Submission National Mental Health Commission
National Review of Existing MH Programs & Services

Background

In February 2014, the Minister for Health, Peter Dutton announced the Terms of Reference for a Review of Mental Health Services and Programmes. The wide ranging review being undertaken by the National Mental Health Commission fulfils a Coalition election commitment which the Government stated is aimed at delivering mental health services and programmes more efficiently and effectively. The National Mental Health Commission (NMHC) has engaged with state and territory governments and other stakeholders in undertaking the review and invited all interested people and organisations to make a submission to inform the Commission's deliberations.

This review has sought to "examine existing mental health services and programmes across the government, private and non-government sectors. The focus of the review will be to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community."

The Terms of Reference stated that:
Programmes and services may include those that have as a main objective:

- The prevention, early detection and treatment of mental illness;
- The prevention of suicide;
- Mental health research, workforce development and training; and/or
- The reduction of the burden of disease caused by mental illness.

The review will also consider:

- The efficacy and cost-effectiveness of programmes, services and treatments;
- Duplication in current services and programmes;
- The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programs except where they have mental health as their principal focus);
- The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services;
- Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments;
- Existing and alternative approaches to supporting and funding mental health care;
- Mental health research, workforce development and training
- Specific challenges for regional, rural and remote Australia;
- Specific challenges for Aboriginal and Torres Strait Islander people; and

- Transparency and accountability for outcomes of investment.

The submission process designed to focus input to help the Commission to meet the review Terms of Reference, with a timeframe deadline of 14 April 2014, the final report to be provided to the Government by 30 November 2014.

The Mental Health Coordinating Council (MHCC) provided feedback via the online survey, which was the method provided to the community. In order that members may review our comments, we have provided the section headings and questions asked, together with our responses in this document.

Evidence of the Mental Health 'System' Working Well

1 Please provide an example from you own experience (or that of your organisation) of a service, programme, policy or initiative demonstrating value for money.
HASI (NSW) – a strong partnership model between Government departments (Health & Housing) and specialised psychosocial support services (NGOs). It has been evaluated for the NSW Government by the SPRC to demonstrate a substantial cost saving to the public MH system and strong positive outcomes for participants. Similar models now exist in Victoria, Queensland and South Australia.

While traditionally a state responsibility, much of NSW HASI appears to be transferring to the responsibility of the NDIA. There will need to be careful work done at Commonwealth, State and local levels to ensure that the successful partnership model is retained.

2 An example of an innovative approach to funding, organising, or delivering mental health support:
Developed by MHCC in collaboration with the NSW Consumer Advisory Group, the Recovery Oriented Service Self-Assessment Toolkit (ROSSAT) is a robust validated organisational and workforce reflective practice assessment process developed from the ground-up through extensive consumer and carer consultation. It has been evaluated and adopted across the community mental health sector, as well as more broadly within public and involuntary settings (although these are currently trials in response to the National Recovery Framework, and require further development).

3 An example of good integration, joint working, or collaboration with other services, programmes or initiatives:
The NSW Community Hub model, funded by the Ministry of Health, and piloted in two sites, is a good example of collaborative care across human service providers. These services include supported employment, primary health care, counselling, clinical services, housing support, carer support, and others. Crucially, they are accessible at single site, a "no wrong door" approach, through multiple referral processes, including self-referral.

Headspace is a strong model of innovative, practical and effective joint service delivery. Many in the child and adolescent MH sector see it as a best practice model, as do many in the

international mental health community. The NSW Community Hub model is a similar adult-focused service that borrows heavily from the design of Headspace services.

4 An example of a service or initiative which supports the needs of the whole person (e.g. physical health, housing, education and training):

The Health Prompt – Neami
The Health Prompt is a tool that guides workers in conversations around physical health with consumers. Consumers are offered the opportunity to complete the tool on a six monthly basis. Responses are recorded and consumers are supported to engage with appropriate health services and to develop follow-up plans.

Back On Track Health (BOTH) Program – RichmondPRA
BOTH support people to manage their own physical health. Staff work with people who use the service to find out what health issues they would like to manage and

5 Up to 2 examples of services, programmes, policies or initiatives which effectively target and meet the mental health needs of specific communities:
Adults Survivors of Childhood Abuse (ASCA) provides an Australia-wide support network that helps people affected by childhood trauma. They also provide support services, training and education to the human service sectors on Trauma Informed Practice.
The Catholic Community Services (CCS) Hoarding and Squalor service is a unique specialised response to a group of people with complex needs, who are generally very isolated, not well understood, and are unable to access mainstream services. This service type was initially in-scope for the NDIS, but now appears to be at risk.

6 An example of effective and efficient use of reporting:
The detailed reports on national and jurisdictional mental health activity by the AIHW are essential resources for policy development. The community sector remains mostly absent from these reports, or if reported is insufficiently detailed.

7 An example of a service, programme, policy or initiative which is not subject to unnecessary red tape (e.g. approvals processes, extensive forms, reporting etc.):
Block funded group support programs for people with enduring psychosocial support needs, such as those provided under the Day to Day Living program, clubhouses, and supports for less severe issues (e.g. Men's Sheds).

8 An example of effective monitoring of outcomes and experiences to drive service improvement:
MH-COPES, currently undergoing review, has been develop in NSW over a 10 year period to monitor consumer experience of care in public MH settings. It has developed an extra high level of trust through the implementation employing primarily consumer-workers (peer) and by publicly reporting outcomes and evaluations. This has enabled the Ministry of Health to review its policies and practice directions with access to a genuine consumer voice.

9 An example of meaningful involvement of people living with mental health problems and/or their families/supporters:
RichmondPRA is a model Commonwealth-funded organisation regarding how it operationalises inclusion practices for people with lived experience and their carers. Every level of service delivery, organisational structure and governance includes employed people with lived experience at professional pay rates. There is a senior executive manager appointed with the role of oversight and development of innovative inclusion and participation practices.

10 An example of clear public accountability for the outcomes of investment:
The HASI program is one of the few mental health programs that was properly resourced and evaluated to demonstrate the economic savings derived from the service partnership and delivery outcome data. Results were undeniably beneficial to consumers, their families, and the community. The similar IPRSS program in South Australia has also been thoroughly evaluated and found to generate major cost-savings to the state and Commonwealth governments.

11 An example of regular and effective use of evaluation or research to inform evidence-based practice:
The Australian Centre for the Study of Sexual Assault (ACSSA) is hosted by the AIFS. It is a central collection point for information and resources for sexual assault and trauma, and their health impacts on survivors. Its key role is to facilitate access to research evidence to support organisations, agencies and others to develop policy and practice directions.

12 An example of effective workforce planning, development or training:
MHCC Learning and Development is a Registered Training Organisation at the forefront of industry-based training and professional development. It has won multiple industry awards through its consultative sector research approaches. Its unique positioning within the NSW peak body enables a dynamic cycle between policy, practice, sector development and sector feedback. The reputation of MHCC LD as a provider of recovery-oriented material has led to national and intersectoral projects including the development of the National Peer Workforce Qualification.

13 An example of the use of technology to improve the experience or effectiveness of services:
Lifeline's online chat service, which began two years ago, is a rare example of a professionally implemented and thoroughly evaluated online crisis support program. Through a client needs analysis, Lifeline identified a cohort of the population which was being under-serviced by their traditional phone-based support services. The online chat service was accessed far more by younger and predominantly female clients, but is well known as a service available to all people in the community needing crisis support. Evaluation data demonstrated very positive outcomes at a low cost-point.

14 Any other example of a service, programme, policy or initiative which has proven to be efficient and effective and has resulted in good outcomes for people experience:
Dialectical Behaviour Therapy (DBT) is a cognitive behavioural approach that emphasises the psychosocial aspects of treatment. It has proven to be very effective with people with a range of disorders that are particularly impacted by intense emotional affect. DBT is model (approach/

method) of teaching skills that assist people control their distress. Practitioners of this model range across professional disciplines, enabling a broader spectrum of specialised mental health service providers able to employ this effective therapeutic model.

Evidence of the Mental Health 'System' NOT Working Well

1 Please provide an example of services, programmes, policies or initiatives (from your own experience or that of your organisation) which demonstrate or encourage…

- Short term funding of NGO services (e.g. Govt. funding "at the last minute")
- Pilots studies with good evaluations that do not receive ongoing support
- Insufficient contact of primary health care at points of mental health engagement

2 An example of an inappropriate balance or prioritisation of funding:

- Over-representative funding of hospital-based services. VERY EXPENSIVE.
- There should be more balanced community/hospital mix. There should be more that 50% allocated to community, and half of that should be NGO-based.
- Better Access funding (MBS psychological services) is uncapped, and has been demonstrated to be under-used by those most in need of this form of MH service access. There is string anecdotal evidence that psychologists and allied health professionals are charging equivalent out of pocket fees above the Better Access schedule.

3 An example of where different services, programmes, policies or initiatives are not well integrated or don't communicate with each other:

- Drug and Alcohol and Mental Health still predominantly work in silos, with massive ideological and practice approach differences. The number of people with co-existing issues is a compelling case for more development of collaborative processes and policy initiatives.

4 An example of the needs of the whole person not being effectively addressed or met (e.g. physical health, housing, education and training):

- The shrinking of social housing and worsening housing affordability crisis are leaving people with mental illness without anywhere to turn to.
- Physical health still requires much more attention. All MH services should be responsible for reducing negative physical health impacts (e.g. medication related problem such as obesity, diabetes and heart disease).

5 An example of practices which result in people living with mental health problems and/or their supporters having a poor experience:

- Seclusion and restraint
- Services not understanding or minimising the impact of the service environment on people who have experienced trauma
- The overutilization of police in responding to episodes of mental illness in the community (e.g. psychosis)

6 Up to 2 examples of services, programmes, policies or initiatives where the specific needs of particular communities are not effectively recognised or met:

- The overuse of the criminal justice system as the only means to treat people with co-existing cognitive disability and mental illness.
- Almost no long-term interventions are available nationally for people who have experienced childhood abuse. This is especially important given that these people characteristically occupy many service places across the human services.

7 An example of excessive red tape (e.g. unnecessary and burdensome reporting requirements taking resources away from service delivery):

One example is the need for a full assessment by the NDIA in order to access any services. As per the MHCA proposal, there should be a more tiered response BEFORE psychosocial disability is documented in order to reduce demand for the NDIS.

8 An example of failure to use outcomes monitoring as a quality improvement tool:

There is little evidence that outcome measurement is being compared between inpatient settings and community equivalents. This is needed to establish the cost/benefit of maintaining expensive bed-based places for people capable of being cared for in the community. Limitations placed on the scope of Activity Based Funding (ABF), exacerbates the problem.

9 An example of failure to meaningfully involve people who use services in their design or delivery (e.g. by incorporating their feedback):

The NDIA has developed many processes without inclusion of consumers, carers and NGO service providers during the construction of the assessment and package-development process. Recovery-orientation at an agency-wide level is poorly understood.

10 An example of unclear or opaque accountability for outcomes:

The National Mental Health Service Planning Framework has been in development for many years, yet very little of it has been made public. This is an essential planning tool for all stakeholders of the MH service system. Access to this information would ensure that we better understand the gaps in service delivery and strengthen efficient allocation of services where necessary.

11 An example of a locality/area where there is duplicated provision of services or programmes:

In general, there are too few community services available, especially in rural, regional and remote areas. Where it is perceived that there is a duplication of services, often those services provide support for specialist needs in that location.

12 An example of an area, state or territory where there are gaps in services or programmes:

- Community services in general.
- Access to Psychiatric services in rural, remote and underprivileged area. Especially for children and adolescents.
-

13 An example of where research activity is poorly prioritised, funded or organised:
Whilst governments demand the evidence of outcomes, there is very little interest by government agencies in developing a strong data infrastructure or research system for non-government organisations. This leads to skewed "evidence" of better outcomes in publicly funded MH services and a tendency to support programs based on hospital-led research.

14 An example of poor use or planning workforce/human resources:
The development of the NDIS has occurred without an appropriate Workforce Development Strategy for psychosocial disability capacity building. Recruitment, retention, training and development for psychosocial disability workers are markedly different to generalist disability skill-sets. Many workforce initiatives for disability services explicitly exclude psychosocial disability services.

15 Any other example of a service programme, policy or initiative which has proven to be inefficient or ineffective and has not resulted in good outcomes for people
Arbitrary reductions in funding of Commonwealth mental health programs will result in worse outcomes and greater demand on inpatient psychiatric services.

Actions Needed for Change

1 One practical step to improve things in the mental health system would be:
Increase funding for mental health services to match the evidence for burden of disease. This means that mental health should be at least 14% of the national health budget.

Within mental health there are also specific service types that are comparatively underfunded within the mental health service system. This includes community managed mental health services, access to mental health specialists in rural and remote services, Aboriginal and Torres Strait Islander mental health services, specialised homelessness and mental health services, as well as others.

2 A second step to improve things in the mental health system would be:
Broaden community education and information to address conditions other than those addressed by Beyond Blue.

Stigma and discrimination are still big issues with no well-funded national public campaign for the more prevalent conditions.

3 A third practical step to improve things in the mental health system would be:
Work with the NGO to develop highly functional, flexible and efficient data systems to reduce administrative burden, create more accountability, and build the evidence for innovative services.

Your views on Mental Health Programmes Funded by the Australian Government

1 Do you/your organisation have an interest in commenting on Commonwealth-funded mental health programmes?
Yes

2 Please indicate the programme/s you wish to comment on:

- ✓ Better Access to Psychiatrists, Psychologists and GP's under the Medicare Benefits Schedule
- ✓ Access to Allied Psychological Services (ATAPS)
- ✓ Mental Health Services in Rural and Remote Australia
- ✓ Personal Helpers and Mentors (PHaMs)
- ✓ National Suicide Prevention Programme

3 Please briefly your involvement with the programme/s (e.g. as a provider, stakeholder, consumer, family member, carer, professional administrator etc.)
MHCC is the NSW Mental Health peak body for community managed mental health organisations. Our members provide a range of clinical and psychosocial support services. The organisation works with its members in a number of diverse contexts, including consultations, sector development projects, research, training and policy development. We are also a founding member of Community Mental Health Australia, which is an alliance of the eight states and territory mental health peak bodies.

4 Please indicate in which state(s)/ territories/town(s)/area(s) your involvement is or has been (or if national, state 'national').
State and National

5 Please describe what, in your/your organisation's experience, has worked well with this/these programme/s. Please include brief concrete example/s of good practice:

- Better Access has improved more general access to Psychological services across demographic boundaries, especially in rural and remote settings.
- ATAPS has addressed an important need reducing limitations on access to Psychological services for people in low income brackets.
- PHaMs has been evaluated by consumers and carers as one of the most empowering models of support in the community. Its open program structure has allowed the flexibility to tailor against unique needs with a very easy referral method.

6 Please describe what, in your/your organisation's experience, has NOT worked well with this programme/these programmes. Please include brief concrete examples:

- Better Access has an uncapped fee-for-service structure which is dependent on individual professional discretion. It has resulted in limited access for people who cannot afford major gap payments.

- Better Access also suffers from poor understanding of Psychological models of treatment by GP's. This leads to waste and poor outcomes. There is no accountability for GP referral outcomes.
- ATAPS has been very poorly promoted in the community across service sectors.
- Mental Health Services in Rural and Remote Australia are very thin on the ground. In some areas they are completely absent across the mental health spectrum.
- PHAMS is being absorbed into the NDIS. However, as PHAMS was an effective program designed to cater to people with either moderate or severe mental health conditions, the NDIS is primarily targeted to people at the severe end of the spectrum. There is a growing service gap emerging for people not eligible for NDIS but still need support in order to stay well in the community.
- The National Suicide Prevention Program does not sufficiently address issues concerning people at risk of suicide after they are discharged from Psychiatric facilities.

7 Please describe what specific actions, in your/your organisation's view, would improve the design, delivery or operation of this programme/these programmes in future:
MHCC urge the Commonwealth to acknowledge that they have a responsibility to provide sufficient support services for people with mental health conditions. This stretches beyond the confined remit of the NDIS. Substantial new gaps are being created between the current combined responsibilities of the states and the NDIS.

Your views on Special Issues

1 Do you (or your organisation) have an interest in commenting on any of the following issues?

- Mental health in Aboriginal and Torres Strait Islander communities
- Mental health in rural and remote Australia
- Mental health research
- Mental health workforce development and training

2 What is your/your organisations view about the current provision of support for Aboriginal and Torres Strait Islander people's mental health?
There needs to be ongoing workforce capacity building in the area of cultural competence. It is necessary that all practitioners and support workers are able to work with Aboriginal consumers (and other people from diverse cultures).

What specific action or strategy do you think has the potential to improve this?
Training across all disciplines in cultural competence needs to be enhanced and there also should be ongoing support, e.g. scholarships, mentorships etc., for training the Aboriginal workforce, including peer workers.

3 What is your/your organisations view about the current provision of mental health support in remote and rural Australia?
Problems in R & R are:
Key issues that need to be addressed and resourced in rural and remote areas include:

- A lack of local services and mental health professionals (e.g. doctors, mental health professionals, financial advisers, government agencies) also sexual assault and child/adolescent services
- Improved access – support services are too far away or too expensive.
- Some communities have only periodic access to specialist mental health workers, who may visit the area from a nearby regional centre. This can create difficulties in regard to early intervention, the building of positive patient-clinician relationships, and the continuity and effectiveness of treatment.
- GPs may be only point of contact and their level of experience varies with the treatment of various mental health conditions.
- Suicide is a major problem particularly amongst young men, adult men and Aboriginal young men and adult men. There are shortages of early intervention services and psychological support. Access to ATAPS is limited by the 6 week allocation
- Waiting lists, lack of treatment options or the need to travel to access health care services may result in many people with mental health problems or illness who do not access support services, or who are not seen until their condition has deteriorated significantly.
- More information and support resources available from GPs, mental health services and online.
- People try to manage problems without support due to stigma / fear of being judged by others in the community / concerns regarding confidentiality
- Issues affecting mental health of young people in rural areas including: isolation, lack of employment opportunities, lack of confidence in the future, lack of leisure activities, boredom and limited transport options

What specific action or strategy do you think has the potential to improve this?

- Services should be offered in a more integrated model of care across service systems and types – one stop shops or hubs within a community setting where relationships can be built between clients and professionals and where professionals can support their clients and each other. This could include other non-health related services such as legal, home-care etc.
- Importance of cross disciplinary training and working in teams across sectors.
- Greater recognition of interface between health/mental health and a more holistic approach to health care.
- Recent changes to remuneration and travel reimbursement for psychiatrists in NSW has led to some practitioners being reluctant to continue visiting remote regions. It is necessary to further accommodate and offer incentives for practitioners to travel far afield, not make claims and reimbursement more onerous.
- Establish a well-funded travelling clinical care program that employs professionals in a way that promotes careers and has community profile, like the flying doctors.

4 What is your/your organisations view about the current funding, organisation and prioritisation of mental health research?

- Current funding in MH research provides few opportunities for research conducted by the MH community managed sector. Given the growth of services in the wake of a realignment of services from public to community, it is vital that the sector has the

resources to profile and measure their programs, service models and practice and present its findings.

- Particularly important in this area of research is to evaluate services that provide care coordination across coexisting conditions, e.g. MH, D & A, physical and cognitive disabilities, trauma and complex psychosocial disability etc.

What specific strategy do you think has the potential to improve this?
Promote MH as a priority area for research/research into practice

- Ensure research is embedded with practice outcomes
- Specific provision for funding stream for CMOs working in MH and coexisting conditions
- Provide backup in services to enable CMO employees to conduct service based research.

5 What is your/your organisations view about the current way mental health workforce development and training is carried out in Australia?
Directions for implementation of the inaugural National Mental Health Workforce Strategy and Plan (2013) are fragmented subsequent to the demise of the national Mental Health Workforce Advisory Committee in late 2012 with implementation accountability now sitting with the National Mental Health Drug and Alcohol Principle Committee.

The work of the HWA MH WF Reform Project Advisory Group (Peer Workforce Project, Core MH Capabilities Project and MH Workforce Data Project) has slowed with much of its current work plan having been achieved. Further government directions for MH WFD are uncertain given possible delays with endorsement of the NMHSPF (including uncertainty surrounding their workforce).

The SPQS is establishing a MH Working Group and the relationship between this, HWA and other entities undertaking former MHWAC work need to be better understood (i.e. AIHW, MHISS, NMHDAOPC). The recently reviewed National Practice Standards for the Mental Health Workforce (2013) had now been made publicly available with no formal launch or fanfare (minimal applicability to community sector settings, unlike the 'capabilities' that are under development). WFD directions continue to not be sufficiently inclusive of the community sector MH workforce. This is a major concern given policy and funding direction for more MHSs to be delivered from community sector settings.

What specific action or strategy do you think has the potential to improve this?
A national workforce strategy that promotes psychosocial skills and competences in the NDIS workforce which utilises 30 years of experience and expertise developed by the community managed mental health sector.

Any Extra Documentation

1 If you have any further comments, please briefly state them in the box below or use the link to upload further documentation relevant to the review.

The National Mental Health Service Planning Framework (NMHSPF) is an important tool that should be made public as soon as possible. Without the information about where gaps have emerged, it is hard to plan for the future.

Additional document:

Community Mental Health Australia (CMHA: 2012). Taking Our Place — Community Mental Health Australia: Working together to improve mental health in the community. Sydney: CMHA. Available at :http://mhcc.org.au/media/3056/cmha-taking-our-place.pdf

Corinne Henderson

A/Chief Executive Officer

Mental Health Coordinating Council

April 2014