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Submission: Select Committee on Mental Health and Suicide Prevention

Introduction

The Mental Health Coordinating Council (MHCC) welcome the opportunity to provide a submission to the Select Committee on Mental Health and Suicide Prevention. MHCC is the peak body for community managed mental health organisations (CMOs) in NSW. Our purpose is to support a strong and sustainable community managed mental health sector that provides effective health, psychosocial and wellbeing services to the people of NSW. Our submission will focus primarily on the issues raised in the findings of the Productivity Commission Inquiry Report into Mental Health, which are similar to the findings of numerous other enquiries, reports and Royal Commission's into the mental health sector including the Report of the National Suicide Prevention Officer, the Victorian Royal Commission and the National Mental Health Workforce Strategy.

This submission will address issues most pertinent to MHCC members and the community managed mental health sector. It will outline the key gaps and barriers to accessing community based psychosocial support services, the benefits of improving access to such services and some of enablers required to do so. It is the view of MHCC that the Productivity Commission's recommendations 17 and 23 are crucial to improving the availability of psychosocial support services and improving the quality of lives of people with a lived experience of mental illness. The recommendations which address navigating the system, creating a person-centred mental health system, and providing community based services (12,13, 15) along with those that clarify government responsibilities, planning and funding arrangements (24) should also be early priorities for action.

The Productivity Commission found that "Australia's current mental health system is not comprehensive and fails to provide the treatment and support that people who need it legitimately expect." The mental health system was struggling prior to the 2019 bushfires and the COVID pandemic. While there have been some initiatives and limited funding to address the mental health impact of these two events, extensive reform of Australia's mental health system is required to ensure people can get mental health services and supports when they need them, and that are flexible enough to meet their changing needs and aspirations. It is the view of MHCC that ample advice and evidence exists from the many reviews and inquiries that have been conducted over the last few years; and it is now time for all levels of government to take action to reform and realign the mental health system by providing the necessary resources to shift the emphasis from hospital treatment towards prevention, early intervention and community based supports.

Improving Access to Psychosocial Rehabilitation and Support Services

Key Gaps and Barriers

Access to support services should be available to people living with mental health conditions without a crisis occurring before assistance is available. There have been many inquiries into how to improve the mental health service system and while there have been some resulting changes, too many people still fall through service delivery gaps. Many people remain unable to get the support they need and find the mental health system confusing and hard to navigate.

The Productivity Commission Inquiry was established to investigate these very issues and is one of the most comprehensive inquiries of the mental health system ever undertaken. Many stakeholders, including MHCC, invested considerable time and energy making submissions and participating in the inquiry process. There is great expectation that the final report from the Productivity Commission's inquiry into mental health will result in real and lasting reform.

MHCC agree with the Productivity Commission that reform of Australia's mental health system means addressing the key gaps and barriers that lead to poor psychosocial outcomes and that support and enhance economic participation and growth. It is possible for people with mental health conditions to live well in the community when they have the right mix of medical, psychosocial rehabilitation and support services. It is critical that people be provided with the right services at the right time. In particular, people cycling in and out of hospital at great personal cost as well as a cost to taxpayers, should be addressed. Emergency departments should not be the primary entry point for people needing mental health support. More community-based alternatives must be developed and hospital discharge into unsuitable housing arrangements or homelessness should be avoided.

Community treatment and supports should be expanded for people who do not require hospital care but do require more care and support than can possibly be provided by a GP - the group that has been described as the "missing middle". Seamless care between hospital and community services for people recovering from a suicide attempt should be a priority, as should reducing the life expectancy gap for people experiencing severe mental and physical illness.

Spending on psychosocial support services delivered in the community by the non-government sector is still far too low and there is a demonstrable imbalance in the mental health system with more resources spent on acute care in hospital settings than on community-based services. The Productivity Commission's recent Report on Government Services (ROGS) shows that nationally only 12.7% of the total mental health budget is spent on psychosocial and rehabilitation services provided by community managed services.[1] Utilising the National Mental Health Services Planning Framework, the Productivity Commission estimates that nationally 154,000 people will still be missing out on crucial psychosocial support services at full implementation of the NDIS.[2] The estimate of people who are missing out on psychosocial support services in NSW would therefore be approximately 46,000 simply based on the size of the NSW population.

MHCC urge the Parliamentary Committee to support the Productivity Commissions recommendation 17 to improve the availability of psychosocial supports.

See endnote for Rec 17 from PC Report[i]

[1] Productivity Commission Report on Government Services: Mental Health, 2021.

[2] Productivity Commission, Mental Health, Inquiry Report, Volume 3, p. 862.

What are Psychosocial Rehabilitation and Support Services?

Psychosocial rehabilitation and support services are designed to target the specific difficulties that arise when people have a severe and enduring mental health condition. People are supported to manage self-care, improve their social and relationship skills, and achieve an improved quality of life in relation to physical health, social inclusion, secure accommodation, education, and employment.

Psychosocial rehabilitation services and supports are collaborative, person directed, and individualised, and an essential element of the human services spectrum. They focus on helping individuals develop skills and access resources to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice and include a wide continuum of services and supports.[3]

These services play a vital role in maximising recovery for people living with enduring mental health conditions. They promote personal recovery, successful community integration and an improved quality of life for people and their families. They also embody the values and principles of a trauma-informed recovery-oriented culture and practice approach.

In NSW psychosocial rehabilitation and support services are largely provided by community-managed organisations (CMOs). Core support activities include accommodation and outreach, employment and education, leisure, and recreation activities, as well as family and carer support, self-help and peer support services, helplines, counselling, rehabilitation and clinical care, online programs as well as promotion, information, and advocacy.

It is important to note that CMOs are not a service system as such but a collection of individually funded organisations. Some CMOs provide commissioned services and programs through PHNs whilst others provide a range of services and/or individual packages funded by state or Commonwealth agencies.[4]

The Benefits of Psychosocial Support

It is generally accepted by policy makers and practitioners alike that mental health services are optimally delivered in community settings addressing more than just the symptoms of illness. Evidence clearly demonstrates that people accessing psychosocial rehabilitation and support programs and services stay well for longer; have more chance of completing their educational goals; as well as gaining and sustaining employment and experiencing social participation and achieving a 'contributing life'. This greatly impacts on both admission and readmission rates to hospital thus reducing the need for more acute services in mental health facilities.

Evaluation of the NSW Government funded program the Housing Accommodation Support Initiative (HASI) (see text box, p.4) provides evidence of the effectiveness of these programs in keeping people well in the community and improving quality of life. Findings from an evaluation conducted by the University of New South Wales in 2012[5] demonstrated that HASI has provided significant benefits for those who have received support from the program as well as the broader NSW community.

This evaluation demonstrated a 24% reduction in mental-health related hospital admissions following HASI supports; a 51% reduction in emergency department presentations following two years of participation and an estimated $30 million in savings each year (in 09-10 dollars) compared to an allocated budget of $118 million for 4 years from 2006 to 2010. The beauty of these initiatives is that they support people to maintain stable housing that people can call home. This security really helps people remain well in the community, by

[3] MHCC Submission to Productivity Commission, January 2020, p.5.
[4] Ibid.
[5] Bruce, J, McDermott, S., Ramia, I., Bullen, J. and Fisher, K.R. 2012, *Evaluation of the Housing and Accommodation Support Initiative (HASI) Final Report,* for NSW Health and Housing NSW, Social Policy Research Centre Report, Sydney.

providing a level of support that can be altered according to need which may fluctuate over time. Despite the success of these types of programs, Australia remains under underinvested in them, which is why implementation of recommendation 17 is critical. Not only will it mean a better quality of life for people living with mental health conditions, it will have positive flow on effects to other parts of the health and human service system.

What is HASI?

Housing and Accommodation Support Initiative (HASI) & Community Living Support (CLS) services help people to achieve their own unique goals. The types of support people receive depends on their individual needs and what they want to achieve. People in the program often get help with: daily living skills like shopping, looking after finances, cooking or catching public transport; remembering appointments, medications and other treatments; meeting people in the local community and participating in social, leisure or sporting activities; learning new skills; accessing education or help to get a job; moving from a hospital or a prison back to home; accessing other supports like alcohol and other drug services and the National Disability Insurance Scheme (NDIS). The level of support is flexible. Some people might need only a few hours of support a week while some HASI consumers might get more than 5 hours support a day.

HASI providers and mental health services work closely with the NSW Department Communities and Justice, Housing, (previously FACS) because many HASI participants live in social housing. However, a person is not automatically eligible for public or community housing just because they are a HASI participant. The normal application process and eligibility criteria for social housing apply. CLS is a more recent addition to the service program.

Reform Enablers

Funding Arrangements

To rebalance and reorient the mental health system to improve the lives of those missing out on services will be challenging and both funding reform along with increased funding will be required. The current funding arrangements for community managed mental health organisations can lead to significant costs arising from reporting, compliance, and data collection and the impacts of uncertain and tenuous contracts on service provision, recruitment and consumer and staff wellbeing are clear. MHCC encourages the Parliamentary Committee to support the Productivity Commission's recommendation for minimum five-year contracts with non-government service providers, with clear and early renewal advice.

A five-year contract provides relative certainty for staffing and investment decisions. It allows for business risk to be managed with minimal impact on consumer care and provides for greater stability in consumer/provider relationships. Importantly it also reduces the need for government staff to engage in expensive tendering processes. All these outcomes lead to a better investment return for government. Achieving the balance between the competition associated with contracting and the collaboration required for service development is a major challenge for funders. Providing an option to renew the contract without further open competition can further enhance these benefits. This would need to be based on having met the contract conditions and activity levels, having maintained all necessary accreditations, and having demonstrated appropriate corporate governance. It would assist services to have a presumption of renewal in the absence of performance issues.

Action should also be taken to reduce the reporting burden for providers who receive funding from multiple PHNs, often for the same program.

While these changes would make the existing funding work more efficiently, the Productivity Commission has identified that governments need to increase overall funding. The Productivity Commission estimate that expanding the provision of psychosocial support to the 154 000 people presently missing out could cost approximately $610m. A National Mental Health and Suicide Prevention Agreement will be essential to

specify additional mental health and psychosocial support funding contributions by each level of Government and provide a mechanism to monitor implementation.

The Australian Government should support State and Territory governments to increase the quantum of funding allocated to psychosocial supports for at least a conservative estimate of the number of people who need such supports. This can occur concurrently whilst seeking to establish a more reliable estimate of the shortfall across Australia (and in each region and jurisdiction).

Regional Planning for Psychosocial Support Services

For psychosocial support services to have the greatest impact in improving lives, there must be a public mental health service system in place that provides holistic services that are sufficiently resourced, integrated and work collaboratively. Regional planning involving a collaborative approach between CMO's, PHNs and LHD should be undertaken to estimate the gaps in psychosocial support services in individual geographical catchments.

Effective regional planning should be supported by use of the National Mental Health Service Planning Framework (NMHSPF) to assess need and service gaps. The NMHSPF is an invaluable planning tool and is the only known attempt to assess need nationally in Australia, overcoming the historical accountability transfer and counter-transfer between state and federal governments. Over 250 experts contributed to the NMHSPF development over many years, including senior figures with expertise in the delivery of psychosocial support services and academics with published research and data to support the estimates provided. The NMHSPF was recently endorsed by the Commonwealth Government for use by PHNs to estimate mental health service needs and provide data for service planning. The NMHSPF should continue to be refined and updated to support accurate service planning and thereafter estimate funding requirements.

The NMHSPF is a tool designed to estimate global needs in standard populations, but it does not account for regional variations or local complexities. As such, local knowledge is required to translate the outputs of the tool into clear service plans to meet the needs of local populations, that can be implemented and are consistent with the skills available in those populations. Working together CMOs, PHNs and LHDs could quickly calculate the need for local and regional psychosocial support services by type and volume and therefore address the current gap. CMOs must be involved in regional planning structures and have a meaningful role in the governance that supports those structures. Evidence of the inclusive participative process in the development of regional plans should be provided to both the National Mental Health Commission and state/territory based mental health commissions where they exist. The new National Mental Health and Suicide Prevention Agreement should enshrine the role of CMOs in regional service planning.

National MH and Suicide Prevention Agreement

Additional immediate investment is necessary but in the longer-term improved planning and funding governance arrangements, including clarity of accountability for outcomes, is central to better experiences for people with a lived experience of mental illness. The Productivity Commission recommends that: "Mental health planning and funding arrangements should be reformed to remove existing distortions, clarify government responsibilities and support regional decision making."[6]

A key enabler will be the development of a new National Mental Health and Suicide Prevention Agreement (NMHSPA) to clarify responsibilities and funding contributions. Australian, State and Territory health ministers should be responsible for developing the NMHSPA and it should clarify the roles for mental healthcare, psychosocial supports, mental health carer supports and suicide prevention, authorising

[6] Productivity Commission, Mental Health, Inquiry Report, Actions and Recommendation, p.82

Australian Government transfers to State and Territory Governments to support provision of these services, and establishing arrangements for monitoring, reporting and evaluation.

The Commonwealth as the primary revenue receiver and disperser in the federation must retain equal accountability with the states for addressing gaps in funding for the delivery of services.

The agreement should also stipulate:

- A clear articulation of the importance of psychosocial support services and their role in the national service system
- A clear role in planning for CMOs and their peak bodies
- Clear performance and accountability mechanisms for all levels of government
- Articulation of how service delivery will be scrutinised and by whom
- A mechanism to ensure the integrity of funding intent is maintained when funds are applied operationally. (This is particularly important in ensuring that all funds directed to mental health services are used for the provision of mental health services).

Workforce

Reform will mean very little without the appropriately skilled and trained workforce to implement the changes. A serious commitment is required to undertake workforce planning and build capacity, so the mental health workforce is available where it is needed and so that supply matches demand. Of particular importance is the expanded role of the mental health and peer workforces that undertake the role of working with people living with psychosocial disability.

Psychosocial rehabilitation and support services have historically been delivered by a skilled and qualified workforce with specialist capability and competence to practice in ways that promote recovery, as well as help to prevent relapse, psychiatric crises, and suicide risk. The community-based psychosocial rehabilitation and support service workforce is close to a quarter of the total mental health workforce in NSW and collaborates alongside other specialist mental health and primary health care service providers in delivering treatment, rehabilitation, and support services.

In 2019 MHCC undertook a survey of the NSW CMO mental health workforce [7] to better understand its size, nature, and context.

In summary, the NSW CMO mental health workforce survey found that:

- the size of the mental health workforce is approximately 4,745 paid workers (this includes both direct care and managers/ administrators) as well as 4,160 volunteers.
- The full-time equivalent (FTE) for the paid workforce is 3,464.
- the workforce was female dominated (70%) and nearly two-thirds of the workforce were under 45 years of age.
- the workforce was primarily Mental Health Support Workers (63%) and there were also significant numbers of allied health workers including nurses (12%) and Peer Workers (11.3%).
- almost half of the workforce (49%) was employed on a temporary contract or on a casual (hourly rate of pay) basis, and there was a high level of part-time employment.
- qualifications of the main workforce categories were a mixture of levels ranging from no qualification to an undergraduate degree. The predominant qualification was a relevant Certificate III or Certificate IV in, for example, Mental Health Work or Mental Health Peer Work with 46% of the workforce holding a certificate level qualification and 36% holding a degree qualification.

[7] Ridoutt, L & Cowles, C 2019, *The NSW CMO Mental Health Workforce: Findings from the 2019 MHCC Workforce Survey*, MHCC, Sydney.

A major problem for the sector identified in the workforce survey is that by necessity providers are shifting to an increasingly casualised workforce (49% of the NSW workforce are employed on temporary contract or on a casual basis). Likewise, funding uncertainty due to program changes and NDIS pricing pressures have resulted in skilled and experienced workers leaving the mental health sector. This has put enormous pressure on the existing services.

The NSW 2019 workforce survey focused on current workforce supply. MHCC anticipates growth in future workforce demand given policy and funding directions. Funding and policy settings that ensure a skilled and experienced community-based mental health sector and its workforce are essential. Current models of funding rarely provide adequate resources to upskill and build the capacity of the community-based workforce. The sector needs to be able to accommodate different levels of complexity with new and innovative training and professional development. In an environment often funded based on hours of direct service delivery provided, allocations also must recognise the additional funds required to cover supervision and mentoring/coaching costs, particularly in a developing workforce but also to maintain the health and wellbeing of long-term employees. It is vital that amongst the many aspects for consideration in building and sustaining the mental health community workforce that health and safety concerns are prioritised so services can provide sufficient coverage and ensure risk is minimised

Continuing to grow the peer workforce is also essential. Evidence has shown that wellbeing and quality of life for people living with mental health conditions can be significantly improved by access to support from peers. This is now seen as integral to best practice supports. All jurisdictions in Australia have demonstrated a commitment to the mental health peer workforce in existing mental health plans and strategies, in the development of a peer workforce and the codesign of frameworks, or standards and guidelines. The Fifth National Mental Health and Suicide Prevention has mandated the development of the National Peer Workforce Development Guidelines, and in the forthcoming National Mental Health Workforce Strategy, the Taskforce has identified the peer and lived experience workforce as one of its five priority areas.

Conclusion

MHCC thank the Select Committee for the opportunity to provide input into their deliberations and look forward to the Committee further advancing action by governments to ensure people living with mental health conditions get the support and services they need, to live full and contributing lives. Mental illness is the largest contributor to years lived in ill health and many people living with mental health conditions encounter stigma and discrimination; have a lower life expectancy and experience poorer physical health than the community in general as well as higher rates of unemployment, poverty and disadvantage. Australia can and must do better than this and many inquiries and reviews show the way forward. It is not acceptable for the outcomes of these inquiries and reviews to be delayed through yet further reviews- lives are being lost, quality of life is diminished, and action is needed now.

Substantial system reform is necessary to create a mental health system that is reflective of a trauma-informed recovery-oriented approach to care, treatment, and support. One that promotes a human rights perspective that aligns with the United Nations Convention on the Rights of People with a Disability, which maximises self-determination and social inclusion and promotes a co design imperative in service design and development. This submission address issues most pertinent to MHCC members. MHCC acknowledges that there are many other areas and issues that also require attention and our submission is not exhaustive- it reflects the expertise and experience of the community managed mental health sector in NSW. MHCC are happy to provide any further information the Committee may require.

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[i] RECOMMENDATION 17
IMPROVE THE AVAILABILITY OF PSYCHOSOCIAL SUPPORTS

The delivery of psychosocial supports — including a range of services to help people manage daily activities, rebuild and maintain social connections, build social skills and participate in education and employment — has been hampered by inefficient funding arrangements and service gaps. This is affecting the recovery of people with mental illness and their families, who can benefit substantially from improved access to psychosocial supports.

As a priority:
Governments should ensure that all people who have psychosocial needs arising from mental illness receive adequate psychosocial support.

To achieve this:
The shortfall in the provision of psychosocial supports outside the National Disability Insurance Scheme (NDIS) should be estimated at a regional and State and Territory level. (Action 17.3)

Over time, State and Territory Governments, with support from the Australian Government, should increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall. (Action 17.3)

Additional reforms that should be considered:
As contracts come up for renewal, commissioning agencies should extend the length of the funding cycle for psychosocial supports from a one-year term to a minimum of five years. Commissioning agencies should ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle. (Action 17.1)

State and Territory Governments and the National Disability Insurance Agency should streamline access to psychosocial supports both for people eligible for supports through the NDIS and for people who choose not to apply for the NDIS or are not eligible. (Action 17.2)

State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the NDIS. (Action 17.3)