



Mental Health
Coordinating Council

**The Development of the
4th National Mental Health Plan
Discussion Paper**

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**Mental Health Coordinating Council
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The Development of the 4th National Mental Health Plan Discussion Paper

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The organisation

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW representing the views and interests of over 200 NGOs. Member organisations specialise in the provision of services and support for people with a disability as a consequence of mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community.

Facilitating effective linkages between government, non-government and private sectors, MHCC participate extensively in public policy development. The organisation consults broadly across all sectors in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector, and is a registered training organisation, delivering mental health training to the workforce.

MHCC sits on a range of advisory committees at the Mental Health Drug and Alcohol Office (MHDAO) and have participated in consultative processes surrounding the 4th Mental Health Plan (hereafter to be called the Plan) through MHDAO. Nevertheless, we deem it important to respond more fully to the Discussion Paper at a Commonwealth level. MHCC express our willingness to assist Government by contributing to any discussions in the future.

Targets

The Discussion Paper states at the outset that it *'does not intend to describe all reform processes and changes needed to improve the mental health of Australians. Rather it is a plan of actions....'* (p. 2).

To meet its stated goals a plan must state targets with actions to be taken; outcomes to be achieved; with accountability that is measurable. For example we propose that the Plan identify targets with sufficient mechanisms in place to measure relapse and re-admission rates over the short and medium term. Twenty-eight day readmission rates are inadequate to capture the degree to which treatment and support programs have been properly implemented and maintained. Readmission at three, six and twelve months must also trigger a critical incident review of support plan adequacy.

Readmission rates would provide rich data from which the mental health sector could better understand and identify risk factors relating to for example: gender or age; cultural or indigenous background; co-morbidity with substance abuse or intellectual disability. Since no actions or measurable outcomes are evident, the Plan as presented is only a broad statement of intentions - a 'what and why, but not a how and by when.'

Language

The language used in the Plan confusingly bundles together the key areas '**prevention**' and '**early intervention**'. The terminology needs to be clearly defined. We also suggest that a third category must be considered - **Relapse Prevention**. We propose that the three categories require plans with specific goals in mind, and we identify them under separate headings in this submission, proposing that the Plan follow suit.

General comments on the Plan

1. The term 'integration' is consistently used throughout the plan. To minimise misinterpretation the terminology needs defining. Some parties promote the concept of '*integration*' between public and community based non government (NGO) service providers. We strongly urge that the Plan adopt a perspective placing at its centre the need for NGO services to maintain their autonomy.

Our favoured model is collaborative capacity building, cooperation and '*coordination*' not '*integration*'. We do not advocate integration since it implies (or may result in) larger agencies absorbing and ultimately controlling or managing smaller organisations, which may result in a loss of local knowledge, skills, expertise and innovation.

MHCC support the objective stated in the Plan of continuity of care, collaboration existing across and between governments, and between government, non-government and public sectors, whilst stressing that NGOs must maintain independence, flexibility and the ability to respond to local and individual need.

Responding under different portfolios is an important mechanism to promote social inclusion of people with mental health disability and promotes departmental responsibility. We welcome for example the involvement of FACSA and DOHA in NGO service delivery, which has improved mental health awareness in those departments.

However, smaller organisations frequently lack the capacity to undertake some of the onerous systems management tasks that larger organisations can accommodate, and as a consequence they may lose out in tendering processes etc. These community organisations must be appropriately resourced so as to enable them to remain part of the service delivery mix so important in providing a range of programs tailored to individuals and specific communities.

2. We agree with the aims of the Plan for improved access and advocate that the Plan clearly articulate its philosophical approach to service delivery - the goal being to recognise the Social Inclusion platform that considers the economic, physical and social conditions that influence the health of individuals and communities as a whole. This includes housing, education, family and social networks and connections, physical infrastructure and employment, in addition to service delivery in both mental health clinical and community settings.

It is critical to consider where people live in the community and how services are delivered. Whether services are delivered on a state or national basis may vary across services, with some services maintaining a very local focus. Particular needs may vary according to local demographics, cultural and socio-economic characteristics – what may be appropriate for a remote area in the NT might be completely irrelevant in a state's CBD.

Our understanding of what makes and keeps people healthy continues to evolve and be further refined. A population health approach reflects the evidence that factors outside the health sector significantly affect health. It considers the entire range of individual and collective factors and conditions - and their interactions - that have been shown to be correlated with health status, commonly referred to as the '*social determinants of health*,' these factors are complex and interrelated.

A population health approach focuses on improving the health status of the population which necessitates the reduction in inequalities in health status between population groups. An underlying assumption of a population health approach is that reductions in health inequities require reductions in material and social inequities. Addressing inequities must be understood as a key component in service design and redesign promoted within the Plan.

3. Despite the move toward collaborative service delivery articulated in earlier plans, other than in housing, there remains a siloing of services. For example, mental health and drug and alcohol services mostly remain poorly connected despite moves towards integration.

Development of real partnerships across portfolio areas has frequently been patchy and under funded. Services require the resources to develop, maintain and foster partnerships. Some successful pilot programs have not been supported long-term despite evidence base studies establishing benefits.

An example of this was the Jacaranda Project which was developed and established by North Sydney Health Sexual Assault Service in 1997. It promoted a holistic approach to service provision and interagency 'capacity building.' Responding to the well-documented negative impact of child sexual abuse (CSA) on physical and mental health, the project endeavoured to design and provide a cost effective model of service delivery to a 'high-risk' group of clients. With minimal funds, an extensive project was developed and implemented. Critical to the project was capacity building and networking between health and community services to provide interventions for survivors of CSA. This was successfully initiated and implemented and yet failed to sustain long-term funding (Reframing Responses: Improving Service Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems. MHCC, 2006).

4. As identified in the Plan, the establishment of minimum accreditation standards is of critical importance to ongoing Quality Improvement for the community sector. The workforce must be provided the opportunity to meet those expectations and be supported to undertake training and development without compromising service delivery. Standards must be in keeping with the philosophy, language and directions of each of the service sectors, i.e. public, private and NGO. This will require interpretative guidelines for each sector under a code of practice and set of mental health standards.
5. The aims of the 4th Plan are only achievable within 5 years if resources are made available and adequate monitoring, evaluation and reporting given priority status under this Plan. This is not evident in the Plan as presented.

Key Areas for Reform

1. Wellness and Recovery

1.1 MHCC support the recovery principles outlined in the Plan, and emphasise the role the NGO sector has played. The relationship between recovery principles and organisational development has been extensively explored in *Mental Health Recovery – Philosophy into Practice: A Workforce Development Guide* (MHCC, 2008) a copy of which is enclosed with this submission.

The recovery philosophy provides people with mental health problems access to a set of principles by which to help them conceptualise and manage the individual and unique effects of that experience. The recovery principles also provide a set of mechanisms by which others including family and friends and those people employed within mental health treatment and support system can frame and determine the nature of the assistance they provide (Bateman. *Mental Health Recovery – Philosophy into Practice: A Workforce Development Guide*. MHCC, 2008).

2. Prevention

2.1 Important to the aims of the Plan is access to coordinated community mental health services provided through the enhancement of NGO sector services, which is not clearly articulated in the Plan. This will only be achievable if the NGO sector is appropriately resourced to sustain and expand these services.

To date there has been little coordination between national suicide prevention activities, other than in clinical services. Important is the recognition of what can be achieved in the community. Historically, NGOs have been very successful particularly in working with young people and older males.

2.2 Whilst we support a national campaign approach as outlined in the Plan, evidence tells us that there is greater impact if local level campaigns are undertaken. We suggest a small grants program scheme to engage people at the local level to provide awareness and de-stigmatisation programs.

Australia is seriously behind other countries such as NZ and Canada in their adopted strategies regarding mental health literacy and awareness. There is need for a National Community Awareness Strategy which focuses on education, awareness and de-stigmatisation in schools, CALD and Indigenous Communities as well as targeting the community more generally: through primary health care, in the workplace, aged care, pre and post natal, etc.

2.3 Improving ways to access the MBS Better Access to Psychological Services & the ATAPS is important to include in the Plan. We propose that the service be more flexibly accessible by offering a range of services through the community sector, using a broad range of mental health and allied professionals for individual, family and group work. This will necessitate:

- supporting the accreditation of allied professionals through state and national Professional Associations to provide suitably qualified practitioners with accreditation under the BAI and ATAPS Schemes

- evaluation and outcome monitoring of MBS referrals to private practitioners. Reporting thus far has only recorded take-up of services with no consumer satisfaction or clinical feedback.

There is need to understand how well these funds are being utilised, such a mechanism needs to be appropriately funded under the scheme and evaluated by an independent body.

3. Early Intervention

3.1 Access to coordinated community mental health services need to be provided through enhancement of NGO sector services. NGOs have a role in assessment and early intervention and should be viewed as an option in terms of first point of contact for individuals and their families and carers when acuity is not high to enable referral to GPs or appropriate community based supports rather than unnecessary service from overstretched public health facilities.

3.2 Whilst there has been a growth in access to Psychiatric Emergency Care Centres (PECCs) – an initiative that aims to improve patient flow in urban Emergency Departments (EDs) to provide a rapid pathway to specialist mental health assessment and care, to date, the ability of crisis teams to respond to need in the community has been severely hampered by a lack of funds resources. Availability of crisis teams to prevent the need for access via emergency departments is vital particularly in areas that do not have access to such services and a preferable model of care, averting the need to provide access via EDs. This requires greater coordination between crisis teams and sub-acute community services so as to prevent the need for hospitalisation where possible.

We support the funding of early intervention sub-acute services that use existing partnership models with NGOs that have a strong evidence base. In mental health services a model for achieving this is the Victorian Prevention and Recovery Care (PARC) service model. PARC presents a step-up and step-down alternative to hospitalisation for people with complex health and social problems and is a partnership between NGO community mental health services (i.e., provides individual support, psychosocial rehabilitation, therapeutic group activities) with 24-hour community clinical services (i.e., provides clinical treatment and support through at least twice daily visits to the PARC and access to other clinical services as needed). “Step-up” occurs when a person is becoming unwell. The client will enter PARC and receive early intervention services to avoid a hospital stay. “Step-down” provides short-term transitional support after discharge from an acute admission, providing supported discharge, to minimise problems associated with early discharge.

The focus during a PARC stay is on encouraging participants to explore four key life areas: living; learning; socialising and working and establishing goals to address their areas of need. Staff working individually with participants can enable transition into: employment, housing, education and community life. This model aims to intervene early, and so prevent admission to acute mental health inpatient care.

4. Relapse Prevention

4.1 As with prevention and early intervention, it is necessary through the enhancement of NGO sector services to provide access to coordinated community mental health services. This is the bread and butter of NGO continuity of care of people from clinical services, and despite this having been a stated objective in the past, there are no comprehensive plans in place that provide appropriate ongoing care through community services.

4.2 Critical to relapse prevention is the enhancement of the capacity of employment services in the community sector to provide for those with mental health problems not accessing clinical services. We see the role of clinical services is to partner with employment services for referral, and to provide mental health education to disability employment staff.

Programs currently being developed that provide funds to clinical teams within public mental health services to assist people into employment, benefit only those accessing clinical services. These resources are better targeted to build the capacity of employment services in assisting people with mental health problems who may, or may not be in contact with mental health services. We know that 65% of people with some kind of mental health problem do not access clinical services.

4.2 Supported accommodation options must include long-term housing options with alternatives such as sub-acute facilities provided for those at risk, and security of tenure to ensure housing is secure during periods of hospitalisation.

4.3 Mental health promotion and education in the community needs to be particularly targeted to front of office staff, with reference to stigma and discrimination as described under the Mental Health Strategy 2006-2011.

4.4 Mechanisms for consumer and carer participation must be in place to include involvement in policy and systemic reform at all levels of government to include the development of programs and service delivery, and employment in clinical and community settings.

5. Improved Access to Services

5.1 It is a difficult to plan when there is uncertainty around the funding jurisdictions under COAG arrangements. From the community sector's point of view there are implications to State versus Commonwealth funding. We welcome involvement of FACSIA and DOHA in NGO service delivery, which improved mental health awareness in those departments. Nevertheless enhanced awareness in departmental coordination still needs to be further developed.

5.2 There must be multiple points of access in addition to a 1800 number. Whilst this may sound complex, access occurs at a local level and is therefore quite manageable, provided services are working collaboratively.

5.3 Community services characteristically require different types of data collection to clinical services and have their own way of managing data and relationship building. Therefore they would not want to be incorporated into clinical service data systems but rather have systems that are compatible with them to increase the ease of data transfer.

6. Quality

6.1 The NGO sector is well placed to promote education, training and accreditation to/for the community health workforce (including clinical and non-clinical community services), provided they are given adequate resources to undertake this role.

6.2 We support greater investment in undergraduate and postgraduate mental health competency training for GPs and the NGO sector. This training needs to be formally included as part of an accreditation and accountability process. It is unclear as to the expertise of GPs generally in the field of mental health and we strongly urge that outcomes be monitored.

6.3 Under COAG, a reporting framework needs to be prioritised in the National Action Plan. It should be transparent, independent and provided with dedicated funding.

6.4 Accreditation, reporting frameworks, supervision and accountability must go all the way to the top. Senior clinicians must be similarly accountable as their junior colleagues and the community workforce - via report mechanisms and peer supervision.

- We accept that monitoring, reporting and evaluation are to be developed in parallel to this framework. Nevertheless, we propose that it requires them to be line items underneath each priority area in the Plan.
- Monitoring, reporting and evaluation must be included as a priority area. In order to establish best practice, organisations must meet KPIs and resources must be allocated to support this aspect of program delivery.
- Development of protocols between services at key transition points, e.g. release from custody, transition from youth to adult, adult to aged, exit from child protection have been suggested. The Plan does not include the important role of the NGO sector who are well placed to maximise the opportunity to make connections with community services for people with mental health problems when transitioning from other services. Delineation of responsibility and organisational development would enable less duplication for these target groups, and prevent people falling through the gaps.

6.5 Important is the development of partnerships to provide smooth transition from Juvenile Justice, the criminal justice system, youth to adult, adult to aged, and exit from child protection and refugee environments. This requires a case management model providing a step down process that supports people during these transitions. For example a person leaving goal could be connected to a number of community services, i.e. supported accommodation, health, drug and alcohol, family and employment services.

7. Omissions in the Plan

7.1 A complete review of the MBS scheme for psychological services is necessary because:

- people most at risk are often unable to access services because of an inability to bulk bill fees, and a gap payment between the Medicare and clinician's fee
- whilst access is available through ATAPS Scheme, people with mental health disability are generally unable to access a service except via clinical services
- service provision is geared towards short-term CBT interventions, which may not be appropriate for clients with a range of complex presentations such as adult survivors of childhood abuse (who frequently require long-term alternative interventions)
- although there is a plethora of qualified allied and mental health professionals offering a wide variety of skills and therapeutic approaches, they are unable (under the MBS scheme) to provide ongoing care in the community. This is a significant under utilisation of trained specialists. We therefore advocate partnering with state and national professional associations to provide suitably qualified practitioners with accreditation for the MBS Scheme

- the MBS Scheme has not been appropriately evaluated. There is a need to understand how well funds are being utilised when there is no data collection or report back mechanism in place other than service take-up
- such a mechanism needs to be appropriately resourced under the scheme and evaluated by an independent body.

7.2 The Plan has failed to address the needs of survivors of childhood sexual, physical and emotional abuse.

Sexual, physical and emotional abuse and neglect have significant mental health repercussions. Research studies consistently demonstrate that adult survivors of all forms of childhood abuse manifest high rates of mental illness: depressive and anxiety symptoms, substance abuse disorders, eating disorders, post-traumatic stress disorders, suicidality as well as poor physical health.

Child abuse and neglect are the root cause of many of Australia's social ills – substance abuse; welfare dependency; homelessness; crime, relationship and family breakdown; chronic physical and mental illness. If not effectively targeted, the life-long impact of child abuse will continue unabated, putting increased pressure upon already stretched government health and social services.

Access to psychologists and social workers through the MBS scheme is not (in most cases) appropriate for the long-term psychotherapeutic needs of adult survivors. We strongly urge Government to acknowledge the mental health needs of this long neglected group of clients.

Central to removing long-term barriers to access, is a need for consumers to have the option to be referred directly via community services rather than necessarily via clinical services. We propose that in line with the Government's social inclusion agenda and a strong theme of prevention and early intervention, there needs to be an unambiguous acknowledgement of the absolute necessity to provide a wide range of clinical and NGO services operating collaboratively to provide for the complex needs of people with mental illness in the community.

7.3 Other groups at risk not mentioned in the Plan include:

- HIV sufferers
- Domestic violence victims
- Veterans and their families
- Carers
- Gender specific
- People with co-morbid mental health and substance abuse issues, intellectual disability and brain injury in the criminal justice system.

7.4 Consumer and carer participation

The objective of consumer and carer participation is not included in the Plan. As part of recovery principles consumers and carers must be engaged at all levels with government consultative processes and meaningfully participate at all levels of policy reform, advocacy, program development and implementation.

7.5 Research agenda

We also note that absent in the Plan is any reference to a national research agenda that prioritises innovation across clinical and non clinical sectors in government and non-government agencies. We suggest that this is critical to the enhancement of information sharing and the development of models of best practice.

MHCC thank the Minister for her interest in these matters and look forward to the outcome of the Government's deliberations. For further comment on this submission please contact Corinne Henderson at corinne@mhcc.org.au or Tel: 02 9555 8388 ext 101

A handwritten signature in blue ink, appearing to read 'Jenna Bateman', with a large, stylized flourish above the name.

Jenna Bateman
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