediate situation. So the role-modelling or the success examples are the things that cause a person to say: 'You know what? I might be homeless and destitute, but there's someone like me who's been able to get to a better place.' We need to celebrate that, because that is what motivates people and lifts their gaze. If we keep talking about the problems and the numbers and all that, we just go in, in, in. So we need to celebrate those achievements, and that is the thing that actually elevates things for people.

Prof. Kyrios: Can I add just add that a lot of the e-therapy programs have patient stories or personal stories of recovery using actual patients, actors or whatever, and I think they make a huge difference in terms of engagement. The more sophisticated our programs become, the more likely people are to engage and finish the treatment successfully.

Senator McLUCAS: I was going to talk some more about NDIS transition, but I think you have covered the issues with PHaMs and Partners in Recovery. I think we have made those points strongly.

Mrs Rosenthal: Can I just make a very brief point—not in relation to the NDIS but on the introduction of the Commonwealth Home Support Program. We run a carer counselling, information and support service in Queensland which supports carers of older people and people with disabilities—often people who have mental health problems. Under the new Commonwealth Home Support Program, that program does not fit. So we do not see a commitment from government to the ongoing support and funding of those services.

Senator McLUCAS: It does not fit because?

Mr Bewert: There are multiple other providers who also run a very similar service, and they are expressing the same concerns on the consultation periods with CHSP. In terms of it not fitting, the guidelines that have been set for the new Commonwealth Home Support Program do not include within their scope programs such as that.

Mrs Rosenthal: It is missing.

Mr Bewert: Again, our colleagues at PHaMs said, 'We're very concerned about these people falling through the gaps.'

ACTING CHAIR: On that note, I would like to thank all our witnesses for their valuable contribution.

Senator McLUCAS: I too thank you all very much for your contribution to this inquiry.

Proceedings suspended from 15:34 to 15:49

ANDERSON, Ms Janet, First Assistant Secretary, Health Services Division, Department of Health

AYRES, Dr Russell, Branch Manager, Mental Health, Department of Social Services

BARTNIK, Mr Eddie, Strategic Adviser, National Disability Insurance Agency

CHRISTIAN, Mr James, Group Manager, Disability, Employment and Carers, Department of Social Services

CORMACK, Mr Mark, Deputy Secretary, Strategic Policy and Innovation, Department of Health

HARTLAND, Dr Nick, Group Manager, National Disability Insurance Scheme, Department of Social Services

KRESTENSEN, Ms Colleen, Assistant Secretary, Mental Health Policy Branch, Department of Health

NICHOLLS, Ms Fiona, Assistant Secretary, Mental Health Services Branch, Department of Health

ACTING CHAIR: I now welcome representatives of the Department of Health, the Department of Social Services and the National Disability Insurance Agency. I remind committee members and officers that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given a reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. I particularly draw the attention of officers to an order of the Senate of 13 May 2009 specifying the process by which a claim of public interest immunity should be raised. Copies are available from the secretariat.

I invite you to make a brief opening statement, and then the committee will ask questions.

Mr Cormack: Thank you for the invitation to attend today's hearing. As you would be aware, the government is committed to developing a more effective and efficient mental health system to improve the lives of people with a mental illness and their families. In considering the committee's focus on mental health issues and challenges, I wanted to provide you with an overview of the activity that is currently taking place that may impact on services and supports to people with a mental illness.

As you will appreciate, it is a very busy policy space. Significant work is currently being undertaken to review and reform areas of primary health, disability support and mental health services, all of which have the capacity to improve aspects of a system that is there for many of us who will suffer from some form of mental illness in our lifetime. A substantial piece of work has been undertaken by the National Mental Health Commission, which was tasked by this government to undertake a Review of Mental Health Programs and Services. The commission's final report is a significant review of the current state of the mental health system and provides details on the breadth and complexity of the mental health sector as well as the opportunities and challenges for change. An expert reference group has been established, chaired by Ms Kate Carnell, to inform the development and implementation of the government's response to the review. The department has also used existing advisory structures, such as the Australian Suicide Prevention Advisory Council and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, to get advice on how some of the reforms proposed in the review could be taken forward. Key policy directions being considered for future development include opportunities for early intervention to reduce the impact of mental health problems; the use of stepped care to better match services to need; and improving service planning and integration, recognising that a local and integrated approach is often the best solution.

Consultations are currently underway as part of the review, with representation being sought from peak mental health bodies, health professional bodies, Indigenous mental health, child and youth mental health, and the private sector. The role of the states and territories in mental health is well recognised, and the government will also work closely with them to develop a new National Mental Health Plan. The Fifth National Mental Health Plan will provide the opportunity to pursue a commitment to delivering regional planning and service integration for mental health and suicide prevention activities, and a better way of supporting people with severe and chronic illness, given the shared responsibilities of the Commonwealth and the states and territories for this client group.

Reform of primary care to better support people with chronic and complex conditions is also important to delivering better services to people with mental illness, particularly those with more severe illness. The Primary Health Care Advisory Group, or PHCAG, is currently holding consultations on strategies to deliver stronger, more effective and better integrated and coordinated primary care services. The consultations focus on the recently released discussion paper 'Better outcomes for people with chronic and complex health conditions through primary health care'. The PHCAG's remit is to provide the government with short-, medium- and long-term options to reform the primary healthcare system. Its work will be influenced by and will also influence other reviews of the health system. There is also a review of the Medicare Benefits Schedule, with the Medicare review task force leading an accelerated program of MBS reviews to align MBS funded services with contemporary clinical evidence and improve health outcomes for patients.

Mental health is one of the six priority areas targeted for work by Primary Health Networks. This is not surprising given PHNs' key objectives of increasing the efficiency and effectiveness of primary healthcare services for patients, particularly those at risk of poor health outcomes, as are many of those with mental illness. PHNs currently receive funding for primary mental health clinical care through both Access to Allied Psychological Services and Mental Health Services in Rural and Remote Areas programs. Many PHNs are also involved in the Partners in Recovery program. PHNs are expected to deliver a strong role in supporting service planning and integrated service delivery at the regional level. They have been tasked with needs assessment and population health planning to support their role as commissioners of services. They are also expected to be central to the integration of primary, secondary and hospital services by developing strong working relationships with local hospital networks and public and private health providers. This is particularly important in addressing the needs of people with severe and chronic mental illness.

The National Disability Insurance Scheme and the establishment of the National Disability Insurance Agency also present significant opportunities for people with a disability arising from mental illness. The operation of the trial sites has provided the opportunity to work through some of the challenges in ensuring appropriate access to support through the NDIA for people with a severe and ongoing mental illness. The department continues to work with our colleagues in the Department of Social Services, the NDIA and the mental health sector to support effective transition processes.

It is also recognised that these reforms are being undertaken at a time when the respective roles of the Commonwealth and the states are being considered in the context of the reform of federation. Our understanding is that the government intends to issue a green paper, to be followed by a white paper, all within the next 12 months.

In summary, a number of things are happening that have the potential to positively influence mental health policy and planning at a national level and which are expected to converge in the comings months.

ACTING CHAIR: Thank you very much. Would anybody else like to add to that?

Dr Hartland: I do not want to add to that, but I should have said at the start that Felicity Hand, our deputy secretary, would normally have wanted to be here, but she is very unwell at the moment. She does regard this as a very important part of her job. It is not that she figures she has better things to do.

ACTING CHAIR: On that note, I put in apologies from our chair, who is also unwell at the moment. Senator McLucas.

Senator McLUCAS: Thanks very much for appearing today and also for coming in such numbers. It is much appreciated that you share our view that this is an important issue that needs consideration. I dare say you heard some of the discussions that have been held today, so there are some questions that I want to put from witnesses who have come before us already. Let's go first of all to the mental health service planning framework. Some of you will have heard me ask questions about this at Senate estimates over some time. Can you tell the committee where the framework is up to? You would have heard this morning that the commission indicated that they were not provided the framework and the data that sits under that framework in their deliberations in pulling together their review, so I would like an understanding of why that happened.

Mr Cormack: The framework is still under development. It is a collaborative piece of work that is being progressed through the Australian Health Ministers' Advisory Council. It is well advanced. In fact, I might ask Ms Anderson to give a more detailed update as to where that is heading.

Ms Anderson: As Mr Cormack said, the framework exists now, but it is what is known as a beta version. It has had some testing in several jurisdictions, including New South Wales, WA and Queensland. The Mental Health and Drug and Alcohol Principal Committee of AHMAC has agreed to establish a steering committee to take forward the framework into its further and final stages of development. They are aware of a number of areas where further work is required. It does need some further effort. Apparently there are some technological bugs, which I do not presume to know much about, but they also want to look more closely at some elements of the design model such as the way the care packages are put together. There are further considerations to be given to rural and remote residents in terms of mental health and also to Indigenous communities, and at the far end of all of that there is the need to seek state and territory sign-off to the framework in order for it to be a genuinely national product.

My understanding is that the expectation of the time frame is that it will take at least 11 or 12 months—probably to the middle of the next calendar year—before this work is completed. A steering committee is being established that is chaired by the Commonwealth and has representation from a number of jurisdictions. It has not yet met, and I think its first meeting will be in September. There is work now underway to establish its specific terms of reference and a work plan which will guide its efforts over the coming 12 months.

Senator McLUCAS: I understand that New South Wales was the lead agent in the initial work. Is that correct?

Ms Anderson: New South Wales did a lot of the fundamental base planning. It was seen by other jurisdictions to be a valuable effort and regarded as something which could be usefully built upon. That is the additional work that is now going to get underway.

Senator McLUCAS: What is the task of the steering committee that the Commonwealth is chairing?

Ms Anderson: Essentially to lead this additional work—to move it from a beta model to something which is—

Senator McLUCAS: Sorry; what is a beta model?

Ms Anderson: It is a testing model. It is something which is recognised as not yet fully developed but has enough of the moving parts to see how it might apply in real life but in a piloted way. It is not currently being used as a planning model, but it is being tested as if it could be used and to identify things that might need further development. Indeed, that list which I partially rendered is still being developed. There is still the need for further identification of the issues to be worked on to move it from its current testing phase into a framework which nine jurisdictions can agree to.

Senator McLUCAS: What role did DSS have? You might be able to assist us, Dr Ayres. What role did DSS have in developing the mental health service planning framework?

Dr Ayres: I think Dr Hartland might be better placed to answer that.

Dr Hartland: We have been briefed a couple of times by the officers developing the framework and aware of how it is evolving. Where it is sensible for us to do so we would offer review on what it means—any information on service or the construction of the packages in particular—but we are not directly involved in authoring it or approving its use.

Senator McLUCAS: Does it capture the services that DSS is funding currently in mental health?

Dr Hartland: Yes, it does.

Senator McLUCAS: Did DSS request a bigger presence in the process?

Dr Hartland: No.

Senator McLUCAS: You feel very confident that DSS has been well represented by this?

Dr Hartland: We are very confident that we have got visibility from our colleagues in health as to the bits of the framework that relate to us. We are very happy with the briefings we have been provided on it. They have helped us think through some issues in our areas, so we do not have any problems with the governance of the framework or our access to officers and information about how it is progressing.

Senator McLUCAS: Mr Bartnik, your NDIA was basically being born when this was all happening. Are you aware of any consultation with the NDIA around the service planning framework?

Mr Bartnik: In my previous role in Western Australia I had very direct involvement. Since joining the insurance agency, we do have regular discussions with both health and social services regarding population data in the scheme. I also attend as a stakeholder the Mental Health and Drug and Alcohol Principal Committee, in which there have been some discussions about this. I am very engaged with the discussions, and we are aware of the status of the work.

Senator McLUCAS: Did the commission ask for access to the framework during their deliberations?

Ms Krestensen: I understand they did ask for the framework towards the beginning of the process of them undertaking the review. As you have heard, the framework had not been finalised. The decision was made not to release that framework to the commission at that point in time.

Senator McLUCAS: Simply because it was not finished.

Ms Krestensen: That is right.

Senator McLUCAS: Clearly, the commission would have the capability to recognise that it was in a form that was incomplete. There has been a lot of work put into this framework. Hundreds and hundreds of people have been involved.

Mr Cormack: We certainly acknowledge that, but it is important to recognise the governance of this. It is a Commonwealth/state piece of work. It obviously has very significant implications for the way services are planned, designed, delivered and resourced. Any endeavour that requires collaboration across the Commonwealth, state and territory governments on matters that would potentially require changes or increases in their levels of resourcing do require a significant degree of scrutiny within the budget processes of nine jurisdictions. Accordingly, there are appropriate safeguards on the release of unfinished, unapproved work. So it is not unusual for something that is in its development stage within this governance context not to be made more broadly available, particularly as it is subject to change. Whatever version they might have been access at that point in time may not even have been the beta version; it may have been an earlier version. Clearly, things have moved on.

Senator McLUCAS: After the request from the commission was made to the Department of Health, did the Department of Health request of state colleagues, through the ministerial council, permission to release the framework to the commission?

Mr Cormack: We would probably need to check the facts on that one. I am not quite sure what the story was.

Senator McLUCAS: Thank you. I now go to the Fifth National Mental Health Plan, which you referenced in your opening comments. What involvement does DSS have in the development of that plan? How does DSS engage with the development of that plan?

Mr Cormack: Probably an important point to note is that the Fifth National Mental Health Plan was a decision taken by the COAG health council to progress that work. It is really just in its early stages. It has been assigned to be led by Tasmania under the Mental Health and Drug and Alcohol Principal Committee of AHMAC auspices, and a working group has been established to progress that work. Through the course of the development of The Fifth National Mental Health Plan there will be extensive consultation with a wide range of stakeholders within the Commonwealth and also within state and territory governments, the NGO sector and the private sector. At this stage—Ms Krestensen might be able to add some further detail—I think there have been two meetings of the working group. It is hitting its straps, but it is certainly not into the level where they would be ready for wide-scale consultation with the sector. That has always been the process for previous national mental health plans. There is extensive consultation, and that will be the case with the Fifth National Mental Health Plan.

Senator McLUCAS: Given the recommendations of the commission that go to the fact that mental health is not a health-only issue—according to Professor Fels this morning, it very much sits in every single department of the Commonwealth and the states—has there been consideration that the Fifth National Mental Health Plan might have a different construction from the first four, which were basically based in health?

Mr Cormack: To go back to the governance of the process: we are, as public officials, responding to a decision of the COAG health council. They determined the pathway and the governance for this. So I think that is an important point to note. Certainly in the development of the National Mental Health Plan we will be recognising—as indeed will the states and territories—the context of the commission's work. It is a landmark piece of work. I outlined in my opening statement the other moving parts that are going on at the moment. Our expectation is that there will be full engagement across government. The fact that it has been carried by the COAG health council through a health process does not in any way give it a licence to minimise the scope or not consult appropriately with the full range of Commonwealth, state and territory government agencies.

Senator McLUCAS: The report of the commission was leaked only four days before, I think, the last COAG health council meeting. There has not been a subsequent one?

Mr Cormack: It was the one before. It was in April.

Senator McLUCAS: There has been a subsequent ministerial council meeting?

Mr Cormack: Yes. There was one in Darwin only a couple of weeks ago, and I was up there for that.

Senator McLUCAS: Was the Fifth National Mental Health Plan on the agenda for that meeting?

Mr Cormack: I would have to check. I do not have the agenda with me.

Senator McLUCAS: Maybe other staff could answer that.

Mr Cormack: They do not have the agenda with them either.

Senator McLUCAS: If we could have an answer on notice, that would be great.

Mr Cormack: Sure.

Senator McLUCAS: Can I now go to the Expert Reference Group. Once again, you talked about that in your opening remarks. Has the Expert Reference Group asked for or been briefed on the Mental Health Service Planning Framework?

Mr Cormack: They have met on a number of occasions now and they have gone through in great detail the National Mental Health Commission's report, the themes that underpin the recommendations and indeed some of the specific recommendations. The context of the work they are doing is still deliberative it at this stage. They are getting to the business end of providing their advice to government. It is not really appropriate for me to foreshadow or forecast what their advice to government will be. But certainly we have been supporting that group, and the framework is very much a topic of conversation among the many aspects of the National Mental Health Commission report they have been working through. I would be very surprised if they do not have something to say about that. Again, it is their prerogative and it is their report to the minister.

Senator McLUCAS: Have they requested to receive either the beta version of the framework or a briefing on the framework?

Mr Cormack: I am not aware of a specific request. Ms Nicholls and Ms Krestensen are very actively involved in the process and I have sat through a number of the meetings. I have to say that they are an Expert Reference Group and many of them would have a pretty clear line of sight through their other roles. Some of them are very active in working with the state governments, for example. So I would be very surprised if the views of some of them had not been sought—not through our process but through the AHMAC process. I would be surprised if a number of them are not reasonably familiar with varying versions of the framework. As I mentioned, it has been raised in discussions but they are yet to come to a landing in terms of the advice they will be providing to government.

Senator McLUCAS: I think what you are telling me is yes, they have seen the framework.

Mr Cormack: They have not asked for the framework—

Senator McLUCAS: I think what you are saying is that they did not need to.

Mr Cormack: I am saying they have not asked us for the framework. So all I am saying is that they are experts in the field and a number of them would have broad familiarity with the framework, as indeed many other people in the sector do.

Senator McLUCAS: In the Fourth National Mental Health Plan one of the items was that the framework would be published. Has a decision been made not to pursue that action item or is that in abeyance?

Mr Cormack: I am not sure whether a decision has been taken to publish or not publish. All I know is that the Fourth National Mental Health Plan has been somewhat overtaken by events and we are now in the process of developing the Fifth National Mental Health Plan. And obviously the Commonwealth's response to the National Mental Health Commission report will consider the importance of the framework. It clearly features prominently in the Mental Health Commission's report, but I am not aware of any specific decision to publish or not publish.

Senator McLUCAS: Can I go to the time frame for the Expert Reference Group. It was meant to report in October?

Mr Cormack: That is correct. That is the time frame we have been supporting the Expert Reference Group to work towards. Certainly from our observation they are well advanced in their work.

Senator McLUCAS: Has there been a consumer or carer representative appointed too?

Mr Cormack: Yes, there has.

Senator McLUCAS: Is that in addition to the original names that were published?

Ms Krestensen: The original names that were published included Julie Anderson, who is a consumer representative.

Senator McLUCAS: And that was subsequent to the original announcement?

Ms Krestensen: No, it was part of the original announcement.

Senator McLUCAS: Sorry, I do not have that material with me. And is that a carer representative too?

Ms Krestensen: No. Julie Anderson is a consumer representative. There is no carer representative on the committee.

Senator McLUCAS: Was consideration given to adding a carer representative following the calls for that from the community?

Mr Cormack: We provided a whole range of advice to government in relation to the establishment of the Expert Reference Group in terms of some names of people. The decisions were taken and we have the Expert Reference Group that has been published.

Senator McLUCAS: So it was a decision of government?

Mr Cormack: Indeed, it was.

Ms Krestensen: I would just add that we have separately consulted consumers and carers through a stakeholder workshop, through a separate consumer/carer forum that was held this week and also through their participation in some of the other specific consultations which were built on existing forums such as the ASPAC forum.

Senator McLUCAS: But you would have heard the calls for the inclusion of a carer representative on the ERG following the announcement of the membership.

Ms Krestensen: Yes. I understand the issues you are raising.

Senator McLUCAS: Mr Cormack, you made the point about how many balls we have got in the air at the moment.

Mr Cormack: There are a lot.

Senator McLUCAS: We have got the ERG and this lovely report; it is doing my left arm a lot of good carrying it around the country, so I thank them for that! We have got the reform of federation, the Medicare item number review and the primary healthcare review. The time lines for all those reviews are different. How are you lining that all up in the department? Dr Hartland, are you engaged in any of those reviews? Sure, they are in health, but they do have impacts for mental health consumers in the country.

Mr Cormack: I would like to make a comment on that. There is a very senior Commonwealth officials group that is working to pull together the many threads of reform that are the subject of development or consultation or indeed implementation across the health sector. That includes a senior official from DSS who is a member of the interdepartmental group that I chair. In fact, we had a meeting today. Certainly DSS is being kept well briefed on the range of activities. Indeed, the senior official there also gave us some good cross-briefing on other areas of policy activity within the DSS portfolio.

Senator McLUCAS: Dr Hartland, do you want to add anything to that?

Dr Hartland: We are happy with our level of engagement. One of our central policy people participates in the group Mr Cormack just mentioned. In addition, we work through issues offline with our colleagues in the health department as they arise in my area or in James's area. So we certainly do not feel that we have a lack of visibility or an inability to put our points of view or engage on these matters. But we are not seeking to get more work either. We do not have any complaints. It seems to be working relatively smoothly.

Senator McLUCAS: Mr Cormack, the ERG is tracking to report in October?

Mr Cormack: That's right.

Senator McLUCAS: Let's go to the recommendations from the commission around Primary Health Networks. As I said this morning, Primary Health Networks are one month and 25 days old today. This big change that the commission is proposing would come into their purview. What work, if any, is being done at this time to plan for that sort of change?

Mr Cormack: The PHNs officially came into being on 1 July. However, the transition process from the former Medicare Locals has been going on for quite some time. The first year of operation of the PHNs is obviously focused on their initial establishment, and that is largely underway—getting their governance arrangements in place, including their consultative mechanisms. They are required to undertake in their first 12 months a detailed regional needs assessment, which they will undertake in conjunction with the local hospital networks, public and private providers. On the basis of that, they will be required to begin to commission services within the geographical area that line up with the specific needs that they have identified in their service planning.

Mental health has always been one of the six priority areas identified for PHNs in their role as service integrators and commissioners. The former Medicare Locals were undertaking a range of service delivery functions in the mental health space, so it is not as if they are unfamiliar with the territory. They are certainly not unfamiliar with primary health care. We are working with them on their planning efforts to build their capability with commissioners and also to provide a number of funding pools so that they can have some program funds and some flexible funds available for them to put in place services that are responsive to local needs. In the fullness of time, that will include mental health services. A number of them are already doing that. As you know, the specifics, the timing and the scope of all of those have been identified in some detail in the commission's report.

But the government has not yet provided a full response. That will certainly follow shortly after the conclusion of the ERG's advice and, no doubt, the government will have something to say at that time about the extent to which PHNs will have an expanded, different or modified role to what they currently have.

Senator McLUCAS: That is part of the ERG's work at the moment—to look at what amendments might need to be made to PHNs.

Mr Cormack: The ERG's role is to work its way through the themes in the commission report, and I think we have covered off on what some of those themes are. They will be providing specific advice to government on virtually all aspects of the report, including the potentially different or bigger role for PHNs. Again, I cannot pre-empt what they are going to say and nor can I pre-empt what the government is going to decide in its response.

Senator McLUCAS: ATAPS will continue to be delivered by the Medicare Locals? Who is delivering ATAPS now?

Mr Cormack: A number of PHNs are involved in delivering ATAPS. They are going through a transitioning phase from being service deliverers to service commissioners. Also, the government will provide a much clearer picture on all of the mental health programs. As you are aware, with many of the programs the funding agreements have been extended for 12 months and that in many ways was to enable the government to fully consider the National Mental Health Commission report and indeed the advice it gets from the ERG. Once that advice is received the government makes its response. Then no doubt it will be clearer on the scope and range of any changes to program configuration and the extent to which they come within the commissioning purview of the PHNs.

Senator McLUCAS: You may not have heard—I think it was Mr Quinlan this morning who gave very specific evidence to the committee that said that if he was providing a program and a staff member were to resign, or leave, or go he could offer only an eight-month contract to someone to replace that staff member because of the contract ending on 30 June next year. He expressed concern that this was going to provide difficulties for continuity of service. We had exactly the same problem in November of last year when Mental Health Australia did a survey of their members, which showed a lot of extreme uncertainty in the ability to deliver ongoing mental health services. I think his point is that we are going down that same track and we will get to that same point in November of this year where people will not be able to fill positions in their services and, therefore, people with mental illness will not be able to get the services that they need. I am sure the department is aware of that. I am sure the government is aware of that. What work is being done to mitigate exactly that same scenario being developed by November this year?

Mr Cormack: You are right—we are aware of the concerns that have been raised. I think Mr Quinlan is a very articulate and well-informed advocate for the sector and freely provides detailed advice to us on those issues. We are in agreement that there has been some level of uncertainty, and that level of uncertainty is not ideal. What we are working to do is to support the Expert Reference Group to complete its advice to government. Government will then release its response to the commission's report and within that response we anticipate that there will be a greater degree of certainty about the timing for contract extensions, renewals and any changes or modifications in the way that services are delivered. Certainly our minister has been making sure that we support the work of the Expert Reference Group to get the advice to her as quickly as possible and then it is really a matter for government decision making. As I said, we believe that the information from the ERG will be made available to government in the time that it is requested and then the deliberations of government will continue on from there, at which time we should be able to identify the impacts on the sector as a result of government decision making.

Senator McLUCAS: So you cannot point to a date that you are expecting the government review.

Mr Cormack: We are confident that we will be providing the—

Senator McLUCAS: Sorry, I mean the government response to be received.

Mr Cormack: The precise timing of the government response is a matter for government. But all the indications are that they want us to support that being delivered very quickly.

Senator McLUCAS: I want to go to transition to the NDIS. This is why we invited those people on that side of the table to come along as well. The four programs that are in scope for the NDIS have been the subject of a lot of the commission's report, the subject of a lot of what we have heard today. People are recognising that we are inventing a huge change to the way we deliver disability services in our country and that for those people who are currently receiving a Partners in Recovery or a PHaMs service and will get a tier 3 package that is a good thing. But there is concern around those people who may currently be receiving either a PIR or a PHaMs package but when they go through the process of assessment for NDIS are found not to be in tier 3.

Can you talk to us about the guarantee in the intergovernmental agreement that a person will be no worse off—that is, a person who is currently receiving a service will continue to receive that service—and how that happens in practice? What is the process for the agency, Mr Bartnik, for the referral of a person who is not deemed eligible for a tier 3 package but clearly needs support?

Mr Hartland: I will start, then we will go round to the people who know what is going on, on the ground, which is probably where you want to go. As you recognise, the intergovernment agreements for the trial stage of the NDIS had a commitment from all governments that people currently receiving services would get, what we call, continuity of support. If they are receiving a program at the moment and their program gets rolled into the NDIS and they are not eligible for the NDIS—or, alternatively, they do not get the same service offer—the government is committed to providing, outside the NDIS, continuations of service.

We keep working with our colleagues in health and watching our own programs to make sure that happens. We have not yet heard of cases where that commitment is not being met, and I will pass on in a moment. Also, it is relevant that for many of these people the reason they do not get an NDIS package is that their needs are not high enough to get into the scheme. They might have a need but it is not the type of need that is best addressed by an individually funded support package.

In addition to the continuity-of-support guarantee, as you would be aware, there is capacity in the NDIS to fund programs outside of individually funded programs. We have toyed with various names for this. We have called it tier 2—which, of course, meant nothing to anyone who did not know what tier 1 and tier 3 meant—so we have now tried to call it 'information linkages and capacity building'. Unfortunately, that is about as opaque as tier 2. We move forward gradually into these policy areas and we hope we are making progress, but there is capacity for the scheme to fund support for people who do not get the individual package.

That service office is still developing so, in the medium to long term, if someone is in a program and is not eligible for an individually funded package that may well also be a source of support. I think I have told the Senate community affairs committee this before, but it is worth repeating. When we were looking in detail about how, at a policy level, this information linkages and capacity building should work we were very mindful of a couple of areas where it had been raised with us that it was going to be an issue. Mental health was one of them. So we made sure that how we described this ILC service offer fitted in with, what we understood to be, what you would get in these programs if you had a fairly low need and wanted to go in and out of programs.

We certainly described that in a way that should be pretty seamless. With a number of these things—as you pointed out, if you look at the NDIS it is only just three-quarters through its trial phase, so we are continuing to watch this area to make sure that it works. We will continue to do that until the end of trial and start of transition. We do not yet see any huge problem. There are obvious issues that we work through with Frank and others who are part of this area. It will work for people to make sure that they continue to get support or there is a source of support once the NDIS rolls in. I will see if we can add to that about the specific ways in which it is being—

Mr Christian: I will start at a very high level. We do have a set of principles for determining the responsibilities of the NDIS and other service systems. They were agreed by COAG in April 2013. They do cover 11 service-system domains, including mental health. We also have to complement that with an agreed set of tables of support, which assist decision makers—whether they are in the NDIA, in a state agency responsible for mental health or in DSS or DSS funded programs—to determine whether particular services are eligible in the trial sites and that full scheme.

We in DSS, and in engaging with our colleagues in other agencies—health, in particular—around the four mental-health programs that are moving to the NDIS have developed detailed transition plans for the programs. In those plans we do specifically have a focus on continuity of support and the transition of clients to the NDIS. The key areas covered in those plans, for example, are strategies to identify and address potential service gaps linked to continuity of support in trial sites, including reviewing eligibility decisions and refining operational processes, and identifying funding and transitional Commonwealth programs that might need to be there to complement continuity of support from the period 2016-17 onwards.

If there is an issue identified in the trial sites—and we know there have been some issues identified—we do escalate. There is a process to escalate and resolve issues. But it may be a little more reassuring to know that in Barwon and the Hunter of those PHaMs clients who are currently eligible it has been assessed that 80 per cent of them are eligible for NDIS.

Senator McLUCAS: That is very important. So 80 per cent are eligible from the PHaMs client group.

Mr Christian: Yes.

ACTING CHAIR: I am going to have to jump in here because we are running out of time. Senator Williams would like to ask a couple of questions.

Senator WILLIAMS: Mr Cormack, I made a point earlier on, to witnesses here today prior to you, that we seem to have a lot of groups, and many of them are not here. Are most of those groups funded by the department to carry out their services?

Mr Cormack: Which groups you are referring to?

Senator WILLIAMS: The groups we have here today. I can call a list of them out. We have Anglicare, the Salvation Army, Black Dog Institute, United Synergies, BoysTown, SANE Australia, Mental Health Australia, RichmondPRA, and the Brain and Mind Centre—that would not be under the university. The point I am getting to is: has the department looked at bringing some of these groups together by not having so many groups, so they see that all of the services are covered or covered better?

Mr Cormack: We are aware of the large number of groups and organisations involved in the provision of mental-health services. We do, from time to time, have a look at opportunities to streamline programs to look at whether there are areas of overlap or duplication. We do look for opportunities to address those. The government, in response to the National Mental Health Commission report, will have some things to say about the future of the system as a whole, and the system is very heavily reliant on the non-government sector for its delivery mechanisms. Rather than comment on any specific plans or ideas that may or may not be on the table, I think it is just best to wait for the government's response to the commission report, which I do not think will be too far away. I am sure they will have something to say about the range of programs that are delivered and if there are ways to make them work more efficiently, more effectively and in a better coordinated way to better support individual clients.

Senator WILLIAMS: Mr Christian, I can say with total confidence that my impression is that with the introduction of NDIS mental health will not be neglected in any way whatsoever. We are getting evidence today about people being excluded from the program because of the NDIS introduction. Can you elaborate on that please?

Dr Hartland: Certainly. We do not believe there is any reason why they should be excluded from programs because of the NDIS introduction. Actually, we would recognise that we have heard concerns that the way in which a person should come into the scheme—the application process, the planning process—does perhaps need to be handled slightly differently for some people with a mental illness than you would normally for someone with, for example, quadriplegia. Mr Bartnik might like to tell you about the work he is doing on that issue. So we do recognise there is some work we need to do on that.

Mr Bartnik: When I first started with the NDIA, this was the biggest issue—that is, the language of the scheme, the processes, the forms, and how individuals who sometimes become quite suspicious of government or institutions would engage with the scheme. My early work was around establishing a national mental health sector reference group where we got consumers and carers, families, sector people, government people and agency people all around the table. We scoped a number of reviews, but the first and the biggest was a review of the access process. We had five working groups and we had very strong leadership from people with lived experience and people from the sector. We have just completed the analysis part of the review. There are 39 recommendations; about half of those are to do with the language and the processes of the scheme. We are now around the implementation phase of those: rectifying documentation, communication, making the forms easier. We also have a stream of work around outreach, knowing there are programs like Partners in Recovery, for example, and also some of the specialist mental health programs, for example the Street to Home program, that do a great job of going out to where people are and supporting people, and we will use those to assist people to connect with the scheme. We have a very substantial piece of work underway, having reviewed the access process, and now we are into the serious business of implementing the recommendations.

I do want to say that I think the first two trial sites got started quite some time ago. There was a lot of learning not only about their very best intentions and their very good work but also about more respectful language, more engaging processes and to support people to access the scheme in an easier way. We are confident that we have a good work plan there and, even with those recommendations, that will go a long way.

Senator WILLIAMS: Can anyone tell me: is it the case, with the funding heading towards the NDIS, that funding has been reduced for mental health services?

Dr Hartland: Not in total, no. What happens with the NDIS is that in some programs, in our PHaMs program for example, funding in the PHaMs program will roll into the NDIS and so people, instead of getting support via DSS giving money to a PHaMs provider, will become a participant in the NDIS and the money is maintained. In fact, in the NDIS there is actually a massive investment in mental health. So the actual funding available for mental health will increase.

Senator WILLIAMS: That explains the words of the previous witnesses today.

Senator McLUCAS: Dr Ayres, you said that 80 per cent of current PHaMs clients are being assessed as getting a tier 3 package. That is very comforting. That is in Barwon and the Hunter. That is across both sites?

Dr Ayres: Yes.

Senator McLUCAS: What is the experience in Tasmania of the adolescents that are coming into the program there? Would any of those people have been PHaMs or PIR clients already, or is it just that the cohort is too small?

Dr Ayres: I think it is a small cohort. I might have to take on notice to provide you with the detail about Tasmania, but I believe the numbers are quite small in Tasmania.

Dr Hartland: [inaudible] I cannot tell you. Obviously, someone has the numbers, but we cannot tell you them now. Dr Ayres is right; the numbers of people going in are fewer as a proportion than in New South Wales and Victoria. I think he is right, too, that that would be explained by the age cohort. If you look at the overall age cohort of people with a mental illness, they tend to be most concentrated in the 25- to 64-year-old group, which I guess reflects the experience of people with a need with that condition. Because the Tasmanian trial is targeted to younger people, you would not expect to see the same numbers, but there are—

Senator McLUCAS: Although they are adolescents, and there is a high propensity of mental illness around adolescence.

Dr Hartland: Yes, but the point is that it is less than the older groups. The incidence is still less than in the older groups. So, yes, it is a concern, but you would not expect it to be at the same level as the other trials. It looks like it is about 10 per cent overall, but we can get you some detailed notes. As I said, we have got them. We can pull the numbers. We just do not have them in a numeric way that we can quote back to you.

Dr Ayres: It might also be worth mentioning that for that age group, in terms of the program offerings through the Department of Social Services, we have the Family Mental Health Support Services, which are particularly focused on children, including that age group. That program is not in scope for rolling into NDIS, so for that cohort in Tasmania I suspect quite a number of them would be being serviced through the FMHSS.

Senator McLUCAS: Is there anything you can provide on Western Australia to the committee, particularly around take-up in the two different trial approaches? Mr Bartnik might be able to help us.

Dr Hartland: Mr Bartnik might be able to help us.

Mr Bartnik: I can in a general sense, not specifically for the Commonwealth programs. The last figures for the My Way Lower South West site are that there were 89 people with a primary psychosocial disability. In the Midland site, where the phase was much later, there were about 20 that had come in—

Senator McLUCAS: They are raw numbers.

Mr Bartnik: So it is good progress but small.

Dr Hartland: They are small numbers and they reflect the phasing of those sites, not the population.

Senator McLUCAS: The 80 per cent figure on the PHaMs participants—do we know what number of former Partners in Recovery participants have been able to achieve a tier 3 package?

Dr Ayres: I do not have that. I do not know if colleagues from the Department of Health do.

Ms Nicholls: I do not think we have that data yet. We do not have a Partners in Recovery site in the Barwon trial. We have a Partners in Recovery site in the Hunter trial and we are working closely with them, but I do not know that we have up-to-date data.

Senator McLUCAS: Essentially, what I am trying to ascertain is what proportion of people who currently receive PIR, as with PHaMs, do get a package. Is there any early indication of what that proportion is?

Dr Hartland: In relation to the PIR site in the Hunter, the only information I have—and I am going on my memory—is that there was some initial concern about the administrative arrangements and people being able to talk to each other, which largely seems to have been resolved. Like Ms Nicholls, we have not yet done a full analysis of the kind of cohort who were in the service before and then tracked them through. We can do that and that is what we have done with the PHaMs groups, but you need everybody who is going to go in to get in and then you can trace them back through the NDIS system and find out at what point they exit it. Just on the 80 per cent—can we just go back to that for a sec?

Senator McLUCAS: Yes.

Dr Hartland: The 80 per cent figure is of people who complete an access request, and 80 per cent of the people who complete an access request become participants in the scheme. That is the experience in the Barwon PHaMs group. There are quite a few people who do not complete an access request. I am actually very optimistic about the 80 per cent figure. It is tremendously reassuring to me given that, initially, people were claiming that it was 20 per cent.

Senator McLUCAS: That was evidence we received today.

Dr Hartland: I can tell you I was very relieved to find out that there were substantial numbers of people getting in. The number of people who do not complete an access request is substantial, and we are trying to examine why that is. The evidence at the moment appears to be that, actually, they have just left the area. The people were on the books of the providers. A letter was sent out saying, 'You should get in contact with the NDIA,' the people never get back to the NDIA and do not complete an access request—actually probably because they live in Queensland. Of course it is a possibility that there are people, as Mr Bartnik talked about, with quite severe needs who do not necessarily think that a big new organisation with a government stamp on it is the thing they want in their lives just at that point in time. So we still need to work on outreach and making sure that we are getting all of the people in.

Mr Bartnik: I think the Barwon site is a good example because they have been at it the longest and have more of a full population. In fact, we have had a series of two or three meetings with the consumer and carer advocates, the providers and the clinical mental health services. We sat around a table like this with all those people, looked at the data and asked everybody: are there people who we are missing? At the last meeting I was part of the feeling was that it was a very, very small number of people, who were too unwell at this point in time to be accessing the scheme. But it was a very small number according to all the providers around the table. So I have a level of confidence that for people now in the target group for tier 3 of the scheme we are very close to reaching the most appropriate people.

Senator McLUCAS: But that is not picking up the people Dr Hartland is talking about, who are the people who have disappeared from the system somehow.

Dr Hartland: There would be a group who are too unwell to complete it.

Senator McLUCAS: Yes, I understand.

Dr Hartland: Of course, they can apply later. That is the group that you want to be really concerned about, but there are another group who probably have just left the area or do not have a need and did not see the need to get in contact with the agency. It is the group who are very unwell and need a bespoke, special way of accessing the scheme who are the ones of most concern. As Mr Bartnik is saying, that looks like a very small group, so it would not radically change the 80 per cent figure.

Senator McLUCAS: It is concerning to me that the evidence from earlier today from a pretty respected witness was that 20 per cent of people on PHaMs are getting a package, compared with the evidence here, which is 80 per cent. I do appreciate the fact that you have tried to explain that to the committee. What I now want to see is how many people we have lost. What is the number of people who used to be on the PHaMs list but are now not completing an access request, not those who are very sick—I accept your point, Mr Bartnik; we can probably tell you the names of that group of people because they are pretty close to the system—but the other group that we seem to have lost somewhere?

Dr Hartland: The problem with the group who do not complete an access request is that you cannot go back and ask them why not because many of them you just do not make contact with. So I think we—

Senator McLUCAS: I understand what you are saying. You cannot go to that individual and say, 'You didn't fill the form in,' but surely we can learn stuff from the current providers of PHaMs around what numbers they cannot see in the cohort that have a tier-3 package. I accept the confidentiality aspect too.

Dr Ayres: We are aware of this issue and, as Dr Hartland has said, it is one that we are looking to tackle. As part of our data collection strategy, we have plans for gathering as much information through the PHaMs providers as we can about that particular cohort. We will be dependent on what the PHaMs providers know about them. It is a voluntary scheme and program, so, if a participant drops off the books because they choose to, there is not a lot we can do about chasing them down. There will be some limits to how far we can go with collecting that data, but we have a data strategy in place to get as good data as we possibly can about that cohort, as well as the cohort who get into the NDIS and those who do not get through the access process.

Senator McLUCAS: I accept that; thank you. Dr Hartland, have you done any work to identify the number of people who will fit into that tier 2 group, or the ILC group, who we know will not get a tier 3 package but will need to be able to be in touch with the NDIA or with mental health services on an ongoing basis? How many of those people exist in the country, given the population-wide thinking that we had when we designed the NDIS? How many of those people are there?

Dr Hartland: The answer is complex. Initially when we were talking about the eligibility criteria we did look overall at the numbers, which was the difference between the number of people who needed an individually funded package and those who have—

Senator McLUCAS: Perhaps I could clarify that. I am talking only about mental health.

Dr Hartland: Yes. I am trying to step carefully to the answer. So, there is a group of people who have a disability and have a support need, and then a smaller group who need an individually funded package, and the difference between the two is about 200,000 people. Mental health would be a part of that cohort. We have not gone much further than that at this stage. To some degree we would be relying on the finalisation of the planning framework to get a feel for the actual numbers outside of that, and we would also be relying on where we think we are going to get to in relation to numbers of people with a mental illness who have an individually funded package. The NDIS was budgeted for on the basis that basically 57,000 to 60,000 people with a mental illness would have an individually funded package. Whether it ends up at that we will, of course, still have to wait and see. We are on track for something close to that but perhaps slightly under, and I think we would need more information from the population planning framework to then make an assessment about the tier 2 effort. So, no: we do not have an answer. We have a feel for it but not a precise answer.

Senator McLUCAS: But you are aware of that document that is in the commission's report—in the summary, not in the actual report, on page 14. You might want to take a look at that, and perhaps you could take it on notice—because it is nearly five o'clock—and see whether those figures are the same sorts of figures you are looking at to identify that group of people who will be eligible for tier 2 support. And perhaps you could answer the question for me in the rough—how many people are we really talking about who will need a tier 2 support or an ILC or whatever it is called? The way the commission has classified people is that there are about 65,000 people who have severe and persistent illness, there are about 210,000 who have chronic illness with major limitations and then two per cent of people have severe but episodic presentations. My final question, Dr Hartland, is: how much money is allocated for the tier 2 component in the current budgeting arrangement?

Dr Hartland: At full scheme it is about one per cent of costs, I believe. I think we get to about $100 million a year in addition to provision for LACs, which will be funded outside of that. So, there is a fairly substantial capacity in the scheme to fund this type of work. I am aware of these figures. They are somewhat similar to the early work that was done to derive the PC estimate of mental illness, which stepped through the mental health figures in a similar way. As with other disabilities, they show that there is a core group that needs an individually funded package—and the scheme is funded to provide that—and then there is a wider group of people who have a constant need but do not have very high needs or have a need that fluctuates. For that group, while it is a substantial number of people—here you get to 150,000 plus 400,000, which is a lot of people—they do not all need support at the same time.

So, the issue really is: how do you design a scheme that can support these people at what will remain, at the state level, outside of the scheme? We know this is something you have been interested in, and I am surprised we have not been asked about it—we still have a couple of minutes! That is also an issue about what remains outside of the scheme at the state level to support these people. We continue to look at that. The scheme does increase funding for people with a mental health condition, and I would be surprised, if we could not get it right, if we did not go backwards. There is still an issue about the design of ILC and what remains outside it that we need to keep monitoring, and we will do that as the trials roll out.

Senator McLUCAS: I am going to have to finish, because I have to go and talk on ABC Radio to the regional people of Queensland. But my favourite story is the story of a woman who was quite ill and was a Partners in Recovery client. The cost of making her well was the cost of a bicycle. They bought her a bicycle and she then could go to volunteer at the animal refuge, where she went every day, every week, and she is as happy as Larry and very well. For one bike, we fixed somebody. It is a good story to remind us that not everyone needs a lot of money; they just need the right service. Thank you very much for your evidence today. This committee is hoping to report soon, and if we need to we will send you some questions in writing.

ACTING CHAIR: Thank you very much for appearing before us today. I would like to seek resolution on a date of return of answers to questions on notice. The date of 18 September has been suggested. Is that all good?

Senator McLUCAS: Yes, that would be great.

ACTING CHAIR: Okay. Then I would like to thank all the witnesses who appeared before the committee for giving their time today. I wish the chair, Senator Deborah O'Neill, a speedy recovery.

Committee adjourned at 17:03