CALL TO ACTION

Rethink on Community Based Recovery Oriented Approaches to Mental Health

MHCC Position Paper on Policy and Funding

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Mental Health Coordinating Council
Building 125, Corner of Church & Glover Streets
Lilyfield NSW 2040

PO Box 668
Rozelle NSW 2039

For any further information please contact:

Jenna Bateman
Chief Executive Officer
Email: jenna@mhcc.org.au
Tel: (02) 9555 8388 ext 102

Tina Smith
Senior Policy Officer
Email: tina@mhcc.org.au
Tel: (02) 9555 8388 ext 111

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1. Executive Summary

The Mental Health Coordinating Council (MHCC) is the peak body for not-for-profit community-managed non-government organisations (CMOs/NGOs[1]) working for mental health in NSW. The *"Call to Action" Position Paper* has been developed in the lead up to the 26 March 2011 NSW State election to map out a reform agenda to improve the health and wellbeing of people with mental illness, their carers and families and includes recommendations for recovery oriented community based mental health policy and funding directions.

The *"Call to Action" Position Paper* highlights:

- The value and benefits of community based approaches to mental health (i.e. demonstrated efficiencies of NGOs and the need to further develop and transfer a range of existing non-acute public mental health services including supported accommodation, vocational, education and employment support and some rehabilitation programs to NGOs thus allowing public services to respond to psychiatric crisis and focus primarily on acute work toward reducing hospitalisation rates).
- The low level of funding provided to NSW NGOs to provide mental health community support services (i.e. 6.6% of the 2007/08 mental health budget with the national average being 8.3%, NSW ranks second lowest nationally and is the only State with a downward trend in community mental health funding). The Mental Health Council of Australia (MHCA) has recommended NGO funding targets of 15% by 2013/14 and 30% by 2020.
- The need for programs emphasising interagency and interprofessional partnerships as well as consumer, carer and community collaboration to achieve integrated and coordinated care - particularly in the areas of housing, employment, child protection and criminal justice (i.e. this notably also includes but is not limited to homelessness, drug & alcohol and emergency services).

The community mental health sector in NSW consists of an increasingly complex mix of Commonwealth and State funded public, NGO and private providers. The majority of State funding is directed to public mental health treatment programs whose focus is acute/psychiatric crisis management with an emphasis on hospitalisation and medication. NGOs typically provide community based support services that help keep people well in the community by providing prevention, early intervention and rehabilitation programs that support recovery from mental illness. Many also provide clinical/counselling services (e.g. Lifeline and through Medicare access).

Mental health programs delivered by NGOs in NSW are diverse and are fully described in the MHCC's *"Sector Mapping Project Report"* (2010a). They include the following service types:

- Accommodation support and outreach;
- Employment and education;
- Leisure and recreation;
- Family and carer support;
- Self-help and peer support;
- Helpline and counselling services; and,
- Promotion, information and advocacy.

There is a lack of clarity as to which sector has a primary role in the delivery of rehabilitation programs that support people in their recovery from mental illness (i.e. as opposed to treatment).

[1] The NSW not-for-profit, non-government mental health sector prefers the language of community managed organisation (CMO), community based services and community managed mental health sector etc. as this is a more positive affirmation of our value, identity, history and function. However, the term NGO is used in this paper.

Many advocate that rehabilitation programs are likely best achieved through clearly defined integrated care approaches involving public, NGO and private mental health service providers incorporating consumer self-directed care.

To achieve integrated and consumer self-directed care approaches (i.e. rehabilitation programs and recovery oriented service delivery) it is critical to further develop the NGO sector and the programs that it is best situated to deliver. The trialling of new approaches and the transfer of public mental health rehabilitation and support programs more appropriately placed in the NGO sector is recommended thus freeing up already stretched clinical/acute care resources.

The specific existing and proposed programs identified in the *"Call to Action" Position Paper* in the context of advocating for further NSW state funded community based mental health sector development, policy and funding directions are summarised below.

Residential Programs	***Non-Residential Programs***
Existing	
Housing and Accommodation Support Initiative (HASI)	*Employment and Education* – Vocational Education Training and Employment (VETE)
Other non-HASI NSW Health funded supported accommodation	*Family and Carer Support Program* (implementation of Keep them Safe initiative)
	Recovery and Resources Services Program
Proposed	
Step-up and Home Based Outreach (i.e. sub-acute) Mental Health Service (MHCC, 2010b)	*Recovery and Wellbeing Locals* (MHCC, 2010c)

The following mental health policy and funding direction recommendations are made for the four year time period 2011/12 to 2014/15:

Residential

- $20M to develop the 16-24 hour support Extended Care HASI program and increase the availability of 8-16 hour high need HASI beds across the State.
- $15M to trial a sub-acute Step-up and Home-based Outreach Mental Health Service.
- $500K to assess and respond to the housing and support needs of other non-HASI NSW Health funded supported accommodation (including programs currently provided by public clinical mental health services requiring transfer to the NGO sector) and bring these programs into funding equity.

Non-residential

- Ascertain service levels and transfer the VETE program from the public to the NGO sector.
- Increase funding to the Recovery and Resource Services Program (RRSP) from $3M to $6M annually.
- $4.96M annually to further develop the Mental Health Family and Carer Support Program with a specific focus on developing respite programs and building community sector capacity to engage with implementation of the Keep them Safe initiative.
- $4.554M to trial Recovery and Wellbeing Locals.

The MHCC calls on political parties, advocates, consumers, families, carers, the media and the broader community to take action to ensure implementation of the above policy directions. NSW needs the public mental health service to focus on the needs of people in crisis and to reduce readmission rates by investing in development of the community sector to provide home-based outreach and psychosocial support, education, employment and housing in the community where those with mental illness, their families and friends live their lives.

2. Achieving Community Based Recovery Oriented Approaches to Mental Health

The *"National Mental Health Policy"* (2008) defines recovery as:

> *"A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources."*

More simply stated, recovery is about being connected to the community in meaningful ways and facilitating this is where the strengths of the community managed mental health sector lie. The importance of the concept of recovery to mental health treatment and support service provision was further emphasised during recent review of the *"National Standards for Mental Health Services"* (2010a) with the introduction of a new standard *"Supporting Recovery"* and *"Principles of Recovery Oriented Mental Health Practice".*

For too long people with a mental illness, their carers and families have endured fragmented and under-resourced services that might be more accurately described as a crisis management system rather than a recovery oriented mental health system. The community has increasingly welcomed moves from all sides of politics to address mental health sector development toward achieving community based and recovery oriented treatment, rehabilitation and support services (including increased levels of funding). However, lobbying must continue to implement more planned and effective approaches.

The *"Fourth National Mental Health Plan: An Agenda for Collaborative Government Action 2009 - 2014"* (2009a) commits all governments to achieving a mental health system that enables recovery, prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and support to enable them to participate fully in the community. Knowledge of the concept of recovery is critical for achieving these outcomes as it is about so much more than the absence of mental illness and related symptoms or the availability of hospital beds and medication.

Achieving the government's stated policy objective of recovery oriented service provision requires the evidence base for the social and environmental determinants of health to be better understood and to inform the development and implementation of programs and policies. The continuity, coordination and range of primary, multidisciplinary and sub-acute health and community services available to meet the health and social needs of people living with mental illness also needs to be better understood and strengthened. National Health and Hospital Reform (NHHR) is now providing an important opportunity for review of community based mental health services (MHSs) and NSW risks being greatly disadvantaged in this process as a result of historically low levels of funding for community care delivered by NGOs.

In NSW, the MHS system will continue to be stalled and dysfunctional in the absence of forward thinking regarding the positioning of community MHSs. Ongoing development of primary and secondary community based MHSs is essential to ensure access for the two in three Australians who need MHSs and do not receive them (a rate of access that has remained unchanged since first benchmarked in 1997 by the *"National Survey of Mental Health and Wellbeing"*, 2009b). The MHS system cannot continue to be acute care focused and hospital based. It must be inclusive of the social determinants of health and wellbeing (e.g. income, employment and housing) and to work with the community sector and other government agencies to more effectively and efficiently meet need.

The World Health Organisation (WHO; 2008, 2007 & 2003) provides a rationale for the many benefits of, and guidance for establishment of, community based MHSs and these are more fully described in *Attachment 1 – WHO Optimal Mix of Mental Health Services Pyramid*. This model is highly reliant on "informal" MHSs delivered by NGOs and that support client self-care. Specialist mental health treatment services should be the least frequently used MHS and achieving this requires a well-developed community based mental health sector. While the WHO model provides a good vision for a best practice system of service delivery it does not give guidance as to how countries might best re-orient service delivery in-line with the model or the nature of the services (i.e. medical, psychological and social) to be provided.

Over the last 16 years, the NSW Labour government has understood the need to transition services from hospitals to the community but this has not been achieved. The value and benefits of, and directions for, community mental health sector development are documented in the NSW Health publication, the *"NSW Community Mental Health Strategy 2007-2012: From Prevention and Early Intervention to Recovery"* (2008). A major component of this Strategy is the enhancement of specialist community mental health rehabilitation services delivered through a partnership between public sector MHSs and by specialist mental health NGOs to promote recovery and reduce the disability associated with mental illness. Unfortunately, the Strategy does not include specific activities or targets for this to occur and fails to clarify the differential roles of respective service providers. There is also a lack of key performance indicators or outcome measures against which the success of the Strategy can be measured.

NSW accountabilities for mental health largely lie embedded within the *"NSW State Plan: Investing in a Better Future"* (2010a) and *"A New Direction for NSW: State Health Plan – Towards 2010"* (2007) and these are insufficient for achieving meaningful sector reform that reflects the known value and benefits of community based approaches. The indicators are largely about reducing hospital readmissions within 28 days, increasing consumer satisfaction and increasing the community participation of people living with mental illness, including employment (see *Attachment 2 – Mental Health Targets in the NSW State Plan and State Health Plan*). There is only one target that relates to program development and this Position Paper seeks to redress that situation.

Alignment with national directions and accountabilities for community mental health sector development is needed and, as demonstrated next, NSW lags well behind most other States and Territories in this regard.

3. Provision of Community Mental Health Services in NSW

The revised *"National Standards for Mental Health Services"* (2010a), *"Fourth National Mental Health Plan"* (2009a) and *"National Mental Health Policy"* (2008) emphasize the importance of community based and recovery oriented MHS provision. The most recent statistics available indicate that between 1993 and 2008 the proportion of mental health funding spent on community care increased nationally from 29% to 53% (*"National Mental Health Report 2010"*). However, the scale and pace of change varies considerably between States and Territories as do directions for mental health service delivery by NGOs.

Funding of NSW Community Mental Health Services

In NSW, mental health funding continues to be mostly spent on hospital based care. According to the "*National Mental Health Report 2010"* the proportion of funding to community MHSs in NSW only shifted from 30% to 45.8% - a decrease from 46.9% in 2002/03 and NSW ranks second lowest amongst the States/Territories with the national average being 53.4% and Victoria ranking highest at 65.8%. NSW also ranks second lowest among States/Territories for funding to NGOs at just 6.6% of the total mental health budget compared to the national average of 8.3%. Most growth to NGO mental health funding has been achieved in the last four years.

Public Mental Health Services

The 2009/10 NSW mental health budget is $1.2B. In 2007/08, NSW Health delivered public community MHSs had 2.24M contacts with 216K people (*National Mental Health Report 2010*). It is not known what sorts of services were provided or the outcomes that were achieved for these people through these contacts. Most contacts are likely related to the management of acute psychiatric crisis to prevent hospitalization. However, it is known that the degree to which this was achieved is greatly limited by the lack of availability of community based rehabilitation and support services.

NGO Mental Health Services

The development of the NGO mental health sector in NSW has been defined by both organic and government funded strategic growth at different points in its history. Despite strong evidence for the effectiveness of recovery oriented approaches and the clear role the community sector has in promoting and applying recovery principles and supporting social inclusion for mental health consumers and carers, the dilemma for the sector lies in its struggle to fully take its place as an integral and contributing part of the mental health system in its own right.

Mental health programs delivered by NGOs in NSW are diverse and are fully described in the MHCC's *"Sector Mapping Project Report"* (2010a). They include the following service types: accommodation support and outreach; employment and education; leisure and recreation; family and carer support; self-help and peer support; helpline and counselling services; and, promotion, information and advocacy.
http://www.mhcc.org.au/documents/Sector%20Development/MHCC%20Sector%20Mapping%20Report%202010.pdf

Little is known about private sector mental health services in NSW although significant enhancements to Medicare funding for MHSs has increased their availability for those that can afford them as well as opportunities for partnerships in service delivery. However, it must be noted that partnership opportunities and care coordination will be limited by the prevalence of NGOs providing mental health support services within Medicare Local catchment areas.

4. Interagency Partnerships & Collaboration

Community MHSs – and especially NGO MHSs – focus on the social determinants of health and wellbeing. This requires strong linkages with a wide variety of health and community service providers as well as consumers, their families and carers, and the mainstream community. Organisational cultures of partnership and collaboration are seen as a major strength of the NGO sector. Interagency partnerships and collaboration – or integrated/coordinated care approaches – take into account a person's wider social environment, especially in the key areas of housing, employment, child protection and criminal justice (i.e. this notably includes but is not limited to homeless, drug & alcohol and emergency services). They also take into account the informed choices of the client in choosing the services to be received (i.e. consumer self-directed care).

The Council of Australian Governments (COAG) *"National Action Plan on Mental Health 2006-2011"* (2006) takes a whole-of-government approach, based on recognition that many of the determinants of good mental health are influenced by factors beyond the health system. It also recognises that effective services to support consumers and their families and carers towards recovery require coordination between the health system and other areas of government service delivery, including housing, disability services, family services, education and workforce training and development. A priority area of the COAG mental health plan is care-coordination with the agreed outcome of increasing the ability of people with a mental illness to participate in the community, employment, education and training, including via an increase in access to stable accommodation. Regrettably, this priority was not resourced and outcomes have been modest in this area. The *"Fourth National Mental Health Plan 2009-2014"* (2009a) is subtitled *"An agenda for collaborative government action in mental health"*.

The NSW Government's *"Interagency Action Plan for Better Mental Health"* (2005) is focused on improving the coordination of services to realise three key aims:

- Prevent or intervene early in the onset of mental illness;
- Improve community support to those who need continuing care; and,
- Improve coordinated responses to mental health emergencies.

Providing psychosocial rehabilitation services that facilitate recovery demands care coordination approaches - even more so than providing either treatment and/or support or approaches that are simply about where the money and programs are located. This requires service role delineations, referral pathways and joint review mechanisms that are person-centered and ideally self-directed by the person living with mental illness rather than "case managed". Achieving good practice in care-coordination also requires a range of residential and non-residential community based mental health program types from which a person living with mental illness might make choices about what they need to help with their recovery at different stages of their illness and across the lifespan (i.e. beyond hospital beds, medication and crisis intervention).

The NSW Health *"NGO Program Review Recommendations Report"* (2010) makes a number of proposals to improve the way things work in administration, accountability and service delivery for both NGOs and NSW Health. The essence of the reforms will allow a greater integration of NGOs with all their skills, knowledge and community connectedness into the planning process. As the report states: *"one of the broad outcomes of this Review is that NSW Health and the NGO sector should strengthen partnerships to improve health service planning across all health services in NSW"* (p36).

All of the following *"Call to Action" Position Paper* policy and funding recommendations are about developing a mental health sector that: is community based; recovery oriented; uses integrated care approaches; and, is consumer self-directed.

5. Policy and Funding Recommendations

MHCC makes seven specific recommendations for community based mental health sector development, policy and funding directions for the four year time period 2011/12 to 2014/15. In discussing these recommendations we also highlight some themes arising from the preceding pages, namely:

- Mental health/social support NGO programs work and produce good outcomes;
- There are demonstrated efficiencies for NGOs delivering services;
- Social support services being delivered by public MHSs are best transferred to NGOs thus allowing specialist clinical services to do more acute work to prevent hospitalisation; and,
- The importance of partnership and collaboration in achieving outcomes for clients with complex health and social problems.

Both residential and non-residential community mental health programs are considered.

RESIDENTIAL PROGRAMS

The intersection of mental health issues, housing and homelessness, and criminal justice systems is well documented. Community based supported accommodation and other residential programs are critical for people with mental illness in order to live well and stay well and prevent hospitalisation.

Housing and Accommodation Support Initiative (HASI)
The HASI program is managed by NSW Health in partnership with Housing NSW and support services are delivered by NGOs. NSW Health also provides clinical services as may a range of private mental health providers.

Early evaluation findings for the first group of HASI clients included (Muir et al, 2007):

- 70% decrease in demand for acute hospital admissions;
- 80% reduction in hospital bed stay days (i.e. the “revolving door” phenomenon had all but disappeared);
- 66% of clients reported improved mental health;
- 46% of clients with a substance use disorder were no longer experiencing substance use problems; and,
- 23% reported on entry not having any friends, reduced to 6% over 2 years.

On average, all clients increased their independence in living skills (i.e. exercise, diet, transport, banking, cooking, laundry, shopping, medication, cleaning, budgeting, accessing community services, making appointments, dressing and bathing/showering). The majority of consumers reported an increase in connectedness with their community.

NSW lags behind all other States and Territories in establishing community based supported housing (i.e. 6 places per 100,000 of population compared to Victoria at 24 places). There are currently 1134 HASI places with varying support levels available in NSW and these are more fully described in *Attachment 2 - Overview of Bed Based Mental Health Housing Stock in NSW*. However, 460 of the existing HASI places are low level support and there is a great need to expand high support and establish very-high support HASI. The later program is also known as extended care (X-HASI) and NGOs provide 16-24 hour support daily.

NSW Health's *Mental Health Clinical Care and Prevention* (MHCCP) model demand estimates for X-HASI roll-out over the next 10 years are as follows:

X-HASI Population Type	***#***
Long stay inpatients	144
Frequent readmissions	55
Boarding house residents	66
Consumers sleeping rough	700
Homeless aboriginal consumers	50
At risk of failed tenancies	145
Forensic	5
TOTAL	1115

MHCC estimates X-HASI packages at $50K per annum and that over the next four years about 40% of this projected demand will need to be met at a cost of $20M.

Recommendation 1: $20M to develop the 16-24 hour support Extended Care HASI program and increase the availability of 8-16 hour high support HASI beds across the State.

Step-up and Home Based Outreach (i.e. sub-acute) Mental Health Service

Services for people with severe mental illness will be improved by the Commonwealth Government's $1.6 billion investment to expand sub-acute care facilities and mental health is a targeted area. Extra community-based residential mental health places ease transitions from hospital to the community and reduce the need for hospitalisation. Step-up to the sub-acute residential MHSs occur when someone is becoming mentally unwell to prevent the likelihood of hospitalisation. Time limited home-based outreach is provided as an alternative to step-up and can also be provided when someone returns home from the step-up facility.

MHCC's has submitted a detailed proposal to NSW Health to establish a Step-up and Home Based Outreach/sub-acute MHS (MHCC, 2010b). Our proposal asks for $15M over three years to pilot the model in three areas (metro, regional & rural). The proposed service has both NGO support staff and clinical support is via contracted private providers funded through Medicare Benefits Scheme (MBS) mental health care items. Public MHS clients are given priority of access and there is a focus on early intervention to prevent psychiatric crisis requiring hospitalization.
http://www.mhcc.org.au/policy/MHCC%20Step%20Up%20Proposal%20FINAL%20Nov%202010%20.pdf

The development of the new non-acute inpatient units (NAIPU) and planned implementation of X-HASI has been cited as the reasons for not pursuing other residential sub-acute service models. However, the important points must be made that:

- NAIPUs are hospitals and achieving preventative, early intervention approaches and recovery oriented service provision in these environments is challenging at best;
- HASI support is intended to be time unlimited with most clients receiving care for many years (i.e. it is available as long as there is a need, the accommodation is the consumer's home and their rights are protected through Residential Tenancy Agreements); and,
- There is nowhere in the NSW spectrum a current short-term and time-limited residential sub-acute service type and the demand for such a service is known to be very high with an estimated 30% of mental health hospital beds being used for this purpose at any given time.

In discussing step-up step-down facilities NSW Consumer Advisory Group (CAG) stated:

"These types of services address not only the issues of continuity and coordination between acute, hospital based care and return to the community, but provide the important buffer between a consumer's need for increased support and acute care services as a first resort". (NSW CAG, 2008)

The innovative community managed Step-up and Home-based Outreach sub-acute MHS model is aligned with emerging best practice and also meets a gap in the existing spectrum and quantum of bed-based MHSs in NSW. This includes addressing demand for respite services (see related discussion regarding Family and Carer Support Services).

***Recommendation 2*: $15M to trial a sub-acute Step-up and Home-based Outreach Mental Health Service.**

Other Non-HASI NSW Health Funded Supported Accommodation

NSW Health both provides and funds NGOs to provide approximately 1000 mental health supported accommodation beds whose establishment mostly pre-dated HASI. This supported accommodation is believed to be NSW Health NGO Grant Program funded at just one fifth the tendered rate of the HASI program for people with similar levels of support need.

The non-HASI housing stock was last surveyed in 2007 and the results of this audit have never been made public. At that time there were 238 sites of 405 dwellings housing 990 residents and 80 vacancies. The vast majority of the housing stock is in the category of group homes and are no longer considered best practice. For example, there were identified instances of some people not even having their own bedroom. It might be argued that many vulnerable people are receiving inequitably funded supported accommodation when compared to what the 1134 HASI clients receive but the concern is that we just don't know.

The situation of these people is thought to be similar to those in NSW boarding houses where a Licence to Occupy is used in preference to a Residential Tenancy Agreement (i.e. whereby the tenant has no rights). Ten years ago this situation prompted the NSW Boarding House Reform Strategy following intense media attention. Furthermore, there are no safety nets for monitoring the quality of treatment and care provided. The NSW Ombudsman Office Community Visitors Scheme regularly check standards at places funded through the Department of Human Services and while the NSW Health Official Visitors Scheme attends hospitals their reach does not extend to residential programs in the community.

Some of these programs are delivered by public MHSs and others by NGOs. Programs delivered by public MHSs should be transferred to the NGO sector. The housing stock is mostly owned and/or managed by NSW Health and/or the Department of Housing (DOH). Housing stock owned and/or managed by public MHSs should be transferred to DOH. There is potential that some of this existing housing stock may present opportunities for establishing the Step-Up and Home Based Outreach Service (i.e. those that are consistent with best practice some of which will have been purpose built by DOH in recent years).

It is imperative that the current situation of people living in non-HASI places have their needs assessed with people at immediate risk being relocated and recommendations made to improve the treatment and care of others. This needs to include the transfer of services currently delivered by public MHSs that are more appropriately delivered by community sector supported accommodation providers thus making available additional services for managing acute care needs including psychiatric crisis.

<u>Recommendation 3</u>: $500K to assess and respond to the housing and support needs of people in pre-HASI NSW Health funded supported accommodation and develop a plan to bring these programs into funding equity.

NON-RESIDENTIAL PROGRAMS

Exploration of the current situation for community based residential MHS delivery in NSW has not been inclusive of other existing non-residential community based rehabilitation and support services - either public, private or NGO. The balance of both residential and non-residential MHSs must be considered when planning community mental health sector development and for capacity building to be effectively achieved. This balance is also critical for discontinuing the entropy toward acute and hospital based MHSs that has hindered effective implementation of *National Mental Health Strategy* policy in NSW including delivery of recovery oriented services and practice.

***<u>Employment and Education</u>* – <u>Vocational Education Training and Employment (VETE)</u>**
Mental illness is the biggest barrier to workforce participation than any other illness in Australia. The Commonwealth *"National Mental Health and Disability Employment Strategy"* (2009c) outlines preferred approaches for sector development in this area and is highly dependant on NGO employment service delivery for people with mental illness. There is no similar NSW policy for mental health employment services although targets related to increased employment of public mental health service clients is included in the State Plan (2010a) and State Health Plan (2007); see also *Attachment 2 – Mental Health Targets in the NSW State Plan and State Health Plan*. However, it is of concern that the target of 40% employment for people with mental illness was removed during a recent performance review of the State Plan (2010b).

NSW Health is funded to deliver the VETE program which is designed to work with consumers and services to ensure there is a coordinated pathway and targeted plan to address consumer education, training and employment needs. This is a best practice Individual Placement and Support/ISP program model (i.e. place and train not train and place) that involves strong partnerships between both mental health and employment specialists. There is reported to be a VETE program in each of the eight former Area Health Services (AHS) and there is likely a need to reconfigure the program to somehow align with the new Local Health Network (LHN) and/or Medicare Local boundaries.

VETE essentially involves staff employed by public MHSs – including some with clinical skills – delivering employment support and consultancy both within and external to AHS MHSs. The criticism has been made that these clinical resources could better be deployed providing acute care and managing psychiatric crisis. An additional concern is that the VETE program is seen by NSW Health as non-essential mental health care and implementation in some AHS has been hampered by budget/hiring freezes for non-essential staff (i.e. those that are not hospital based). Had the VETE program been situated in the NGO sector, as is the position in Victoria, this would not occur.

The Mental Health Senior Officers Group, reporting to the Human Services CEO Group, monitors the progress of the VETE initiative under the "*NSW Interagency Action Plan for Better Mental Health"* (2005).The budget for VETE is not known by MHCC but is estimated to be about $2.5M annually. The VETE program is ideally suited for transfer from public MHSs to the NGO sector.

MHCC recommends this program is more effectively delivered from the existing Resource and Recovery Services Program (RRSP) which is targeted at increasing participation levels of people

through employment, education, training and other community access activities. This program is community based and delivered by NGOs in partnership with public MHSs. RRSP staff are well placed to undertake the ISP model in partnership with the specialist employment agencies with which existing linkages are already in place. MHCC views establishment of VETE services within public MHSs as poor use of funds given the existing partnership program structures already in place through RRSP.

***Recommendation 4*: Ascertain service levels and transfer the VETE program from the public to the NGO sector.**

Resource and Recovery Services Program (RRSP)

NSW Health established the RRSP in 2007/08 and it is funded at $3M per annum. The RRSP is delivered by six NGOs at 19 locations across NSW (i.e. this is $166K per annum for each site which employs just 2 FTE). The program is designed to increase the capacity of NGOs to provide support and access to quality mainstream community social, leisure and recreation opportunities and vocational and educational services for people with a mental illness, based on the best available evidence and practices. A criticism of RRSP is that at $3M per annum it is not adequately funded either for individual or community/population needs.

The RRSP is seen as an integral part of the continuum of care provided by AHSs for existing public MHS clients with moderate to severe mental illness. A review of the RRSP program is currently underway. MHCC recommends a doubling of RRSP funding to more fully address the populations unmet needs for non-residential rehabilitation and support services.

***Recommendation 6:* Increase funding to the Recovery and Resource Services Program (RRSP) from $3M to $6M annually.**

***Family and Carer Support Program* (implementation of Keep them Safe initiative)**

Mental health family and carer support services in NSW are in extremely short supply despite recent funding increases by both the State (Family and Carer Support Program/FCSP from 2005) and Commonwealth (the Mental Health Community Based Program and Mental Health Carer Respite Program from 2007) governments. At just 7%, these programs ranked lowest of the seven NGO service types reported in the MHCC's *"Sector Mapping Project Report"* (2010a).

NSW Health funds four NGOs to provide FCSPs across NSW. There is one NGO service provider in each of the former AHSs and there are 27 service delivery locations across the State. The NGO funding for each of the FCSPs is $620,000 per annum. Over 8 AHS, this works out to be $4.96M per annum or about $184K per site. It is the role of these NGOs to provide:

- Education and training packages which teach families and carers about mental illness and its management and help to build coping skills and resilience;
- Individual support and advocacy services for families and carers of people with a mental illness; and,
- Infrastructure support for peer support groups.

An additional $8M is spent on increasing "Family Friendly" practice within public MHSs although some areas have failed to implement these programs fully and the actual amount of spending is unknown.

A key role for the NGOs delivering support services under this program is to provide individual support, advocacy and information to families and carers – including children and young people - during the early stages of a person first becoming mentally unwell to build coping skills and resilience including peer support. NSW Health also funds Carers NSW and ARAFMI (the Association of Relatives and Friends of the Mentally Ill) as both peak bodies representing the interests of families and carers as well as FCSP service providers.

The Commonwealth funds another seven NGOs to deliver Mental Health Community Based Programs for families and carers. They also fund partnership networks in just three geographic areas to deliver the Mental Health Carers Respite Program (i.e. respite services target the person with mental illness and may be residential or non-residential, with the latter being more preventative in approach, and provide carers with a sometimes necessary break).

This combined Commonwealth and State service configuration highlights both the lack of family and carer support services and especially the lack of respite services. The proposed Step-up and Outreach MHS could address some of the unmet need for respite services in NSW. While NSW views respite service development as a Commonwealth responsibility they are at the same time using a large number of much needed acute hospital beds for this purpose.

The NSW FCSP needs further respite service development to ensure the mental health of consumers and families/carers including the safety and wellbeing of children and young people. The later will require these services to better engage with the NSW Keep Them Safe (KTS) initiative ($750M over 5 years from 2009/10 including $306M that has been set aside to develop NGOs). The new KTS structures and services being established will mean more referrals to NGOs delivering mental health programs and the case must be made for more new funding to meet the additional demand. There is concern that the bulk of the NGO budget will be spent on Out of Home Care arrangements for children and young people rather than early identification and preventative support to families via strategies such as respite MHS provision.

A related concern is that the Department of Community Services (DoCS) plans to use funds to expand access to clinical MHSs through planned expansion of their Drug and Alcohol Expertise Unit (i.e. to be renamed the unit the Clinical Issues Unit and include a focus on mental health and domestic violence). This approach will reinforce crisis driven approaches used by public MHSs and further marginalise the early intervention and prevention approaches offered through mental health NGOs and community based programs.

***Recommendation 5*: $4.96M annually to further develop the Mental Health Family and Carer Support Program with a specific focus on developing respite programs and building community sector capacity to engage with implementation of the Keep them Safe initiative.**

Recovery and Wellbeing Locals

MHCC has submitted a detailed proposal to NSW Health to establish Recovery and Wellbeing Locals (MHCC, 2010c). These are one-stop shops in the community for mental health recovery, improved health & wellbeing and social inclusion. The proposed target population includes people with health and social problems that may not have been diagnosed with mental illness and are at risk without a primary healthcare intervention. They may be stand alone or co-located with existing services such as neighbourhood centres, women's health centres or mental health psychosocial support services.
http://www.mhcc.org.au/policy/Project%20Proposal%20Recovery%20Locals%2003122010.pdf

The innovative service proposal asks for $4.554M over three years to pilot the model in three areas (metro, regional & rural). The proposed service has both NGO support staff and clinical support

that is accessed via contracted private providers funded through MBS mental health care items. There is a focus on access to physical healthcare and "talking therapies" (i.e. counselling) in addition to psychosocial rehabilitation and support services.

At the NSW Health Mental Health and Drug and Alcohol Office's (MHDAO's) request, this proposal has been shared with the incumbent Mental Health Minister, Barbara Perry, who has expressed great interest in the model. The proposal is consistent with, and builds upon, NHHR directions outlined for increasing access to mental health care for people with severe mental illness in the *Flexible Care Package/FCP Discussion Paper* (DOHA, 2011a).

MHCC has made additional comments relevant to innovative ways forward in increasing access to mental health care in primary healthcare settings in our responses to the *FCP Discussion Paper* (2011, **http://www.mhcc.org.au/documents/Submissions/Flexible-Care-Package-Submission.pdf**) and *"Discussion Paper on Management and Governance of Medicare Locals"* (DOHA, 2010b and MHCC, 2010d, **http://www.mhcc.org.au/documents/Submissions/MHCC-Submission-Medicare-Locals-Discussion-Paper-22Nov2010.pdf**).

***Recommendation 7*: $4.554M to trial Recovery and Wellbeing Locals**

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Attachment 1 – World Health Organisation Optimal Mix of Mental Health Services Pyramid

The WHO (2008 & 2003) model for mental health service delivery is based on known best practice and promotes the involvement of individuals in their own mental health care, a community-based orientation, a human rights focus and embraces the following principles:

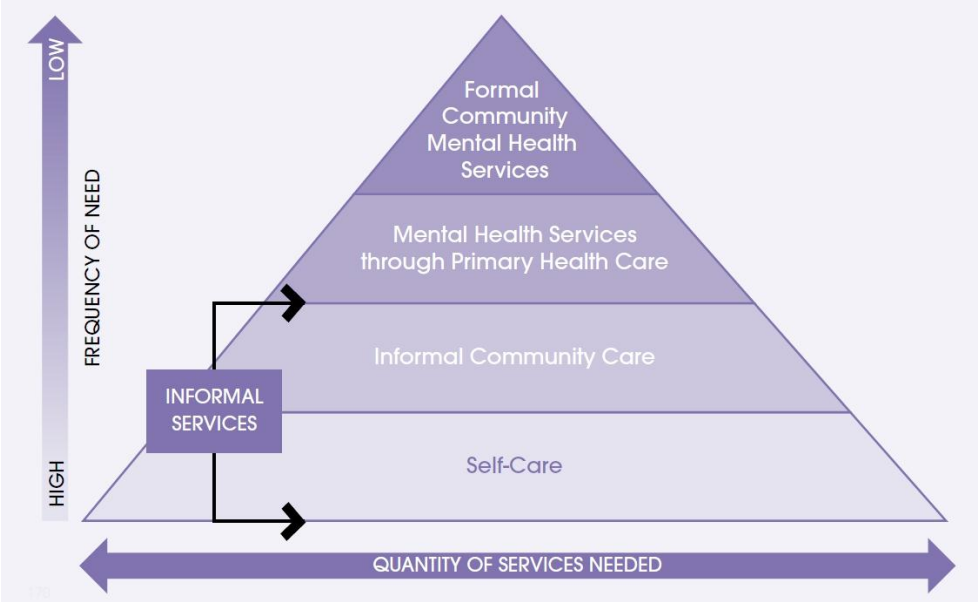
- No single service setting can meet all population health needs;
- Essential components of any mental health system include: support, supervision; collaboration; information-sharing and education across different levels of support; and,
- Individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery.

WHO note that mental health services should exist in primary health care, community-based and institutional settings. For community based settings there should be both "formal" (i.e. treatment) and "informal" (i.e. support) mental services. The Optimal Mix of Services Pyramid developed by WHO 2007 indicates that:

- Psychiatric hospitals should be the least frequently used service type in the mental health system;
- Psychiatric services based in general hospitals and specialist community mental health services should be available;
- Primary healthcare is an essential component supporting mental health; and,
- Informal community mental health services provide broad based, general support.

Figure 1 shows an extraction of the community mental health services components of the Optimal Mix of Services Pyramid which was elaborated upon by WHO and the World Organization of Family Doctors in 2008. The model indicates that "informal" mental health services (comprising of "informal community care" and "self care") should be the most frequently used mental health support followed by mental health services through primary care and then "formal" community mental health services. Informal mental health services are delivered by NGOs.

Figure 1: Community Mental Health Component Adapted from the WHO Optimal Mix of Services Pyramid (2007 & 2008)



The WHO model provides a good vision for a best practice system for service delivery but it does not give guidance as to how countries might best re-orient service delivery in-line with the model or the nature of the services (i.e. medical, psychological and social interventions) to be provided. To re-orient services in Australia it is critical to strengthen the research and development base of the mental health sector and this must also involve improved service delivery, workforce and consumer/population outcome data collections as well as a more clearly articulated model/s of community mental health services

The development of informal mental health services delivered by the community managed mental health sector in Australia has been defined by both organic and government funded strategic growth at different points in its history. Despite strong evidence for the effectiveness of recovery oriented approaches and the clear role the community sector has in promoting and applying the recovery principles and supporting social inclusion for mental health consumers and carers, the dilemma for the sector in the large majority of the eight Australian States and Territories lies in its struggle to fully take its place as an integral and contributing part of the mental health system in its own right.

Attachment 2 – Mental Health Targets in the NSW State Plan and State Health Plan

Both the *"NSW State Plan"* (2010a) and *State Health Plan* (2007) contain inadequate specific targets for community mental health sector development and this is a major barrier in ensuring that these approaches are achieved. The current targets are largely about reducing hospital readmissions within 28 days, increasing consumer satisfaction and increasing the community participation of people living with mental illness - including employment - with only the first two being currently measurable. There are also conflicting targets regarding the government's policy directions for developing additional hospital based mental health services.

The NSW State Plan

The *NSW State Plan* (2010a) was recently updated and includes priority to *"Improve outcomes in mental health"* which involves the following targets:

- Reduce re-admissions within 28 days to any facility;
- Increase the rate of community follow-up within 7 days of discharge from a NSW public mental health unit; and,
- Increase the employment of public mental health service clients.

Some of the mental health targets in *"A New Direction for NSW: State Health Plan – Towards 2010"* (2007) are those of the previous State Plan, namely:

- Reduce re-admissions within 28 days to same facility;
- Increase the percentage of people with a mental illness aged 15-64 who are employed to 34% by 2016; and,
- Increase the community participation rates of people with mental illness by 40% by 2016.

NSW State Plan *"Priority F5: Reduce preventable hospital admissions"* targets a reduction by 7.6% over 5 years in hospital admissions. Mental health is not just excluded from this target in the NSW State Health Plan but includes a target for increased hospital admissions (i.e. to achieve reduced admissions there would need to be a significant expansion of both the public and NGO community mental health sector including consideration of the role of private providers).

The Plan commits to providing *"extra resources for community based programs"* including *"increased mental health rehabilitation programs in the community*" but does not set targets for achieving this (p 35). The current mental health targets in the State Plan do not facilitate community mental health sector development – indeed, they keep the focus inappropriately on hospital beds and crisis care. There is no performance measure for the employment target which we alarmingly note has become unquantified since the previous State Plan (baseline is 23% in employment in 2009/10).

The *"NSW State Plan Performance Report November 2010"* (2010b) indicates that:

- Hospital re-admission rates within 28 days have not changed in 8 years (around 15%); and,
- The number of people receiving community follow-up within 7 days of discharge from a NSW mental health unit increased from 36% in 2007/08 to 43% in 2009/10 (part year only).

The Housing and Accommodation support Initiative (HASI) HASI and the Vocational Education and Employment (VETE) programs are noted as key achievements and there is a considerable evidence base that tells us that these types of programs keep people well and out of hospital.

The NSW State Health Plan

The NSW State Health Plan speaks generally to the importance of, for example, NGOs and mental health for: promotion, prevention and early identification; achieving better client outcomes in partnership with other stakeholders; and, transformation to community based care. Specific mental health targets in the NSW State Health Plan are:

Strategic Direction 2: (Better Experiences) Health Services

- Improve consumer satisfaction surveys through annual patient satisfaction surveys (i.e. MH-CoPES Survey).

Strategic Direction 3: Care in the Community

- Reduce readmission within 28 days to the same mental health facility;
- Reduce suspected suicides of patients in hospitals, on leave, or within seven days of contact with a mental health service;
- Increase the number of occasions where mental health patients are seen by clinicians through increasing the number of clinicians;
- Increase the number of occasions where a patient is admitted to an acute mental health unit bed and remains overnight through the opening of new acute units; and,
- Increase the proportion of HASI places filled.

Strategic Directions 4: Partnerships for Health

- Increase the percentage of people aged 15-64 years of age with a mental illness who are employed to 34% by 2016 (together with other agencies); and,
- Increase the community participation rates of people with mental illness by 40% by 2016 (together with other agencies).

As previously noted the mental health targets in the NSW State Health Plan no longer align with the recently revised State Plan which suggests that accountabilities for achieving them will be reduced. Furthermore, the targets are not optimal for developing services that help facilitate recovery from mental illness. These may be reasons why NSW ranks second lowest amongst the States/Territories in shifting resources from hospital to community based care and is even demonstrating a backwards trend in this regard.

Attachment 3 – Overview of Bed Based Mental Health Housing Stock in NSW

The *"NSW State Plan Performance Report November 2010"* (NSW Government, 2010b) claims that as at June 2009 there were 2,491 funded mental health beds in NSW. There is a lack of clarity as to how many of these are in hospitals and how many are in the community. The availability of community based residential places has been clearly demonstrated to reduce the need for hospital and other psychiatric emergency services but there are just six places available per 100,000 of population in NSW. More than 4000 additional medium to high level supported accommodation places are needed.

Hospital Beds

There are 720 non-acute inpatient unit (NAIPU) beds for extended and/or rehabilitative care: 600 of these are in large psychiatric institutions and 120 are new hospital beds. NSW is one of the only State/Territories continuing to develop stand-alone mental health hospitals and this direction has not been supported by the *National Mental Health Strategy* for 20 years. This would suggest that remaining 1771 beds are in acute mental health hospital settings, however, it is likely that the figures in the Performance Report included some NSW community residential places.

Community Places ("Beds")

In recent years NSW has increased access to community based supported accommodation programs delivered by NGOs and 2,134 funded community residential places are available. Some of these are delivered by NSW Health.

The Housing and Accommodation Support Initiative (HASI)

HASI offers very low, high and very high level support to people with mental illness in their own home. There are 1,134 HASI places but 62% offer only very low levels of support of a few hours a week or month (see Figures 1 & 2 below).

Figure 1: Overview of NSW HASI Stock Roll-out as at November 2010

Roll-Out	***# Places***	***Year***	***Support Levels***
Stage 1	100	02/03	High level support in public/community housing
Stage 2	460	05/06	Lower level support in public/community housing
Stage 3A	126	05/06	High level support in public/community housing
Stage 3B	50	06/07	Very high level support in public/community housing
Stage 4A	100	07/08	High level support in public community housing
Stage 4B (HASI in the Home)	240	07/08	Lower level support for people with existing private housing
Stage 5A (Aboriginal HASI)	58	09/10	Support for Aboriginal families across all support levels
Total HASI	1134		

Figure 2: Overview of NSW HASI Support Levels as at November 2010

HASI Support Level	***# Places***	***% Stock***
Low	700	62%
High	326	29%
Very high	50	4%
Variable	58	5%
Total	1134	

An "extended care" HASI model is currently under consideration (i.e. X-HASI, 16 to 24 hour care). Demand for extended care HASI over the next 10 years has been estimated by NSW Health to be 1115 places (i.e. a projected doubling of stock).

Other Supported Accommodation

NSW funds approximately 1000 mental health community residential places whose establishment mostly predates HASI. Some of these programs are delivered by NSW Health and some by NGOs. These places are believed to be NSW Health NGO Grant Program funded at just one fifth the tendered rate of HASI services for people with similar support needs. Support provided to these sites is unknown. The last time the non-HASI stock was surveyed was 2007 and this data has never been made public. At that time there were 238 sites of 405 dwellings housing 990 residents and 80 vacancies. The vast majority of this stock is in the category of group homes which are no longer considered best practice. For example, there were identified instances of some people not even having the dignity of their own bedroom. It might be argued that many vulnerable people are receiving inequitably funded supported accommodation when compared to what the 1034 HASI clients receive but the concern is that we just don't know.

Reconciling the Numbers

This totals 2854 hospital based non-acute and community based supported accommodation residential places for NSW (i.e. 720 NAIPU and 2134 NGO respectively with the number of beds in acute mental health hospital settings remaining unclear).

NSW Health's draft *"NAIPU Strategy"* notes that the current averaged amount of supported accommodation for an Area Health Service in NSW is 27.8 places per 100,000 of population and this figure ranges considerably from 19 to 80 places per 100,000. It also notes that the majority of the supported accommodation is low support (12.3 places per 100,000) with rates for both medium and high support needs being similar (4.1 and 6 places per 100,000). Very high supported accommodation averages just 0.7 places per 100,000 population.

It is unknown if these figures include just HASI or also other supported accommodation stock. In addition, low level HASI should probably not be factored into supported accommodation formulas for population based mental health service planning. We suggest that the actual numbers for community based residential places in NSW are six places per 100,000 of population at most.

Projecting the Numbers

Population benchmarking of mental health community based rehabilitation and support service types is only in its infancy in NSW and Australia (e.g. see the *"MHCC Sector Mapping Project Report*", 2010a and also NSW Health's review of the *"Mental Health Clinical Care and Prevention Model/MH-CCP"* currently underway). However, the *"Queensland Mental Health Plan 2007 – 2017"* (2007) does set some population targets for bed based and residential programming as follows.

"Beds"/Places	***Per 100,000 of Population***
Hospital Beds	**40**
NGO Places	**88**
Residential recovery	15
Supported social housing	35
Support hostels/private homes	35
Crisis respite services	3

The NSW population at the end of March 2010 was 7,221M (i.e. 72.21 X 100K). If the Queensland population formula is applied to NSW then one would expect to see 6354 non-hospital based supported accommodation beds available (i.e. 88 X 72.21). Even if the demand estimates for extended care HASI are fully realised NSW will still be considerably below population needs for mental health community residential places and lacking in a range and diversity of service delivery models to allow choice when selecting services.