Mental Health Coalition of SA- Submission on the Fifth National Mental Health Plan

Introduction

The Mental Health Coalition of SA (MHCSA) has over 20 organisational members. The MHCSA provides a unified voice for the Community Managed Mental Health (CMMH) Sector in South Australia. The CMMH Sector comprises non-government organisations that deliver mental health services and work with people with mental illness and families across the state. The MHCSA work includes a strong focus on supporting and growing the lived experience workforce and promoting positive messages that support people to improve their well-being and reduce stigma and discrimination.

The MHCSA Vision is that all people with mental illness in South Australia and their families will receive the mental health support they need when and where they need it. The MHCSA promotes a recovery approach meaning the goal of support is to assist people living with a mental illness to build a contributing life in the community including social and economic participation.

With this holistic approach to outcomes, MHCSA advocates for and promotes evidence-based practice and capacity building for community based mental health services, including close collaboration with people with lived experience. MHCSA does this at a state level and works closely with Community Mental Health Australia (CMHA) and Mental Health Australia (MHA) at the national level.

The MHCSA strongly supports the submissions of both the CMHA and MHA.

The MHCSA thanks the Australian Government for the opportunity to provide comment on the Fifth National Mental Health Plan (5NMHP). Our submission to the Plan consists of overall comments on the Plan as well as specific comments on the Priority Areas and proposed recommendations.

General Comments

In its current form, the 5NMHP represents a retrograde step regarding the vision for mental health policy direction in Australia. There is minimal commitment regarding overall funding for mental health. Nor is there commitment to the specific targets generated by the Expert Reference Group of COAG with significant input from consumers and carers. Worse, unaddressed in the 5NMHP is the seismic shift towards more reliance on 'crisis' services represented by the defunding of CMMH services in the transition to full implementation of the National Disability Insurance Scheme (NDIS). The Commonwealth Department of Health Guidance to Primary Health Networks specifically excludes CMMH Service-delivered psychosocial rehabilitation. These dramatic changes will take Australia in the opposite direction to that recommended in the National Mental Health Commission Review. A 5NMHP that does not address these issues is effectively endorsing a quantum shift to increasing emphasis on the 'crisis' end clinical and acute services by its silence on the current path to defunding CMMH Services that deliver community-based rehabilitation that. This will result in a significant reduction in the capacity of the system to support people severely impacted by mental illness to recover in the community. This will
result in a mental health system that is even more unbalanced and will undo many years of progress under the National Mental Health Policy, the four previous mental health plans and the Roadmap.

To gain credibility in this important area, the 5NMP must prioritise increased investment in community-based rehabilitation services delivered by CMMH Sector to support people severely impacted by mental illness. An associated strong focus on capacity building with the CMMH Sector will enable increased focus on continuous improvement in supporting people to recover. Key elements of capacity building include investing in improved data collection and reporting systems and in workforce development with a particular focus on lived experience workers.

In South Australia, we have already lost ground with the conclusion of two relevant Commonwealth State agreements, resulting in the demise of approximately $25m per annum of innovative mental health programs. Whilst the SA Government provided funding to continue some of these services, the demise of the agreements represents a significant net loss of innovative mental health services. The two CMMH programmes defunded - Intensive Home-Based Support Services (IHBSS) and Crisis Respite - were high functioning and the independent evaluations \(^1\)\(^2\) showed strong outcomes in terms of quality of life but also in terms of reduced use of acute and crisis services. The evaluation of IHBSS showed that it would more than pay for itself in terms of offsets in reduced hospitalisation costs. The 5NMP makes no reference to the funding that was previously provided to mental health services through these Commonwealth -States Agreements. This represents a net loss of $10m per annum for effective CMMH services and reduced options for people severely impacted by mental illness to get the assistance they need to recover in the community. **The failure to address this seismic shift in balance of services and the impact on support for people with severe mental illness highlights a significant weakness in the 5NMHP.**

Massive change is occurring in mental health with the transfer of funding for federally funded mental health programs to the National Disability Insurance Scheme (NDIS). The programs affected include Department of Health funded Partners in Recovery (PIR) and Day to Day Living (D2DL) and Department of Social Services funded Personal Helpers and Mentors (PHaMs) and Mental Health Respite: Carer Support carer respite programs.

In addition, responsibility for a number of Department of Health programs is shifting to the PHNs, via a mental health program funding pool from which the PHNs will commission services for their area.

A key requirement of a successful mental health and disability support system is the need to deliver treatment, community-based rehabilitation and disability support for people more severely impacted by mental illness. Some people severely impacted by mental illness will need access to all three service

\(^1\)https://www.sprc.unsw.edu.au/media/SPRCFile/1_SPRC_Report__Evaluation_of_Intensive_Home_Based_Support_Services_v2.pdf
types. At full implementation of NDIS, people with significant disability associated with their illness who qualify should be able to get their disability support needs met. **Unfortunately, the associated defunding of successful rehabilitation-focused mental health program will mean that a growing number of people will not get their community-based rehabilitation needs met.**

In addition, it is not clear how state jurisdictions will deal with transition to NDIS in terms of state funding to community-based rehabilitation programs.

A survey completed by the MHCSA, whilst not comprehensive, showed CMMH Sector supporting around 7000 people in SA from both Commonwealth and State funded sources. It was estimated that around 5400 of these people currently receiving services were unlikely to gain access to an NDIS package. These services were developed to address failures and inefficiencies in our mental health system and many have been evaluated and shown to be highly effective at supporting people to recover. Most of these services are designed to be relatively short term, so any gaps that are created will multiply over time. Assuming an average length of stay of 12 months, PHaMS in SA supports over 2000 people per annum in SA so **over the 5 year life of the 5NMHP the defunding of this service will mean loss of access for 10000 people. That is more than twice the number of people that the NDIS is designed to support and PHaMS is only one program.**

**This growing gap will not be met by PHNs given that the current guidance documents**, developed to assist the PHNs on the implementation of the reforms, **include a clear directive that PHNs cannot commission psychosocial services.** The Guidance states that PHNs can promote links to broader services, and recognises that these services are vital, but that they are not within scope for PHN funding.\(^3\)

The 5NMHP must be rewritten to address this important issue and avoid delivering a mental health plan that will erode hard-won progress achieved over many years. At stake is the support delivered by the CMMH Sector support that is evidence-based and demonstrably delivers the recovery oriented services that help individuals and the families to build contributing lives in the community.

A key element of the 5NMHP should be achieving properly funded state and territory and federal mental health programs, with a strong focus on community-based rehabilitation. The 5NMHP must address the growing gap that will occur in this important part of the mental health system or the 5NMHP will be seen as disconnected from what is actually happening.

From the consultation process, it appears that a possible reason why the 5NMHP is silent on NDIS is because of a decision to make this a ‘Health’ plan. And perhaps this narrow focus has been adopted based on experience of past plans and the difficulty of gaining agreement across Ministers within and

\(^3\) MHCSA. Discussion Paper: Community-Based Psychosocial Rehabilitation: A Casualty of the National Disability Insurance Scheme? 2016

\(^4\) Primary Mental Health Care Services for People with Severe Mental Illness. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. Department of Health Australian Government.
amongst jurisdictions. MHCSA strongly disagrees with this logic and urges Commonwealth, state and territory governments to work together and aim higher. Mental health cannot be adequately addressed if the 5NMHP ignores the inconvenient fact that a holistic approach is necessary for recovery as consumers and carers have advocated it. Housing, employment, physical health and disability are critical to mental health and wellbeing and are key indicators identified by the Expert Reference Group to COAG that developed indicators and targets. The current 5MHP effectively advocates a siloed approach which is contrary to previous plans and policy, disrespectful to consumer and carer advocacy over many years and contrary to the evidence-base showing the need for balanced investment across a range of services most effectively assists people to recover. The 5NMHP canvasses the broad range of issues that impact on individuals with mental illness, but the priorities and actions fail to deliver a comprehensive response.

Within the limited approach of the 5NMHP there is a need from strong processes for monitoring and reporting on progress. MHCSA advocates independent monitoring and reporting by the National Mental Health Commission, with an appropriate level of funding to ensure strong engagement with external stakeholders, especially consumers and carers.

Workforce planning is a key issue in mental health and should be addressed in the 5NMHP. There should be emphasis on the needs of the CMMH Sector including a strong focus on development of the lived experience workforce.

The 5NMHP should include targets and timelines in line with the findings of the Expert Reference Group of COAG. The measurement chapter has a good range of measurement tools but there is little detail regarding implementation. A key element of this should be to develop better information systems for the services delivered by the CMMH Sector. This should include the national collection and reporting of the NGOE Data Set Specifications as a National Minimum Data Set. Another key action is to work with the CMMH Sector to deliver a national roll out of key tools such as the YES CMO Version, Living in the Community Questionnaire (LCQ) and Carer Experience of Care surveys. This will ensure visibility of this activity and provide ongoing data to assist consumers, carers, service providers and funders to focus on continuous improvement.

The MHCSA advocates that the 5NMHP requires significant review in order to achieve a high level of support from mental health stakeholders. These views are provided in good faith to assist jurisdictions to develop a better 5NMHP.

**Recommendation 1:** The 5NMHP must redress the reduced access and growing service gaps that will result from the proposed defunding of mental health services as part of the implementation of the NDIS. The impacts of this run counter to a key strategic goal since the first national mental health plan and the recent National Mental Health Commission Review to dramatically increase investment in such services.
**Recommendation 2:** The 5NMHP must include clear targets and timelines that are meaningful for consumers and carers including adoption of those proposed in the work of the Expert Reference Group of COAG.

**Recommendation 3:** The 5NMHP must implement the key recommendation in the National Mental Health Commission Review to significantly rebalance investment in 'non-crisis' services that assist people severely impacted by illness to recover and build contributing lives in the community. A key Commonwealth action is to rewrite the guidance for PHNs to encourage an appropriate level of investment in effective community-based rehabilitation services delivered by CMMH service providers. The impact of loss of innovative mental health services developed through Commonwealth States agreements that has occurred since the Review must also be addressed, particularly independently evaluated services such as IHBSS and Crisis Respite.

**Recommendation 4:** There must be a specific priority area addressing workforce, including the role of peer workers. The Plan should also articulate the process for the development of a National Mental Health Workforce Strategy

**Priority Area 1 – Integrated Regional Service Delivery**

Regional planning and delivery of services through PHNs makes sense and is in line with the NMHC Review. The 5NMHP must address the issue of the Guidance for PHNs to not commission psychosocial services delivered by CMMH services. This leaves the current focus from the Commonwealth for the PHNs as very clinically oriented and whilst a stepped care approach is promoted, the result will be more costly and less effective than a more balanced approach to meeting the full spectrum of needs of people severely impacted by mental illness.

The 5NMHP offers little detail about how actions will get done. There is frequent reference to the difficulty and complexity in getting different portfolios and levels of government to cooperate. This language does not inspire confidence that the 5NMHP will deliver on its proposed actions.

PHNs must be able to commission psychosocial services if indicated by their needs assessments and plans. There is no discussion about the role of CMMH services in the 5NMHP. Whilst promoted as a national plan, the level of detail about state services is minimal. There is a need for more emphasis on the role of the LHNs and/or emphasis on state and territory planning. In the current environment, CMMH services are central to a 5NMHP that is consistent with the National Mental Health Policy, the four previous Plans, the Roadmap and the NMHC Review. All of these documents included rebalancing the mental health system investment to more investment in CMMH Services that help people to get well and stay well as a way to make the investment in the crisis, acute and more clinical services more effective.

**Recommendation 5:** The 5NMHP must consider the role of the community-managed mental health service sector including in the context of reforms via PHNs and state mental health investments.
Priority Area 2 – Coordinated treatment and supports for people with severe and complex mental illness

Over the life of the 5NMHP, a significant and growing gap in this priority area will occur which is not addressed by the 5NMHP. Only a relatively small percentage of people living with a mental illness will be eligible for the NDIS and as previously stated, the Commonwealth guidance for service offerings from PHNs is unduly restricted.

In the 5NMHP there is an action that the Mental Health Drug and Alcohol Principle Committee (MHDAPC) will report to Health Ministers on issues arising from mental health reforms and the NDIS. There is no indication regarding how such issues should be addressed. Another action states that PHNs and LHNs will ‘work with’ the community sector. Again there is no detail regarding how.

In terms of implementation the 5NMHP there is no indication regarding how jurisdictions will work with the CMMH Sector. The Commonwealth Government must continue to fund flexible, low barrier to entry services (such as Partners in Recovery, Day to Day Living and Personal Helpers and Mentors (PHaMs)). These services were originally created to address gaps and problems in mental health services therefore must be funded outside of the NDIS for people who need ongoing community and coordination support. People receiving NDIS services may also at times benefit from these service types.

Recommendation 6: The 5NMHP must address the gap that will be created in CMMH service delivery for people both eligible and not eligible for the NDIS. A key element of this strategy is for the Commonwealth Government to continue funding to flexible, low barrier to entry services.

Priority Area 3 – Suicide Prevention

A key omission in the 5NMHP is the need for more emphasis on the role of community in suicide prevention and communities leading response.

The 5NMHP recognises the lack of a nationally consistent approach to follow-up care after a suicide attempt but fails to articulate a clear way forward. There are internationally proven models and the 5NMHP could include actions based on this.

Action 6 states that governments will ‘renew efforts’ to develop a nationally agreed approach to suicide prevention and this should be strengthened to reflect an intent to complete this action within a set timeframe.

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5 Black Dog Institute and Centre for Research and Excellence in Suicide Prevention, A World-Class Integrated Approach to Suicide Prevention. 
The 5NMHP should ensure that PHNs develop consistent approaches outcomes measurement and reporting.

**Recommendation 7:** The 5NMHP should build on an examination of existing successful approaches or programs in suicide prevention to develop a nationally agreed approach to suicide prevention.

**Recommendation 8:** The PHNs should have nationally consistent outcomes measures.

**Priority Area 4 – Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention**

Aboriginal and Torres Strait Islander people should lead work in this area. Aboriginal Community Controlled Health Organisations should be leading implementation.

Funding originally allocated for Aboriginal and Torres Strait Islander suicide prevention has been transferred to the PHNs mental health funding pool. This funding should be specifically used for its original purpose with specific reporting of outcomes by PHNs.

The 5NMHP actions should respond to the existing National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

**Recommendation 9:** Aboriginal and Torres Strait Islander people should lead the suicide prevention aspects of the 5NMHP with Aboriginal Community Controlled Health Organisations leading implementation.

**Priority Area 5 – Physical health of people living with mental health issues**

Physical health is a key issue for all service providers and the actions in this area could reflect that better.

Improving the physical health of people is a key focus of CMMH services. Working with the CMMH sector to identify better methods of data collection, reporting and continuous improvement would lead to better outcomes.

This work could also be strengthened by reference to the National Strategic Framework for Chronic Conditions\(^6\) and Health Carer Homes\(^7\) within which mental health has been identified as a target area.

All workers who provide services to people with severe mental illness should have an understanding of linkages with chronic health conditions.

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**Recommendation 10:** The 5NMHP should better address physical health for people severely impacted by mental illness by considering the role of CMMH services as well as other relevant programs and initiatives in Health and other portfolios.

**Priority Area 6 – Stigma and discrimination**

The action regarding governments broadening efforts to reduce stigma and discrimination for people with severe mental illness is supported. More information is required regarding how this will be achieved including targets, timelines and detail as to how this will be achieved.

**Priority Area 7 – Safety and quality in mental health care**

Consumers and carers have consistently raised concerns regarding amendments to the National Standards for Mental Health Services.

**Recommendation 11:** The 5NMHP should note that the rights of consumers and carers in safety and quality standards in the NSMHS must not be reduced.

**Monitoring and Reporting on Reform Progress**

Proposed oversight of the 5NMHP is via Government and COAG monitoring the implementation and progress of the Plan, along with a number of intergovernmental advisory groups or committees. This approach provides no independent oversight. The monitoring of the Plan should be undertaken by the NMHC. State jurisdictions with mental health commissions should be involved in a collaboration with the NMHC.

The CMMH service providers have continuously called for increased focus on better data collection and reporting. The 5NMHP does not address this specifically which is a significant oversight.

The lack of outcomes measures is an ongoing issue that needs addressing in the 5NMHP including with the newly established PHNs.

The indicators and proposed collection tools are solid, but there is little detail regarding how they will be implemented and used for continuous improvement.

The Plan has little focus on the work of the Community Managed Mental Health Sector which is a key driver of recovery. There is a need to improve collection and reporting of activity and outcomes of the CMMH Sector.

**Recommendation 12:** The 5NMHP should prioritise the following activities:

- National collection and reporting of the NGOE Data Set Specification as an NGOE National Minimum Data Set
- Work with Community Mental Health Australia to deliver a targeted roll out of YES CMO Version, LCQ and CEC (when completed) with the CMMH Sector.
Summary and Recommendations

Overall MHCSA believes the 5NMHP has significant flaws particularly regarding increasing emphasis on the clinical and acute treatment of mental health and a move away from recovery focussed community-based mental health services.

The 5NMHP includes good content around the range of issues which impact on people’s lives, but the actions are generally lacking in specificity.

Increased emphasis on the roles of PHNs is supported but the lack of emphasis on roles for consumers, carers and the wider community is a deficiency. A key problem with PHN role is the Guidance from the Commonwealth excluding the commissioning of community-based psychosocial rehabilitation services.

The 5NMHP fails to address the gap that will be created for people living with a mental illness when jurisdictions de-fund CMMH services as we move to full implementation of the NDIS. This will impact hardest on those who are not eligible for the NDIS.

The 5NMHP does not address the loss of innovative mental health services with the cessation of Commonwealth State agreements. Two CMMH services in SA - IHBSS and Crisis Respite - were independently evaluated and shown to be highly effective.

The 5NMHP could usefully include workforce development with specific attention on the needs of the CMMH sector and development of the lived experience workforce.

The 5NMHP should include clear actions requiring the CMMH sector to work with jurisdictions to improve collection and monitoring of data for CMMH services.

The 5NMHP should include adoption of indicators and targets proposed by the Expert Reference Group of COAG.

The 5NMHP needs significant re-alignment to gain support of mental health stakeholders.

The recommendations from MHCSA that should be included in the Plan are:

**Recommendation 1:** The 5NMHP must redress the reduced access and growing service gaps that will result from the proposed defunding of mental health services as part of the implementation of the NDIS. The impacts of this run counter to a key strategic goal since the first national mental health plan and the recent National Mental Health Commission Review to dramatically increase investment in such services.

**Recommendation 2:** The 5NMHP must include clear targets and timelines that are meaningful for consumers and families including adoption of those proposed in the work of the Expert Reference Group of COAG.

**Recommendation 3:** The 5NMHP must implement the key recommendation in the National Mental Health Commission Review to significantly rebalance investment in 'non-crisis' services that assist people severely impacted by illness to recover and build contributing lives in the community. A key
Commonwealth action is to rewrite the guidance for PHNs to encourage an appropriate level of investment in effective community-based rehabilitation services delivered by CMMH service providers. The impact of loss of innovative mental health services developed through Commonwealth States agreements that has occurred since the Review must also be addressed, particularly independently evaluated services such as IHBSS and Crisis Respite.

**Recommendation 4:** There must be a specific priority area addressing workforce, including the role of peer workers. The Plan should also articulate the process for the development of a National Mental Health Workforce Strategy

**Recommendation 5:** The 5NMHP must consider the role of the community-managed mental health service sector including in the context of reforms via PHNs and state mental health investments.

**Recommendation 6:** The 5NMHP must address the gap that will be created in CMMH service delivery for people both eligible and not eligible for the NDIS. A key element of this strategy is for the Commonwealth Government to continue funding to flexible, low barrier to entry services.

**Recommendation 7:** The 5NMHP should build on an examination of existing successful approaches or programs in suicide prevention to develop a nationally agreed approach to suicide prevention

**Recommendation 8:** The PHNs should have nationally consistent outcomes measures.

**Recommendation 9:** Aboriginal and Torres Strait Islander people should lead the suicide prevention aspects of the 5NMHP with Aboriginal Community Controlled Health Organisations leading implementation.

**Recommendation 10:** The 5NMHP should better address physical health for people severely impacted by mental illness by considering the role of CMMH services as well as other relevant programs and initiatives in Health and other portfolios.

**Recommendation 11:** The 5NMHP should note that the rights of consumers and carers in safety and quality standards in the NSMHS must not be reduced.

**Recommendation 12:** The 5NMHP should prioritise the following activities:

- national collection and reporting of the NGOE Data Set Specification as an NGOE National Minimum Data Set

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