



Australian Government

Department of Families, Community Services  
and Indigenous Affairs

## REPORT ON THE NATIONAL MENTAL HEALTH CONSULTATIONS SEPTEMBER 2006

**By the Mental Health Branch, Australian Government Department of Families,  
Community Services and Indigenous Affairs**

The Mental Health Branch undertook a national consultation round in September 2006. The consultations covered all three new mental health measures:

Respite Care - \$224.7 million over five years for over 650 day and night respite places to assist carers of people with a severe mental illness or intellectual disability. These additional respite care places will provide families and carers with the support they need to maintain their caring roles. It is expected that the first round of respite care services will be implemented in early/mid 2007.

Personal Helpers and Mentors - \$284.8 over five years for 900 personal helpers and mentors to assist people with a severe mental illness. Personal Helpers and Mentors will help people to manage their daily activities and access a range of appropriate and integrated community, social support, accommodation, health, welfare and employment services. It is expected that 100 of the Personal Helpers and Mentors will be implemented in 2006/07.

Community Based Programs - \$45.2 million over five years to deliver flexible projects to assist families, children, and young people affected by mental illness. These projects will have a particular focus on young people aged 15-24, Indigenous families and those from a culturally and linguistically diverse background.

### CONSULTATIONS

The consultations were conducted in Perth, Albany, Darwin, Brisbane, Townsville, Canberra, Sydney, Hobart, Melbourne and Adelaide during September 2006. Site visits were also conducted in several locations. The national consultation followed on from the earlier targeted consultations conducted in July/August 2006 for the Personal Helpers and Mentors measure, which were held in Parramatta, Sydney, Wollongong, Melbourne and Ballarat.

The Directors of Mental Health in each state and territory were invited to participate in the national consultation sessions by providing an update on that state's initiatives under the National Action Plan on Mental Health. All state governments participated by addressing the session, with the exception of the NSW state government, who provided written material; and the ACT government, who were unable to participate.

Approximately 1000 people attended across the 10 sessions, with representatives from service providers; mental health, disability, carer, Australians from culturally and linguistically diverse (CALD) backgrounds, Indigenous and housing peak bodies;

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state and local government departments and agencies including housing, justice, disability and health; consumers and their families and carers; mental health workers including GPs; community groups and other interested parties.

There was some complaint that FaCSIA was not consulting in far northern Western Australia or in Alice Springs. Whilst we were unable to visit these areas, provision was made for interested parties to submit comment via the FaCSIA website. Over the consultation period, 16 submissions were received via the website – four on respite care, four on community based programs, and eight on the Personal Helpers and Mentors measure. One complaint was received on the lack of parking at the venue in Perth, which was located in the city.

The new measures were explained in an opening presentation to the whole group. The group then split into three smaller groups to discuss each measure in more detail. In some venues, due to the large number of participants, the Personal Helpers and Mentors and the Community Based Programs measures discussions were conducted jointly.

### **KEY THEMES**

Overall, comments from participants were very positive, both on the new measures and the willingness of FaCSIA to talk to the community.

#### Personal Helpers and Mentors

- **Terminology** – support for a recovery approach for the program and the importance of an appropriate name for the workers, with Recovery Support Workers, or Community Support Workers suggested.
- **Family/carer involvement** – importance of involving carers, families and supporters when working with a person with a mental illness and particular issues around the needs of children where a parent has a mental illness. Parenting responsibilities need to be considered. A more holistic approach to working with a person is required. It is not just about the individual but also their family, carers and support network.
- **Assessment procedures** – definition of severe mental illness and current access to services was a key issue at every session. Participants expressed frustration with current assessment models as being too onerous to complete. The assessment model decided upon needed to be user friendly and as short as possible. The assessment needs to take into account other assessments the person has already had.
- **Workforce issues** – including qualifications, salary rates, caseloads, use of volunteers, and age of workers. The use of peer support workers was strongly

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favoured by consumers. Retention rates are poor across the sector, a team approach with adequate supports would improve this.

- **Housing** – accommodation is an important connection for the program. It is very difficult to work with a person and get good outcomes where stable and secure housing is not available.
- **Dual diagnosis/co-morbidity** – training and skill development is needed for service providers to work effectively with people with mental illness and either drug and alcohol, intellectual disability or acquired brain injury.
- **Rural and remote service delivery** – special problems will occur due to the lack of existing services in these areas. How can we provide priority access to services that do not exist? It was suggested that the new workers link in with the existing clinical teams.

### Respite Care

- **Flexibility** - a wide range of flexible and responsive respite models is needed so that respite can be tailored to the needs of individual carers, care recipients and their families. There was a strong view that a ‘one size fits all’ approach to respite would not work and that a mix of models should be available to meet the varying needs of each family and their differing situations.
- **Priority and access** – it was noted throughout the consultations that the respite program will service both people with mental illness/psychiatric disability as well as people with intellectual disability. Whilst the needs of both groups were widely acknowledged, there was a strong view that these are two distinct groups of people with specific needs. There was also a strong view that people with mental illness have significant barriers to accessing respite services and that this group needs good access and appropriate services to their needs.
- **Appropriate services** - to be effective, the various types of respite need to offer positive and meaningful activities for the care recipient with a focus on community integration and/or recovery. The needs of particular groups were highlighted with emphasis on the need for appropriate services for people from indigenous or other cultural backgrounds. The needs of people with dual disabilities, dual/multiple diagnosis and people with challenging behaviours were also acknowledged with a concern that there are limited respite options for people with severe or complex conditions.
- **Relationships** -.there was a very strong view that service providers need to build strong relationships of trust with their clients, taking a holistic perspective on family needs. Carers face multiple barriers to accessing respite services and strong

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relationships of trust between carer and service provider and care recipient can assist in reducing these barriers.

- **Service delivery** – brokerage service delivery models were generally supported as providing easy access for carers through a “one-stop shop” arrangement. The limitations of this approach were highlighted in situations where there are limited respite services/options to broker. These services should also be strongly promoted so that carers understand the service role, what services are available and how to access them. There was a view that the new program should build on existing brokerage services rather than create new infrastructure for this purpose.
- **Assessment criteria** - there was a strong view for assessment to be based on the level of carer need and/or through an assessment of functional ability/level of dependence of the care recipient rather than a clinical diagnosis, and that entry to the program should not depend on a medical diagnosis. Assessment methods need to be simple, streamlined, user friendly, consistent and appropriate to the circumstances of the care request.
- **Funding** – needs to be flexible and realistic to take into account the different costs across regions, and across service types. It needs to provide adequate funding for operational costs and in the case of brokerage services it needs to provide adequately for the costs of coordination and brokerage as well as the cost of the respite service to the client.
- **Planning** – there was a strong view that respite should be planned with carers, the person they care for and their families so as to develop a plan for respite that will suit their needs. This emphasis on early intervention was considered important so that carers are supported and sustained in their carer role. There was also support for planning to be undertaken at a community or regional level to assist with regional coordination of respite services and to identify supply issues.
- **Respite supply** –the supply of services varies considerably with some areas having very limited or no mental health respite services. In general there was a view that it is difficult to find appropriate respite options for people with mental illness or psychiatric disability. Overall there is a need to increase the supply of mental health respite options either through expansion of existing services in some areas, the development of new services/options where appropriate, or by strengthening the capacity of the existing respite sector (in particular workforce training).

### Community Based Programs

- **Program Design** – support was voiced for the program to fund a broad range of social support, community awareness, and information sharing programs. Some concerns were expressed about the complexity of applying for government

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funding and a perception that funding was targeting at metropolitan areas and high profile conditions.

- **Sustainability** – some concern was noted that after a service has been established, subsequent government funding is made available in a competitive model that results in the funding going to another organisation. This can result in a fragmentation of the sector. It can then take time for services to establish programs and relationships of trust with clients. This can have a particular impact in rural and remote areas and for Indigenous consumers.
- **Co-morbidity** – this issue should be recognised to include a wide range of conditions that increase the impact of mental illness.
- **Workforce** - concerns were raised about the sector workforce: experiencing burnout; having low numbers in rural/remote areas, there being insufficient workers to support culturally and linguistically diverse consumers and Indigenous people being under-represented in the workforce.
- **Terminology** – some suggestions were made about the need to be attuned to preferred terminology including talking about mental health rather than illness and working with consumers rather than to or for consumers. Important to recognise that some communities do have different cultural concepts of mental health.
- **Service coordination** - Service delivery needs to be coordinated to ensure that when people are discharged from hospital a care plan is developed and appropriate support engaged. Coordination is also required for when young people with mental illness leave home and travel interstate they can continue to access appropriate services interstate.
- **Service gaps** - young people moving between school and the workforce, people at the point of adult transition, Peri-natal, children of parents with mental illness.
- **Barriers to accessing services** – language barriers, men from some culturally and linguistically diverse communities do not access services provided by women, and homeless people.
- **Evaluation** - Evaluation requirements should be established bearing in mind the capacity of the funded organisation, and not disproportionately time-consuming or onerous. Program evaluations should include the experiences of consumers who received the service. Evaluations should also take into account that success for a consumer may be different to the criteria established for the program. For a consumer a successful outcome may be a sense of wellness or the ability to re/enter employment etc, but this may not be a ‘recovery’.

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### **WHERE TO FROM HERE?**

The Mental Health Branch is currently using the information gained from the consultation sessions to draft program guidelines. The program design will be submitted to the Minister for approval, and announcements regarding funding opportunities will be published on the FaCSIA website [www.facsia.gov.au](http://www.facsia.gov.au) and in the media as appropriate.