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Taking our place: Community mental health services in Australia

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Community mental health services in Australia have a patchily documented history stretching back over 100 years. The term “community” has figured in how the sector has described itself, particularly in the past 60 to 70 years. This paper explores the centrality of the term ‘community’ to the sector’s identity and discusses some of the challenges which have been faced in maintaining this concern with community.[i]

Jim Ife, an Australian academic at Curtin University, provides some insight into the concept of community as applied to human service provision.

> *‘The essence of this approach to human services is that the community must be responsible not only for the delivery of services but also for the identification of needs, the planning of services to meet those needs, .. and the monitoring and evaluation of program .. It is only when all aspects of service delivery are in fact controlled at community level by the people most directly affected, that human services can be said to be genuinely community-based.’* [ii]

Thus, a concern with community requires giving primacy and overarching control in service development and delivery to the needs and experiences of the people most affected. This approach to human service delivery focuses on recognizing and utilizing existing wisdom and skills and on developing new skills. Knowledge and skills are ‘owned’ at the community level, and shared widely among community members.

Historically, community organisations have sought to help people with mental illness, their families and local communities to develop the types of services they feel they need. Key elements of this approach have given rise over the years to a lexicon of terms which at different times appear to be “new” but which in reality are restatements and a re-emphasis of an approach to human service provision which lies at the core of the community mental health sector’s identity.

Central elements contained in this approach include self determination and autonomy; community directed and owned; recovery-focused; participatory governance; and the valuing of local knowledge, expertise and wisdom.[iii] Implementation of this approach to community mental health has not happened in an unhindered or unchallenged way. It is an approach which has sometimes sat in contrast or in parallel to more dominant paradigms of mental health or human service response. These paradigm conflicts have often led to notable compromises and struggles for identity within the community mental health services sector. During these struggles several tensions, orthodoxies or myths have emerged to limit the response capacity and to challenge the identity of the community mental health services sector. These orthodoxies claim that:

- The sector provides complementary rather than *core* mental health service responses;
- Good organisational governance and service management is inconsistent with a participatory community management framework;
- Organisations characterised as charitable or voluntary are incompatible with professional approaches to service provision;

- The sector can be usefully characterised or is a ‘non-clinical’ service provider;
- The distinctions and practice separations which exist between public, private and not-for-profit non-government service providers is valid in today’s context;
- The community mental health sector has no profit motive.

Before discussing the current day challenges arising from these orthodoxies, it is important to note their emergence at different points throughout the history of community mental health services in Australia.

Early 20th century – Seeking to establish a community-base to redress an imbalanced ‘mental health system’

During the first quarter of the twentieth century in NSW, a broadly based Lunacy Reform League was active in lobbying for support services to enable the discharge of people from institutional care. Other groups, including psychiatrists, were advocating legal provisions for voluntary treatment which they argued would reduce the need for institutionalisation.[iv] Interestingly, and perhaps considerably ahead of their time, the League and other community groups argued for programs to both help people avoid incarceration as well as to resume their lives in the community.

The NSW Aftercare Association was established in 1907 by concerned citizens with support from prominent mental health professionals to provide discharged psychiatric patients with residential care.[v] Is it reasonable to ask whether this was the first ‘step-down’ program?

The return of traumatized soldiers from the First World War (and later in the century, from the Second World War) hastened the call for treatment and support in the community. The NSW Association for Mental Health was established in 1932 and set about lobbying for a broader range of both treatment and support services.[vi] Similar associations were to be established in the other states and territories throughout the second half of the 20th century.

All of these early developments arose out of community concern about the imbalanced and limited range of services for people experiencing mental illness and their families. The community-based supports that arose were largely or initially provided by dedicated groups of volunteers. Hence, key components of the community mental health sector’s identity had begun to emerge during this period, namely, its community base and its strong relationship with voluntary and charitable organisations.

Perhaps surprisingly, the ‘sector’, at least in NSW, was not consigned to just providing support either side of hospitalisation, with support services being provided both during admission and prior to discharge. This early example of co-operation and co-ordination between public mental health services and community mental health services was perhaps greater than what exists today.

1940s – Responding to individual need locally

In the 1940s in Victoria, Prahran Mission established a voluntary drop-in centre which was increasingly used by people having been discharged from mental health institutions. Consumer feedback reported that:

> *‘it felt like a really safe place to be. It was warm, friendly, nurturing, protective.’* [vii]

It was not until the 1980s that a small amount of government funding was received to support this initiative. This period continued to shape another aspect of how government viewed the community mental health sector's identity, namely a largely voluntary and charitable force which could provide valuable support with no or minimal financial assistance from government. It also strengthened how community mental health services viewed their own role, particularly the centrality of the concern to respond to individual need, locally, in the environs where people live. There was also a sense of organisations and groups reaching out to understand the support that people actually wanted and needed.

1950s – Articulating a non-government identity and a recovery and rehabilitation role

The 1950s in NSW saw the establishment of the Psychiatric Rehabilitation Association of NSW (PRA). Its early initiatives included the Aftercare Club which was a 'self help' initiative aimed at supporting people in their return to the community, and the formation of a supported employment program because people were not able to get or maintain employment in the open market. PRA was one of the first community mental health organisations to receive government funding. It did so reluctantly because

> '… *the Board feared a loss of independence and with it the ability to speak out and if necessary, criticise government policy'.* [viii]

Later in this decade, GROW, originally known as 'Recovery', a self help and mutual support grassroots organisation, was established in NSW. It is important to note the strength of the recovery concept in the community mental health sector as early as the 1950s. This period of identity formation was marked by an emphasis on maintaining a separation or distance from government even if that meant reliance on volunteers and charitable and philanthropic contributions and donations. Hence, the 'non-government' component of their identity had begun to be articulated by service providers.

1960s and 1970s – A reluctantly state-funded provider of complementary but non 'core' services

The 1960s and 1970s were a period of rapid identity formation in community mental health. Organisations including PRA, Richmond Fellowship and the NSW Aftercare Association established or expanded group homes and other supported accommodation programs. Mental Health Associations were active in promoting community understanding of mental illness. Employment programs were expanded. In NSW, this was, in part, a response to the Royal Commission into Callan Park's recommendation that people with mental illness have the right to employment.

Overall, this era saw an expansion in drop-in services, accommodation, vacation programs, mutual support and work/employment initiatives mirrored by public mental health services establishing similar programs in some states. Collaboration between the two sectors was reflected in the work of hospital auxiliaries and groups of citizens who lobbied governments for change and for new service types.

Support groups for families also emerged. These included now iconic organisations such as ARAFMI in NSW and later in other states, and organisations like the Schizophrenia Fellowship which were initially concerned with a specific mental

illness. These organisations were soundly embedded in the community having their beginnings around kitchen tables followed by a series of public meetings.

In this era organisations such as PRA commenced talking about psychosocial rehabilitation. Richmond Fellowship explored the role of therapeutic communities in recovery and rehabilitation. Importantly, optimism was growing about the capacity for recovery and participation in the community. Mental illness was being viewed in the community mental health sector as curable rather than a life long sentence of exclusion. But other paradigms of mental illness clearly held sway in policy and practice. Government acknowledgement and support for the developing community mental health sector was severely limited in both vision and financial commitment. It was not however, non-existent.

Queensland Mental Health, reflecting back on this at a later time, concluded that:

> '… *historically the nongovernment sector was afforded minimal recognition in the system of service delivery and policy development. The mental health service system lacked a coherent and deliberate strategy to include the non-government sector in all aspects of service delivery.'* [ix]

Governments continued to describe the activities of the community mental health sector as voluntary, charitable and nongovernment, thereby giving minimal recognition to the services provided or their roots in community need. In an historical reflection, the National Health and Medical Research Council (1979), in its report, 'Voluntary Activity in the Field of Mental Health', claimed that nongovernment organisations were seen to function in areas of relative shortage of professional services and could substitute for professional services and provide a cheaper alternative.[x] These were clear depicters of ancillary or complementary service provision, somewhat non-essential and certainly, non-professional in nature.

Despite these conceptions of the community mental health sector, governments and administrators were, in fact, attempting to articulate a service system involving public, private and nongovernment organisations. Ways were being sought to tie the commonwealth government into funding non-government service development to support clinical and hospital-based care. Dr Barclay, Director, NSW Psychiatric Services in 1971 stated:

> *'I consider that an important role could be played by PRA in developing a program, preferably based on a permanent centre, which would have as its aims the provision of a social experience, the supervision of vocational rehabilitation, and the placing and supervision of ex-patients in suitable accommodation…. One would hope that with the new Commonwealth attitude towards such projects, some arrangement could be entered into whereby Commonwealth finance was attracted to such a project.'* [xi]

So as early as the late 1960s and early 1970s, community mental health organisations were being viewed as a complementary service provider, but a service provider to whom states were reluctant to transfer state funding. This policy context of Commonwealth/State responsibilities perhaps explains the failure of state governments to make that transfer of resources both during the early phases of deinstitutionalisation and some might argue, still.

1980s – Formation of 'peaks', emphasis on community management and service innovation based on local need and a growing 'core' status

The 1980s saw the beginnings of growth in community mental health services in both NSW and Victoria. In NSW in the late 1970s and early 1980s community mental health organisations were talking with each other about the need for a peak body. From 1982, an organising committee met regularly and began to engage community organisations, public mental health services and government in discussion about how to establish a peak body. In 1985, funding was received to establish what became known as the Mental Health Coordinating Council of NSW.

In Victoria, a systematic growth in community mental health services was associated with formal acknowledgement of a policy and program of deinstitutionalisation, a process which had already been occurring for some 30 years but which had not been formally acknowledged at a governmental policy level. With this policy acknowledgement in the early 1980s, a small funding program was established in Victoria to support the development of services through community organisations.

In order to assist in the development of appropriate services and to act as a community voice in support of the now established policy of deinstitutionalisation, the Victorian government provided funds and directly sponsored the establishment of a peak body for community organisations providing services to people with mental illness and their families. VICSERV (Victorian Voluntary Mental Health Services) Inc. was established in 1986 and worked collaboratively with its government sponsor despite a growing frequency in the exchange of terse messages, to raise the profile and resourcing of existing services and to assist communities to take up newly developed funding opportunities.[xii]

Two years after its foundation, in 1988, VICSERV sought to lay claim to the sector's own identity and to move away from the understandings of the sector's role entrenched in government policy. At this time VICSERV underwent a name change to encompass 'community-managed mental health services' within its title. This direction eventually proved to be a serious challenge to its relationship with government.

This was an exciting time and place where communities were encouraged to identify local mental health needs, think outside the square, propose strategies and service responses to address those need and apply for and receive funding. One outstanding example of this was the Macaulay Community Support Association Inc. The evaluation of the first three years of operation reported on an in-home or outreach community support service which:

- Dramatically cut the 'revolving door' readmission rates of its high needs client group;
- Made significant gains in addressing stigma and discrimination in the local community and within the context of a high density public housing estate;
- Demonstrated a capacity to develop an effective collaboration between public mental health and community sector workforces; and
- Worked from a highly participative community management framework.

Importantly, on the simple measure of 'revolving door' readmission, financial calculations at the time established that this service delivered an efficiency dividend to government of three times its funded cost during the first three years of its operation.[xiii] This and other new services fundamentally changed views about what achievements were possible through community mental health services. It proffered serious challenges to established views about the roles and responsibilities of the community mental health services sector.

By the end of the 1980s, in Victoria and in developments elsewhere, community mental health services were providing a broad church of services which included housing, accommodation and support, respite, outreach and community rehabilitation, psychosocial rehabilitation day programs, employment services, advocacy, mutual support and self help, information and referral, promotion and prevention. Even so, the sector's service provision was limited in many instances by the lack of linkages between health and human services and by a lack of a mental health service and policy framework which focused energies on responding to the needs of people with mental illness and their families at the point where those needs were occurring. That is, in the community.

David Plant in 1989 enunciated a key challenge for the sector and government to develop a model of care inclusive of:

> *'… community outreach, support, and linkage, housing and income, and expanded community services.*[xiv]

Plant called for government funding programs to develop a national framework for providing the full range of community based support services. In both Victoria and NSW, at least, there was a sense in which community mental health services were acknowledged by government as service providers who could initiate new core service types. There were significant limits to that recognition and support. In reality of course, community mental health services had been devising and providing core mental health services responsive to community need for many years, in fact at least as early as 1907. Other states, sooner or later throughout the next two decades, also established peak community mental health organisations.

The 1990s – Rapid expansion and an emphasis on 'non-clinical' and service partnerships

The 1990s saw a rapid expansion in community mental health services in Victoria and a slower but positive development in other states, particularly in Queensland, Western Australia, South Australia and Tasmania. Many things fuelled this development, including the Australian Human Rights and Equal Opportunity Commission's Inquiry into the Human Rights of People with Mental Illness, the advent of the National Mental Health Strategy, a successful community campaign to include psychiatric disability within the new Commonwealth Disability Services Act of 1992, and in several states, the further dismantling of institutions around Australia.[xv]

Although still generally considered a state government responsibility, the Commonwealth government, having acknowledged the extent of its existing commitments under Medicare and through social security provisions, entered the mental health service delivery landscape through a number of new programs. New initiatives included the Disability Employment Program, seed funding to establish the Australian Psychiatric Disability Coalition (APDC), and reform incentive funding associated with National Mental Health Plans.

Generally speaking, however, Commonwealth funding and commitment to the community mental health sector remained very low. In 1991 a House of Representatives report gave legitimacy to the calls for a national peak community mental health organisation to advance nationally the representative work which was occurring at state level.

'this would have the benefit of allowing government to be informed across a broad range of community services and health issues'. [xvi]

Importantly, the Committee recommended the *'funding of both consumer and service provider organisations to achieve comprehensive representation'*. [xvii]

The APDC was formerly established in 1992 to provide a representative voice for the community mental health sector. It became known as the 'psychiatric disability' Coalition in part to reflect the sector's concern to champion non-illness based models of care and service delivery and to position the sector in relationship to existing commonwealth funding programs as a provider of disability support and non-clinical mental health services.

The impact of this positioning was evidenced in Victoria where the sector was rebranded to reflect both the emerging philosophy of service as well as program funding sources. Its peak council became known as 'Psychiatric Disability Services of Victoria (VICSERV)'.

Both VICSERV and APDC experienced significant periods of conflict with government in consequence of challenging the limited roles afforded to the sector by both national and state mental health policy frameworks and service plans. From the beginning, the 'non-clinical' aspect of the sector's new identity did not sit well. One reason was that large numbers of clinicians had begun to work for community mental health services. They of course brought their clinical training, knowledge and expertise with them and helped to design and shape new service types. Describing many of these new service models as 'non-clinical' did injustice to the resulting therapeutic, personal and social outcomes they achieved.

By the mid 1990s much service development and expansion was occurring at the ground level. In the space of a few years, several minimally funded community mental health organisations had become large and well funded organisations. At this time, one commentator described the sector throughout Australia as '*trying desperately'* – trying desperately to provide new, innovative and expanded services with severely limited, though increased, policy and funding support.[xviii] Relatively speaking, the small community-based organisation appeared to become smaller and less able to compete for new funding opportunities, whilst the larger organisations became larger and possibly more remote from the communities that had led to their establishment.

The larger organisations increasingly were consumed with responding to requests for tenders by all levels of government whilst the smaller organisations felt overwhelmed by the level of community need they were witnessing first hand. This included growth in complexity of need, poverty, homelessness, unemployment and engagement with the criminal justice system. It is possible that this growth in complexity of need was directly related to the failure by national initiatives to adequately fund services which were able to respond to this complexity of need at the point where it was occurring. That is, in the community. Certainly, major inquiries since have identified a link.

By the end of the 1990s more state/territory governments were giving more voice to acknowledging the advantages of 'non-government' community organisations. In 1996 Queensland Health listed the advantages of nongovernment community organisation as service providers, identifying a long list of characteristics including adaptability to community need and 'consumer friendly' relationships.[xix]

Despite agreement about the unique nature and contribution of community mental health services, this period of rapid growth through competitive tendering, resulted in many community mental health services struggling to maintain the characteristics upon which they were founded. In the competitive tendering environment, the sector's connection to local communities was increasingly under threat because service developments were directed by the centrally determined priorities and service design preferences of funding bodies. New services were less likely to be community 'owned' and 'shaped'. Commitment to community, consumer and carer participation in governance was tested as 'community management' was considered antithetic to the demands of professionalization and corporatization. Further, some organisations, rather than openly sharing expertise and experience, began to license its use and charge other services for something that once was freely exchanged. At the same time, the sector clung to its identity as being 'not-for-profit' and fundamentally different from the private or business for profit sectors.

The Report of the Mental Health Forum on Intersectoral Linkages (July 1995) sought action on the problems created by a competitive tendering environment and identified the need for community and health services including mental health services to collaborate and expand existing service provision.[xx]

Throughout the 1990s, the community mental health sector around Australia was loudly voicing the need for the establishment of significant funding programs for community mental health organisations, for expanded community education and individual advocacy, and for affirmative action strategies in a range of policy areas including housing, income support, disability services and home and community care services. The sector was clearly stating that it had the expertise and knowledge to play a key role in providing these core services.[xxi]

The New Millennium – Rapid challenging of orthodoxies and the struggle to remain community-based and centred

For the community mental health sector the new millennium has heralded an exciting era, promising of self determination and a newly afforded status as a service provider acknowledged as integral to the mix.

Community mental health services around Australia, through their peaks[xxii], have set about defining and stating their strengths, roles, responsibilities. [xxiii] Simultaneously with this public declaration of identity as defined by the sector there has been an increased acknowledgement by government of the role of community mental health services.[xxiv] Recent initiatives under the COAG National Action Plan and administered by FAHCSIA have recognised the importance of investments in the community and have significantly increased the small (relative to need) base of government financial contributions to mental health community services provided by non-government organisations. Still lacking, is a consistent national framework that is shaped by, and accountable to, the people and communities directly affected.

Despite this increased acknowledgement, program investments in community mental health services have remained extremely low compared with other OECD countries such as New Zealand and the United Kingdom. In New Zealand three quarters of all funded services are community based and 31% of total expenditure is directed to mental health community services provided by non-government organisations.[xxv] In contrast, the Australian *National Mental Health Report 2007,* reported that only 6.3% of mental health expenditures are directed to mental health community services provided by non-government organisations, with this level varying markedly across the states and territories.[xxvi] However, there is movement with consideration being

given in the ACT, for example, to the development of a mental health services system in which investments in community mental health responses command a resource share on a similar scale to that reported in New Zealand.

Current national programs could be further enhanced through development of a *National (Commonwealth and State) Community Mental Health Services Strategy.* Such a strategy would utilise and further develop the capacity of mental health community services to implement new and innovative prevention strategies in order to intervene early and minimise personal, family and social dislocation.

Recently, community mental health services throughout Australia represented by each of the state/territory peaks have collaborated to form a national alliance known as Community Mental Health Australia. CMHA identifies community mental health services as an:

> '*… integral component of Australia's mental health service system, leading the way in the promotion of social inclusion and recovery focused services.*
>
> *Mental Health Community Services:*
>
> - *prevent crises in the community;*
> - *avert homelessness and family dislocation;*
> - *reduce demand for high cost acute inpatient services; and*
> - *divert people away from inappropriate involvement with the criminal justice system* [xxvii]

The formation of CMHA is a significant milestone. Until quite recently the community mental health sector across Australia has had limited opportunity to articulate a national vision and plan for its future development. Even so, the sector by year 2008 has grown considerably and includes over 800 community groups providing recovery and support services.

The year 2008 is also presenting the sector with a number of important challenges as it seeks to shape its identity nationally. The Australian government is challenging orthodox conceptions about the roles or 'turf' of public, non-government and private service providers and of the career pathways of their employees. On 1st May 2008, The Australian (newspaper) reported:

> *Mr Rudd has called for contestability in the provision of tax-payer funded services, insisting he had no preference for one sector over another. 'Service delivery should be contestable', Mr Rudd said. 'This means that we will sometimes support services being delivered by those outside of the public sector but with the proviso that we examine all the costs and benefits of service delivery options .. '*
>
> *Mr Rudd said he wanted public servants to have hands-on experience with business, finance, logistics and strategic planing. He also wanted the bureaucracy to include people with experience in the third sector of voluntary and community organisations. .. Indeed we should encourage Australian public servants to spend time working in the private sector, the community sector and in overseas public sector roles, as opportunities to build a broader skill base.* [xxviii]

The sector is also being challenged about its 'not-for-profit' nature, internally by larger organisations who are rapidly expanding their income base and externally, by the growth of social entrepreneurialism. In a publication soon to be released, Nic Frances calls for non-government, voluntary or not-for-profit community organisations to operate as 'social businesses'. He notes:

> *The growing recognition that corporate social responsibility benefits businesses as well as the community and that welfare organisations will only be effective when they start exploring social enterprise and corporate partnerships.*[xxix]

How the sector responds to these challenges must be weighed against how it responds to its biggest challenge, namely, the struggle to remain centred on people with mental illness, their families and communities. It is important at this stage, that the sector ensures that its community-based roots and core values are brought to the fore. The community-base must not be lost in the struggle to attain a larger slice of the spoils.

It is clearly time for the sector to be acknowledged and supported as an effective partner in the national reform arena alongside government, consumers and carers, key professional bodies and other national stakeholders. The sector must ensure that people with mental illness, their families and their local communities are equal partners in this next phase of development and identity building. It is imperative that there be reflection on Ife's assertion that it is only when '*all aspects of service delivery are in fact controlled at community level by the people most directly affected, that human services can be said to be genuinely community-based*'.

Conclusion

It is timely for the sector to consider the orthodoxies, tensions or myths that have emerged during the struggle to define itself. The following questions are possibly a good starting point for such a process of self-reflection.

- Should the sector view itself, or allow itself to be portrayed, as providing 'complementary services' when it has been addressing core mental health needs and providing core service responses from as long ago as 1907?
- Is the sector solely, or at all, a provider of services which are 'non-clinical'? Is this a useful distinction to make or does it simply mask the nature and complexity of the community mental health problem and the sophistication of service types and technologies which have developed to address it?
- Are the distinctions and practice separations between private, public and nongovernment service providers valid in today's context? If not, why have these barriers to integration not been more effectively broken down and how can this be achieved?
- Is a charitable or voluntary ethos truly incompatible with professional approaches to service delivery?
- Is good organisational governance and service management inconsistent with a participatory community management framework, or might it be enhanced by it?
- Is the community mental health sector unaffected by profit motive and if not, what parts of its community focused identity are up for sale? History suggests that the sector, in part, has been capable of making this sale.

The way in which the sector answers these questions will influence the extent to which it can legitimately stake its claim to being community based and community focused. The extent to which the sector remains community based and community focused, will influence the extent to which it achieves its full potential as a provider of core mental health services in the community.

References:

[i] The authors acknowledge that the historical account provided in this paper is limited by its reference to their familiarity with developments in NSW, Victoria and Queensland, over and above other states and territories.

[ii] Ife, J. (2002) *Community Development: community-based alternatives in an age of globalisation*, Longman, Sydney, 92
[iii] Craze, L. with Phillips. J. & Petrovski, B. (2007) *Building Capacity in the ACT Community Mental Health Sector*, Mental Health Community Coalition ACT, Canberra, 12-13
[iv] Sydney Labour History Group (1982) What Rough Beast: The state and social order in Australian history, Allen & Unwin, 106-107
[v] 'Mental health care group marks 100 years' accessed at: http://www.abc.net.au/news/stories/2007/10/10/2055566.htm
[vi] Chesterton, J, Maller, S, & Turner, B. (2005) PRA, The Story: Celebrating 50 years Golden Jubilee Publication, PRA, Sydney, 21
[vii] Prahran Mission (2002) Happy Birthday Open House: Celebrating 21 years of partnerships, Prahan Mission, Melbourne, 4
[viii] [viii] Chesterton, J, Maller, S, & Turner, B. (2005) PRA The Story: Celebrating 50 years Golden Jubilee Publication, PRA, Sydney, 32
[ix] Mental Health Branch Queensland (14 February 1996) Information Paper: Mental health specific service responses by non-government community organisations, Queensland Health, Brisbane (Written by Amanda Hammer), 18
[x] National Health and Medical Research Council (1979) *Voluntary Activity in the Field of Mental Health, Commonwealth Government Printer*, Canberra, 21
[xi] As reported in Chesterton, J, Maller, S, & Turner, B. (2005) PRA, The Story: Celebrating 50 years Golden Jubilee Publication, PRA, Sydney, 35
[xii] Source: Personal reflections of Leanne Craze and David Plant who worked at VICSERV during this period
[xiii] Montague, M. (1991) *The First Three Years 1987 – 1990: An Evaluation on the Macaulay Community Support Association,* Macaulay Community Support Association, Flemington
[xiv] Plant, D. (1989) A new paradigm in mental health. *Health Issues* 19, June 1989, 19
[xv] Source: Personal reflections of David Plant, who was at the time the founding Executive Director of APDC, and Leanne Craze who was then the initial Secretary of the HREOC Mental Illness Inquiry
[xvi] The Parliament of the Commonwealth of Australia, House of Representatives Standing Committee on Community Affairs (February 1991) *'You Have Your Moments': A Report of Funding of Peak Health and Community Organisations*, AGPS, Canberra, 12
[xvii] Ibid, viii
[xviii] Wade, T & Associates (May 1995) *Trying Desperately: The role of non-government organisations in an integrated system of care for people with psychiatric disability or acquired brain injury*, The Australia Psychiatric Disability Coalition Inc & Head Injury Council of Australia Inc., Canberra
[xix] Mental Health Branch Queensland (14 February 1996) Information Paper: Mental health specific service responses by non-government community organisations, Queensland Health, Brisbane (Written by Amanda Hammer), 20-21
[xx] National Mental Health Strategy (July 1995) *The Report of the Mental Health Forum on Intersectoral Linkages*, A collaborative exercise established by the Health, Housing and Community Services Ministers, AGPS, Canberra
[xxi] Australian Psychiatric Disability Coalition Inc (October 1999) *Achievements in Intersectoral Mental Health Care: An Evaluation Study*, A National Mental Health Strategy Project funded by the Mental Health Branch, Commonwealth Department of Health and Aged Care, 18
[xxii] For example: VICSERV (2002) *Defining the Role and Functions of the PDSS Sector – The VICSERV Consultation Report and Recommendations to DHS*, VICSERV, Melbourne; Mental Health

Coalition of South Australia (2006) *The Roles, Strengths and Functions of the Community Mental Health Sector (non-government),* Paper 1, MHCSA, Adelaide; MHCC NSW (15 November 2005) *Building Effective Non-Government Mental Health Services in NSW,* MHCC, Sydney; Craze, L. with Phillips. J. & Petrovski, B. (2007) *Building capacity in the ACT Community Mental Health Sector*, Mental Health Community Coalition ACT, Canberra, 12-13

[xxiii] For example, Mental Health Coalition of South Australia (2006) in *The Roles, Strengths and Functions of the Community Mental Health Sector (non-government)* articulates the strengths of community mental health services as including community linkages, community capacity building, participation by consumers and carers, accessibility of information and services, value and quality in service delivery, flexibility, partnership-based and a skilled, committed and motivated workforce (Paper 1, MHCSA, Adelaide).

[xxiv] Mental Health Council of Australia (2006) *Time for Service: Solving Australia's mental health crisis*, MHCA, Canberra; Council of Australian Governments (2006) *National Action Plan on Mental Health 2006-2011*, COAG, Canberra

[xxv] Counties Mankau website http://www.cmdhb.org.nz/Counties/News_Publication/Planning-documents.htm Accessed 30 October 2006

[xxvi] Department of Health and Ageing (2007) *National Mental Health Report 2007: Summary of twelve years of reform in Australia's mental health services under the National Mental Health Strategy, 1993 – 2005*, Commonwealth of Australia, 34 -35

[xxvii] Community Mental Health Australia (2008), Internal Working Documents

[xxviii] *The Australian*, 1 May 2008, 4

[xxix] Accessed at http://www.allenandunwin.com – Nic Frances with Maryrose Cuskelly (2008) *The End of Charity: Time for social enterprise*, Allen & Unwin, Sydney