1 February 2012

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The Hon Mark Butler MP
Minister for Mental Health and Ageing
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Subject: Ten Year Roadmap for National Mental Health Reform: Draft 4.

Dear Minister Butler

The Mental Health Coordinating Council (MHCC) writes this submission in order to comment on and express concerns regarding the *Ten Year Roadmap for National Mental Health Reform: Draft 4* (the Roadmap) released in January 2012. Whilst we acknowledge that a survey was designed to provide Government with feedback, the questions are so self-focused as to render it impossible to comment on issues outside of its particular interest. Indeed, it gives the impression that it is designed specifically to make broader comment impossible due to the word limit. This is certainly counter to Government's stated objectives to consult widely with the sector and give consumers and carers a meaningful voice in mental health planning and policy development. We propose that a more consultative approach that provides sufficient time for interested stakeholders to comment in a variety of ways would have met with a less hostile response than emanated across the mental health sector. Nevertheless, in addition to this submission which provides recommendations surrounding the issues of concern, MHCC have also completed the online survey.

In the first instance, MHCC suggest that the Roadmap itself is putting the 'cart before the horse'. With a newly established Federal Mental Health Commission commencing operations in 2012, we recommend that the Commission be closely involved in drafting the 10 Year Roadmap, rather than being provided with a document already setting directions for appointees advising Government. Whilst our preference is to go back to the drawing board and identify a 10 Year plan as one of the National Mental Health Commission's priority tasks; on the basis that the Roadmap exists, we comment on its contents as follows.

MHCC are disappointed by the absence of anything new and innovative in the Vision. Moreover, there are a number of areas clearly absent, and others that whilst mentioned, are insufficiently emphasised when they should be highlighted aspects in the Key Directions.

1. As you are already aware MHCC and partner organisations Adults Surviving Child Abuse (ASCA), Education Centre Against Violence (ECAV), and the Private Mental Health Consumer Carer Network Australia (PMHCCN) have been leading the call for a national agenda for Trauma Informed Care & Practice (TICP). Subsequent to MHCC's TICP conference in June 2011, for which you kindly made the opening video address, we established an Advisory Working Group (AWG) to progress the process. The Advisory Group is a small expert group representing the mental health and allied human service sectors, in community, public and private contexts nationally.

The Advisory Working Group is concerned that nowhere in the Roadmap is a Key Direction referring to the need for a cultural shift to trauma informed care and practice across all human service settings; and that acknowledges the need for specific services for adult survivors of trauma including access to a range of short and long-term services across the psychosocial spectrum.

The TICP AWG advocate a key direction which is the development of a national approach to trauma informed care and practice to assist publicly-funded agencies, programs, and services (both in the government and non-government sectors) to create a human services environment that is more supportive, comprehensively integrated, empowering and therapeutic for a diversity of trauma survivors with mental health problems. The Roadmap must identify the problem and set out what needs to happen in terms of policy reform and service delivery.

Trauma-informed programs and services internationally represent the "new generation" of transformed mental health and allied human services organisations and programs which serve people with histories of violence and trauma. Trauma survivors engaged in these services are more likely to have histories of physical and/or sexual abuse as well as other types of trauma including chronic neglect and/or protracted emotional abuse, witnessing domestic violence, civilian involvement in wars and civil unrest, refugee and combatant trauma. Such trauma frequently leads to a diversity of mental health issues as well as other types of co-occurring problems such as poor physical health, substance abuse problems, eating disorders, relationship and self-esteem issues and contact with the criminal justice system. When a human service program seeks to become trauma-informed, every part of its organisation, management, and service delivery system is assessed and modified to ensure a basic understanding of how trauma impacts the life of an individual who is seeking services.

The TICP AWG recommends that:

a) Key Direction 1 recognises the long-term consequences of childhood trauma i.e. complex trauma resulting from all forms of abuse and neglect including living with family violence or dysfunction impacting the mental, physical and social wellbeing of survivors; and the need to promote community awareness to support prevention and early intervention strategies across all human service sectors. This will involve close collaboration between mental health public, community and private sectors and across government departments and health sectors. This is an important priority with the objective to transform service culture and delivery.
b) A cultural shift to trauma informed services must clearly be reflected across all key directions stated in the Roadmap.
c) Both aspects of the key direction above must be supported by targets, goals and outcome measures, with a commitment to a percentage of health care funding achievable by 2022.

Furthermore, MHCC recommend a number of issues be clearly reflected in the key directions supporting the stated 10 Year Vision for Mental Health in Australia, which are:

2. **Aged Care:** Whilst the issue of aged care is mentioned (p.9) in the context of cross government collaboration, the problem of responsibility for people with chronic mental illness transferred from health to aged care services as a result of age and age related disability is poorly addressed. This problem is not just about older people suffering depression and anxiety as a result of ageing, isolation and poor health etc., but because of the characteristically complex needs of people with long-term mental

illness poorly met by an aged care system that is under-resourced and often under-skilled. In many such circumstances challenging behaviours and complex presentations are met with medication and management solutions rather than holistic and recovery orientated care.

3. **Physical health:** Is identified in the Roadmap, but the important relationship to mental health is not clearly stated. The physical health needs of people living with a mental illness have been neglected for decades. Due to poor health care, people with mental illness are more likely to develop chronic diseases at a younger age; have increased drug and alcohol use; experience greater lifestyle risks; develop complex health needs and co-morbidity due to un-treated conditions; are less likely to receive evidence-based treatments and health checks; face barriers in accessing services, and die 15-25 years earlier than the general population. Complex physical and mental health needs may also relate to trauma in that the 'coping mechanisms' trauma survivors may adopt to survive may become risk factors for physical health issues in later life.

   Research shows links between:

   - Depression and anxiety with cardiovascular and cerebrovascular diseases;
   - Chronic pain and suicide;
   - Psychotropic medication and metabolic disorders e.g. cardiomyopathy, obesity, & diabetes; and
   - Co-morbidity and depression

   The link between physical and mental health has been well established, both nationally and internationally, with many studies confirming the need to provide holistic care for people with mental health issues. For this to take place any mental health plan must break down service delivery silos; maximise care coordination by promoting cultural change that supports the recognition of health care as an essential component of the care provided to mental health consumers.

4. **Workplace initiatives:** The Roadmap refers to workplaces needing to support the mental health and wellbeing of employees. Without strong statements and a commitment to initiatives that bring about human rights/discrimination law reform calling employers to account for discriminatory treatment of people with mental illness (supported by a compensation system that does not re-traumatise the victim); linked to OH & S policy that meaningfully protects employees from unhealthy work practices affecting their mental health, such statements (p.5) are but a weak attempt to acknowledge a significant problem.

5. **The role of Community Managed Organisations (CMOs) in integrated systems of coordinated care:** Whilst the Health and Hospital Reform Agenda came into effect in 2011, there is poor recognition of the impact creation of LHNs and MLSs will have upon the Roadmap's big picture. Highlighted as a key direction must surely be the gatekeeping role of GPs providing prevention and early intervention strategies and serving as a link to holistic care coordination that promotes a close relationship to community managed organisations as key providers of integrated services across and between the public, private and community sectors. Nowhere in the Roadmap does the role of CMOs present as critical to integrated systems of coordinated care, or describe how GPs might be supported to undertake an enhanced role.

6. **Recovery Orientated Practice:** The public mental health system has a poor record of responding to mental illness other than via the 'medical model' which tends towards diagnosis, medication and management. An important aspect of promoting care-coordination is the willingness of consumers to engage with a range of service delivery providers. However, many consumers have had poor experiences in the public system, starting with police interactions resulting in hospital admissions. This often leads to a general mistrust of services and professionals. The resulting isolation many consumers experience renders early intervention problematic. Cultural change across public service sectors to incorporate and promote recovery orientated practice into their environment (including clinical contexts) is a must in the Roadmap across Key Directions.

7. **Investment:** The Roadmap loosely mentions future government investments "in services to improve outcomes related to mental illness," (p.8) without making any specific commitment other than to headspace. It is important to name some of the identified problems that need to be addressed and specify where support will be targeted, such as physical health needs of consumers (already mentioned); providing a culture of trauma informed care and access to specific trauma services (already mentioned); services for people with complex mental health needs including those for example with mental health diagnoses of trauma spectrum disorders, drug and alcohol problems, gambling addiction, personality disorders, intellectual disability, and ABI.

8. **Workforce capacity building:** The Roadmap must acknowledge the problem in relation to care coordination particularly in rural and regional Australia and clarify its commitment to workforce capacity building across the sectors. Without substantial commitment, i.e. targets and measurable outcomes across all key directions, the Roadmap is destined to fail.

9. **Naming the problems and actions necessary:** Key Direction 1 loosely identifies some of the risks that can lead to poor mental health and the role Government must play in fostering environments that promote mental health. However, apart from the fact that the Roadmap provides no targets, deliverables or accountability, urgent problems need to be clearly stated, for example regarding the social disadvantage resulting from poverty, substance abuse, childhood abuse and neglect, domestic violence, which all require Government commitment to actions that are concrete. The Roadmap must clearly identify the *how* and *when* and by *how much* rather than using vague language which expresses mostly hope of 'improving, helping, recognising, building, developing and encouraging.'

Lastly MHCC urge the Government to reconsider a number of definitions in the Roadmap Glossary and recommend the following amendments (original in italics):

Non-government organisations: *Private, not-for-profit, community managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, prevocational training, residential services and respite care.*

Recommended alternative:
Non-government organisations (NGOs): Preferably referred to by the sector as Community Managed Organisations (CMOs), these organisations are not-for-profit, or charitable organisations that may or may not be wholly or partly funded by state and/or Commonwealth funding grants. CMOs provide a wide diversity of recovery orientated community based support, advocacy and clinical services for people with a mental health problem or mental illness, and their carers. Characteristically, CMOs provide psychosocial rehabilitation including supported accommodation, employment, living skills, day programs, respite, education and training, peer support, counselling, advocacy and information services as part of the integrated mental health service system.

Peer support and peer support workers: *Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems and/or mental illness to others sharing a similar mental health problem and/or illness. Peer support aims to bring about a desired social or personal change.*

Recommended alternative: Add as a last sentence.
Peer support aims to bring about a desired social or personal change, and peer workers may assist with issues including tenancy, employment, social connection, living skills and community integration.

Person-centred approach: *An approach to service which embraces a philosophy of respect for, and a partnership with people receiving services. A collaborative effort consisting of consumers, consumers' families, friends and mental health professionals.*

Recommended alternative: Add some text.
Person-centred approach: *An approach to service* and assessment of need *which embraces a philosophy of respect for, and a partnership with people receiving services.* It is *a collaborative effort consisting of consumers, consumers' families, friends,* mental health and allied health professionals*.*

Recovery: *A personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life.*

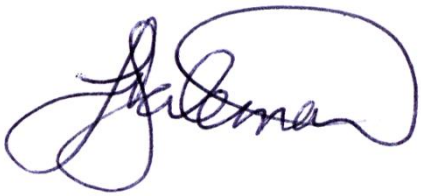
Recommended alternative:
Recovery: Recovery is a deeply personal process and no single, universally accepted definition of recovery currently exists. In the simplest sense, recovery is a lived experience of moving through and beyond the limits of a person's mental illness. In the process, individuals develop a positive and meaningful sense of identity separate from their condition, disability or its consequences in their life. Recovery can occur within or outside the context of professionally directed care and treatment. Recovery is a personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life.

Recommended additional definition
Recovery Orientated Practice: The recovery vision and recovery principles must be incorporated into all aspects of staff development, service planning and delivery. Recovery competencies should be closely linked to staff performance management and reflected in service delivery. This can be achieved through a continuous process of sharing knowledge and information between Mental Health Support Workers,

consumers and carers. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

We thank the Government for the opportunity to comment on the Roadmap and express our willingness to be consulted on this matter in the future. Any further questions regarding this submission please contact me at jenna@mhcc.org.au or Corinne Henderson at corinne@mhcc.org.au

Yours sincerely



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