

25/01/19

Mr Stephen King
Presiding Commissioner
Productivity Commission Enquiry into Mental Health
GPO Box 1428, Canberra City ACT 2601

Dear Mr King;

I would like to make a personal submission to the enquiry.

INTRODUCTION

My submission is reasonably straight forward.

Mental Health Recovery (Recovery) is the accepted major modern focus for management of people affected by severe mental illness. An important goal of the Recovery Process is full participation in society, including economic participation.

Recovery involves a much broader health concept than just health care (see Parker 2011) (1) (Attachment 1).

The current process of tracking who funds and delivers what component of Recovery (Federal, State, Non Government Organization) (as per the example of JS below) is complex and often hard to identify and account for in a coordinated process.

Other Australian initiatives such as the COAG National Indigenous Reform Agreement (NIRA) (2) (Attachment 2) may point the way to developing a more effective process of funding and assessing forward process in the various areas required for Recovery. The economic theory and objectives underlying the COAG NIRA have been previously described by Ken Henry (3) (Attachment 3). It should be noted that a similar strategy developed in Canada, the Canadian Aboriginal Horizontal Framework (4) (Attachment 4), designed to redress the health and social disadvantage of Canada's First Nations Peoples and based on health principles of the WHO Ottawa Charter (5), had similar funding "pillars"

to the NIRA with “sub pillars” within each funding category to review specific funding goals.

An Australian mental health funding strategy, similar to the NIRA and based on standard principles of Health described below may provide a better strategic economic view of the multiple programs being currently funded. Such funding includes Australian Federal (Medicare, PHN, Headspace, PBS, Indigenous, Aged Care), State and Territory (Mental Health Service Provision, Law Enforcement, Forensic) and the NGO sector (Housing, Employment, Community Integration) that contribute to the current rather confused situation that is the focus of the current enquiry (as per the example of “JS” below).

THE EXAMPLE OF “JS”

JS is a 40 year old Aboriginal male affected by Chronic Schizophrenia which he has suffered from since first diagnosed when he was 20 years old. JS also has a significant co-morbid issue with alcohol and cannabis dependence. He has required a number of hospital admissions in the past and is currently being managed on a Community Mental Health Order by his mental health service to ensure that he receives his depot antipsychotic medication. Police have occasionally been involved in managing JS’s behavior prior to hospital admissions for exacerbations of his mental illness. John has a significant experience of trauma and was removed from his parents at an early age. JS prefers to go to his own GP although he may have occasional access the services of the local Aboriginal Community Controlled Health Organization Social and Emotional Wellbeing Service (ACCHO SEWB) as required. JS is also on parole after being released from prison. He had a brief sentence for an assault that occurred in context of alcohol inebriation. The various agencies that may be involved in JS’s management and their potential funding source are listed in Table 1 below.

Service	Delivered By	Funding
Hospital/ Community Mental Health Care	Mental Health Service	State/Territory
Specialist Psychiatric Review	Mental Health Service Private Psychiatrist	State/Territory Commonwealth
Medication	Hospital Pharmacy	State/Territory

	PBS	Commonwealth
Primary Care	General Practitioner ACCHO	Commonwealth
Housing	Housing Department NGO Housing	State/Territory State/Territory/ Commonwealth
Psychological/Trauma Focused Care	Psychologist (Medicare) ACCHO SEWB	Commonwealth Commonwealth
Crisis Care, Enduring Mental Health Support	Crisis Line, Beyond Blue PHN	Commonwealth
Alcohol/ Cannabis Dependence	Rehabilitation via Government Department Rehabilitation via NGO	State/Territory State/Territory/Commonwealth
Forensic (Prison)	Prison Medical Service (Medical Services via Medicare not allowed under the Health Insurance Act)	State/Territory
Forensic (Community)	Community Corrections	State/Territory
Community Integration and Workforce Participation		State/Territory/Commonwealth
Specific Disability Funding	NDIS	Commonwealth
Agency Education	Police Education in Mental Health Response	State/Territory

TABLE 1: FUNDING SOURCES FOR THE RANGE OF SERVICES REQUIRED BY "JS" FOR HIS MENTAL HEALTH RECOVERY

RECOVERY AND BROADER ISSUES OF HEALTH

Wolfson and Holloway (6) comment on the history of managing mental illness including nascent concepts of recovery such as the development and closure of asylums and the development of “psychiatric rehabilitation”, particularly so from the needs to rehabilitate servicemen psychologically injured by the second world war.

A subsequent development of the Ottawa Charter for Health Promotion by the World Health Organization (WHO) in 1986 (5) provided a framework for concepts of health recovery that emphasized social and personal resources, as well as physical capacities that allowed a broader strategic map for health development ..

These broader strategic concepts to providing Recovery nationally in Australia suggest a substantive “Macro” funding strategy, based on the WHO principles, that may also reflect the more “Micro” issues of the clinical and social resources required for every individual requiring such assistance.

The “Recovery Mapping” concept that is based on the above is being gradually incorporated into mental health policy and health funding agreements in Australia. “Contributing Lives, Thriving Communities” (7), the Australian Government Response to Contributing Lives (8) and potential benefits for people affected by severe mental illness from the NDIS (9) also increase the imperative of such mapping. Hickey (10) has commented “the National Mental Health Commission (NMHC) has placed great emphasis on the crucial need for local co-ordination between the new primary health networks and (and specifically expanding their mandate to focus on mental health services), state based acute care and community services and psychosocial support and accommodation services (which are largely supplied by non-government agencies, often operating under contract to the federal government)”. This attempt to link funded resources would benefit from the more comprehensive “Macro” view for Recovery initiatives, such as that developed thought the Australian COAG National Partnership Agreement on Mental Health (11)

NON GOVERNMENT ORGANISATIONS (NGO's) AND RECOVERY

Mental health reform in Australia has had significant advances with the Richmond Report and subsequent de-institutionalisation of the Asylums, the Burdekin report in 1993 that “shamed governments into action” and four subsequent mental health plans. The Australian Health Ministers Advisory Council (AHMAC) has also recently

issued guidelines for Mental Health Services to operate within a Recovery Framework (12). Closely aligned to this strategic development of policy in Australia has been the growth of the Non Government Organisational (NGO) involvement in the management of people affected by mental illness. As an example, the increase in funding for the mental health NGO sector increased from 2% of total health services expenditure in 1992-3 to 5% of the total health services expenditure in 1997-8 (13). In 2010, it was estimated that almost 30% of people suffering from psychotic illness in Australia had received mental health services from NGO's (13). Such services offered by NGO's included Counselling or emotional support, help to access other community services, information about mental illness, information on recovery planning, support to link with mental health services, home help, assistance with meals, help to access education, accommodation services, vocational training and skills experience, help in finding paid or volunteer work and financial assistance (13)

The National Disability Insurance Scheme (NDIS) and its governing Agency the National Disability Insurance Agency (NDIA) will become the main vehicle that commissions the above NGO services for individuals with Severe Mental Illness. The NDIA has as it's fundamental objectives :supporting the independence and social and economic participation of people with disability:

- providing reasonable and necessary supports, including early intervention supports, for participants
- enabling people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports
- facilitating the development of a nationally consistent approach to the access to, and the planning and funding of, supports for people with disability and
- promoting the provision of high quality and innovative supports to people with disability (14)

A good model of this potential for NGO involvement for people affected by severe mental illness is offered in California. The California Mental Health Services Act (2004) provided a significant funding base for Mental Health Recovery programs administered by non-government organisations in that state. The initiative is popularly called "the millionaire's tax" because it places a 1% tax on gross incomes over \$1 million with the money being used to provide mental health services and supports. Such services and supports include medication management, crisis intervention, case management, peer support, food, housing, respite care and treatment for co-occurring disorders such as substance abuse (15). Surveys of the "consumers" or "partners" (people affected by severe mental illness who enrol with the various programs offered by the non-government organisations) reported

that they had 27% higher functioning than similar people not enrolled (ibid). In terms of the impact on other public services, “partners” were 56% less likely to be arrested and, after eight months of being enrolled in the program, were 57% less likely to present to an Emergency Room (ibid). It was estimated that by February 2010, \$US 3.7 Billion had been allocated by the California state government over the five years since the inception of the initiative with 25,000 “partners” being served by the Full Service Partnerships and 40,000 people generally being involved in Mental Health Service Partnership Programmes (15).

The Bonita House HOST program is a non-government organisation based in Oakland, California, that “partners” with 108 homeless individuals affected by severe mental illness in the context of the objectives developed within the California legislation. Bonita primarily works to place their “partners” in stable accommodation, offering varying levels of skill training to support the rehabilitation needs required of such accommodation placements. Symptom management and control of co-morbid substance abuse are also important components of this focus on rehabilitation. Bonita also acts as a resource to provide training for the “partners” to enter work and offers additional problem solving for issues that the “partners” may face in the workplace such as bullying, discrimination or adapting work to suit their level of disability. With the discretionary funding that Bonita receives from the State of California each month, the staff of Bonita are quickly able to respond to situations that may advance a “partner’s” recovery. Such situations may involve organising a driving license to enable a partner to take advantage of an employment opportunity or being able to quickly pay for damage to one of their residences caused by a “partner”. The “partner” is able to remain in the residence and pays the money back over time.

Bonita’s data (16) shows that its 108 “partners” who had been with the program for at least twelve months had a significant reduction in hospitalisation (88%) along with substantial improvements in employment (147%) and participation in education (485.7%) compared to their experience before enrolment in the program. This appears to show the significant economic benefit through reduced “system drainage” (significant reduction in the use of law enforcement and health system resources) and increased benefit via economic and educational participation of such a sustained broad based approach in addressing mental health Recovery.

THE NEED FOR “CASE CO-ORDINATORS”

Of further interest, around 70% of people affected by psychotic illness in the Australian 2010 survey had a “case manager” with 61.6% provided by the public services and 20.2% via NGO’s (17). Davidson et al (18) note that the concept of case

management arose out of community support programmes as a result of deinstitutionalisation. The “case manager” was initially tasked with identifying, accessing and co-ordinating the various services to meet the multiple needs of individuals with serious mental illness living in the community.

The role initially encompassed a range of different models of care (19) but the two most common approached in Australia are assertive community treatment teams and case workers with individual case loads. The Australian Department of Health document “The role of Case Management” (20) notes a number of problems with the “case worker” model with case workers having to undertake a number of tasks including assessment, monitoring, planning, advocacy and linking of the consumer with rehabilitation and support services. Reductions in hospital based care and subsequent higher caseloads for the case managers have made it difficult for them to provide the complex range of activities required for each consumer.

However, in the context of the above current confusion of adapting the “Macro” resources to the “Micro” requirements of each individual requiring assistance for their mental health needs, a term such as “Recovery Co-ordinator” may be more appropriate to describe this function. Recovery Co-ordinators could then work with the range of services required by each individual along with their expert clinicians to provide the most optimal functional and economic service for that individual.

CONCLUSION

The “Macro” aspects of Recovery, based on the WHO health principles, may thus guide the economic strategy and accountability of the funding required to enable a sustainable focus on the value of effective treatment of individuals affected by mental illness. These strategic health concepts may also guide economic allocations that reflect the range of resources available to clients to enable their Recovery in day to day clinical care. Australia has already managed this economic initiative previously through COAG policies such as the National Partnership Agreement on Mental Health (11) and National Partnership Agreement on Indigenous Economic Participation of 2008 (21).

The “Micro” aspects of Recovery “mapping” the requirements of each individual could then be developed, drawing on appropriate aspects of medical care, case management and skill sets within the NGO sector to develop the optimal Recovery resources for each individual suited to their level of disability. The example of California points to the way such funding to enable the “Micro” co-ordination of services could be sustained.

Robert Parker BA (Hons), BMed, MHA, DRACOG, AFACHSE, FPRCP, FRANZCP, FAMA
Associate Professor, School of Medicine, Flinders University and the Northern
Territory Medical Program.

President Australian Medical Association, NT Branch
Director of Psychiatry, Top End Mental Health Services NT

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ATTACHED DOCUMENTS:

ATTACHMENT 1: Parker (2011) A New Economic and Social Paradigm for Funding Recovery in Mental Health in the Twenty First Century

ATTACHMENT 2: Cover Sheet and Pages 3-5 of 89 of the National Indigenous Reform Agreement

ATTACHMENT 3: Henry (2007) Addressing Extreme Disadvantage Through Investment in Capability Development

ATTACHMENT 4: Canada's Performance; Canadian Aboriginal Horizontal Framework

A New Economic and Social Paradigm for Funding Recovery in Mental Health in the Twenty First Century

Robert Parker

*Northern Territory Clinical School,
Darwin, Northern Territory,
Australia*

1. Introduction

Mental illness is a significant factor in disease related disability throughout the world. About 16% of the global burden of disease not attributable to communicable disease has been attributed to mental disorders (Prince et al 2007) with substance abuse disorders contributing to a further 4% of this burden (*ibid*). In Australia, "Mental Disorders" were considered to be the third major cause of health loss (behind cancer and cardiovascular disease) in 2003 but were estimated to increase at a significant rate to move ahead of cancer and become the second major cause of "health loss" by 2013 (Begg et al 2008). This burden of mental illness is particularly pronounced in the youth of Australia with disability-adjusted life years (DALY's) for mental illness calculated to be above 90,000 (compared to the next highest of 48,000 DALY's due to injury) for the 15 to 24 year old age group in 2003 (Eckersley 2011). Along with the current burden of disease attributed to mental illness, there is a number of challenges facing societies in the developed and developing world that are likely to lead to an increase in mental illness. Sartorius (pers comm) has recently outlined some of these challenges. They include: weakening of community resilience mechanisms, increasing awareness of gaps and unreachable opportunities, migration of people, talents and capital with the subsequent loss of social capital in some societies, the challenges of increased urbanisation on community supports and family structures, the changing nature of privileged families in developed society with less children, longer life spans and more fragile family structures, the decrease of middle class "norms" in developed countries and the additional increase of the middle class in developing countries with potential economic and social alienation from less privileged groups, the changing role of women and the implications that this has for child care and care of the elderly and the changing paradigms of medicine itself with increasing use of technology in addition to evolving ethical issues such as euthanasia.

The severity of personal disability from mental illness is pervasive.

The poetry of Anne Sexton in the poem "Sickness unto Death" (1977) helps describe some of this inner experience for severe mood disorder:

*"God went out of me
 As if the sea dried up like sandpaper,
 As if the sun became a latrine
 God went out of my fingers,
 They became stone
 My body became a side of mutton
 And despair roamed the slaughter house..."*(Porter 1991)

The recent poem by Sandy Jeffs (2009) describes her life affected by schizophrenia.

*"I am many things, in many places
 Fool that I may be, mad that I may be.
 I am, in all my precarious guises
 The creation of a cruel mind"*

People suffering from severe mental illness currently face significant levels of poor health (Symonds & Parker 2007), high levels of unemployment (Dunne E et al 2008), homelessness (Browne & Hemsley 2010), alienation from family members (Druss et al 2009) and services (Luhrmann 2008). The economic cost of these issues to society generally is significant with people affected by schizophrenia estimated to have provided a direct cost to the United States economy of \$62.7 billion in 2002 (Wu et al 2005)

2. Primary health care

The above issues have gained increasing importance against a background of increasing international recognition about what should constitute the ideal of health for individuals and communities. The Declaration of Alma-Ata (1978) defined health as "a state of complete physical, mental and social wellbeing and not merely as the absence of disease and infirmity" as a fundamental human right. The Declaration further called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in co-ordination with other sectors". The Ottawa Charter for Health Promotion (1986) built on the initial foundations of the Declaration of Alma-Ata. The Charter reported that health "is therefore seen as a resource for everyday life, not the objective for living" and "as a positive concept emphasizing social and personal resources as well as physical capacities". The Charter goes on to define the prerequisites for health as: "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity".

The Declaration of Alma-Ata was produced in the context of a new "global approach" to health developed initially through the creation of the World Health Organisation (WHO) as a key agency of the United Nations and then the broad visionary strategy of the drive to "Health for All by the year 2000" by the then WHO director, Hafldan Mahler. This coincided with the increasing involvement of the World Bank as the major external funder for health sector development in developing countries and it has been noted that the Bank has "positioned itself operationally and intellectually at the fulcrum of international health development" (Walt 2006).

In the context of the above initiatives mental health is currently defined by the World Health Organisation as "a state of well being in which the individual recognises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community" (Herrman et al 2005)

3. Amartya Sen and the concept of human agency

Apart from health, there has also been an appreciation of economic opportunities associated with the empowerment of human agency, ideas further developed by Amartya Sen, who was awarded the Nobel Prize for Economic Science in 1998. Sen (1999) defines "agency" as "someone who acts and brings about change and whose achievements can be judged in terms of their own values and objectives, whether or not we assess them in terms of some external criteria as well". Sen then goes on to discuss the way that *instrumental effectiveness* of freedom may enhance this potential for agency. "This instrumental role of freedom concerns the way different kinds of rights, opportunities and entitlements contribute to the expansion of human freedom in general and thus to promoting development". Sen then defines his instrumental freedoms as (1) political freedoms (civil rights), (2) economic freedoms (the opportunities to utilize economic resources for the purposes of consumption, production and exchange), (3) social opportunities (arrangements for education, health care etc), (4) transparency guarantees (transparency and trust in personal interaction) and (5) protective security (unemployment benefits, famine relief etc). These instrumental issues then underpin *substantive freedoms* for humanity such as political and civil liberty, social inclusion, literacy and economic security. The work of Sen is having as significant impact on individuals concerned with enhancing the agency of deprived groups such as those people affected by severe mental illness and this will be further discussed later in the chapter. Henry (2007) further defines the issues that Sen promotes "Sen also notes that a second subset of other relevant capabilities of considerable interest to the classical economists – such as the capability to live without shame, the capability to participate in the activities of the community, and the capability of enjoying self-respect – provides a basis for relative poverty comparisons....policy makers should be concerned with opportunities. Specifically, they should be concerned to ensure that individuals are endowed with capabilities that allow them the *freedom* to choose to live their lives in ways that have real meaning and real value....".

The concepts that Sen defines have been usefully applied to Indigenous disadvantage in Canada and Australia (as described below). They may have also particular importance in supporting strategic policy initiatives to develop a mental health Recovery framework.

4. Effective funding models for primary health care: The indigenous paradigm in Canada and Australia

The broad spectrum of disadvantage experienced by those afflicted by severe mental illness is to a degree, similar to the current predicament of the Indigenous populations of Australia and Canada. Recent innovative government policies to redress this disadvantage have been based on the definitions of Primary Care previously described in addition to policies based on the desire to enhance substantive freedoms as promoted

In Canada in 2002, First Nations tribes constituted 976,305 people or about 3 percent of the population (Indian and Northern Affairs Canada Communications Branch 2004) Kirmayer et al (2000) note that First Nations Tribes have had contact with European culture since the sixteenth century. They comment " the history of European colonisation of North America is a harrowing tale of the indigenous peoples' decimation by infectious disease, warfare and active suppression of culture and identity that was tantamount to genocide (*ibid*). Kirmayer et al note that it is likely that 90% of an original population of 7 million Canadian First Nations people died as a direct and indirect result of European contact (*ibid*). The authors

comment that First Nations people were removed to settlements that were chosen by government or mercantile interests rather than by the Indigenous Canadians themselves. This often resulted in major social dislocation for the community structures. In addition, from 1879 to 1973, there was a Government policy of removing First Nation children from their homes to church run boarding schools where their heritage was denigrated and suppressed. In addition, these children were subject to physical, emotional and sexual abuse (*ibid*).

Indigenous First Nations Canadians have high unemployment rates (25%) compared to the general Canadian population (10%) with particularly high rates on reservations (31%) (MacMillan et al 1996). First Nations people generally live in poor housing and only a limited number of communities have adequate water and waste disposal (*ibid*). They have high infant mortality rates of 13.8 per 1000 live births for all Canadian Indian infants compared to 7.3 for all Canadian infants. Age standardised mortality ratios for Canadian First Nation women is almost double that for Canadian women generally whilst the aged standardised mortality rates for First Nation men is about 50% above that for Canadian men generally with higher death rates for men on reserves. The leading cause of death for Canadian First Nation people between 1986 and 1988 was injury and poisoning that accounted for 31% of all deaths in this population compared to 7.5% of all Canadians (*ibid*). Suicide rates for Indigenous Canadians are two to three times higher than Canadians generally. There is a particularly high suicide rate for the Inuit people with the suicide rate in Inuit youth being up to 5 times the rate of Canadian youth generally (*ibid*). Canadian First Nation communities also report high rates of alcohol abuse, other substance abuse and family violence (*ibid*) that are probably relevant in respect to the high suicide rates. Solvent abuse, including petrol, glue and cleaning products in isolated First Nation communities (*ibid*, p1576). Kirmayer et al (2000) also report that there are generally high rates of mental illness in many Indigenous Canadian communities. They note "the high rates of suicide, alcoholism and violence and the pervasive demoralisation seen in Aboriginal communities can be readily understood as the direct consequences of a history of dislocations and the disruption of traditional subsistence patterns and connection to the land". However, conversely, the First Nation communities with more "cultural control" factors such as employment of First Nations people in key positions in the community (such as the police) and with increased community governance appear to have less suicide (Chandler & Lalonde 1998).

A response to the significant disadvantage of Canada's First Nations Peoples, very much developed in the spirit of primary health as outlined in the Ottawa Declaration was the Canadian Aboriginal Horizontal Framework (Canada's Performance 2005). This government policy was co-ordinated between the Canadian Federal government and Provincial governments to address the disadvantage in Canadian First Nation social determinants across a "wide front". Leadership from the top was a key initial factor in the development of the Framework with the then Canadian prime minister Paul Martin committing to a round table discussion with all levels of Canadian government and First Nation leaders. A policy retreat with members of the Canadian Committee on Aboriginal Affairs and First Nations leaders followed. There was also a commitment to the development of an Aboriginal report card to track progress with the Canadian health strategy.

The Canadian Aboriginal Horizontal Framework was then developed as a strategic guide to funding priorities and co-operation between the various levels of government as well as allowing the establishment of performance indicators. The Framework appears to place the

"pillars" of health at equal value. The "pillars" were: Health, Lifelong Learning, Safe and Sustainable Communities, Housing, Economic Opportunity, Lands and resources and Governance and Relationships. Each of the "pillars" of the Framework was then be divided into "sub pillars". As an example, Safe and Sustainable communities were divided into: Community Infrastructure, Social Support and Community Well-being and Community Safety and Justice. Unfortunately, the policy appears to have been wound back following the election of the Conservative Government in Canada in 2006. However, the policy remains an important example of the way that a government can enact policy to remedy the broad range of disadvantage with financial "strategic pillars" attached to the relevant issues of "Primary Health" as outlined in the Ottawa Charter.

In Australia, Archaeological evidence suggests that Aboriginal people have been present for the last 45000-50,000 years. The ethnographic evidence from early contact suggests that Aboriginal people who survived infancy were relatively fit and disease free (Flood 2006). Further, Australia's native foods supported a nutritious, balanced diet of protein and vegetables with adequate vitamins and minerals with little salt sugar and fat. Life on the move kept people physically fit (*ibid*).

In terms of "mental health", traditional Aboriginal culture had a number of strong reinforcing factors that have been well defined by Professor(s) Helen and Jill Milroy (Milroy et al 2003). Aboriginal sense of self was seen in a collective sense, intimately connected to all aspects of life, community, spirituality, culture and country. The culture also provided for everyone through sharing rules and relationships and kinship were of prime importance, defining social roles. Aboriginal people were also given a sense of meaning and understanding of life experience through their connection to country and their Dreaming. Spiritual beliefs offered guidance and comfort and offered a sense of connectivity and belonging despite distress, death and loss. Lore, the body of knowledge that defined the culture and the tribal elders who contained and interpreted the Lore were highly valued. Customary law defined rules and consequences. Over 200 traditional languages and other methods of communication allowed a rich expression of interaction in the above social context and formal ceremony allowed a method of dealing with life's transitions thought birth, initiation and death. Men and women had defined economic and cultural roles within the tribe. Children were well protected within the group with a range of "aunties" and older siblings able to take over the child care role if the mother was stressed.

Franklin and White (1991) describe the elements of destruction of this optimum physical and mental good health of the Aboriginal people following the British colonization of Australia in 1788. These elements were the introduction of new diseases, the removal of ancestral land which led to psychological distress and spiritual despair and the herding of Aboriginal people into reserves and settlements, destroying lifestyle and leading to marginalisation and poverty. Other specific policies such as the Stolen Generations from the 1930s to the 1960s where Aboriginal children were forcibly removed from their parents and raised in Mission settlements reinforced government social Darwinist ideology and led to the destruction of family life with resulting emotional desolation for many individual Aboriginal people.

The current significant disadvantage of Aboriginal health and social determinants is well recognized. Hospitalization rates for cardiovascular disease in Aboriginal and Torres Strait Islander was 80% higher than for other Australians in the North West of Australia in 2002 to 2004. (AHMAC 2006) Rheumatic heart disease was nine times more common for Aboriginal and Torres Strait Islanders than other Australians (*ibid*). Diabetes and renal failure also figure prominently in Aboriginal health issues. In 2004-2005, three times as many Aboriginal

and Torres Strait Islanders were reported to have diabetes compared to other Australians (ibid). Hospitalization rates for Aboriginal and Torres Strait Islander people with diabetes are six times higher than for other Australians (ibid). End Stage Renal Disease, often the consequence of poorly controlled diabetes was eight times higher for Aboriginal and Torres Strait Islander peoples than other Australians (ibid). Given these alarming health statistics, it is not surprising that life expectancy for Aboriginal and Torres Strait Islander people is 17 years less than for other Australians (ibid), an issue now well recognized in the "CLOSETHEGAP" (HREOC 2008) agenda.

Aboriginal and Torres Strait Islander disadvantage is also apparent in other social indices. The 2002 National Aboriginal and Torres Strait Islander Social Survey estimated that 26% of the Aboriginal and Torres Strait Islander population over 15 were living in overcrowded housing. The overcrowding becomes more apparent in remote areas where it is estimated that 62% of Aboriginal and Torres Strait Islanders live in overcrowded housing (AHMAC 2006). In respect to education, the National Schools Statistics Collection reported that the retention rate of Aboriginal and Torres Strait Islander students in Year 7/8 to Year 10 was 88.3% compared to 98.6% for other students. Unfortunately, the retention rate for Aboriginal and Torres Strait Islander students from Year 7/8 to year 12 of high school was only 39.5% compared to 76.6% for other students (ibid). Given this trend in education, the accompanying statistics of significant Aboriginal and Torres Strait Islander disadvantage in employment and income to the rest of Australia are no surprise along with data from the prisons that shows that Aboriginal and Torres Strait Islander people are twelve times more likely to be in prison compared to the remainder of the Australian population (ibid).

Poverty and racism also provide a framework for the above statistics. Walter & Saggars (2007) point to the significant association between poverty and adverse health outcomes. They note that a significant proportion of Australia's Indigenous population live in a situation of "absolute poverty" as defined by the United Nations where they have severe deprivation of basic human needs including food, safe drinking water, sanitation facilities, health, shelter education and information. Some diseases such as scabies and diarrhea are directly related to inadequate sanitation and living conditions (ibid). The issues of Indigenous poverty appear particularly marked in rural areas. In addition, the failure of a recent plethora of policies to advance Aboriginal health has been attributed to a pervasive culture of "welfare colonialism", an aspect of continuing poverty. "Welfare Colonialism" (Anderson 1997) affects Aboriginal communities where most Aboriginal populations rely heavily on the provision of public sector resources. Over time, the mechanisms to deliver these overlie the traditional methods of Aboriginal governance, reducing the capacity of the communities to develop leadership in the solutions to their problems. In addition, the continuing experience of widespread racism against Aboriginal people generally within the Australian community appears to have a continuing negative effect, particularly on the mental health of Aboriginal people (Paradis 2007).

The Australian government policy environment has also recently produced a number of innovative solutions in respect of government approaches to the above Aboriginal and Torres Strait Islander disadvantage leading to the formal Council of Australian Governments financial funding strategy, the National Indigenous Reform Agreement. The Agreement in 2008 was prefaced by a paper written by Ken Henry, Secretary of the Australian Treasury. Henry (2007) suggested a broad based approach across Australian Government Departments to address Aboriginal and Torres Strait Islander health disadvantage, similar in some ways to the Canadian Framework. Henry described three key

interdependent foundations to current Aboriginal and Torres Strait Islander disadvantage in Australia. Poor economic and social incentives, the underdevelopment of human capital and an absence of the effective engagement of Aboriginal and Torres Strait Islander Australians in the design of policy frameworks that might improve these incentives and capabilities. Henry commented that he and other Secretaries in the Australian Government Secretaries Group on Aboriginal and Torres Strait Islander Affairs had identified seven platforms that need to be prioritized within a framework of Aboriginal and Torres Strait Islander capability development. These included: basic protective security for women and children, early childhood development, a safe and healthy home environment, an accessible primary care health service, ensuring that incentives in the welfare system do not work against promotion of investment in human capital, real job prospects as a result of education and governance systems that support political freedom and social opportunities of local Indigenous people to be engaged in policy development.

The proposal by Henry resulted in the formation of the Council of Australian Governments National Indigenous Reform Agreement in 2008. The building blocks of the strategic financial agreement between the Australian Federal and State Governments were based on the primary care principles outlined in the Ottawa Charter. The Building Blocks outlined by the Agreement are: Early Childhood (early learning, development and socialization opportunities), Schooling (infrastructure, workforce, curriculum, student literacy and numeracy achievement, and opportunities for parental engagement and school/community partnerships), Health (access to effective, comprehensive primary and preventative health care), Economic Participation (real jobs, business opportunities, economic independence and wealth creation), Healthy Homes (adequate water and sewerage systems, waste collection electricity and housing infrastructure), Safe Communities (improved, accessible law and justice responses, effective policing, "safe houses", child protection and alcohol policy) and Governance and Leadership (capacity building so that Indigenous Australians can play a greater role in exercising their rights and responsibilities as citizens) (COAG 2008). The Agreement also has specific funding of \$ 4.6 Billion overall for the "Building Blocks" to allow their progression by the Australian Commonwealth and State governments. COAG continues to monitor the progress and outcomes of the funding strategy.

The above discussion of government programs for the Indigenous peoples of Canada and Australia shows that government is able to construct realistic funded policy initiatives based on the accepted international principles defining primary health.

5. The Recovery Movement in mental health

The Recovery Movement in mental health has gained increasing momentum in recent years. Leff & Warner (2006) note that " the model refers both to the subjective experiences of hope, healing, empowerment and interpersonal support experienced by people with mental illness, their carers and service providers and to the creation of recovery-oriented services that engender a positive culture of healing and a support for human rights". The authors add that, as a result of the Recovery Movement, there is renewed interest in fighting the stigma that leads people with mental illness to lose their sense of self, to provide access to the services and education that give consumers the knowledge and skills to manage their illness, empowering consumers to share responsibility with providers in the healing process and providing access to peer support that validates the possibility of recovery (*ibid*). Recent discussion about the Recovery Movement has also focused on the "capabilities" approach of

Amartya Sen. Davidson et al (2010) note “the capabilities approach diverts our attention away from the possession of resources to the exercise of freedoms. This shift is not meant to deny the crucial role that resources play in social and political life but rather places emphasis on the fact that the usefulness of wealth lies in the things that it allows us to do—the substantive freedoms it helps us to achieve”. The authors go on to argue that Sen’s concepts of active agency and freedoms should apply to the “here and now” in respect to people’s choices on a daily basis rather than some theoretical ideal future. In addition, the pursuit of agency generates diversity as each individual will pursue such agency according to individual need and a supporting system needs to accommodate such diversity (*ibid*). The end result should be to “increase the access of people with serious mental illness to opportunities and supports that allow them to live a decent and self determined quality of life” (*ibid*). Sen’s economic concepts are also closely aligned to emerging discussions of social capital that are discussed later in the chapter.

Piat et al (2010) review a range of government initiatives to develop the recovery model. The US President’s New Freedom Commission identified a fragmented health system and gaps in care as obstacles to recovery and this led to all 50 US States adopting recovery mission statements and implementing at least one evidence-based service. In New Zealand, discrimination and stigma were identified as most problematic and this led to a significantly enhanced role for psychiatric patients (consumers) within the system with good consumer-provider being identified as a key indicator for recovery orientated services (*ibid*).

Unfortunately, the economic basis of supporting effective recovery does not appear to have matched the theoretical process of empowerment and particularly so in the developed world. The observation that people suffering from schizophrenia often have a better outcome from disease in the third world (Warner 1986) may be related to the situation where economic opportunity (such as having meaningful work on a family farm or in a family kitchen) along with a place to sleep and adequate diet may be much easier to provide within the economic restraints and social supports of third world countries. Warner (*ibid*) has also commented on the nature of work in less developed countries that may be protective for someone suffering from severe mental illness. He notes that the person’s family is less likely to emotionally smother the individual and the tasks allocated to the individual are likely to be geared to the level of performance that the person can actually achieve. In comparison, the costs of providing adequate housing and meaningful employment to individuals in developed countries are often significantly higher. In addition, it often has been difficult for governments to provide coordinated sustained funding for such programs across a range of different government departments that have responsibility for each program. The difficult task of addressing the above issues in the developed world is exemplified in a recent evaluation of the cost of mental illness in Canada in 2003. The review found that the cost of undiagnosed mental illness was about 28% of a total cost of \$50,847 million dollars with direct medical costs of treating mental illness contributing only about 10% of this amount with the remainder being attributed to lost productivity (Lim et al 2008).

6. The Australian mental health plans and the Canadian Mental Health Commission

Federal Governments in both Australia and Canada have attempted to develop strategies to enhance services for those people affected by severe mental illness in a variety of ways.

Since the early 1990's, the Federal, in co-ordination with the State and Territory Governments of Australia have developed four successive mental health plans through the Australian Council of Health Ministers. The most recent plan of 2009-2014 has the following five priority areas for government action in mental health:

1. Social inclusion and recovery
2. Prevention and early intervention
3. Service access, coordination and continuity of care
4. Quality improvement and innovation and
5. Accountability - measuring and reporting progress. (DOHA 2009)

The authors of the plan note that "the plan is ambitious in its approach and for the first time includes a robust accountability framework. Each year, governments will report progress on implementation of the plan to the Council of Australian Governments. The plan includes indicators for monitoring change in the way the mental health system is working for people living with mental illness as well as their families and carers. Health ministers have agreed to develop targets and data sources for each of the indicators in the first twelve months of the plan." (ibid). Although the plan stresses "A Whole of Government Approach", it is unlikely that it will develop the appropriate sustained funding strategy to support outcomes similar to that initiated by the Council of Australian Governments National Action Plan on Mental Health 2006-2011 (COAG 2006), a government response to substantial deficiencies in public mental health provision outlined in the "Not For Service" Report (MHCA 2005). This contrasts with the normal rather disorganised system of mental health funding in Australia where one recent review (AHHA et al 2008) commented "there is still no single agency, organization or level of government with the remit and responsibility for the setting of strategic mental health policy or for the oversight, monitoring or operationalisation of mental health care. Funding methodologies and funding amounts vary between jurisdictions and have traditionally not been based on population need. This and the range of agencies and providers involved in the provision of mental health care has lead to inequities in access, service provision and health outcomes".

The Canadian Government established the Mental Health Commission for Canada in 2007. After extensive consultation with a range of stakeholders in Canada, the Commission published its strategy document in 2009 (MHCC 2009). The strategy has seven goals: the engagement of people suffering from mental illness in the process of recovery, mental health promotion and mental illness prevention, a responsive mental health system, recognition of the role of families, equitable and timely access to effective treatments and support, actions informed by best evidence with measurable outcomes and support for research and social inclusiveness (ibid). The Commission was allocated \$130 million by the Canadian Federal Government for 10 years in 2008 with the money being targeted towards the three key initiatives of the Commission which were to conduct a 10-year anti-stigma campaign, build a pan-Canadian Knowledge Exchange Centre, and elaborate a national mental health strategy for Canada (Government of Canada 2008). However, there does not appear to be any overall funding strategy for mental health in Canada apart from this with services being provided through its Medicare system and mental health services bundled in with other general health services through the Regional Funding Authorities within each Province (Block et al 2008). It has been estimated that funding of mental health for Canada in 2003-2004 was 5% of total health spending which was lower than most developed countries (Jacobs et al 2008). Other authors have argued that the funding models of Medicare in Canada have led to the restriction of community services and other professional services

such as psychologists for people suffering from mental illness (Mulvale et al 2007, Moulding et al 2009)

7. A new paradigm for mental health funding

Given the complexities of developing sustainable funding models for mental health, one solution would be to develop policy and funding strategies around a series of "pillars or "building blocks", similar to the Canadian Aboriginal Horizontal Framework and Council of Australian Governments National Indigenous Reform Agreement. This would align government policy to internationally accepted principles of health care and may allow a broader government overview and responsibility for the various components necessary to develop mental health. Funding could be allocated to each "pillar" and benchmarks attached to each pillar to assess progress. The "pillars" suggested are: Physical Health, Social Inclusion, Education, Effective Treatments, Substance Abuse, Mental Health Response to Disaster, Housing and Governance. Each one of these will be discussed in turn with a view to relevance and with mention of previous and current programs that could provide a basis of funding.

8. The physical health of people suffering from severe mental illness

There is a significant amount of information that people who suffer from serious mental illness also are at increased risk of increased morbidity and premature mortality from co-morbid medical illness. Viron & Stern (2010) talk of patients suffering from severe mental illness losing over 25 years of potential life with 87% of years of potential life lost being attributable to medical illness. They further comment that the mortality gap, based on data from 1997 to 2000 is 10 to 15 years wider than it was in the early 1990's. Observations at the beginning of the twentieth century noted that physical morbidity and mortality were greater amongst psychiatric patients than in the general population. Other commentators have noted the lack of thorough medical evaluation and inadequate treatment of medical disorders amongst psychiatric patients (Felker B et al 1996). The issue of co-morbid medical conditions is particularly prominent in patients suffering from schizophrenia. This is not surprising given the social isolation, problems with adequate housing and the lack of organisation of proper meals and poor diet reported for this group of patients (Jablensky et al 2006, Brown et al 1999). High rates of tobacco and other substance use in this group also add to the disease burden (Jeste et al 1996).

Apart from the obvious issues of significant disability related to the illness process itself, there also appear to be a number of medical and health system barriers to recognition and management of medical illness in people with schizophrenia. Such barriers include a reluctance of non-psychiatrists to treat people with serious mental illness, frequent changes of treating doctor, lack of adequate follow up due to patients' itinerancy and lack of motivation and the available time and resources for an appropriate review of medical issues of people who may be uncooperative or have trouble communicating their physical needs (Lambert et al 2003). Higher rates of poverty in those experiencing severe mental illness (d'Amore et al 2001) along with stigma related to the experience of mental illness (Barney et al 2006) may also be further barriers patients with mental illness developing an effective relationship with a General Practitioner. The atypical antipsychotic medications may also lead to an increased prevalence of endocrine disorders such as Type 2 Diabetes (Lambert & Chapman 2004), thus necessitating increased medical vigilance in this regard.

As a way of attempting to improve the co-ordination of the care of medical illness in those patients with serious mental illness, there has been a significant stimulus to develop shared care models between psychiatric specialists and general practitioners. Such models include a Consultation-Liaison model (Gask et al 1997), collaborative case discussions between specialist psychiatrists and groups of General Practitioners (Davies et al 1997) and shared care projects with extensive education for involved General Practitioners (Meadows 1998). There have also been substantive improvements in remuneration for shared care in Australia with the Medicare Plus program encouraging a collaborative care mode.

The General Practice Clinic operated within a mental health service (Symonds & Parker 2007) compensates for a number of the barriers to health engagement discussed above and allows for a high quality of health care with extended clinical review times and health screening significantly above the Australian national average. Other recommendations for improved health care for people suffering from severe mental illness are: improved health screening and health promotion along with systemic models of medical and mental health care integration such as the VHA system in the USA (Viron & Stern 2010). Increased awareness by psychiatrists of the metabolic effects of psychotropic medication along with improved information to carers of people affected by severe mental illness in respect to appropriate medical care (De Hert et al 2010). Better co-ordination of a range of specialist services such as occupational therapists, pharmacists and dieticians in respect to the medical health care of people affected by severe mental illness may also be useful (Heald et al 2010).

9. Social Inclusion

A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person into the community (Cappo 2002). Leff & Warner (2006) have outlined factors that lead to social exclusion for people affected by severe mental illness. These include the disabilities produced by the illness itself (such as the negative features of schizophrenia which include apathy and reluctance to engage with others), disabilities produced by professional care (including institutionalization and side effects of medication), stigmatizing attitudes of the public and self stigma of individuals (which may affect recognition of illness and ability to obtain appropriate treatment), media influences, poverty and discrimination in housing and employment.

Some of these factors are going to be considered in other sections of this chapter. The key focus on this area of social inclusion in the current context is addressing stigma and the maintenance of people suffering from severe mental illness within their social group. Sartorius (2010) discusses a range of barriers to effective campaigns to reduce stigma. He notes that anti-stigma campaigns have to be longer than a year to be effective. Sartorius comments that other factors that have been proven to reduce stigma such as legislation to effect employment and housing, ongoing promotion of useful strategies (such as education of health care professionals, public education forums for members of the public by people who have suffered from mental illness and avoidance of pejorative comments in the media) and permanent networks of interested business people, professionals, patients and their families that respond to local issues within cultures and communities.

To an extent, the *headspace* Model of Care for young people suffering from severe mental illness in Australia attempts to fulfill some of the above requirements in an organizational

sense. A principal aim of *headspace* is “to establish a highly accessible, more specialized multidisciplinary model of care to target the core health needs of young people” (McGorry et al 2007). To enable these objectives, *headspace* has developed a number of funded centers within Australian local communities with the aim of building greater awareness of youth mental health within these communities and building capacity within these communities to ensure early detection and early intervention of emerging mental illness and substance use disorders, create a youth and family friendly environment, benefit from significant improvements in access, service integration and quality through co-location, secondment of clinical staff and outreach and access evidence-based interventions for the treatment of mental and substance use disorders (*ibid*).

The engagement of family members of people suffering from severe mental illness in the treatment process is crucial. This is because of the therapeutic value that family members may bring to the care of the person through their knowledge of expert and longitudinally developed information about the person which is helpful for appreciation of psychosocial deficits and current mental state in addition to their involvement in any case planning for the person’s further management (Furlong & Leggatt 1996) Further evidence that therapeutic family interventions, particularly behavioural education, in reducing relapse for people suffering from schizophrenia and thus improving the cost-effectiveness of treatment (Mihalopoulos et al 2004) add emphasis to the value of family intervention in the illness.

The psychological effects of any chronic illness in relation to the family members of the person so affected are well recognised (Bloch et al 1994) Such factors include the issues surrounding the illness itself (acute onset, chronicity, acute exacerbation), the life-cycle stage of the family and the meaning of the illness to the family. Such “meaning” will be influenced by the family’s previous experience of illness and belief systems about illness (*ibid*). Whilst these issues are relevant in the case of family members of someone suffering from schizophrenia, there is additional evidence of the devastating additional effect of the illness on family, leading to comments such as that recently made in a textbook of mental health law that “like other service providers but perhaps more than other service providers, the family and friends of the individual will have an emotional and practical interest in the fate of that individual” (Bartlett & Sandland 2003)

The family burden of living with a person suffering from a major mental illness such as schizophrenia is well described. It has been noted that stigma associated with the illness spreads to the whole family and may cause them to avoid talking about how they are feeling or deem themselves as social outcasts, leading to barriers between them and mental health professionals (Teschinsky 2000)

Recent reviews of the pressures faced by carers of people suffering from severe mental illness describe the “Objective Burden” that involves disruption to the household routines, finances and relationships and a “Subjective Burden” which involves the psychological consequences of the individual’s illness for the family (Martens & Addington 2001, Wong et al 2008). The “Subjective Burden” of the illness appears to be higher for relatives of people experiencing first onset illness associated with schizophrenia (Martens & Addington 2001) and promotes the beneficial therapeutic value of psycho-education for the family in respect to information about the illness, illness management skills, communication skills and problem solving skills (Motlova 2007) therefore being an effective way of reducing this distress through empowerment of family members. Culture and differing family belief systems may be particularly important in this regard (Lesser 2004) The legal issues of confidentiality allowing such engagement with families are complex but can be negotiated

in legislation, such as recent Mental Health Acts in Victoria and the Northern Territory of Australia (Parker et al 2010)

Participation in the workforce is an important factor in social inclusion. Warner (1983) comments that a key factor for any work for people affected by severe mental illness is that there should be stable expectations geared to the level of performance that the individual can actually achieve and this is more difficult to achieve in industrial society where there are high productivity requirements and competitive performance ratings. Further issues that may interfere with effective workforce participation in developed countries are co-morbid substance abuse and physical illness (Cornwell et al 2009). Employment programs for people affected with severe mental illness that are integrated into public mental health services appear to be one way to improve outcomes. One example of this is the Individual Placement and Support Approach in the United States that has been found to have almost a three fold increase in employment participation (60% versus 22%) (Waghorn et al 2007). A recent collaboration between Mental Health Services and the Vocational Education Sector in New South Wales that integrates supported education along with supported employment for mental health consumers is hoping to have similar results, maximising chances for consumer choice in employment and enhanced long term employment outcomes (VETE 2011, J McMahon pers comm). Apart from the economic benefits of the participation of people affected by severe mental illness in paid employment, there are also other personal benefits for those such engaged such as increased pride, self esteem, empowerment and facilitation with coping (Dunn et al 2008).

A range of issues may assist with social inclusion of individuals affected by severe mental illness in the third world. It has been noticed that cultural mechanisms may be more accepting of mental illness in these countries (Kermode et al 2009, Postert 2010). However, Rahman & Prince (2008) note that there is a significant amount of stigma experienced by families of people affected by severe mental illness in third world countries. They go on to suggest the incorporation of mental health treatment into primary care services as a way of reducing this stigma along with the training of primary care workers in the use of psychotropic medication. It has also been noted that regular use of such medication (with a subsequent reduction of difficult behaviours) may lead to greater social function and acceptance of the person within their community (de Jong & Komproe 2006).

10. Education

It has been recognised for a considerable period of time now that education in itself leads to empowerment in health. The review by DeWalt et al (2004) displayed that patients with poor literacy had poorer health outcomes including knowledge, intermediate disease markers, measures of morbidity, general health status and use of health resources. Cutler and Lleras-Muney (2006) suggest a range of mechanisms for education to enable health behaviours. They note that the effect of education increases with increasing years of education. Education in relation to income and occupational choice has some relationship to health empowerment but that different thinking and decision making patterns as a result of increased education may also have significant effects on health behaviours.

Henry (2007) comments on required "development platforms" which need to be in place for education to be effective. These include: security from violence, promotion of early childhood development, a home environment that is conducive to regular patterns of sleep and study, free from overcrowding and distraction and ready access to suitable primary health service

infrastructure. A good example of the essential nature of such platforms to improved educational outcomes has been the success of the Clontarf Foundation education programs with Indigenous male adolescents in Australia. The Clontarf Foundation, a not for profit organisation, was established in Western Australia in 2000. It was established to improve the discipline, life skills and self esteem of young Aboriginal men so that they can participate meaningfully in society. The Foundation currently has contact with 2000 young Aboriginal men in Western Australia and the Northern Territory. The Foundation's programmes to young Aboriginal men are delivered through a network of 25 Academies, each of which operates in partnership with (but independently of) a school or college. Australian Rules Football (AFL) is used to attract the young men to school and then keep them there. In order to remain in the program, participants must continue to work at school and embrace the objectives of the Foundation. Each Academy has an individual staff member who, in addition to delivering the football program, acts as a mentor and trainer addressing many of the negatives impacting on the young men's lives. Many of the Academy staff are ex AFL players. Participation by young Aboriginal men in the Clontarf Foundation has resulted in significantly increased retention rates for the participants through to the completion of secondary education and then on to participation in the workforce. By the end of 2008, 41 (76%) graduates of the 2007 program were employed. In April 2009, 51 of the 76 graduates of the 2008 program were in full time employment (Clontarf Foundation 2010)

Examples of successful education programs in mental health are: initiatives to improve mental health literacy, education programs to empower carers of people affected by severe mental illness and mental health training for police.

Health literacy appears to be a key component of improved education and health outcomes. Health literacy has been defined as "the ability to gain access to, understand and use information in ways which promote and maintain good health (Jorm et al 1997) Jorm and his colleagues found that health literacy in respect to mental health was not well developed amongst a sample of the Australian population and that this lead to unwillingness to accept help from mental health professionals or to a lack of adherence to advice given (ibid).

A potential solution to poor health literacy are the "mental health first aid training programs" developed for the Aboriginal and Torres Strait Islander Population of Australia (Kanowski et al 2009) in addition to the wider Australian population (Kitchener & Jorm 2006). The programs aim to provide help to a person developing a mental health problem or in a mental health crisis (Kanowsky et al 2009) and are aimed at Instructors who develop the skills for staff working in Aboriginal and Torres Strait Islander primary health organisations. The programs are based on education about a range of symptoms of mental illness as well as a response to a range of potential mental health scenarios such as helping a suicidal person, a person experiencing a panic attack, a person who has experienced a traumatic event and a psychotic person who is perceived to be threatening (Kitchener & Jorm 2006). It was estimated that in 2005, 350 people who worked area health services, non government organisations, government departments or as private practitioners had completed the Instructor training in Australia (ibid).

A further, school based initiative in mental health literacy is the "Mind Matters" Curriculum that was developed for Australian Secondary Schools (Wyn et al 2000) The project is based on a model of school change developed by the World Health Organisation and involves curriculum materials about emotional and mental health issues in addition to creating a school environment that is safe, responsive to student needs and that assists students in their ability to cope with challenges and stress (ibid).

Psycho-education for the family involving information about the illness, illness management skills, communication skills and problem solving skills (Motlova 2007) has been demonstrated to be an effective way of reducing this distress. It has been shown that, as a result of the training, families become empowered to better manage their relative's mental illness and their reactions to it. A recent evaluation of formal group training provided to carers of people affected by early psychosis resulted in the carers reporting less isolation, improved confidence, greater understanding of psychosis, reduction in guilt and increased confidence in their caring role (Riley et al 2011).

Education of other professional groups who have involvement with people affected by severe mental illness is also an important aspect to the strategy to improve knowledge and skills and effect better management of these individuals. A good example of this is the Mental Health Intervention Team Course offered by the New South Wales Police Force (Donohue D et al 2009). It is recognised that police often are at the fore front of interactions with people who are severely affected by mental illness and may significantly aroused as a result. Kesic et al (2010) in a review of fatalities as a result of interaction with police in Victoria found that 54.2% (26/48) of the victims had a history of DSM IV Axis I disorder, 39.6% of the 48 events had a history of substance abuse/dependence, 10.4% had formal diagnosis of Axis II personality disorder and that 87.5% were known in some capacity to mental health services or police. It was also estimated that in any given year, Currently New South Wales Police Officers can expect to attend approximately 22,000 mental health related incidents (about 30% of total call outs per year) with some of the incidents posing the biggest risk to their safety (Donohue et al 2009).

The New South Wales Police Mental Health Intervention Team course runs over four days and includes formal education sessions in respect to mental illness, substance abuse, legal issues and available services in addition to "real situation" education scenarios such as role plays. The formal aims of the course are: to reduce the rate of injury to police and mental health consumers on interaction, improve awareness amongst front line police of the risks involved in mental health incidents, improve collaboration with other government and non government agencies in the response to, and management of mental health crisis incidents and reducing the time taken by police in the handover of mental health consumers to the health care system. An important aspect to the education is the participation of mental health consumers and carers in educating police about the way that they are affected by symptoms and the way that they would like to be approached during acute exacerbations of their illness. The effect of severe mental illness on the carers was also well appreciated by the police participants of the course that I attended and police commented that they found the sessions with mental health consumers and carers some of the most valuable learning that they took from the course. Police (ranging from Area Commanders to constables) who attend the course are awarded a course badge as a formal "police appointment" to be worn on their uniform at the conclusion of the course. To an extent, this also allows people who are severely affected by mental illness and who are in crisis to recognise that attending police, wearing the badge, have training to assist them.

11. Effective treatments

Effective treatments (underpinned by rigorous and continuing research) are an essential component of any broad strategy for quality mental health service delivery. The treatments have specific costs that obviously inform public policy in respect to what particular

economies and cultures are prepared to fund. As an example, the Tolkien II team have estimated that the average cost of treating a case of depression in Australia in 2005 was \$175,566 with psychological therapies and medication. Tolkien II Team (2006). Effective therapeutic interventions are also a major area of concern for key stakeholders of mental health services with this area being considered most important in a recent European survey of Mental Health Recovery initiatives (Turton et al 2010).

A crucial issue that informs the above economic models is the use of Evidence Based Practice as a gold standard for funding decisions. There are complexities with this issue, however. Tanenbaum (2005) defines three potential controversies and a caveat in respect to evidence base practice in mental health policy. The first controversy is how restrictive should the definition of the evidence be and whether dominant definitions privilege some forms of treatment over others. The second controversy raised by Tanenbaum is that there is a significant difficulty translating research findings into clinical practice and this relates to a larger controversy in mental health about whether practice is in fact applied science. It also focuses on a significant paradox where the ‘significantly filtered’ study populations of pharmaceutical trials often have little in common with the complex patients treated by clinicians (Westen 2005). Tanenbaum’s third controversy is “the definition of *effective* health care and who decides the benchmarks for *effectiveness*”.

Notwithstanding the above controversies, there has been increasing emphasis in recent times on evidence based guidelines for the treatment of mental illness with initiatives such as the American Psychiatric Association Practice Guidelines (APA 2011) and the Clinical Practice Guidelines introduced by the Royal Australian and New Zealand College of Psychiatrists (RANZCP 2011)

However, research has consistently shown that education efforts alone do not appear to strongly influence healthcare provider practitioner behaviours in comparison to a range of factors that have been demonstrated to influence such behaviours such as consumer demand for services, financial incentives and penalties, administrative rules and regulations and feedback on practice patterns (Mueser et al 2003). The authors go on to suggest six Evidence-Based Packages that may be useful in the management of people affected by severe mental illness. These are collaborative psychopharmacology, assertive community treatment, family psycho education, supported employment, illness management and recovery skills and integrated dual diagnosis treatment. Mueser et al also propose an implementation strategy for the packages that will enhance their success. These involve standardized complementary training and consultation packages for mental health centres in addition to discussion with health authorities in respect to financing, regulatory and contracting mechanisms to support the introduction of the Evidence-Based Packages (*ibid*). Specific attitudes of mental health providers that may need to be addressed in the adoption of Evidence-Based Packages are the intuitive appeal of the package, the strength of the requirement to adopt the package on the individual, the openness to new practice and the divergence of usual practice with research based/ academically developed interventions (Aarons 2004)

Further issues that considerably affect the implementation of evidence based practice are the pressure on policy makers to justify the allocation of resources and demonstrate add on value, the need for practitioners to have confidence in the likely success of implementing the interventions and that the people who are likely to benefit see that the program and its process of implementation are participatory and relevant to their needs. A further challenge is the application of existing evidence to good practice on the ground, particularly in disadvantaged and low income countries (Barry & McQueen 2005)

Given the above difficulties, an effective best practice model will probably be optimally provided by a knowledge of basic science, best evidence via knowledge of epidemiology and randomised controlled studies along with interpretation and individualisation related to clinical experience and available resources (Belmaker R pers comm.). However, effective treatments will continue to be a constant objective of appropriate funding priority in mental health and require a governance mechanism to review their ongoing usefulness and economic priority.

12. Substance abuse and mental illness

In the current era, no effective mental health policy can be expected to succeed without some measures to control substance abuse that precipitates and sustains mental illness. Although this area is complex and may appear somewhat overwhelming, a brief overview of a major area of practice and public health appears to show a number of factors worthy of policy intervention in a broad sense.

There is substantial evidence that children exposed to trauma in their domestic environment are at later risk of severe mental illness such as schizophrenia (Harley et al 2010) and substance abuse (*ibid*). There are a number of explanatory models for this with stress exacerbating genetic vulnerability to mental illness (Xie et al 2009) and people using substances to self medicate PTSD resulting from childhood trauma as well as increased substance abuse in the context of dysfunctional personalities (Jonson-Reid et al 2009))and aberrant emotional attachment (Rees 2005).

Alcohol abuse continues to be a major contributor to childhood trauma (Nelson et al 2010) with the children of alcoholic parents exhibiting higher rates of anxiety and depression (Eiden et al 2009). In addition, alcohol has further effects such as the higher rates of anxiety and depression in children affected by foetal alcohol syndrome (Hellemans et al 2009)

There is also a growing body of evidence in respect to the close association of substance abuse and mental illness, particularly in respect to cannabis and amphetamine abuse. Paparelli et al (2011) in their review article point to emerging consistent evidence between cannabis abuse and an increased risk of psychiatric symptoms and chronic illness. The authors also discuss the increased risk of psychosis as a result of repeated amphetamine and methamphetamine abuse and point to evidence of probable neuronal damage due to repeated methamphetamine abuse. The issue of brain damage related to amphetamine use was also demonstrated in a recent pilot study that appeared to show that 1:5 of young people who presented to a hospital ED in the context of amphetamine abuse had an occult brain lesion, as a result of their amphetamine abuse, on MRI scans (Fatovich et al 2010).

A range of strategies have been suggested for successful intervention with mental illness and substance abuse. Legislative measures such as increased excise on alcohol, improved policing of drink driving and reducing availability of alcohol to young people through a minimum legal purchase age have been shown to be highly effective in reducing alcohol related harm in Germany (Walter et al 2010). Recent information from Australia indicates that improved policing in respect to amphetamine abuse may have been a factor in reducing inpatient admissions from psychosis secondary to psycho-stimulants (Sara et al 2011). Innovative primary care approaches to managing cannabis abuse (Lubman & Baker 2010) and stimulant abuse (Frei 2010) have also found to be useful. Such management approaches involve improved screening for substance abuse and mental health problems, education and self monitoring for affected individuals, developing harm reduction strategies and patient empowerment through exploring options for change and negotiating a change plan.

13. Mental health response to disaster and trauma informed care

Some of the earliest written records in human history from Sumeria in 2000BC record the anguish and suffering of the population following the destruction of Nippur (Kinzie & Goetz 1996). In more modern times, there has been increasing recognition in a more rigorous scientific manner on the significant psychological and psychiatric sequelae resulting from people affected by disasters (Norris et al 2002)

This increased recognition has also occurred in the co-incident context of political recognition of high public expectation in respect to the quality of services that government in the developed world provides to its citizens involved in a disaster. As an example of this the British Foreign Secretary, Jack Straw, on the anniversary of the 2004 tsunami, apologised to British families caught up in the disaster who had not received adequate support, commenting that British citizens have "very high expectations of what the British government can deliver and fair enough" (Eyre 2008). This co-incident context is of significant concern given projected estimations that in Australia, 65% of men and 50% of women may be exposed to a traumatic event during their lifetime (Forbes et al 2007) and with the current prevalence for PTSD being 1.3%, or 20,000 cases per year (*ibid*).

In recent years, there also has been increased identification of the effect of historical trauma as a subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes and how this intergenerational trauma can lead to the breakdown of a functional society (Atkinson et al 2010). In this context, Professor Helen Milroy (pers comm) also describes the phenomenon of "Malignant Grief" as an end result of persistent intergenerational trauma and stress experienced in Australian Indigenous communities. Professor Milroy defines Malignant Grief as a process of irresolvable, collective and cumulative grief that affects Australian Indigenous individuals and communities. The grief causes individuals and communities to lose function, become progressively worse and ultimately leads to death. Professor Milroy further comments that the grief has invasive properties, spreading throughout the body and that many of Australia's Indigenous people die of this grief.

Enhanced clinician skills for clinicians to assist people affected by disaster and trauma as the need arises can be incorporated into organisational development within mental health services (Guscott et al 2007). On occasion, specific programs may need to be developed to address mass population trauma such as the one organised by the Peking Institute of Mental Health to assist clinicians and volunteers working with the Chinese population effected by the Sichuan earthquake in 2008 (Parker et al 2009). In addition, enhanced education resources devoted to the appropriate response of mental health clinicians to those affected by disaster (Ursano et al 2007) can guide appropriate economic and managerial responses by governments and health organizations.

14. Housing

Homelessness amongst people affected by severe mental illness is a continuing concern. In a recent series of nationwide meetings to discuss mental health policy and service provision in Australia, the lack of appropriate housing for the mentally ill was a consistent and significant theme in the discussions amongst a wide group of stakeholders (R Irving pers comm.). It has been estimated that 46% of homeless people in the United States may have a mental illness (O'Hara 2007) with another review estimating prevalence rates of psychosis at around 10 to

13% and a prevalence of affective disorders at around 20 to 40 % in homeless people (Schanzer et al 2007) Homelessness is also associated with higher rates of readmission to inpatient units along with longer inpatient stays (*ibid*). Additionally, homelessness is linked with excess mortality and particularly so with homeless people who abuse substances (Morrison 2009). Poverty, disabling health, behavioural issues co morbid substance abuse, competition for available public housing stock along with complex processes in applying for such stock all limit the opportunity for the mentally ill to access appropriate housing (O'Hara 2007). In addition, conventional categorical funding streams, bureaucratic program requirements, narrow administrative approaches to resource allocation and management and staff skills not geared to supporting the mentally ill in normal housing have been thought to have limited successful involvement by mental health services in this area (*ibid*).

It has also been noted that housing is a significant aspect of the recovery for people affected by severe mental illness with the concept of a "home" providing "roots, identity, security, belonging and a place of emotional wellbeing" (The PLoS Medicine Editors 2008). The "home" concepts that appear to be valued by the mentally ill are considered to be markers of ontological security: namely constancy, daily routines, privacy and a secure base for identity construction (Padgett 2007). It appears that different levels of housing support may be appropriate in this regard with supervised housing being more appropriate for people with severe disability from mental illness with a graduation to independent housing in the context of recovery (Tsai et al 2010).

Apart from the humanitarian aspects of the provision of a "home" to enhance recovery for people affected by severe mental illness, there also appear to be economic benefits generally with potential savings from repeated and lengthy hospital admissions that should encourage further strategies in this area.

15. Governance

The development of effective governance processes to enable the mental health of a population should be the major concern of any government and health authority. Effective governance processes should have a continuing "flow on" effect over many years with demonstrated benefit for people affected by severe mental illness, their families and communities. Mulvale et al (2007) point to the way that historical factors can mitigate against good governance in developing a modern mental health system that reflects recovery principles. Alternatively, O'Connor and Paton (2008) elaborate key aspects of a modern clinical governance framework (safety of patients and staff, consumer and family focus and participation, a skilled and valued workforce, incidents as learning opportunities, continuous improvement of clinical care, structures of accountability) and the ways that such aspects can be supported at various levels of a health system in the developed world. Governance systems should also be underpinned by strong ethical principles in respect to the appropriate treatment for people affected by mental illness. A good example of such ethical principles is the Code of Ethics produced by the Royal Australian and New Zealand College of Psychiatrists (RANZCP 2010).

In an economic sense, it appears that the key objective of any governance system for mental health would be to maximise the potential of people affected by mental illness in respect to their human value and their contribution to their community and society in general. Porter (2010a) argues that any value in an individual's health status is measured by outputs rather than inputs and depends on actual patient outcomes, not the volume of services delivered.

Porter further notes that such outcomes should involve survival, functional status, sustainability of outcome and "others". Eriksson (2011) comments on a number of preconditions to enhance individual social capital, a significant component of human value, which then results in enhanced health. These are a Macro Structure (Social and Political conditions, Income distribution) and Social Network Characteristics (Internalised Norms, Group Solidarity and Reciprocity) that lead to enhanced social support, social influence, social control, social participation and material resources) which lead to health benefits such as access to support, health enhancing behaviours, increased status and rewards, enhanced cognitive skills, belongingness and meaning of predicament along with improved access to health services and job opportunities. Eriksson (*ibid*) reports that trust and reciprocity are essential cognitive features of such collective and individual social capital and that these appear to be core elements for creating a health supporting environment, one of the five action areas for health promotion defined by the Ottawa charter. It could, therefore be argued that elements of the above should underpin any governance to enhance mental health.

Other key aspects of governance as outlined by O'Connor and Paton above is the development of appropriate mental health legislation and mental health service policies to protect patients, their carers and the community and comparative surveillance of such developments. The Mental Health Atlas (World Health Organisation 2005) reports and compares the presence in and population coverage of mental health legislation and mental health service policies in a range of world regions. The Atlas similarly reports on workforce for mental health. However, statistics do not necessarily supply the full picture of emerging trends. An example is the significant potential decline in numbers of mental health nursing workforce in Australia. Changes to nurse education in the 1980's along with the changing nature of work in psychiatric nursing appear to have significantly reduced the entry of young people into the profession. As a result, there may be major problems replacing the current workforce as they retire, leading to a severe workforce shortage in about a decade.

Mental health consumer employment within mental health services is an emerging and welcome development with consumer assisted services enhancing consumer outcomes with improved social functioning and reduced symptom severity and hospitalization (Nestor & Galletly 2008). However, it is essential that such consumer consultants be supported with training in addition to appropriate pay and conditions (*ibid*). The value of the role of family and carers in the management of people affected by severe mental illness is also being increasing recognised (Parker et al 2010).

The increasing use of outcome measures to assess disability and recovery as well as benchmarking where mental health services are gauged against each other and a number of key performance indicators (Coombs et al 2011) is another emerging mechanism in governance that needs to be considered. Porter (2010b) goes on to suggest a revised tier of hierarchies that is appropriate to assessing health outcomes. Tier One is whether the patient's health status is achieved or retained. Tier Two is the process of recovery of the patient and involves the time taken to achieve recovery and best attainable function in addition to the "disutility" of the care process (complications of treatment such as missed diagnoses and the ability to work whilst undergoing treatment). Tier Three involves the sustainability of the treatment process itself as well as any new health problems related to treatment. Such work encourages different ways of viewing different aspects of recovery in mental health and may allow a more accurate estimation of the economic basis of mental health management.

16. Conclusion

The previous chapter has briefly outlined eight potential “mental health pillars of wisdom” that should be a strategic focus in any mental health funding formula to emphasise Recovery. The formula can obviously be adjusted to local economic social and cultural needs but provides a more comprehensive vision of a future for the provision of mental health. The “pillars” are also useful entities to attach specific funding priorities as well as benchmarks to assess achievement in each area.

17. References

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NATIONAL INDIGENOUS REFORM AGREEMENT (CLOSING THE GAP)

Council of
Australian
Governments

An agreement between

- the Commonwealth of Australia and
- the States and Territories, being:
 - ◆ the State of New South Wales;
 - ◆ the State of Victoria;
 - ◆ the State of Queensland;
 - ◆ the State of Western Australia;
 - ◆ the State of South Australia;
 - ◆ the State of Tasmania;
 - ◆ the Australian Capital Territory; and
 - ◆ the Northern Territory of Australia

This Agreement implements intergovernmental reforms to close the gap in Indigenous disadvantage.

National Indigenous Reform Agreement

INTERGOVERNMENTAL AGREEMENT
ON FEDERAL FINANCIAL RELATIONS

PRELIMINARIES

1. This agreement is created subject to the provisions of the *Intergovernmental Agreement on Federal Financial Relations* and should be read in conjunction with that Agreement and subsidiary schedules. In particular, the schedules include direction in respect of performance reporting and payment arrangements.
2. The Parties are committed to addressing the issue of social inclusion. That commitment is embodied in the objectives and outcomes of this Agreement. However, the Parties have also agreed other objectives and outcomes which the Parties will pursue through the broadest possible spectrum of government action. Consequently, this agreement will be implemented consistently with the objectives and outcomes of all National Agreements and National Partnerships entered into by the Parties.
3. In December 2007, the Council of Australian Governments (COAG) agreed to a partnership between all levels of government to work with Indigenous communities to achieve the target of Closing the Gap in Indigenous disadvantage.
4. This National Indigenous Reform Agreement has been established to frame the task of Closing the Gap in Indigenous disadvantage. It sets out the objectives, outcomes, outputs, performance indicators and performance benchmarks agreed by COAG. It also provides links to those National Agreements and National Partnership agreements across COAG which include elements aimed at closing the gap in Indigenous disadvantage.
5. The National Integrated Strategy for Closing the Gap in Indigenous Disadvantage can be found at Schedule A. The foundation of the Closing the Gap Strategy is the identification of and commitment to targets addressing Indigenous disadvantage, and associated building blocks – areas for action. This Strategy acknowledges the importance of Indigenous culture, and engagement and positive relationships with Indigenous Australians. It discusses the contribution of the current COAG reform initiatives to meeting the targets, the frameworks for accountability and performance reporting, and also signals areas for future work.
6. The National Indigenous Reform Agreement, like other National Agreements, is a living document subject to enhancement over time to reflect additions and changes to existing and new National Agreements and National Partnership agreements. As COAG agrees to additional reforms to close the gap in Indigenous disadvantage, these will be reflected in this Agreement.

COAG framework

7. Despite the concerted efforts of successive Commonwealth, State and Territory governments to address Indigenous disadvantage, there have been only modest improvements in outcomes in some areas such as education and health, with other areas either remaining static or worsening. Even in those areas where there have been improvements, the outcomes for Indigenous Australians remain far short of the outcomes for non-Indigenous Australians. To Close the Gap in Indigenous disadvantage, COAG has committed to making significant reforms in order to address six specific targets (see Objectives).
8. COAG recognises that overcoming Indigenous disadvantage will require a long-term, generational commitment that sees major effort directed across a range of strategic platforms or 'Building Blocks' which support the reforms aimed at Closing the Gap against the six specific targets. The Building Blocks endorsed by COAG are:
 - (a) Early Childhood;
 - (b) Schooling;
 - (c) Health;
 - (d) Economic Participation;
 - (e) Healthy Homes;
 - (f) Safe Communities; and
 - (g) Governance and Leadership.
9. COAG recognises that strategies aimed at achieving improvements in any particular area will not work in isolation – the building blocks must fit together through the integration of policy ideas and an agreed approach to their implementation. Further information on the Building Blocks is at Box 1.

COAG commitments

10. In the context of the Building Blocks framework, COAG has commenced the task of addressing Indigenous disadvantage across each of the strategic platforms. Some National Partnership agreements have an Indigenous specific focus, addressing one or more of the building blocks:
 - (a) Remote Indigenous Service Delivery;
 - (b) Indigenous Economic Participation;
 - (c) Indigenous Early Childhood Development;
 - (d) Indigenous Health;
 - (e) Remote Indigenous Housing; and
 - (f) Remote Indigenous Public Internet Access.
11. In 2008, COAG requested the development of an urban and regional strategy to coordinate the delivery of services to Indigenous Australians. The National Urban and Regional Service Delivery Strategy, at Schedule B is a plan for action developed by the Commonwealth, State and Territory Governments. The Strategy recognises that without achieving significant gains in urban and regional locations, it will not be possible to Close the Gap nationally on any of the

COAG targets. The strategy requires jurisdictions to leverage Indigenous specific and mainstream funding agreed by COAG, and other existing resources, to improve Indigenous Australians' outcomes in urban and regional areas.

12. Moreover, an important feature of the new COAG framework is the focus on achievement of outcomes – including Indigenous outcomes – through the renegotiated National Agreements, and mainstream National Partnership agreements. These agreements aim to improve outcomes for a wide range of Australians, including Indigenous Australians. Some National Partnerships (such as Improving Teacher Quality) include Indigenous specific outcomes. Further information on the National Agreements and National Partnership agreements can be found at the Policy and Reform Directions section and at Schedule C.
13. A key feature of the new National Agreements will be enhanced reporting against specified indicators – and COAG has agreed to reporting arrangements which will see many indicators disaggregated by Indigenous and non-Indigenous status. This will facilitate close examination by COAG and the public of progress towards Closing the Gaps and will complement other reporting mechanisms, such as the COAG-sponsored Overcoming Indigenous Disadvantage Key Indicators Report.
14. The objectives, outcomes, outputs, performance indicators, and performance benchmarks noted in this and other Agreements will be used by the COAG Reform Council to assess progress in closing the gap in Indigenous disadvantage. In doing so, the COAG Reform Council will have reference to, among other things, the Closing the Gap Measuring Progress framework agreed by COAG (see Performance Benchmarks).
15. In addition, COAG has agreed to a National Framework for Reporting Expenditure on Services to Indigenous Australians. Annual national Indigenous Expenditure Reports based on this framework will provide governments with a better understanding of the level and patterns of expenditure on services to Indigenous Australians, and assist policy makers to target policies to Close the Gap in Indigenous Disadvantage.
16. The National Framework will enable the reporting of estimates of government expenditure on services to Indigenous people that will be comparable, relevant, reliable, cost effective and timely. The Framework will allow reporting on expenditure in a manner consistent with the COAG Building Blocks.
17. To ensure consistency across the development of National Partnership agreements, COAG has agreed service delivery principles (see Schedule D) and principles for investment in remote areas (see Schedule E). These principles are a guide for all COAG reforms, and all governments are expected to take these principles into account in designing policies and providing services.

**ADDRESSING EXTREME DISADVANTAGE THROUGH
INVESTMENT IN CAPABILITY DEVELOPMENT**

**CLOSING KEYNOTE ADDRESS TO THE AUSTRALIAN
INSTITUTE OF HEALTH AND WELFARE CONFERENCE
“AUSTRALIA’S WELFARE 2007”**

CANBERRA

6 DECEMBER 2007

**KEN HENRY
SECRETARY TO THE TREASURY**

ADDRESSING EXTREME DISADVANTAGE THROUGH INVESTMENT IN CAPABILITY DEVELOPMENT¹

Foreshadowing the content of my speech this afternoon, I would like to begin by acknowledging the traditional owners of the country on which we meet – and I pay my respect to their elders and ancestors.

Thank you to the Australian Institute of Health and Welfare (AIHW), and to Dr Penny Allbon in particular, for organising this conference and inviting me to speak. The AIHW's report '*Australia's welfare 2007*'² is the eighth in a long standing biennial series published by the AIHW but is the first under the stewardship of Dr Allbon.

Reflecting the conference theme 'diversity and disadvantage', I want to take the opportunity today to talk to you about how policy advisers might conceptualise disadvantage and the means of addressing it. In particular, today I would like to look at the situation of Indigenous people because, without doubt, this is the group of Australians who have experienced the highest levels of disadvantage, however measured, over the longest period of time.

I note that to commemorate the 40 year anniversary of 1967 referendum, each chapter in '*Australia's welfare 2007*' provides Indigenous statistics, where available, which illustrate the depth of disadvantage. I am sure these statistics have been highlighted in your discussions throughout the course of today, so I will not repeat them here.

¹ I would like to thank a number of my Treasury colleagues, especially Meredith Baker and Peter Robinson, for their help in the drafting of this paper.

² AIHW 2007, *Australia's welfare 2007*, Cat No. AUS 93, AIHW, Canberra.

If I were to identify two fundamental roles for government they would be these. First, to provide sustainable macroeconomic growth, with low and stable inflation and unemployment, through sound macroeconomic frameworks and the maintenance of well functioning markets. And second, to ensure that all Australians share in the nation's prosperity.

From the Treasury perspective, there is far more to sharing prosperity than simply ensuring that income is redistributed in a way that avoids inequality widening over time beyond some arbitrary level. To our minds, the distributional goals of government must relate to a much broader concept of prosperity, or wellbeing; one that goes well beyond standard inequality measures, or poverty line constructs, based on crude statistical measures of dispersion around mean or median income. These traditional income based measures of poverty and disadvantage are just too simplistic for the task. The dispersion of money income is of consequence, to be sure, but it is not enough.

Some of you would know that I am generally quite favourably disposed to Amartya Sen's concept of disadvantage as *capability deprivation*.³ Sen⁴ emphasises what he refers to as 'substantive freedoms' — including political and civil liberty, social inclusion, literacy and economic security — that, of themselves, form 'constituent components' of development. Among the capabilities of importance to poverty analysis, Sen⁵ identifies

³ Henry and O'Brien 2003 'Globalisation, Poverty and Inequality: Friends, Foes or Strangers?', *Australian Economic Review*, 36(1), pp 3-21.

⁴ Sen, A. 1999, *Development as Freedom*, Oxford University Press, Oxford.

⁵ Sen, A 1983, 'Poor, relatively speaking', *Oxford Economic Papers*, 35, pp 153-69.

one subset including such things as the capability ‘to meet nutritional requirements, to escape avoidable disease, to be sheltered, to be clothed, to be able to travel, and to be educated’. Poverty lines, defined in income terms for example, that captured these capabilities would not vary much from one community to another and would not, for the same reason, vary much over time. In other words, they might provide the basis for an absolute poverty line measure.

But Sen also notes that a second subset of other relevant capabilities of considerable interest to the classical economists — such as the capability to live without shame, the capability to participate in the activities of the community, and the capability of enjoying self-respect — provides a basis for relative poverty comparisons.

Of course, including all of these elements in an all-encompassing measure of poverty (or disadvantage) — built on a person’s endowment of capabilities, rather than their command over commodities — would be quite a challenge. It’s not surprising that, despite an increasing interest in such a broad measure of disadvantage, no universally accepted measure has been developed. There are, however, many examples of broad conceptualisations of wellbeing and disadvantage being used for various analytical purposes.

For example, we in the Treasury have developed a wellbeing framework⁶ as a descriptive tool to provide context for public policy advice. It is built on elements of Sen’s capabilities framework within the context of a

⁶ Treasury 2004 ‘Policy advice and Treasury’s wellbeing framework’, *Economic Roundup*, Winter, pp 1-20.

generalised-utilitarian framework. This quite broad conceptual framework anchors the objective and thorough analysis of policy options that is central to the Treasury's role.

Another pertinent example is the material contained in the final chapter of AIHW's '*Australia's welfare 2007*'. While acknowledging that welfare, in its broadest sense, refers to the wellbeing of people and society, AIHW's primary focus in its *Australia's welfare* series is concerned with the system of welfare services and assistance (including specific targeted cash transfers) now operating in Australia, and the people who receive those services and assistance. To give context to the discussion on specific welfare services sectors, summary indicators of wellbeing have been added in recent volumes of the series⁷. The conceptual framework underpinning these indicators has three components: healthy living; autonomy and participation; and social cohesion.

The Australian Bureau of Statistics (ABS) has been moving along a similar path, especially with their 2001 publication *Measuring wellbeing: Frameworks for social statistics* and the series entitled *Measuring Australia's progress*.⁸

⁷ See chapter 8 in the volume.

⁸ Australian Bureau of Statistics (ABS) 2001, *Measuring Wellbeing: Frameworks for social statistics*, Cat No. 4160.0, ABS, Canberra and ABS 2006, *Measuring Australia's progress*, Cat. No. 1370.0, ABS, Canberra.

And several social policy analysts have also expanded the traditional focus on poverty measurement to develop indicators of deprivation and social exclusion.⁹

Some quite recent work has served to remind us that most measures of disadvantage that are based either at a point in time or on a time-series of cross-sectional data suffer from not being capable of revealing who remains in a situation of disadvantage over time. Nor, generally speaking, do these measures identify the factors that determine whether somebody exits from, or remains in, a position of disadvantage. Increasingly, longitudinal (or panel) data are being used to examine the extent of intra-generational mobility out of poverty.

Significantly, the findings from the first four waves of the Household, Income and Labour Dynamics in Australia (HILDA) survey show that, despite there being consistent levels of income poverty across all households in each year, observing the same households over time shows that income poverty persisted in only a small percentage of households.¹⁰ These findings are consistent with results from other high income countries: the majority of households enter income poverty only temporarily and are able to improve their standard of living over time, while a smaller number of households are at risk of long-term income poverty. As more HILDA data become available we will be able to

⁹ See for example, Daly, A. 2006, ‘Social Inclusion and Exclusion among Australia’s Children: A Review of the Literature’, NATSEM Discussion Paper No. 62, December; and Saunders, P. and Adelman, L 2006, ‘Income Poverty, Deprivation and Exclusion: A Comparative Study of Australia and Britain’, *Journal of Social Policy*, 35, pp 559-84.

¹⁰ See Buddelmey, H. and Verick, S., 2007, ‘Understanding the Drivers of Poverty Dynamics in Australian Households’, *IZA Discussion Paper No. 2827*, June. This paper defines a household as being in poverty if the equivalised household income is below 50% of the median.

develop a clearer picture of the determinants of those at risk of long-term poverty, as well as the effects on those who experience shorter durations of poverty.

In addition, inter-generational analyses on the transmission of disadvantage, measured in a number of dimensions, are also being undertaken.¹¹ The general theme that appears to be emerging from these types of studies is that caution is warranted before assuming that income transfers might be an effective means of breaking the generational cycle of disadvantage. Instead, the evidence points toward the need to design income support programmes and policies in a way that encourages, or at least does not discourage, active labour market participation; and, in addition, to the importance of a human capital investment strategy, broadly defined to include not only education but also physical and mental health and social development. The focus on human capital development is particularly important for disadvantaged children early in life – a point that justifies a public policy focus on equality of access to capability development opportunities.

Miles Corak has argued, persuasively, that ‘the capacity of children to become self-sufficient and successful adults is compromised not only by monetary poverty, but by poverty of experience, influence and expectation’¹². In other words, there are important, though often subtle,

¹¹ See for example, Corak, M. 2006, ‘Do poor children become poor adults? Lessons from a cross-country comparison of generational earnings mobility’ in Creedy, J. and Kalb, G. (eds) *Dynamics of Inequality and Poverty, Research on Economic Inequality, Volume 13*, Elsevier Ltd., pp 143-88; and d’Addio A.C. 2007, ‘Intergenerational transmission of disadvantage: mobility or immobility across generations? A review of the evidence for OECD countries’, OECD Social, Employment and Migration Working Papers No. 52;

¹² Corak 2006, *op cit*, p 171.

non-monetary factors that determine the outcomes of children within families as well as, arguably, the outcomes of adults within communities. These non-monetary factors include the influence of dysfunctional cultural norms; the demoralising impact of passive welfare and labour market exclusion; and the influence on the cognitive development of children of maternal smoking, alcohol abuse and poor nutrition during pregnancy.¹³

Several of the multiple causes of disadvantage draw policy makers into difficult areas of social and labour market policy.

Nobody imagines that social policy interventions should seek equality of outcomes. That is just as well, because social policy couldn't hope to have such potency. No matter how expansive, and expensive, the policy interventions, we will always observe a considerable dispersion in the 'wellbeing' outcomes for individuals, both at a point in time and over time, including across generations. Individuals may be provided with true equality of access to materially rewarding opportunities but might choose not to access those opportunities and to live their lives in what would be considered by others in society as a condition of relative poverty, at least in terms of income.¹⁴ In my (normative) judgement, policy makers shouldn't be too concerned by that. Instead, policy makers should be concerned with opportunities. Specifically, they should be concerned to ensure that individuals are endowed with capabilities that allow them the

¹³ See also Waldfogel, J 2006, *What children need*, Harvard University Press and chapter 2 in d'Addio 2007.

¹⁴ See Corak 2006 and d'Addio 2007, *op cit*, for some other reasons.

freedom to choose to live their lives in ways that have real meaning and real value.

I endorse strongly Amartya Sen's view that people who are deprived of such capability endowments may be described as impoverished; as being in poverty.

Addressing Indigenous disadvantage

Measuring the policy effort against that benchmark, Indigenous Australians are entitled to feel especially disadvantaged.

In June this year, in an address to the Cape York Policy Institute's *Strong Foundations* conference,¹⁵ I argued there were three key interdependent foundations to Indigenous disadvantage: poor economic and social incentives; the underdevelopment of human capital and capability in general; and an absence of the effective engagement of Indigenous Australians in the design of policy frameworks that might improve those incentives and capabilities.

In relation to poor economic and social incentives, I argued that perverse incentives — those that encourage undesirable behaviours — are having a negative impact on many Indigenous communities; reducing self-reliance, self-development, aspiration and responsibility, including — in some cases — the commitment to caring for families and communities. In particular, I noted the deleterious effect of the combined incentives in the welfare

¹⁵ Henry, K 2007, 'Creating the right incentives for Indigenous development', address to the Cape York Institute Conference "Strong Foundations — Rebuilding Social Norms in Indigenous Communities", 26 June.
<http://www.treasury.gov.au/contentitem.asp?NavId=008&ContentID=1275>

system, which have resulted in disengagement in some cases and, in many cases, a passive reliance on welfare payments; and which have also done little to encourage Indigenous Australians to invest in education and to participate in employment. And I noted also the resultant breakdown of foundational social norms in many Indigenous communities, as the effects of passive welfare have become entrenched.

Indigenous disadvantage is a regrettable example of income enhancement, in the form of combined welfare payments, not having led to material gains in wellbeing.

Not all welfare is passive. But some is. If we are to make progress, passive welfare, in all its forms, must be addressed.

While incentives are important, they will not be effective in the absence of the human capital — in particular, good health and education — that is needed to take advantage of positive incentives; and to place Indigenous Australians in a position of being able to opt for, indeed demand, the life choices open to non-Indigenous Australians. So a second key component of addressing Indigenous disadvantage involves human capital development.

In my Cape York Policy Institute speech I argued that the third major reason for continuing Indigenous disadvantage has been the limited engagement of, and opportunities for, Indigenous people to shape policies that affect their destiny. A considerable body of international literature suggests that Indigenous engagement in policy development is key to achieving better results — in itself, it reduces the ‘passivity’ of solutions,

creating ownership of both the problem and the solution. And it is fundamental to Indigenous self-esteem. Active participation in the decision-making that affects one's community can be a powerful source of identity, even of pride.¹⁶ And it is an obvious means of recognising inspirational role models. Indigenous engagement at the grass roots level has to become the norm.

For all who are engaged in Indigenous policy development, it is not a question of choosing which of these three foundations of disadvantage should be the focus — they must all be addressed, and at the same time.

And yet, as a practical matter, one has to start somewhere. Where should that be?

Today I want to float an idea that addresses specifically the second of these foundations: the underdevelopment of human capital and of capability in general. You will see that, even with that focus, we will quickly get into considerations affecting economic and social incentives and Indigenous engagement in policy development.

Human capital development and the key role of education

Human capital is a term economists talk about quite a bit. Essentially, it refers to the intangible knowledge-based assets people develop that help them become productive members of society. High levels of education and physical and mental health are the hallmarks of strong human capital.

¹⁶ The link between identity and behaviour has been explored by many researchers. In the present context, the work of Dr Michael Chandler of the University of British Columbia is especially relevant.

Education can help transform social and economic opportunities, with particularly strong gains for those from disadvantaged backgrounds. People who are better educated are better placed to participate in the labour market and earn higher incomes. Higher levels of education are also associated with lower rates of incarceration and increased engagement in civic life. In short, education is the key to better life opportunities and choices.

As highlighted in chapter 8 of '*Australia's welfare 2007*'¹⁷, the proportion of Indigenous students meeting the benchmarks for reading, writing and numeracy in 2005 were significantly lower than the national rates, in each grade. Moreover, the gap between Indigenous and non-Indigenous students appears to have remained static between 2001 and 2005. The latest OECD Programme for International Student Assessment (PISA) survey results for 2006 confirm there has been virtually no change in Indigenous students' performance across a range of outcomes since 2000.¹⁸

Indigenous education is an important 'means' of securing individual and community development. It links so fundamentally to other aspects of community life that educational gains stand a very good chance of leading to improvements in other areas that are also hallmarks of disadvantage.

But, as Sen has suggested, education is not only an instrumental freedom – that is, a means to an end; it is also a substantive freedom – a constituent component of development. People who are educated have greater

¹⁷ AIHW 2007, *op cit*, pp. 373-4.

¹⁸ OECD 2007, *PISA 2006: Science competencies for tomorrow's world*, volumes 1 & 2, OECD. Paris.

freedom to choose lives of real meaning and real value. Indigenous education is, therefore, important for its own sake; a valuable ‘end’ in itself. It should be seen as a key component of Indigenous development.

This dual role that is played by education warrants an explicit policy focus on a sustained increase in educational attainment by Indigenous Australians. And in this context, I note the Government has a number of specific targets it has set out to achieve for Indigenous people, including a halving of the gap in reading, writing and numeracy achievement within a decade.

But there is another reason for focussing on Indigenous education – a reason that is both strategic and pragmatic: It provides a clear focus for multiple interventions.

Australian public service leaders have given some thought to the value in approaching Indigenous development in precisely these terms.¹⁹ They have come to the view that enhanced Indigenous educational attainment is unlikely to be achieved without seven development platforms being in place.

First, and fundamentally, there must be basic protective security from violence for Indigenous parents and children. Incidentally, Amartya Sen also stresses that the removal of major sources of ‘unfreedom’ – and he specifically instances the lack of effective institutions to deal with crime and violence – are a fundamental pre-condition for development.

¹⁹ Secretaries Group on Indigenous Affairs, chaired by the Secretary of the Department of the Prime Minister and Cabinet, Dr Peter Shergold. The work was initiated and supported by the Treasury and the Department of Families, Community Services and Indigenous Affairs.

Second, there is strong international evidence, to which I referred earlier, that early childhood development interventions, coupled with parental support to develop appropriate at-home learning environments, provide a critical foundational base for young children — especially those from disadvantaged backgrounds — from pre-birth to school.

Third, the home environment needs to be conducive to regular patterns of sleep and study, free from overcrowding and distraction.

Fourth, there needs to be ready access to suitable primary health service infrastructure. In Sen's terminology, the avoidance of deprivations like starvation and premature mortality are 'substantive' freedoms and constituent components of development. But they also play an instrumental role: Healthier individuals are physically and mentally more energetic and robust and, as a result, more likely to be active in all areas of life. Healthier children, in particular, are more likely to attend school, and are better able to learn once they are there. Importantly, the instrumental relationship between education and health runs in both directions: Better educated mothers are less likely to engage in behaviours that cause low birth weight, putting their babies at greater lifetime risk of a range of diseases, including type II diabetes.

Fifth, particularly in an environment where real jobs are not currently the norm, incentives in the welfare system cannot be allowed to work against the promotion of investment in human capital, particularly of children through the provision of safe and healthy living environments and their attendance at school. Nor can those incentives be allowed to work against the active participation of parents and other role models in communities.

Sixth, there must be a realistic prospect of an educated Indigenous person securing a real job, with the support of appropriate employment services. It is worth observing that almost three quarters of Indigenous Australians live in cities and regional centres, the vast bulk of which have thriving labour markets. In other places, there is scope for modest and incremental steps towards developing opportunities based on retail and service activities in the local community and, in some places, much bolder steps that would harness genuine commercial opportunities in art, mining, agriculture and tourism, for example. In yet other places it is difficult to avoid confronting the need for mobility. Where remote locations simply cannot produce sufficient job opportunities for local people, there is no point in relying on miracles. A better strategy is to ensure that people have the opportunity to move to take up work if that is what they want to do.

Seventh, governance systems have to support the ‘political freedom’ and ‘social opportunities’ of local Indigenous people (both men and women) to be engaged in policy development.

These seven platforms necessary to support the goal of a sustained increase in educational attainment shouldn’t surprise anyone; they dovetail quite closely with the strategic areas for action and associated indicators contained in the well-known *Overcoming Indigenous Disadvantage*²⁰ indicator framework.

²⁰ See Steering Committee for the Review of Government Service Provision 2007, *Overcoming Indigenous Disadvantage: Key Indicators 2007*, Productivity Commission, Canberra, especially figure 2.2.1 in chapter 2.

The first four platforms recognise the importance of tackling problems at source and of thinking in causal pathways; points that have been made eloquently, for many years now, by Professor Fiona Stanley.

I am emphasising here the instrumental role played by each of the seven platforms in supporting decent educational outcomes. But it is also the case that each of these platforms, in its own right, tackles an element of disadvantage that we see in many Indigenous communities. So a focus on education would mean addressing the many sources of Indigenous disadvantage. And, as I have noted on the way through, several of the platforms can be viewed as being constitutive components of development; that is, being of more than instrumental significance.

Targeting educational outcomes, therefore, means embracing a holistic Indigenous development strategy.

Policy strategies are one thing; their delivery, on the ground, is another. In recent years we've learned quite a lot about models of Indigenous program delivery. No doubt, we have a lot more to learn. However, I reckon we do know this much: that program delivery must be targeted to local needs, integrated and delivered in a cost effective and non-threatening way. This is important for the proper functioning of government; but it is equally vital for those people for whom the programs exist — Indigenous people themselves. As policy makers and administrators, we understand this at a conceptual level. But we haven't been very good at allowing that understanding to affect the way in which we implement things. Critically, in our understandable focus on compliance and accountability we have a tendency to insist on paperwork of Himalayan grandeur. And to what

end? I have witnessed first hand, in several Indigenous communities, how the mountains of red tape simply bury the limited administrative resources available at the local level.

Concluding remarks

The thought on which I would like to conclude — more by way of a question than an answer — is whether the framework I have outlined as an approach to Indigenous disadvantage has value when considering disadvantage more broadly in Australian society.

I suspect that it does.

Education and the seven platforms required to support it should be seen as capabilities that are critical to development; several of them in a constitutive way.

An individual deprived of these capabilities experiences poverty in a very real and meaningful sense. Certainly, we can say that such an individual is severely disadvantaged. And hopefully, we can agree that such severe disadvantage is unacceptable – whether it manifests itself in a remote Indigenous community, or on the streets of one of our major cities.

Disadvantage is more obvious in remote Australia where it can pervade entire Indigenous communities. In some remote communities, not one of the seven platforms exists. In the cities, if we look hard enough, we see pockets of disadvantage; several of the seven platforms may be mostly in place, with others less developed. There is disadvantage none-the-less.

I have argued here that while poverty assessments based on crude statistical measures of dispersion around mean or median levels of money income are not overly useful, especially because such measures lack a temporal dimension, poverty should, nevertheless, be conceptualised in terms of disadvantage; and, in particular, in terms of capability deprivation. Disadvantage and capability deprivation are concepts that have both absolute and relative meanings. I have argued that education should be accorded special status by policy makers concerned to build capability, and have outlined seven platforms of development that will need to be constructed to support that work. Some of those platforms will be susceptible to measurement; others not so. But whether they can ever be reduced to meaningful quantifiable indicators or not, policy makers cannot be permitted the view that the task of constructing these platforms is too great a challenge. The development of Australia depends upon it.

Thank you for having me here today.



Government
of Canada

Gouvernement
du Canada



balanced
accountable
innovative
transparent
responsive

A black and white photograph showing a diverse group of approximately ten people of various ages and ethnicities. They are all smiling and appear to be in a celebratory or happy mood, with some people laughing and others looking directly at the camera. The background is slightly blurred, making the people in the foreground the main focus.

Canada's Performance

The Government of Canada's Contribution



►►► 2005

Canada

About Canada's Performance 2005

This is a companion piece to *Canada's Performance 2005: The Government of Canada's Contribution*. It includes a CD-ROM containing the full report, the on-line annexes (a glossary, indicator methodology, and indicators and additional information), and a snapshot of the Aboriginal Horizontal Framework.

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Treasury Board, 2005

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Web site at www.tbs-sct.gc.ca

President's Message

Sound public sector management matters. The objective of the government's pursuit of management excellence is to provide more responsive, more innovative, and more accountable service to Canadians. That's why reports like *Canada's Performance* are so important.

Canada's Performance 2005 provides a government-wide overview that enables spending and performance information to be presented in a comprehensible format, easily accessible to parliamentarians and Canadians.



Through *Canada's Performance 2005*, Canadians will be able to see how their government contributes to Canada's performance as a nation. This report helps Canadians understand how their tax dollars are spent.

This year's report is structured around three key policy areas—sustainable economy, Canada's social foundations, and Canada's place in the world. This structure reflects other government documents, such as Budget 2005, in order to assess the federal government's effort to improve the quality of life for Canadians.

Canada's Performance 2005 also includes a special chapter on Aboriginal Peoples that discloses all federal spending on Aboriginal programs. In order to improve outcomes for Aboriginal people in Canada, we need to know how much money is allocated by the federal government and how those funds are spent. By disclosing federal spending, we can work together with Aboriginal people in Canada to improve programs and their results.

Overall, Canada's performance on key economic, social and international outcomes ranks well compared to other countries, but that does not mean we should be complacent. We recognize that many players—other levels of government, the private sector, community groups and individuals—have an important contribution to make. We will continue to develop these partnerships to enhance the quality of life for Canadians. Together, we can move Canada forward.

The paper version was signed by Reg Alcock

President of the Treasury Board and
Minister responsible for the Canadian Wheat Board



Canada's Performance

The Government of Canada's Contribution

About the report

Canada's Performance 2005 is the fifth annual report to Parliament on the federal government's contribution to Canada's performance as a nation—highlighting both strengths and areas for improvement.

Canada's federal organizations play an important role in the quality of life of Canadians. They support the way we govern ourselves as a federation, administer our laws and justice system, develop and deliver our national social programs and services, regulate the economy and promote fair trade, and represent and protect our interests and values in the world.

Canadians rightly expect a lot of their public sector. They expect the government to pursue policies and programs that take into account and are responsive to public priorities. They expect the government to operate in an open, transparent, and

accountable manner. They want to know that government programs and services are well managed. Above all, they want assurances that they are receiving good value for their tax dollars.

What's in the report

Canada's Performance 2005 is structured around three main policy areas:

- ▶ **sustainable economy**, which demonstrates the increased importance given to the links between the Canadian economy and the natural environment;
- ▶ **Canada's social foundations**, which reflects the important role health care plays in Canadian society; and
- ▶ **Canada's place in the world**, which recognizes the international dimension of government activity needed to advance national aspirations.

► Did you know?

To mark the 60th anniversary of the end of the Second World War and the liberation of the Netherlands, the Government of Canada declared 2005 to be the Year of the Veteran in order to honour veterans and their service.

Budget 2005 provides funding of \$6.0 million per year, in addition to the \$16.5 million over two years announced in 2004, for future commemoration activities to recognize the sacrifices and contributions of Canada's veterans.

This year's report also features a special overview of the government's efforts to support improvement in the well-being of Aboriginal peoples.

Chapters on the three policy areas provide a broad overview of the federal government's initiatives, commitments, and achievements related to the long-term benefits to Canadians—referred to as Government of Canada outcomes—that the federal government is working to achieve.

Under the three policy areas, the Government of Canada outcomes are as follows:

Sustainable economy

- sustainable economic growth;
- an innovative and knowledge-based economy;
- income security and employment for Canadians;

- a fair and secure marketplace; and
- a clean and healthy environment.

Canada's social foundations

- healthy Canadians with access to quality health care;
- an inclusive society that promotes linguistic duality and diversity;
- a vibrant Canadian culture and heritage; and
- safe and secure communities.

Canada's place in the world

- a strong and mutually beneficial North American partnership;
- a prosperous global economy that benefits Canadians and the world;
- a safe and secure world; and
- global poverty reduction through sustainable development.

Each chapter starts with an **introduction**, which discusses the policy area of the chapter, a brief description of the Government of Canada's **role** in that policy area, and a list of the outcomes that will be addressed.

Each outcome starts with a **performance context**, which provides an assessment of quality of life in Canada and is based on a broadly accepted set of societal indicators. This section provides context for the federal government's programs, expenditures, and performance in each outcome.

The **Performance highlights** section in Appendix A summarizes the societal indicator information presented in the report.

► Did you know?

The Government of Canada has won recognition for the fifth consecutive year as the world's best in providing on-line services to its citizens.

Accenture—a global management consulting, technology services, and outsourcing company—cited Canada's expertise in its annual international report on e-government. The government's commitment to consulting Canadians and collaborating with federal departments and other levels of government was noted as a key factor to Canada's overall success.

Source: Public Works and Government Services Canada, *Achievements*, 2004

In order to have an objective assessment of Canada's performance, the societal indicators are drawn from established data sources—for example, the Census of Canada, general social surveys conducted by Statistics Canada, public opinion polls, and reports from the Organisation for Economic Co-operation and Development (OECD), the World Health Organization (WHO), and the World Economic Forum. These indicators are reported on annually in order to show consistent and measurable trend data over a period of five to ten years, using the most recent trend data available.

A number of indicators have not been updated for 2005 because they are either based on one-time surveys or surveys that are not repeated annually or because data were not available in time for inclusion in this report. While not every indicator is updated annually due to different reporting cycles, the most recent trend data available are always included.

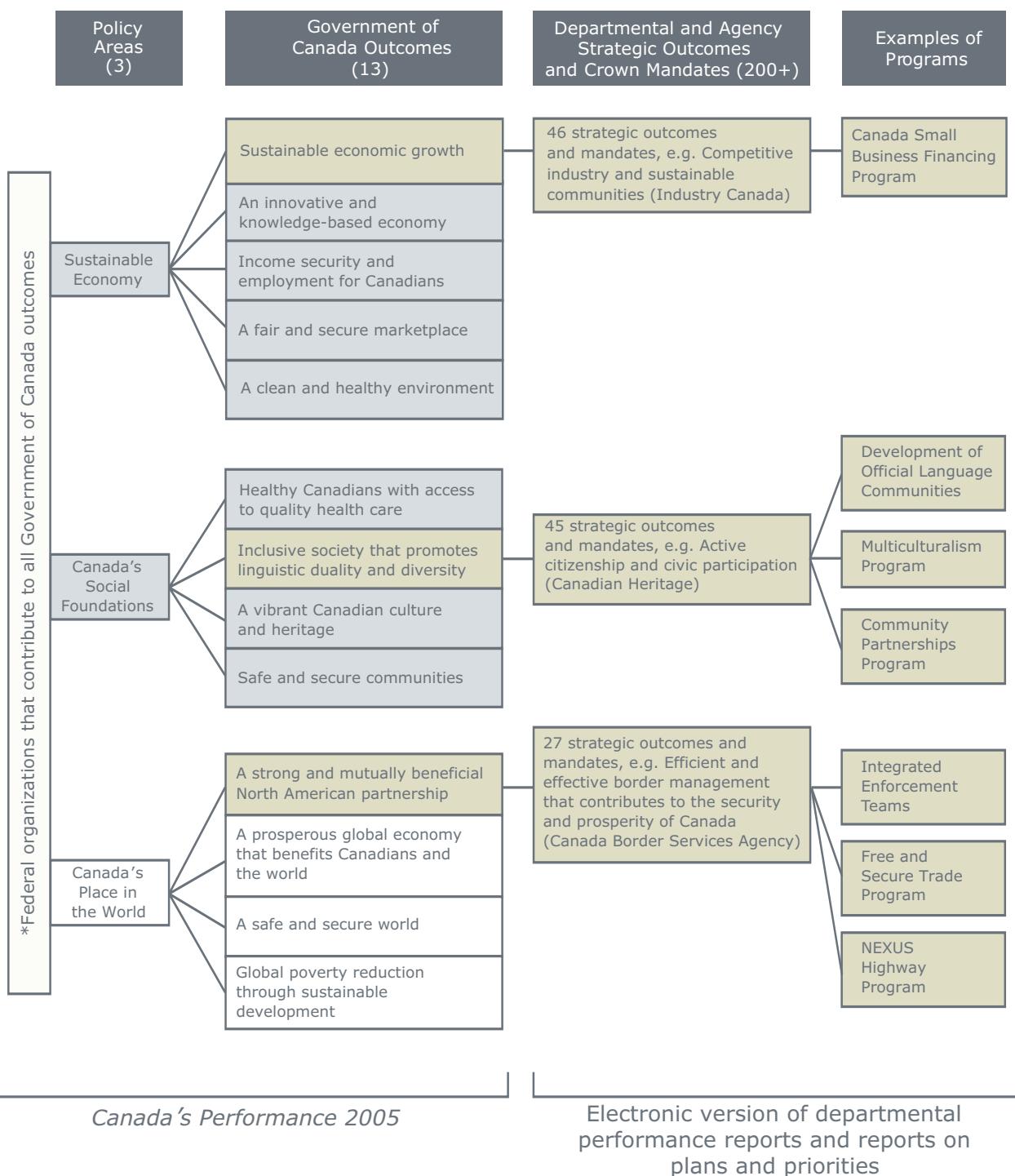
In examining the outcomes, *Canada's Performance 2005* looks at the **Government of Canada's contribution**, recognizing that many players—individuals, businesses, other governments, and non-profit groups—also have an important contribution to make.

Each outcome ends with a list of departments, agencies, and Crown corporations that are working toward its improvement.

Figure 1.1 illustrates the framework used by *Canada's Performance* to report on a whole-of-government perspective.

The illustration goes from very broad (left-hand side) to more specific (right-hand side). For example, the broad policy area "Sustainable Economy" is made up of five Government of Canada outcomes; 37 federal organizations contribute to the achievement of "sustainable economic growth" through 46 strategic outcomes or mandates. The Canada Small Business Financing Program is an example of a program that contributes to the achievement of Industry Canada's strategic outcome: "a competitive industry and sustainable communities."

Figure 1.1 Whole-of-Government Framework



*Federal organizations that support all Government of Canada outcomes by providing government services and support to all departments and agencies (i.e. Treasury Board of Canada Secretariat, the Public Service Commission of Canada, Public Works and Government Services Canada, and Statistics Canada).

► Did you know?

Recruitment of Aboriginal candidates to the Royal Canadian Mounted Police is an effective way to provide culturally sensitive police services to Aboriginal communities, while assisting the Royal Canadian Mounted Police to remain representative of the communities they serve.

In 2004, the Royal Canadian Mounted Police had approximately 850 police officers that self-identified as Aboriginal peoples, representing 5.6 per cent of the total officer contingent.

The Royal Canadian Mounted Police is working hard to increase this number through a variety of programs and also contributes directly to the general health and safety of Aboriginal people, through working with over 600 First Nations, Inuit, and Métis communities.

Aboriginal peoples chapter

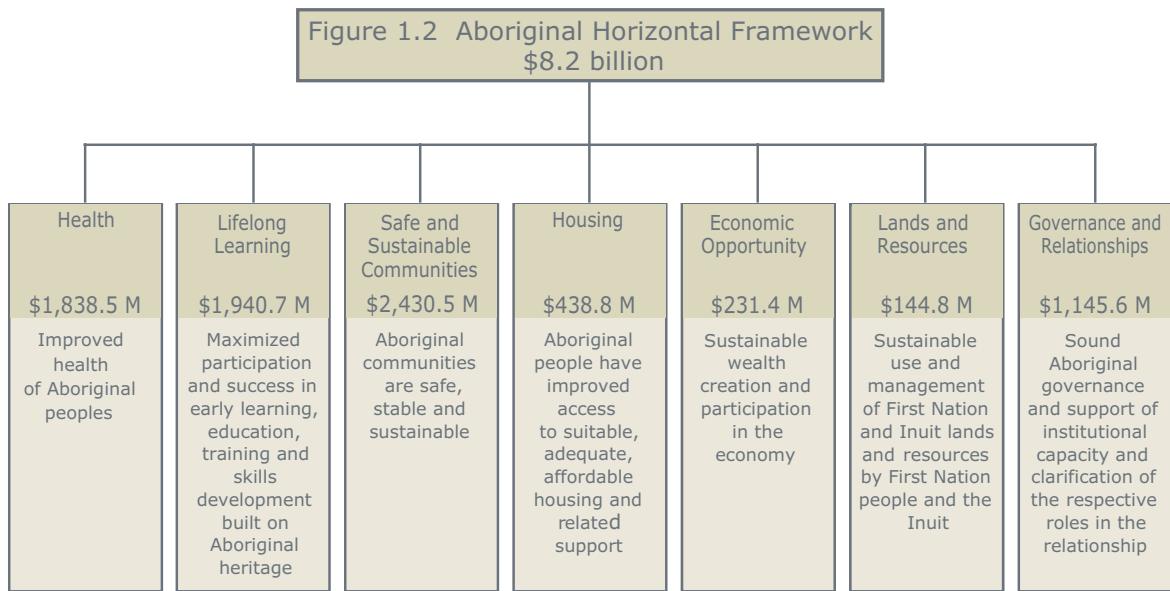
This is the second time that Canada's Performance includes a specific chapter on Aboriginal people. This chapter is the next step following the Canada–Aboriginal Peoples Roundtable, which began in April 2004, in which the federal government committed to improving accountability for results.

This step begins by taking stock of the programs the Government of Canada provides to First Nations and Métis people and the Inuit and by disclosing in detail all federal spending in 2004–05 committed to Aboriginal peoples in Canada.

The Aboriginal Peoples Chapter therefore has a unique look and feel in comparison to other chapters in the report. It contains figures on federal spending rolled up for

all programs within seven thematic headings —health, governance and relationships, lifelong learning, safe and sustainable communities, housing, economic opportunities, and lands and resources—developed as a response to the Canada–Aboriginal Peoples Roundtable.

The electronic version of the report links to the Aboriginal Horizontal Framework (<http://www.tbs-sct.gc.ca/aaps-aapd>), which includes all of the programs offered by federal departments and agencies as well as their objectives and costs. Where possible, the Framework also specifies which programs are offered to First Nations, Inuit, and Métis communities.



Accessing the report

Canada's Performance 2005 is available in multiple formats: print, HTML, and CD-ROM.

The HTML version of the report links to department and agency planning and performance reports as well as to the *Annual Report to Parliament on Crown Corporations and Other Corporate Interests of Canada*.

The HTML version also links to important databases on government audits and evaluations, horizontal initiatives, and detailed program and expenditure information for the federal program suite for Aboriginal peoples. Hyperlinks provide additional information on various publications, policies, and Web sites relevant to each policy area.

In addition, substantial improvements were made to the supplementary on-line annexes. The HTML version of *Canada's Performance 2005* now includes links to

three annexes: a glossary and two annexes on additional indicator information.

Accompanying this summary document is a CD-ROM, which includes the full report, the on-line annexes, and a snapshot of the Aboriginal Horizontal Framework, which contains detailed program and spending information for 2004–05.

Readers are encouraged to consult the CD-ROM or the HTML version of the report (http://www.tbs-sct.gc.ca/report/govrev/05/cp-rc_e.asp) to access the on-line annexes and the relevant hyperlinks throughout the report.

The mouse symbol (☞) is used to identify hyperlinks found in the electronic versions.

responsive

Highlights of the report



Sustainable economy

Policy makers used to think about the environment as something to be protected from the negative effects of economic growth and the marketplace. Today, it is recognized that environmental, social, and economic well-being are inextricably linked. The challenge, therefore, is to integrate all these considerations into the way decisions are made to ensure that Canada's economy, environment, and society are sustainable over time.

While Canada has made progress toward achieving an innovative and knowledge-based economy, there are significant numbers of adult Canadians with low-level literacy skills that constrain their participation in society and in the economy.

Also, while levels of several air pollutants have dropped over the last decade, climate change and the status of many species at risk continue to be causes for concern. Canada has made significant progress on environmental protection, but more needs to be done. The Government of Canada will work with consumers, environmentalists, partners, and stakeholders in further developing its integrated approach to a sustainable economy.

The Canadian economy is, however, considered to be one of the strongest and healthiest among the G-7 countries, and Canada has enjoyed the strongest growth in employment within the G-7. The government's economic and fiscal plan has been, and will continue to be, to generate the greatest possible growth while providing equality of opportunity to all Canadians.

► Did you know?

March 2005 marked the sixth anniversary of the coming into force of the Canada-led Ottawa Convention banning anti-personnel landmines. States parties have destroyed over 37 million stockpiled mines and have contributed over US\$2 billion toward global mine action efforts, the vast majority of which have been leveraged since the Convention entered into force. The Canadian government has done its part by renewing the Canadian Landmine Fund through 2008, bringing Canada's financial commitment to more than \$200 million since the signing ceremony in Ottawa.

Source: Foreign Affairs Canada, 2005

Canada's social foundations

The Government of Canada supports quality of life of its citizens not only by strengthening the social fabric and by reflecting and reinforcing values that are important to Canadians but also by promoting and protecting health and ensuring effective health care services. The Government of Canada also establishes and enforces laws that keep Canadians safe, regulate Canadian society, and protect disadvantaged groups in Canadian communities.

Canada's social foundations are experiencing a number of challenges. While indicators point to a less involved civic society as political participation and volunteering among Canadians are both declining, personal tolerance toward diversity is increasing.

Progress has been noted in housing, as the proportion of Canadians who are unable to afford shelter that is adequate, suitable, and affordable is decreasing.

Although a growing proportion of Canadians are also considered either overweight or obese, Canadians can expect to live longer than ever.

The Government of Canada is committed to having the best possible system for ensuring the health of Canadians. Medicare is a vital aspect of Canada's shared citizenship: it speaks to Canadian values and priorities. Canadians want a system that gives them access to the care they need, when they need it.

Canada's place in the world

The world is changing, rapidly and radically, and these changes matter to Canada. Canada's security, prosperity, and quality of life are all affected by global transformations and the challenges they bring.

Canada must therefore remain engaged abroad if the government is to meet the challenges and seize the many opportunities a global economy can bring, while contributing its share to international peace, security, and assistance.

Canada is committed to improving international security, but many Canadians think that much work remains to be done.

Canadians, who come from every corner of the globe, understand that the life enjoyed by citizens in this country depends increasingly on helping to make life in other countries better as well. Although the federal government has moved forward on three fronts to strengthen development assistance results through increased aid, more effective aid, and policy coherence across government, there is still progress to be made in this area.

Canada is, however, increasingly benefiting from partnership with its North American neighbours, and Canadians are prospering in the global economy.

Aboriginal peoples

Aboriginal peoples, however, have not fully shared in Canada's prosperity. Although important progress has been made in the areas of health, lifelong learning, housing, economic

development, and improving relationships with governments, much more needs to be done. The Government of Canada is working in partnership with Aboriginal leaders and the provinces and territories to find lasting solutions.

Partnering for success

The Government of Canada recognizes that it is only one of many entities that shape Canadian society and that quality of life depends on many factors. For this reason, the federal government partners with other levels of government, private and voluntary sectors, non-governmental organizations, and individuals to achieve the best possible social, economic, and environmental outcomes for Canadians.

Give us your feedback

The Government of Canada is committed to continually improving its reporting to parliamentarians and Canadians. We want to know what you think of this report—what you like best and what you think needs to be changed so that we can make more improvements.

We welcome your comments by mail, telephone, fax, or e-mail.

Treasury Board of Canada Secretariat
Results-based Management Division
300 Laurier Avenue West
9th Floor, West Tower
Ottawa ON K1A 0R5

Telephone: (613) 957-7183
Fax: (613) 957-7044
E-mail: rma-mrr@tbs-sct.gc.ca