3 July 2009

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Mental Health Coordinating Council

Subject: Comment on the Fourth Mental Health Plan: Draft V2. June 2009

Dear Minister

Further to our submission in April 2009, the Mental Health Coordinating Council (MHCC) has been asked by NSW Mental Health Drug and Alcohol Office (MHDAO) to participate in a consultative process on the Draft V. 2 June of the *Fourth Mental Health Plan* (hereafter called the Plan). MHCC wish to refer to a number of issues in detail which the NSW questionnaire process does not facilitate. We therefore respond more fully in this submission. We express our willingness to assist Government by contributing to any discussions in the future.

Whilst the Plan includes a number of encouraging improvements such as: the inclusion of indicators with regards to secure housing; the mental health of people in the criminal justice system; and the prevalence of mental illness in the community (p.60-61), the document primarily provides a history of reforms and 'worthy' statements of good intent, strung out at great length with little concrete evidence as to how those intentions are to be achieved. There is no indication as to funding expectations and the policy provides little in the way of guidance as to how services might be provided to targets with deliverables not clearly identified.

The Draft V.2 June maintains that the Plan will be the standard against which public accountability can be measured and highlights that: *'independent commentaries'* will form part of the evaluative process. We certainly support a process through which the sector can independently contribute to such reviews. Similarly we are pleased to see that Draft V. 2 June includes indicators to measure consumer and carer levels of satisfaction with service delivery, although details are not evident. It is useful to have the 25 outcome markers listed that can be reported on (12), and which need to be developed (13), such as the consumer/carer satisfaction experience.

The Draft V. 19 April commented that the *Third Mental Health Plan* was *too broad and having insufficiently precise outcomes* (p.14) whereas Draft V. 2 June omitted this observation. In response to the Draft V. 19 April, MHCC reflected that in order to meet its stated goals a plan must state targets with actions to be taken; outcomes to be achieved; with accountability that is measurable. We do not believe that the amended draft is substantially different.

The aims of the Plan are only achievable within five years if a commitment is made to provide the necessary resources, and adequate monitoring, evaluation and reporting are given priority status. The Plan identifies some key elements of commitment: *across different levels of government and community; new or re-focussed funding and governance arrangements* (p.9) critical to implement the actions required to achieve the outcomes identified, and to bring about the improvements necessary to deliver the Plan envisaged. MHCC emphasise that this will require a sizably increased commitment from both Commonwealth and State Governments to make the difference outlined in *Scope and Directions* (p.9).

Overall MHCC suggest that the Plan still needs considerable review work due to a number of serious omissions and the lack of substance. We address this under the following headings:

Targets
The Plan does not clearly articulate 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.

The plan does not identify the development of protocols between services at key transition points, for example: release from custody; transition from youth to adult; adult to aged; exit from child protection; etc.

We were pleased to see the reference to *relapse prevention and re-presentation* in both Draft Vs April & June. However, under Priority Area 3, 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 (indicators that are currently available) are inadequate to capture the degree to which treatment and support programs have been properly implemented and maintained.

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.

Accountability
One of the major criticisms with regards to earlier drafts was the absence of commitment to promoting independent and transparent data collection, supported by the necessary resources. Whilst there are statements under Priority Area 5 to establish national reporting on the progress of mental health reform, and build an accountable service delivery system that monitors performance; there are no indicators listed as currently available. The only indicator suggested as requiring development is the proportion of services publicly reporting performance data.

MHCC understood that a 'Summative Evaluation' of the *Third Mental Health Plan* was being undertaken by Curie and Thornicroft. Since this has not been made available it is not clear the extent to which the *Fourth Mental Health Plan* is based on the evaluation of the Third Plan. This is a serious missing piece of the Plan's development and the ability of the sector to evaluate progress thus far. Since it is not referred to, it also gives rise to scepticism as to a commitment to evaluative processes and accountability as an ongoing priority.

Quality
As highlighted in MHCC's earlier submission, accreditation, reporting frameworks, supervision and accountability must go all the way to the top via report mechanisms and peer supervision.

In order to establish best practice, organisations resources must be allocated to support this aspect of program delivery. We acknowledge that monitoring, reporting and evaluation will 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.

Relationship between Documents
The *National Mental Health Policy 2008* endorsed by the Australian Health Ministers' Conference (AHMC) in December 2008 and released in March 2009 was updated to align with the whole-of-government approach articulated within the *COAG National Action Plan on Mental Health 06-11* and with developing policy and practice in other areas.

The Policy provides an overarching vision for a mental health system seen in the context of the Social Inclusion Agenda which focuses on engagement of the whole community, especially in areas social and economic disadvantage. The Plan specifically states that: *the Policy does not set out to provide explicit guidance for service delivery, nor does it set funding expectations, targets or deliverables* (p.14). We ask in which document can the sector expect to have these matters made explicit? The Plan is about what should happen as a result of a collaborative across government approach, but does not include goals, targets and the co-responding incentives and penalties. It ends up becoming a rather woolly statement rather than: *furthering the aims of the Policy through actions*.

MHCC note that a deficiency identified in the *National Mental Health Strategy* (p.14) is that the pace of reform and thus achievements under the Plans varied considerably between jurisdictions. This makes it all the more important that any new Plan be accompanied by strong national direction with national goals and targets; agreed models of best practice; standards and guidelines with national oversight and nationally consistent measurements and evaluation processes. This is too important to be left to each jurisdiction simply to be amalgamated into a national framework. The access and quality of service delivery may well vary according to geography, a situation in other areas of health provision that would not be acceptable.

As identified in the Plan, the establishment of minimum accreditation standards is of critical importance to ongoing Quality Improvement for the community sector. MHCC reiterate that: *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* (MHCC, April 2009, p.5).

Recommendations under Priory Areas

Priority Area 1: Social inclusion and recovery

1. We agree with the summary of actions, nevertheless the Plan needs to 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* (MHCC, April 2009, p.4).

2. Under these actions consideration must be paid to 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.

3. The Plan refers extensively to the concept of recovery (p.18).The relationship between recovery principles and organisational development needs to be articulated in the Summary of Actions as a model of service delivery, otherwise it is unlikely to be given the appropriate seriousness it demands. (See Appendix 1, and reference *Mental Health Recovery – Philosophy into Practice: A Workforce Development Guide.* MHCC, 2008. Available: http://www.mhcc.org.au/resources/staff-development-guide.aspx).

4. Likewise the Plan suggests that *determination of effectiveness could be supported by the adoption of a national tool to measure performance against recovery –based competencies* (p. 21)*.* A national tool needs to be included in the Indicators requiring further development for this priority area.

Priority area 2: Prevention and early intervention

1. Indicators currently available also should include material available from the Criminal Justice System; Juvenile Justice as well as Aboriginal and Torres Strait Islander populations.

2. Whilst the area identifies the need for a whole of government approach and collaborative partnerships to provide coordinated community mental health services, the Plan fails to include amongst its priority actions the need for enhanced NGO sector services, which will only be achievable if the sector is appropriately resourced to sustain and expand service delivery.

3. To date there has been little coordination between national suicide prevention activities, other than in clinical services. We note that rates of suicide are listed in the Indicators but actions need to include supporting community services that have been particularly successful in working with, i.e., young people and older males.

4. We support a national campaign approach as outlined in the Plan, but advocate that campaigns be established locally, since evidence tells us that there is greater impact if undertaken at that level. A small grants program scheme to engage people at the local level might be one way to provide awareness and de-stigmatisation programs.

The following Item 5 (also relevant to Priority area 3)

5. It is important to include actions that improve ways to access the MBS Better Access to Psychological Services & ATAPS in this priority area of 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. This will necessitate:

    - Supporting the accreditation of allied professionals through state and national Professional Associations to provide suitably qualified practitioners with accreditation under the BA 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 re appropriateness of modality used (usually CBT)

    - There is need to understand how well MBS funds are being utilised. A mechanism needs to be developed so that these interventions can be evaluated by an independent body

    - Assessment of access to MBS as a result of the gap payment between Medicare and the psychologists' fees as an obstacle to access for people at risk.

6. NGOs have an important role in assessment and early intervention. This should be offered 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 to overstretched public health facilities. Access to coordinated community mental health services needs to be provided through enhancement of NGO sector services.

7. The expansion of mental health crisis teams is vital to prevent the need for access via emergency services particularly in areas that do not have access to such services. This requires greater coordination between crisis teams and sub-acute community services so as to prevent the need for hospitalisation where possible.

8. We support the funding of early intervention sub-acute services that use existing partnership models with NGOs that have a strong evidence base. A model for this is the Victorian Prevention and Recovery Care (PARC) service model. This model aims to intervene early, and so prevent admission to acute mental health inpatient care. 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 with 24-hour community clinical services. ("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).

Relapse Prevention

9. 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.

10. 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. Resources are best 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.

11. 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.

12. 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*.

13. 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. (Also under Priority area 4).

Priority area 3: Service access, coordination and continuity of care

1. Data based on longer term indicators need to be established. A twenty-eight day parameter is 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.

2. Indicators will need to be developed to measure the cost and challenges of providing services in rural and remote areas as opposed to providing access across large geographic areas.

3. It is crucial that specialist postnatal and early childhood in-patient facilities are provided in public hospitals. These services are no longer available in NSW. Without such services available evidence has shown that mothers and their children will be negatively impacted in terms of long term outcomes. Negative impacts of mother/baby separation can last a lifetime, and indeed present as generational dysfunction.

4. The Plan identifies that population-based planning frameworks need to specify the required mix and levels of services required, along with resourcing targets to guide future planning (p.28). It is important that any nationally agreed planning framework that delineates roles and responsibilities across the community, primary and specialist sectors, needs to be developed as a collaborative process across all the sectors.

5. The Plan has not identified the complex needs of adult survivors of childhood abuse as a priority group. Access to psychologists and social workers through the MBS scheme is not (in most cases) appropriate for the long-term therapeutic needs of adult survivors. We strongly urge Government to acknowledge this long overlooked group.

6. In line with the Government's Social Inclusion Agenda there needs to be an acknowledgement of the absolute necessity to provide a wide range of mental health services that consumers can opt to be referred to directly via community services rather than necessarily via clinical services.

Priority area 4: Quality improvement and innovation

1. Development of the quality improvement and innovation requires access to information on service delivery and outcomes. The Summative Evaluation of the 3rd National Mental Health Plan needs to be made available for consultation before the Plan is finalised.

2. The performance and benchmarking framework that needs to be developed to cover beyond the public clinical services needs to be developed with appropriate levels of involvement of all the sectors collaborating and needs to be national rather that harbouring the expectation that State Health bureaucracies will develop these frameworks independently (p.36).

3. 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.

4. 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.

5. A reporting framework for COAG initiatives should be prioritised in the National Action Plan. It should be transparent, independent and provided with dedicated funding.

6. Absent in the Plan other than as a *cross-portfolio implication* (p.33) is any reference to a national research agenda that prioritises innovation across clinical and non clinical sectors in government and non-government agencies. Under this priority area there needs to be an action that promotes enhancement of information sharing and the development of models of best practice.

Priority area 5: Accountability – Measuring and reporting progress

1. Community services require different types of data collection to clinical services and have their own way of managing data and relationship building. It is important that they do not become incorporated into clinical service data systems but have compatible systems to facilitate data transfer.

2. Accreditation, reporting frameworks, supervision/ peer supervision and accountability must be embedded across all sectors including senior clinicians.

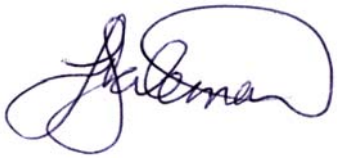
3. Monitoring, reporting and evaluation developed in parallel to this framework need to be line items underneath each priority area in the Plan.

Conclusion

The *4th National Mental Health Plan* is presented as a Plan for treating, supporting and enhancing wellbeing for people with a mental illness and those at risk of developing mental illness and mental disorder, demonstrating a comprehensive *'whole of government'* approach.

Whilst some mental health literacy actions are identified, it falls short of being a plan that enhances wellbeing for the whole of the population. Previous National Mental Health Plans embraced a broader view of health and integrated both a positive concept of mental health and a concept of mental illness. The emphasis now is targeted more towards 'at risk' populations. We emphasise the need for the Plan to embrace more concrete actions to prevent the onset of illness in the first place.

MHCC thank the Minister for her interest in these matters. For further comment on this submission please contact Corinne Henderson at corinne@mhcc.org.au or Tel: 02 9555 8388 ext 101



Jenna Bateman

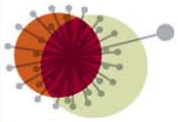
Chief Executive Officer

Appendix 1

FRAMEWORK FOR RECOVERY-BASED SERVICE SYSTEM

Read from the bottom of the page up

www.maryohagan.com



Legislation	Policy	Funding	Development	Service user led oversight
Human rights	Aspirational	Multiple sectors	Services & sectors	Systemic advocacy
Inequality	Achievable	Equitable	Diverse workforces	Monitoring
	Intersectoral alignment	Future driven	Broad research methods	Information provision

8. SYSTEMIC FRAMEWORK

Primary health, Mental health, Public health, Addictions, Social services, Human rights, Justice

Community, service user, government and other agencies

Cooperation and integration

7. INTERSECTORAL DELIVERY

Prevention	Promotion	Anti-discrimination
Trauma	Optimal well-being	Multi-faceted campaign
Inequality, Racism	Well-being literacy	Attitudes, behaviour, systems

6. DELIVERY TO POPULATIONS

Navigation	Peer Support	Personal Assistance	Therapies	Recovery Education	Advocacy
Negotiation	Service users	Day-to-day, Crisis	Talking	Service users	Complaints
Recovery planning	Families	Education, Employment	Drug	Families	Rights protection
Brokerage		Housing	Alternative		Rights redress

5. DELIVERY TO INDIVIDUALS & FAMILIES

Models	Accessibility	Environments	Language	Power
Trauma-informed	Information	'Natural'	Inclusive	Bottom-up
Broad evidence base	Services	Safe	Experiential	Non-coercive

4. ELEMENTS OF SERVICES

Service users	Families	Workforce	Communities	Politicians
Decision makers	Learners	Compassionate	Unfearful	Focus on rights &
Learners	Supporters	Collaborative	Inclusive	social determinants

3. PEOPLE INVOLVED IN SERVICES

To support people to lead their own recovery:

Hope, self-determination over life, choices of services, valued place in world

2. PURPOSE AND VALUES OF SERVICES

A legitimate human experience

Respect for subjectivity, context and meaning

1. BELIEFS ABOUT MADNESS