Fifth National Mental Health Plan

Response to draft for consultation

MISSION AUSTRALIA

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Mission Australia's submission on the Fifth National Mental Health Plan

About Mission Australia

Mission Australia is a national non-denominational Christian organisation that delivers evidence-based, client-centred community services. In the 2015-16 financial year we supported over 131,000 Australians through 452 programs and services. We work with families and children, youth and people experiencing homelessness and also provide specialist services for mental health, disability and alcohol and drug issues.

We deliver community mental health services in most States and Territories, including Personal Helpers and Mentors (PHaMs), Partners in Recovery (PIR), Family Mental Health Support Services (FMHSS) and others. Our Community Mental Health Position Statement is at **Attachment A**. In 2015-16 we assisted 7,657 consumers through our 43 specific mental health services and 22,566 people with mental health issues across all of our 452 services nationwide.

In collaboration with clinical care, Mission Australia provides psychosocial support that assists people to achieve their desired goals and aspirations along their recovery journeys, improving wellbeing, building individual and sector capacity, and strengthening communities.

Executive Summary

Mission Australia welcomes the opportunity to comment on the draft Fifth National Mental Health Plan ('the Plan'). Ideally, the Plan should be an important guide for the mental health system in Australia at a time when the National Disability Insurance Scheme (NDIS) is rolling out and many changes are taking place at the Commonwealth, State/Territory and regional levels. It should be an opportunity for governments to show leadership on mental health, direct the priorities of government and non-government service providers and build a more integrated system that will better meet the needs of Australians with mental health issues.

While we broadly support the seven Priority Areas identified and the Actions within each, we also believe that the Plan falls short of its promise and note a number of gaps and issues. We have particular concerns about the lack of interaction between the mental health system and the NDIS, both in terms of the exclusion of a number of people from eligibility for support and problems with implementation for those who are eligible. This is reflected in the lack of discussion in the Plan about the impact of the NDIS on the rest of the mental health service system.

The other issues and gaps are as follows, and are detailed later in our submission:

- The Plan does not adequately articulate the respective roles of governments and the non-government sector;
- In some cases, the Plan's Values are not reflected in its Actions;
- There is a lack of focus on service availability and workforce shortages;
- There is no inclusion of the National Mental Health Commission in the monitoring and reporting of the Plan; and
- The Plan needs a strong implementation plan to be developed in parallel to ensure that Actions are carried out.

Our submission addresses each of the Plan's Priority Areas and then turns to these issues in detail.

Summary of recommendations

1. That a specific Action be included under Priority Area 1 to address the integration of mental health with other service systems.
2. That the planning tools developed under Action 1 support both information-sharing and formal systemic collaboration between different agencies and providers at the regional level.
3. That the Plan recognise the importance of funding psychosocial and community-based mental health supports and integrating them with clinical treatment and supports.
4. That findings from the LifeSpan trial be drawn upon to inform future suicide prevention efforts across Australia, and if relevant, future iterations of the National Mental Health Plan.
5. That a target be adopted for having the same level of the Australian general population trained in Mental Health First Aid as in general first aid.
6. That priority be given to suicide prevention programs in Aboriginal communities that encourage self-determination, community governance, reconnection, community life, restoration and community resilience, in accordance with the evidence base.
7. That findings from the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project's Final Report be drawn upon to inform Indigenous suicide prevention activities under the Plan.
8. That the National Consensus Statement on the physical and mental health of people with a mental illness be drawn upon to inform Actions under Priority Area 5.
9. That Action 20 specify a basic level of training in mental health for all healthcare workers.
10. That Actions 19 and 20 include peer support approaches to reducing stigma and discrimination.
11. That Action 19 include an ongoing commitment to early universal education about mental health issues at school.
12. That Action 19 include a community mental health campaign for redressing stigma and discrimination against people with a severe mental illness.

13. That Action 22 be broadened to include aligning the National Standards for Mental Health Services with the National Standards for Disability Services, as well as with the National Safety and Quality Health Service Standards.
14. That an Action be developed to support data linkage of regional, State/Territory and Commonwealth data sets to better understand consumer pathways and outcomes across services and sectors.
15. That the non-government sector be adequately resourced to undertake any additional monitoring and reporting functions.
16. That, as a matter of priority, the Commonwealth and State/Territory Governments resolve issues around future funding, program and governance arrangements to enable people living with a moderate and/or episodic mental illness to continue to receive vital support services.
17. That the Commonwealth and State/Territory Governments, non-government sector and consumers and carers engage in a co-design process to ensure that adequate services are provided outside the NDIS for people living with a mental illness who are ineligible for NDIS funding.
18. That training in mental health be offered to Planners and LACs working with the NDIS.
19. That the Plan consider and clarify the priorities and respective roles of the various levels of government and of non-government sectors in the national mental health landscape.
20. That co-production and co-design approaches are embedded into Actions throughout the Plan.
21. That prevention and early intervention approaches are embedded into Actions throughout the Plan.
22. That refugees and asylum seekers, the LGBTIQ community and people in criminal justice facilities are noted as high-needs cohorts and considered for particular inclusion in the Plan.
23. That an Action be added to the Plan under Priority Area 7 to increase the number of trained mental health services staff in Australia, including increasing the number of peer workers.
24. That the National Mental Health Commission monitor and report on the Plan and its associated Actions.
25. That an Implementation Plan be developed to drive the reform process and ensure that Actions under the Plan are carried out.

Priority Areas in the National Mental Health Plan

Priority Area 1: Integrated regional planning and service delivery

As noted throughout the Plan, the mental health policy and service delivery landscape is severely affected by systemic fragmentation and duplication, and urgently needs to be reformed as a more

integrated mental health system. Coordinated care is vital and efforts at improved integration regionally and nationally are welcome.

Leadership on this issue needs to come from the top. Mission Australia supports the Actions outlined in Priority Area 1, to the extent that they move towards a system where an overarching policy framework is set by governments to guide integration at the regional level via the architecture of Primary Health Networks (PHNs) and Local Hospital Networks (LHNs). It is important that policy frameworks and other documents from the Government are sufficiently precise that all PHNs are able to interpret the guidelines consistently, but also allow for some flexibility at the local level so that the regional bodies have the freedom to make decisions based on local need. However, we also note a number of ways in which the Actions under this Priority Area could be broadened or strengthened to better support integrated planning and service delivery.

At the policy level, there are duplications between the States/Territories and the Commonwealth Departments of Social Services (DSS) and Health (DoH) on both community and clinical mental health. This has led to duplicated and fragmented service provision, with the National Mental Health Commission (2014) describing a *'hit-and-miss arrangement of services and programmes across the country, seemingly based on no discernable (sic) strategy, creating duplication in some areas and considerable unmet need in others'*.[i] It has also resulted in confusion around accountability and questions about which agency 'owns' particular issues. For example, as detailed later in our submission, we are concerned that there is a lack of accountability for people with mental health conditions who are ineligible for the NDIS, which is preventing the size and seriousness of this issue being identified and resolved.

The Plan makes passing reference to the need to integrate mental health care with other policy and service areas, such as housing, education, employment and disability. However, there are no proposed Actions within the Plan that provide guidance on a mechanism for this to occur. We suggest that a specific Action be included under Priority Area 1 to address the integration of mental health with other service systems.

This lack of integration is reflected at the service delivery level and has implications for consumers and carers trying to access services. For example, some of our PHaMs services have found that the distinction between Federal and State programs has caused difficulties, whereby if a PHaMs consumer enters a State-funded program Mission Australia has been unable to continue working with them due to a perceived 'double dip' of funding, whereas in fact the services by each are complementary and not duplicative. Further, when consumers access acute services such as hospitals, the PHaMs staff are not notified or are only contacted when the consumer exits the hospital and has no support services in place. Other services experience similar issues, with, for example, the role of PIR staff being made sometimes more difficult by the lack of alignment between government agencies. For example, if consumers are admitted to a mental health facility, PIR staff will try to remain involved in their client's treatment from the point of admission, but finding the right person to grant the permission can be difficult.

More broadly, information is not always shared well between and within the government and non-government sectors. The effect of this is that consumers have to tell their story repeatedly to service providers and government agencies. An information-sharing agreement or single, shared database between different agencies and providers at the State level (with appropriate privacy safeguards and the informed consent of consumers) would address this issue. Depending on the form this takes, a new system could be developed and trialled at the regional level and then rolled out more widely if successful, or alternatively the existing My Health Record system could be promoted for greater uptake by community members.

Mission Australia's experience in delivering programs suggests that systemic collaboration is vital to good service delivery. We note that good relationships between agencies are important but are not sufficient by themselves to ensure that services work well together. Mission Australia encourages the consideration of mechanisms for systemic collaboration at the regional level to ensure that formal collaborative relationships have a strong basis.

Recommendations:

1. **That a specific Action be included under Priority Area 1 to address the integration of mental health with other service systems.**
2. **That the planning tools developed under Action 1 support both information-sharing and formal systemic collaboration between different agencies and providers at the regional level.**

Priority Area 2: Coordinated treatment and supports for people with severe and complex mental illness

Mission Australia acknowledges the need for more coordinated treatment for people with severe and complex mental illness, but is concerned that there is a lack of focus on people with a moderate mental illness and people with a severe and complex but episodic mental illness both in the Plan and elsewhere. Proportionately, the need for treatment and support for these two groups is much higher than those with an ongoing, non-episodic severe mental illness. However, if they are not included as a priority in the Plan and are in danger of being ineligible for NDIS funding, we are concerned that these groups will fall through the cracks of service provision.

Similarly, the Plan focuses on clinical mental health at the expense of psychosocial and community-based mental health supports, which are vital parts of the mental health service infrastructure available to consumers. Many more people need to access psychosocial mental health supports than clinical treatments, and this should be reflected in the Plan.

Mission Australia is concerned that people with either low-moderate or episodic mental illnesses are in danger of becoming more under-served than at present, as many policy and service delivery frameworks currently focus on people with severe and complex mental illnesses. This trend can be seen in this Plan, as well as in the funding directions being pursued by the States, the NDIS' eligibility requirements for permanency of condition, and restrictions on Primary Health Networks to funding clinical mental health services. We note that psychosocial mental health supports need to be funded

and integrated with clinical supports, to fill in the emerging gaps for people living with low-moderate or episodic mental illnesses.

Recommendation:

3. **That the Plan recognise the importance of funding psychosocial and community-based mental health supports and integrating them with clinical treatment and supports.**

Priority Area 3: Suicide prevention

Mission Australia welcomes the Plan's focus on suicide prevention, and particularly supports the proposed Action 8 to prioritise follow-up care for people who have attempted suicide or are at risk of suicide. People with a mental illness who have been discharged from psychiatric wards or emergency departments need follow-up care, and clarifying the roles and responsibilities of services to ensure that consumers receive the support needed is critically important.

The importance of prevention and early intervention is clear in this area. Mission Australia notes the current LifeSpan Integrated Suicide Prevention trial, developed by the Black Dog Institute, the Centre of Research Excellence in Suicide Prevention and the Mental Health Commission of NSW, which is taking place in four NSW regions. The LifeSpan model involves nine strategies for suicide prevention, including aftercare and crisis care, psychosocial and pharmacotherapy treatments, frontline staff training, school programs, community campaigns and media guidelines. Mission Australia recommends that the results from this program, when available, be drawn upon to inform future suicide prevention efforts across Australia.

Mental Health First Aid training is another positive approach that can engage both healthcare workers and the general community in better understanding and being able to assist people with a mental illness as appropriate. At the recent MHS Conference organised by The Mental Health Services Learning Network (Australia and New Zealand), Dr Arthur C Evans spoke about the intention of the city of Philadelphia to have the same level of the general population trained in Mental Health First Aid as in general first aid.[ii] This could be adopted as a long-term aim within Australia as well.

Recommendation:

4. **That findings from the LifeSpan trial be drawn upon to inform future suicide prevention efforts across Australia, and if relevant, future iterations of the National Mental Health Plan.**
5. **That a target be adopted for having the same level of the Australian general population trained in Mental Health First Aid as in general first aid.**

Priority Area 4: Aboriginal and Torres Strait Islander mental health and suicide prevention

Mission Australia welcomes the focus on Aboriginal and Torres Strait Islander mental health and suicide prevention, as it is an area where there is patently high risk and great need. The recent Productivity Commission report *Overcoming Indigenous Disadvantage: Key Indicators 2016* (2016) showed worsening mental health outcomes for Aboriginal and Torres Strait Islander Australians and much worse suicide and self-harm rates than for non-Indigenous Australians.[iii]

Understanding the Aboriginal worldview on health, mental health and wellbeing is an important foundation for building a culturally appropriate service system for Aboriginal and Torres Strait Islander Australians. This worldview is holistic and '*recognises the importance of connection to land, culture, spirituality, ancestry, family and community, how these connections have been shaped across generations, and the processes by which they affect individual wellbeing*.'[iv]

Research has found that programs that show positive results for Aboriginal wellbeing are those which encourage self-determination, community governance, reconnection, community life, restoration and community resilience.[v]

It is particularly important that Aboriginal and Torres Strait Islander people living with a mental illness are equipped and empowered, have access to appropriate prevention and early intervention approaches, equity of access, quality care, coordination and integration and that progress towards equity is measured. This should all occur within a culturally and historically sensitive framework. Developing the Aboriginal health workforce and peer workforce as well as community consultation and involving communities in service design and delivery are important first steps in more culturally sensitive practices.

We note the recent release by the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (at the University of Western Australia) of their Final Report[vi] and recommend that it is used to inform the Actions under this Priority. The Report outlines a number of success factors in Indigenous suicide prevention initiatives and reports on the following tools and resources developed to support Indigenous suicide prevention activity:

- An assessment tool for evaluating proposals for Indigenous suicide prevention activity;
- A community tool to support the development of Indigenous suicide prevention activity;
- An evaluation framework for Indigenous suicide prevention activity for use by communities, government and Primary Health Networks;
- Interactive maps showing Indigenous suicide numbers and rates by postcode; and
- Fact sheets and discussion papers.

Recommendations:

6. **That priority be given to suicide prevention programs in Aboriginal communities that encourage self-determination, community governance, reconnection, community life, restoration and community resilience, in accordance with the evidence base.**
7. **That findings from the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project's Final Report be drawn upon to inform Indigenous suicide prevention activities under the Plan.**

Priority Area 5: Physical health of people living with mental health issues

Mission Australia welcomes the focus on the physical health care needs of people living with a mental illness. We have endorsed the National Consensus Statement on the physical and mental health of people with a mental illness, *Equally Well: Quality of life – Equality in life*, as an important tool to

address the poorer physical health of people living with a mental illness, and agree that a focus on the physical health of people living with a mental illness is an important way of addressing the mind-body gap in treating and supporting people with a mental illness and moving towards a more holistic response to mental health issues. We recommend that the National Consensus Statement be used to inform Actions under this Priority Area.

Recommendation:

8. **That the National Consensus Statement on the physical and mental health of people with a mental illness be drawn upon to inform Actions under Priority Area 5.**

Priority Area 6: Stigma and discrimination reduction

Mission Australia welcomes the focus on stigma and discrimination reduction, and agrees that 1) people with a severe mental illness and 2) discrimination within the healthcare workforce are important issues to address.

If a more integrated system of care is to be implemented, and a focus to be placed on the physical health of people with a mental illness, the general health workforce absolutely needs to be well-trained in working with people with a mental illness. We suggest a basic level of training in mental health for all healthcare workers to ensure their comfort and confidence in working with people with a mental illness.

We also recommend implementing a peer support approach to reducing stigma and discrimination, as peer workers can serve as role models and exemplars for people with lived experience within clinical settings. As noted by the National Mental Health Commission (2014, p. 120):[vii]

> *Peer support workers are a key component of recovery-oriented mental health services as they illustrate to others the possibility of recovery and participation in social and employment activities, and provide support for their own recovery. Increasing the number of peer workers in mental health services nationally is an immediate priority that will be sustained over the Commission's 10-year implementation strategy.*

Further, we recommend that a community mental health campaign be considered under Action 19. This model has been shown to be effective with anti-domestic violence campaigns such as the White Ribbon campaign, and may be a useful way of promoting a whole-of-community response to the reduction of stigma and discrimination around mental health. We note the success of advertising and other campaigns by, for example, beyondblue, and suggest that these be developed further to generate community awareness, acceptance and non-judgement towards people with a mental illness.

We also suggest early universal education about mental health issues at school to increase awareness and reduce the stigma surrounding mental illness. Mission Australia's recent *Youth Survey 2016* found that mental health was one of the top three issues nominated by young people aged 15 to 19 as the biggest issues facing Australia today.[viii] Providing universal awareness programs through schools on mental health that encourage help-seeking and provide pathways to support, as well as ensuring mental

health services are age and culturally appropriate are important steps in addressing concerns about mental health among young people.

We note the success of programs such as MindMatters, KidsMatter, the Resourceful Adolescent Program and Stay on Track (a mental health and wellbeing program for Year 9 students previously run by Mission Australia in Tasmania), and recommend that government support for these or similar programs be continued. The Youth Mental Health Forum held in October 2016 in the Hornsby Ku-ring-gai area of Sydney[ix] is an excellent example of a positive campaign to raise awareness of the importance of mental health and resilience, led by students from local high schools.

Recommendations:

9. **That Action 20 specify a basic level of training in mental health for all healthcare workers.**
10. **That Actions 19 and 20 include peer support approaches to reducing stigma and discrimination.**
11. **That Action 19 include a community mental health campaign for redressing stigma and discrimination against people with a severe mental illness.**
12. **That Action 19 include an ongoing commitment to early universal education about mental health issues at school.**

Priority Area 7: Safety and quality in mental health care

Mission Australia supports the Plan's focus on safety and quality in mental health care, and particularly:

- Action 22, covering the intended alignment of the National Standards for Mental Health Services with the National Safety and Quality Health Service Standards; and
- Action 26, covering the intended work to improve consistency across jurisdictions in the policy underpinning mental health legislation.

Additionally, we suggest that the National Standards for Mental Health Services could also be examined in light of the National Standards for Disability Services to ensure alignment between the two.

Recommendation:

13. **That Action 22 be broadened to include aligning the National Standards for Mental Health Services with the National Standards for Disability Services, as well as with the National Safety and Quality Health Service Standards.**

Monitoring and reporting on reform progress

Mission Australia welcomes the data collection, reporting and monitoring initiatives outlined in the Plan, but suggests that the Plan also include an Action for exploring data linkage between regional, State/Territory and Commonwealth data sets. This will allow the tracking and monitoring of consumers' service usage and outcomes across services and sectors, should help to further elucidate people's pathways through various service systems, and assess various outcomes from particular service interventions or combinations of interventions.

We support the development of targets and indicators to monitor progress and the prioritising of further research in this field. We also note, however, that the non-government sector needs to be adequately resourced and funded to undertake reporting and capture the impact of services on consumers. This cannot be an additional requirement within existing contracts and payment structures without additional resources being provided.

Mission Australia's own impact measurement model uses a client wellbeing survey which includes measures for mental health. We are rolling it out as a priority to the mental health services that we deliver.

Recommendation

14. **That an Action be developed to support data linkage of regional, State/Territory and Commonwealth data sets to better understand consumer pathways and outcomes across services and sectors.**
15. **That the non-government sector be adequately resourced to undertake any additional monitoring and reporting functions.**

Gaps and issues identified

While Mission Australia welcomes the Plan and broadly supports the seven nominated Priority Areas, we have identified some gaps and issues as outlined below.

Interaction between the mental health system and the NDIS

Mission Australia is concerned about the interaction between the mental health system and the NDIS around two particular issues: a. the exclusion of some people from support eligibility and the lack of clear accountability structures for resolving this, and b. the poor implementation of the NDIS for those who are eligible:

a. **The NDIS design excludes some people from eligibility for support, leaving a very real possibility that these people will fall through the gaps of service provision. There is a lack of clear accountability structures between the mental health system and NDIS for resolving this.**

Mission Australia is concerned that these issues in the transition to the NDIS may have unplanned impacts on people with mental health issues who are likely to 'fall through the gaps'. Some consumers of community mental health programs which are transitioning into the NDIS (such as the Personal Helpers and Mentors (PHaMs) program funded by the Department of Social Services) will be ineligible for assistance through the NDIS as they hope to (and in many cases will) recover from their mental health condition. Indeed, the effectiveness of these programs comes from their explicit recovery focus, which contrasts with the NDIS' explicit focus on permanent disability.

The Australian Government Actuary estimated that there are 56,000 people with 'complex needs requiring co-ordinated services from multiple agencies' – those expected to be broadly eligible for NDIS funding. Outside of this group, there are 103,000 people with severe and persistent mental illness who

are likely to need psychosocial support, and 321,000 with an episodic mental illness, neither of which groups are likely to be eligible for NDIS funding.[x]

Mission Australia is concerned that there is a lack of a clear 'owner' within and between governments for this issue. The confusion around accountability for this issue is, from our experience, preventing the size and seriousness of this issue being identified and resolved. Like Mental Health Australia, we are:

> *… agnostic about which system, and which level of government should be responsible for providing services to this group of people. However, we are deeply concerned that it is currently unclear who, if anyone, has policy responsibility for this cohort and how these issues are going to be resolved.*[xi]

This situation, if not speedily resolved, will cause a rise in the number of people with mental illness in the community with no support. This will have flow-on impacts for other government-funded service systems including homelessness, health (particularly hospital Emergency Departments), education and criminal justice. Accordingly, the Commonwealth has an important role to play to resolve issues around the NDIS transition and ensure that people with a moderate or episodic mental illness do not fall through the gaps of service provision.

We recommend that the Commonwealth and State/Territory Governments, non-government sector and consumers and carers engage in a co-design process to ensure that adequate services are provided outside the NDIS for people living with a mental illness who are ineligible for NDIS funding. Such programs will be particularly important for under-served regions such as remote Aboriginal and Torres Strait Islander communities.

Case study: Gus

Gus* is a client of one of Mission Australia's PHaMs programs, who is suffering from obsessive-compulsive disorder (OCD) and anxiety, which forced him into a vicious cycle of physical and emotional stress and homelessness. After his second visit to the mental health ward, he knew it was time to make a change so he connected with Mission Australia's PHaMs program.

Due to escalating tension as a result of his mental state, Gus was forced to move out of his home. The period afterwards was difficult and the added stress of regularly having to access emergency accommodation only made his condition worse and resulted in several visits to the hospital emergency ward.

Gus's case worker helped him develop a plan of action to address this but it proved to be a difficult task due to his obsessive-compulsive neurosis and the remote community in which he lived. With a combination of a mental health management plan and support from his case worker, Gus was finally able to find permanent housing. He is passing all his inspections and has been able to maintain his tenancy for a year now. Gus's case manager often encouraged him to attend social gatherings in order to help him gain confidence and build his social skills. He uses his newfound confidence to raise awareness of mental illness and advocate for programs such as PHaMs in the hope that his journey can help someone that may be experiencing similar issues. This is essential in a remote location where

services may be hard to find.

Gus is now taking control of his life; however, like many clients suffering from mental illness, the episodic nature of Gus's condition may mean that he won't be able to produce sufficient evidence to be deemed eligible for the NDIS. PHaMs are working with Gus to get a formal diagnosis for his illness which will allow him to apply for the NDIS, however, there is no guarantee that he will be successful.

* Name has been changed to protect privacy.

b. The NDIS is being poorly implemented for those who are eligible for support.

In one region, only eight out of 150 Mission Australia PHaMS clients have been approved for an NDIS package. Mission Australia is concerned that the Planners who are allocating these packages are insufficiently trained in mental health issues and are applying guidelines inconsistently. Some seem to be unaware that mental health issues may satisfy the criteria for NDIS funding, indicating that their work is focused exclusively on people with physical disabilities. In our experience in some regions, neither Planners nor LACs understand psychosocial disability and how mental health affects functioning, as indicated in the examples below. We recommend that training in mental health be offered to Planners and LACs working with the NDIS.

Mission Australia is also concerned about the lack of transparency for consumers who are eligible for NDIS funding and their interaction with the rest of the mental health system. It is not clear whether or how people with a mental illness who are eligible for the NDIS will be able to access services that sit outside the NDIS.

Service coordination under the NDIS

The following is a report from a Mission Australia Program Manager in a PIR service about meetings held to discuss the Individual Funded Plan of two consumers with the NDIS Local Area Coordinator (LAC):

Example 1: We attended the Planning Meeting with the LAC and the consumer. We felt the meeting went well and they were very clear that they would be looking at ensuring the supports that the consumer had were maintained and any gaps identified that could support working towards his personal goals would be included in his first plan. We were very clear about the role of PIR in the consumer's coordination of services and the consumer was clear in his views that he wanted this to continue. When the plan was finalised, it had no Support Coordination and limited amounts in other areas. We requested a review and were advised by the NDIA Planner that the original plan was done by an LAC staff member and clearly did not take into account all the consumer's needs. She advised this was a problem occurring 'across the board'. The consumer subsequently received increases in all areas of support and $5000 for Support Coordination. Although this was a high amount, given that the average support time PIR consumers receive is 80 hours annually, it is still below what is considered to 'maintain existing supports'.

Example 2: The planning meeting included attendance of the consumer, PIR Support Facilitator and LAC

staff. Again the meeting was considered to go well. When the plan was received, the amount of Support Coordination was low at $2,400. This translates to less than 30 minutes per week. The consumer had a variety of NDIS services, as well as non-NDIS organisations and services that related to his goals that would necessitate far more than 30 mins/week support coordination. We contacted the NDIS about reviewing the plan and were advised that the consumer would need to utilise the funds allocated before they would review. We are already up to $900 and will be submitting a request for review soon. The request for a review will come out of the Support Coordination budget which would not be necessary had a more realistic amount been allocated in the first place.

Recommendations:

16. **That, as a matter of priority, the Commonwealth and State/Territory Governments resolve issues around future funding, program and governance arrangements to enable people living with a moderate and/or episodic mental illness to continue to receive vital support services.**
17. **That the Commonwealth and State/Territory Governments, non-government sector and consumers and carers engage in a co-design process to ensure that adequate services are provided outside the NDIS for people living with a mental illness who are ineligible for NDIS funding.**
18. **That training in mental health be offered to Planners and LACs working with the NDIS.**

Articulating the roles of the government and non-government sectors

We noted under Priority Area 1 that there is duplication, fragmentation and lack of integration both at the policy and service delivery levels, with direct implications for consumers, carers and services.

This lack of integration is related to a lack of clarity around the respective roles and responsibilities of the government and non-government sectors. The Plan is a missed opportunity to clarify and articulate the roles and responsibilities of the various levels of governments, and the expected or proposed roles and responsibilities of non-government sectors and other stakeholders in the emerging mental health landscape. The Plan could be an important guide for the mental health system in Australia at a time when the NDIS is rolling out – with all of its myriad implications for mental health services - and many changes are taking place at the Commonwealth, State/Territory and regional levels, including reduced funding for psychosocial and community-based mental health programs. However, it fails both to do this and to set the direction for priorities over the short-, medium- and long-term.

As noted under Priority Area 2, Mission Australia is concerned that many policy and service delivery frameworks currently focus on people with severe and complex mental illnesses at the expense of adequately serving people with either low-moderate or episodic mental illnesses, as manifested in this Plan, the funding directions being pursued by the States, the NDIS' eligibility requirements for permanency of condition, and restrictions on Primary Health Networks to funding clinical mental health services. This reduced focus on and funding for psychosocial mental health services is an important issue that has serious implications for the needs of consumers as well as the mental health workforce and the ability of the non-government sector to attract and retain talented, skilled staff members.

The non-government sector at present does not have a clear view from governments about the type of services governments want to purchase from it. Funding is often sufficient only to cover staff salaries at a comparatively junior level (CSW 3 and below). This makes it difficult for the sector to retain staff with degree qualifications who are required to effectively deliver programs for clients with complex needs. Under the NDIS the situation is likely to be even more confronting, with limited funding for psychosocial services. The amounts set out in the NDIS Price Guide[xii] are not enough to fund complex case coordination or skilled staff particularly once expenses such as developing individual case plans and group programs, travelling time, making and following up referrals and so on have been removed, and indicates that the NDIA is interested in purchasing only very basic support services from the non-government sector. However, this is not explicitly stated under the Plan or elsewhere and remains an issue that needs to be clarified.

Recommendation:

19. **That the Plan consider and clarify the priorities and respective roles of the various levels of government and of non-government sectors in the national mental health landscape.**

The Plan's Values and Actions

Mission Australia is concerned that some of the Values of the Plan are not reflected in its proposed Actions, as follows.

- **Co-production:** Other than a discussion of co-design work with Aboriginal and Torres Strait Islander communities and, to a lesser extent, the Your Experience of Service survey tool, the value of co-production is not given life in the Plan. Mission Australia believes that services have the greatest impact when consumers are fully engaged, and their experience and expectations inform the design, delivery and responsiveness of that service. We are piloting ways to enhance service users' capacity to interact meaningfully with our services, including testing best practice approaches to co-design of services with consumers, the establishment of Client Advisory Groups, having consumers on recruitment and media interview panels and supporting a peer workforce in service delivery.

  Government-led commissioning approaches can facilitate such co-design processes and set expectations for providers to incorporate client voice mechanisms in their practice. Importantly, a long lead time should be factored in for genuine consultation and co-design. We also believe that the sector should be engaged in co-production alongside consumers and carers/advocates.

  However, current timeframes for tenders often preclude co-design, peer worker involvement and respect for religious and cultural considerations (e.g. holiday periods). Care needs to be taken about the timeliness of the release of tenders and governments should build in time for adequate collaboration and co-design to ensure that the most effective programs are designed and delivered. The closer integration of mental health policy and service delivery, as discussed under Priority Area 1, should be an important mechanism for ensuring a more coordinated and timely approach to tender release.

Mission Australia supports developments in moving away from substituted to supported decision making, and privileging approaches whereby a consumers' network can support them to make decisions rather than make decisions on behalf of the consumer. Supported decision making needs to be safeguarded across the mental health system, including in the NDIS.

We take a consumer-led approach to support and work in partnership with people with a mental illness and their carers/advocates. Mission Australia's National Recovery Framework has principles which include enhancing a peer workforce to enable us to better understand the value of lived experience, and realise the many benefits peer workers can bring to recovery focused practice. We actively engage the expertise of people with lived experience in policy development, planning, evaluation, education and training, advocacy and service delivery that is more inclusive to the range and needs of people with lived experience.

- **Promotion, prevention and early intervention:** Prevention and early intervention are almost entirely absent from the Plan, other than addressing suicide prevention as a Priority Area. We know that prevention and early intervention are incredibly important in mental health service delivery,[xiii] and also note that they form the bedrock of approaches to many other health and social policy issues from the Commonwealth and State/Territory Governments. Prevention and early intervention are both effective and cost-effective in addressing mental illness, and should be given greater prominence in the Plan.

- **Equity:** Three key groups with significant mental health needs that are not recognised in the Plan are refugees and asylum seekers, the LGBTIQ community and people in criminal justice facilities:
    - Refugees and asylum seekers: Refugees and asylum seekers who have fled traumatic circumstances have specific mental health experiences and needs, and care has to be taken not to exacerbate those issues through exclusion from the Australian mental health system due to language and cultural barriers.[xiv] There is no mention of trauma or trauma-informed care in the Plan (other than training for the provision of trauma-informed care to Aboriginal and Torres Strait Islander people), although this is a critically important approach for many with mental health issues and particularly for those fleeing trauma as refugees and asylum seekers.
    - LGBITQ community: LGBTIQ people are likely to be at increased risk of a range of mental health issues, primarily due to violence and discrimination. These mental health issues include depression, anxiety and psychological distress.[xv] LGBTIQ people are also more likely to self-harm, have thoughts of suicide, and attempt suicide than are members of the general population. Strategies need to be included to address discrimination, provide outreach and encourage help-seeking and to respond sensitively to the mental health needs of LGBTIQ people when they arise.
    - People in criminal justice facilities: Current access to specialist services is inadequate in the community and in the criminal justice system. Transitional supports are required to

improve prospects for successful reintegration to the community,[xvi] including post-release support tailored to the particular needs of people released from the criminal justice system. Without early intervention and diversion, the costs to individuals with mental health disorders and cognitive impairment, their families and communities, as well as the costs to government, can be extremely high. Such costs increase over time, as people with mental health disorders and cognitive impairment become entrenched in the criminal justice system and are further disadvantaged. Robust, holistic, targeted cross portfolio support and intervention for people with mental health disorders and cognitive impairment would reduce the significant economic and human costs of this group of people cycling in and out of the criminal justice system.[xvii]

Recommendations:

20. **That co-production and co-design approaches are embedded into Actions throughout the Plan.**
21. **That prevention and early intervention approaches are embedded into Actions throughout the Plan.**
22. **That refugees and asylum seekers, the LGBTIQ community and people in criminal justice facilities are noted as high-needs cohorts and considered for particular inclusion in the Plan.**

Adequacy of services and workforce shortages

There are not enough mental health services for the people who need them in Australia. This is true both for community and for clinical mental health supports. In rural and regional areas particularly there is a lack of mental health services, with resources spread very thinly across large geographic areas. Although metro areas are better served, there are still long waiting lists for services.

This shortage of services is closely tied to shortages of staff in the mental health workforce. The shortfall in the mental health workforce is briefly noted in the Plan but no Actions are proposed to address it.

In 2014, the National Mental Health Commission noted that the shortfalls in staffing contributed to inequitable access to mental health services in rural and remote communities, and made recommendations for redressing the shortfalls.[xviii] The experience of our service staff, particularly in rural and remote areas, is that there is still a shortage of registered mental health professionals and inadequate service provision in many areas.

There is also a lack of focus on the opportunities presented by a peer workforce. Other than a single indicator in the proposed national indicators of health system performance and reform for *Proportion of total mental health workforce accounted for by the mental health peer workforce*, there is no mention of a peer workforce in the Plan. As the National Health Commission (2014) noted,

> *Peer support workers are a key component of recovery-oriented mental health services as they illustrate to others the possibility of recovery and participation in social and employment*

activities, and provide support for their own recovery. Increasing the number of peer workers in mental health services nationally is an immediate priority …[xix]

Mission Australia's peer workforce brings together lived experience with the knowledge and skills of mental health practitioners. Peer workers enrich our provision of mental health supports through the direct participation and expertise brought by people with personal experience of mental illness and of accessing supports through community mental health programs, and we recommend that the Plan address increasing the number of peer support workers.

Recommendation:

23. **That an Action be added to the Plan under Priority Area 7 to increase the number of trained mental health services staff in Australia, including increasing the number of peer workers.**

Oversight of the National Mental Health Plan

Mission Australia suggests that the National Mental Health Commission should play an oversight and monitoring role for the Plan. As an independent agency, the Commission is well-placed to monitor and report on the progress of the Plan and the Actions under it.

Recommendation:

24. **That the National Mental Health Commission monitor and report on the Plan and its associated Actions.**

Implementation plan to support the Plan

Mission Australia notes the acknowledgement in the Plan that previous Plans have not been as effective as they could have been, due to the lack of a mechanism for embedding change at a regional or local level. While we also note the different circumstances surrounding the Fifth Plan – with regional architecture now present in the form of PHNs and LHNs, and a focus on monitoring and reporting on reform progress – we also strongly recommend that the Plan should be underpinned by an implementation or action plan that will drive the reform process and set out timeframes for achieving each of the Actions.

Recommendation:

25. **That an Implementation Plan be developed to drive the reform process and ensure that Actions under the Plan are carried out.**

End notes

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Position statement | Community Mental Health

What is Community Mental Health?

Community Mental Health refers to complementary clinical care and psychosocial supports delivered in a community setting to assist individuals on their recovery journey to independent and healthy lives. With a focus on the holistic wellbeing of each individual and community inclusion, community mental health can be provided by the public, private and non-government sectors, and community stakeholders.

Why is Community Mental Health important?

Each year, one in five of all adult Australians – more than 3.6 million people – will experience some form of mental illness. Nearly half of all Australians will experience mental illness at some point of their lives (ABS, 2008).

The impact of mental illness can be severe on the individuals and families concerned and its influence is far-reaching for society as a whole. Less than half of people living with mental health issues access treatment each year, with untreated mental illness incurring major personal suffering and economic costs (Department of Health, 2016). The national response of the health and welfare service system needs to include the individuals and their families accessing programs.

Community based recovery orientated supports are needed to complement clinical and acute care services. They can maximise opportunities to prevent the impact of mental illness by intervening early and reducing the need for crisis care and hospitalisations, while improving individual wellbeing and strengthening communities.

Community mental health services work with people with a lived experience of mental illness in their local environment, encouraging social inclusion and holistic support directed by the individual. These services should be responsive to cultural backgrounds and personal experiences and provide support that is tailored to meet individual needs for ongoing recovery.

In collaboration with clinical care, Mission Australia provides psychosocial support that assists people to achieve their desired goals and aspirations along their recovery journeys, improving wellbeing, building individual and sector capacity, and strengthening communities.

Mission Australia's approach

Mission Australia undertakes the following practices across all mental health programs to provide effective support to people with a lived experience of mental illness:

Recovery Oriented Practice

MA's Recovery Oriented Practice Framework was implemented across all of its community mental health programs in 2016. This framework outlines MA's approach to recovery oriented, person led practice, in order to provide high quality collaborative support to people with a lived experience of mental illness. The framework sets out 10 Recovery Practice Principles that underpin practice and emphasise the importance of self-determination and choice. MA's Quality Program provides a framework for review and continuous quality improvement of our mental health practice and service systems. The implementation of Impact Measurement across our mental health programs assists us to understand the way they positively contribute to the recovery journey of people who access our programs, their support networks and the communities we work with.

Communities of Practice

MA's Mental Health and Wellbeing Community of Practice comprises expert mental health practitioners from MA's Community Mental Health programs across the country, to: share current research and evidence based best practice; hear from experts in research and practice; and inform the development of a range of practice frameworks, guidance, and support to ensure currency and best practice in our services.

Peer Workforce

MA's peer workforce brings together lived experience expertise with the knowledge and skills of mental health practitioners. Peer workers enrich MA's provision of mental health supports through the

direct participation and expertise brought by people with personal experience of mental illness and of accessing supports through community mental health programs. MA is currently developing a Peer Workforce Framework for broader application across our services nationally.

Holistic Care Coordination

MA's community mental health programs work in a collaborative, coordinated and integrated way with individuals, family and friends, specialist support networks and other service providers. This collaboration is essential to providing holistic and individualised support to people who identify diverse and complex needs across all domains of wellbeing.

Partnerships and Collaboration

Partnerships and collaborations are critical to MA's provision of community mental health support because they enable holistic care to better meet the complexity and diversity of individual needs. MA developed and implemented a Partnership Framework in 2015 outlining the core principles and practice standards for services across the organisation. This framework aims to improve collaboration and achievement of shared goals leading to an increase in positive outcomes and community impact.

Mission Australia's Community Mental Health Program

Mission Australia's Community Mental Health Programs provide specialist recovery focused supports to people with a lived experience of mental illness, across the country: the public, private and non-government sectors, and community stakeholders.

New South Wales (28)
- Family Mental Health Support Services (FMHSS)
- Personal Helpers and Mentors (PHAMS)
- Partners in Recovery (PIR)
- Housing and Accommodation Support Initiative (HASI), HASI Plus and Aboriginal HASI
- Resource and Recovery
- Family and Carers Mental Health Support
- Bowering House
- Enhanced Adult Community Living Support

Victoria (1)
- Personal Helpers and Mentors

Tasmania (5)
- Personal Helpers and Mentors

South Australia (5)
- Family and Mental Health Support Services
- Personal Helpers and Mentors
- Partners in Recovery

Western Australia (5)
- Partners in Recovery
- Children and Family Support Service
- Suicide Prevention Program

Queensland (1)
- Partners in Recovery

Northern Territory (5)
- Personal Helpers and Mentors
- Partners in Recovery