18 November 2016

mhcc
mental health coordinating council

PO Box 668 Rozelle NSW 2039
T 02 9555 8388
F 02 9810 8145
E info@mhcc.org.au
W www.mhcc.org.au

Australian Government Department of Health
National.Mental.Health.Plan@health.gov.au

Subject: Fifth National Mental Health Plan: Consultation Draft

The Mental Health Coordinating Council (MHCC) is the peak body representing community managed organisations (CMOs) in NSW. Our members deliver a range of psychosocial disability support programs and services including housing, employment and social inclusion activities, in addition to clinical and peer supported services with a focus on trauma-informed recovery oriented practice. MHCC members also include organisations that provide advocacy, education, training and professional development and information services.

MHCC work in partnership with both State and Commonwealth governments, and the public, community and private sectors in order to effect systemic change. We also manage and conduct collaborative research and sector development projects on behalf of the sector and MHCC Learning & Development is a widely respected registered training organisation delivering nationally accredited mental health training and professional development courses to the sector.

MHCC is a founding member of Community Mental Health Australia (CMHA) the alliance of eight state and territory community sector mental health peak bodies. Together we represent more than 800 CMOs delivering mental health and related services nationally. MHCC has provided extensive feedback to CMHA with regards to the Fifth National Mental Health Plan: Consultation Draft (the Plan), to be integrated into a joint submission representing the views of the eight state and territory mental health peaks. Nevertheless, MHCC wish to emphasise some key issues in this separate submission.

MHCC appreciate that the Plan is a high level document describing the Government's overarching future intentions for mental health services across contexts. However, the Plan provides little evidence of directions other than in very broad terms. Without evidence of commitment to identified targets there is little in terms of accountability that is measurable. Whilst the values that underpin the Plan are mostly worthy, there is little indication as to how this list of objectives are to be achieved. The Plan reads as if there is to be an implementation plan sitting under it (p.17) which we would be interested to review.

The Plan proposes that the National Mental Health Service Planning Framework can soon be applied. However, this framework document is still unpublished. We strongly recommend that in order for stakeholders to comment fully, there needs to be a level of transparency about the directions and resource allocation underpinning the Framework (p.23).

We have observed that the Plan as a whole has not demonstrated a consistently meaningful commitment and alignment to recovery orientation as a philosophy and practice approach. Likewise, 'being trauma-informed' as a core principle and requirement of recovery oriented best practice has largely been relegated to matters concerning only Aboriginal and Torres Strait Islander Peoples and services. Since a high percentage of individuals accessing mental health services have lived experience of interpersonal trauma, a practice approach that recognises this fact needs to be incorporated into the Plan. This is specifically necessary in terms of access to services; the need for all services to have an understanding of the prevalence and impact of trauma on mental health, and that all levels of the service system integrate trauma-informed care and practice (TICP) as integral to a recovery oriented philosophy of practice approach. This must be built into the Safety Quality Framework to be developed (p.10, 21). It is vital that this approach is embedded across integrated service delivery contexts.

The Plan primarily focuses on coordinated and integrated service supports for people with severe and complex mental health conditions. MHCC are concerned as to how the system can and will satisfactorily meet the needs of people not assessed as experiencing severe and complex mental illness but who are at risk of deteriorating mental health if left unsupported. The Plan poorly acknowledges the emerging gap in services for people deemed ineligible for the NDIS who may equally have poor access to mainstream services. The Plan states that "for people not eligible for the NDIS, their needs must be met through mainstream services" via commissioning/ tendering of services delivered through the PHNs. However, our understanding is that PHNs will similarly be providing services only to people with severe and complex needs (p.29). This leaves Better Access and ATAPS as the alternatives for those consumers. Unfortunately those services do not currently have the range of access pathways required to enable use of these services by people resistant to clinical treatment. Further these services are not designed to address the psychosocial needs of people which are currently met by the Commonwealth funded community sector programs soon to be transitioned to the NDIS.

MHCC also mention here, that whilst we have data with regards to throughput and costs associated with Better Access to mental health/psychological services, we still have no data concerning access and accountability; i.e. who is using what percentage of the funds spent, and how effective are the interventions utilised under this very expensive national program. Anecdotal evidence has not been encouraging thus far.

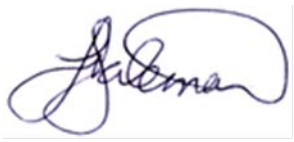
In reference to the physical health needs of mental health clients, the Plan describes GPs as being supported to engage more holistically with their clients. In view of recent statements from Government regarding efficiencies, this does not align with the need for more time per patient and greater access to bulk billing in order for GPs to undertake this enhanced role. With the freeze introduced in 2013 extended to 2020 in the Budget, doctors say costs can no longer be absorbed, and patients are about to start feeling the financial pain (Australian Medical Association). Bulk-billing rates for GP services are at an all-time high of 84.3 per cent, having continued to rise around one per cent each year even after the freeze began in 2013. The Medicare rebate covers only about 50 per cent of the consulting fee recommended by the AMA, which is not sustainable for GPs. This freeze is most likely to affect people in low socio-economic groups, which generally includes people with severe mental health conditions living on pensions. Doctors may no longer be able to bulk bill these patients, and unless the Government has plans to release more funds, the physical health of many mental health consumers is likely to deteriorate. This will surely result in an increased strain on public hospitals and mental health facilities.

Lastly, the Plan fails to speak to the considerable problems related to the mental health workforce vital to the success of the Plan. Apart from the indicator that a "proportion of total mental health workforce be accounted for by the mental health peer workforce" (p.67), there is no plan to meet current unmet or future workforce needs.

Our concern is that the directions of the Integrated Sector, Market and Workforce Strategy (Disability Reform Council 2015, *'NDIS Integrated Market, Sector and Workforce Strategy'*, Australian Government, Canberra) does not sufficiently include consideration of what is already known about the skills required for effective mental health rehabilitation support work, and give due consideration as to what level of support the NDIS will be capable of providing.

Development of the peer workforce is an important strategy to address projected workforce shortages. To ensure the quality of services and supports being provided, there is a need to strengthen both peer and psychosocial rehabilitation work roles and workforce development directions and this needs to be more fully articulated in the Plan. Some people with mental health conditions now eligible for the NDIS may have had access to skilled mental health workers from both public and community managed services. However, in transitioning to the NDIS, the ability to support clients with mental health and complex rehabilitation support needs in the community will only be possible if the Plan supports the growth and sustainability of a skilled and competent psychosocial rehabilitation and disability support mental health workforce. This will likely require establishment of a Professional Association for community sector mental health workers able to set standards and professional development expectations to maintain registration.

MHCC thanks the Government for providing this opportunity to comment on the Fifth National Mental Health Plan. For further information about this submission, please contact Corinne Henderson, corinne@mhcc.org.au



Jenna Bateman
Chief Executive Officer