Community Mental Health Australia 2017-18 Federal Pre-Budget Submission

Introduction

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations, established to provide leadership and direction promoting the benefits of community mental health and recovery services across Australia.

CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for over 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

The organisations represented through CMHA are:

- Mental Health Coalition of South Australia
- Mental Health Community Coalition of the ACT
- Mental Health Coordinating Council NSW
- Mental Health Council of Tasmania
- Northern Territory Mental Health Coalition
- Psychiatric Disability Services of Victoria (VICSERV)
- Queensland Alliance for Mental Health
- Western Australian Association for Mental Health

CMHA promotes the recovery of people living with a mental illness so that they are contributing citizens and included in all of the economic and social aspects of their community. Rehabilitation must be an integral component of both Federal and state and territory approaches to support people to achieve recovery and to deliver recovery goals.

Mental health has been undergoing a significant period of reform particularly in terms of the transition of funding for federally funded mental health programs. Mental health funding is being transferred to the National Disability Insurance Scheme (NDIS), including Partners in Recovery (PIR) and Day to Day Living (D2DL) – both sitting with the Department of Health – and Personal Helpers and Mentors (PHaMs) – sitting with the Department of Social Services. Respite programs for carers are also impacted by this transfer of funding.

Along with the NDIS, a number of Department of Health programs are transitioning to the responsibility of the Primary Health Networks (PHNs), where program funding will go into a flexible mental health funding pool from which PHNs will commission services for their PHN area based on needs assessments and planning they have undertaken.

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

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associated defunding of successful rehabilitation-focused mental health programs, however, a growing number of people will not get their community-based rehabilitation needs met.

How the reforms respond to both community-based rehabilitation and psycho-social disability support needs as well as provide a workforce that is qualified to deliver the services people need is an important issue, particularly within the NDIS structure. CMHA wants to work to develop solutions through a partnership with community mental health service providers, consumers, carers and families, and provide informed input to decision makers to ensure the reforms actually deliver what is needed for people living with a mental illness.

Investment in evidence-based, community initiatives benefit individuals and families, and result in long term economic benefits to the community. Examples of the types of services that should be invested in include:

- well targeted housing support which will be more than offset with savings in use of crisis and inpatient services
- the expansion of court diversion and justice reinvestment schemes where people living with mental illness and comorbidity are diverted to therapeutic rather than custodial interventions; and
- a sustained investment in evidence-based mental health employment programs such as Individual Placement & Support to bring Australia up to the standard of the OECD countries which have higher rates of employment for people with mental health issues.

In order to start shifting towards an investment in initiatives that benefit individuals, families and the community, steps need to be taken to ensure we have the workforce to deliver these initiatives, and an understanding of the impact of the current reforms. CMHA believes the following areas should be included in the 2017-18 Federal Budget in order to address key issues in the reform process:

Initiative	*Budget Impact*
Develop a National Mental Health Workforce Strategy	Cost neutral
Psychosocial services included in the services Primary Health Networks (PHNs) are able to commission	No cost
Establish a cross-government and cross-sector Expert Reference Group to examine and monitor reforms impacting mental health	Cost associated
Conduct regional Communities of Practice to support NDIS transition	Cost-neutral
Develop quality assurance processes specifically tailored for psychosocial support services as a part of the NDIS Quality and Safeguarding Framework	Cost associated
Develop options for funding services for people living with a mental illness who are ineligible for the NDIS and currently access Federally funded programs, ensuring	Cost associated - approximately $70,000

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their rehabilitation and disability support needs are met whether eligible or not

Develop a National Mental Health Workforce Strategy

A key piece of policy work that is required is an examination of the overall workforce in mental health, including the community mental health sector, to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms that are occurring.

A workforce strategy should be developed to support both the mental health workforce and primary health workers, especially GPs, to prepare for mental health reforms, including the NDIS, in relation to mental health and their roles. The inclusion of the community mental health workforce is crucial. The range of reforms occurring in mental health is having an impact on the workforce in community-managed mental health sector including the pricing structures of the NDIS and the impacts on qualified staff.[1]

The workforce strategy should provide particular assistance to the consumer and carer peer workforce (both paid and volunteer), including to prepare for the NDIS. This should build the capacity of this workforce to assist consumers and carers to access the scheme productively. Along with a strategy for peer workers, key areas of need such as the Aboriginal and Torres Strait Islander, rural and remote and early childhood workforce should be a focus and part of the strategy.

The lack of a comprehensive national mental health workforce strategy to develop, support and maintain the mental health workforce has been a significant policy gap and has meant that reforms in the sector which have a significant impact in the workforce, have no guiding policy to account for these issues.

A National Mental Health Workforce Strategy would be best placed being developed by an agency such as the National Mental Health Commission (NMHC) informed by their networks, consumers, carers, along with organisations with connections to the community mental health workforce and professional mental health groups. CMHA is also well placed to assist in delivering this Strategy.

[1] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: Mental Health Coordinating Council.

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A National Mental Health Workforce Strategy be undertaken to develop, support and maintain the mental health workforce. This should include the community mental health sector, the mental health peer workforce, and the primary health workforce.

The cost for developing the strategy would be largely cost-neutral if undertaken within an agency such as the NMHC, which has the existing expertise and structures to undertake the work, along with including consumers, carers, organisations with connections to the community mental health workforce and professional mental health groups. There would be costs associated with meetings or consultations for the strategy's development, which would be a part of the development process.

Psychosocial services be included in the services Primary Health Networks (PHNs) are able to commission

The National Mental Health Commission's (NMHC) 2014 Review of Mental Health Programs and Services focused on 'assessing the efficiency and effectiveness of programs and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community'[2] and put forward a series of comprehensive recommendations to achieve this.

The Australian Government's response to the NMHC report stated a commitment to system change to shift the way services are planned and delivered. This included having person centred care funded on the basis of need; a regional approach to service planning and integration; and having early intervention across the lifespan and care continuum to provide care when it is needed.[3]

The central part of the response was transferring funding for a number of federally funded mental health programs to the responsibility of the PHNs which will transition to a flexible mental health funding pool from which PHNs will commission services based on regional planning and needs assessments, including joint planning with state, territory or local area health services. They are also required to undertake a stepped care approach to providing care.

The guidance documents developed to assist the PHNs on the implementation of the reforms, and which outline the expectations of them, have included the directive that PHNs cannot commission psychosocial services. It states they can promote links to broader services, recognising these services are vital, but they are not within their scope.[4]

This directive appears to be contrary to the intent of the NMHC recommendations, and the announcement of the Government for a mental health system with person-centred care across the

[2] National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC

[3] Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services

[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.

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continuum when people need it. It also does not reflect the stated aim of a stepped care approach, which is about a staged hierarchy of services that is matched to an individuals need.[5] It would also be expected that in being directed to plan with state, territory or local area health services, that this, along with needs assessments and planning, is likely to show that a gap in service provision is in psycho-social services such as housing, employment or other such services.

Programs that have transitioned to the PHNs, such as the Mental Health Nurse Incentive Program, Headspace, and the suicide prevention funding, already apply an approach which works across the care continuum and provides both clinical and psychosocial supports based on a persons need. To change this approach, which has already been providing psychosocial support, loses the flexibility that is currently provided.

Investment in psychosocial mental health services is vital in all areas, particularly in rural and regional areas where less services are available and hospital can be the only option for people. A report from the Australian Institute of Health and Welfare (AIHW) *Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013-14*[6] examined local-level variations in populations across the 31 PHNs and smaller local areas. The report showed that people living in regional areas were more likely to be hospitalised for a mental health condition or intentional harm. This demonstrates further the need for PHNs across all areas but particularly in rural, regional and remote areas to commission the services that their needs assessments and planning identify, and to stop people living with a mental illness from having the acute system as their only option.

CMHA supports the approach of providing regionally planned and based services and believes that the PHNs are the best mechanism for this to occur, and that they should be supported and enabled to deliver on the aims of the NMHC report and the Government's response to the report. This will happen if they are able to be truly flexible; work with state, territory or local area health services; and act on the gaps that are shown through their planning processes.

Psychosocial services be included in the services the PHNs are able to commission from their flexible mental health funding pool. The services they are able to commission should be as is reflected in their joint planning with state, territory or local area health services, and the planning and needs assessment work they have undertaken.

This initiative will be at no cost as it relates to the scope of services PHNs are able to commission from their existing flexible mental health funding pool.

[5] Stepped Care. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. Department of Health Australian Government.

[6] Australian Institute of Health and Welfare 2016. *Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14*. Cat. no. HSE 177. Canberra: AIHW.

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Establish a cross-government and cross-sector Expert Reference Group to examine and monitor reforms impacting mental health

As noted earlier in this submission, there is a range of mental health and other related reform processes occurring including:

- NDIS transitioning of mental health programs
- PHNs – mental health and suicide prevention funding transitioning to the flexible funding pool
- Health care homes – mental health was identified as a target area
- Productivity Commission inquiry on contestability and competition in human services

While each is occurring of their own accord, they will all impact each other and there doesn't at present appear to be a process of ensuring that any cross-over is considered and that there is an overall consideration of how they will interrelate. Each of these reforms will have an impact on the mental health including how services are provided, how the different reform processes will impact on psychosocial service delivery, and how people living with a mental illness will be eligible or not for the variety of programs and services impacted.

There is a precedent for the Federal Government establishing expert reference groups when there is significant reform occurring which impacts on a number of areas of government policy. This includes the Mental Health Expert Reference Group on the Government's response to the NMHA review of programs and services; the Medical Benefits Schedule (MBS) Review Taskforce to represent a range of interest and consumers impacted by the review; and the NDIA Mental Health Sector Reference Group to represent the interests of the variety of groups associated with the NDIS and mental health.

The purpose of a cross-government and sector expert reference group would be to monitor each of the reform processes on mental health including, but not limited to, service delivery and access; workforce planning; overlapping issues such as service pricing and ongoing service provision; and policy consistency. Part of this process could include establishing a risk management strategy and plan for the reforms. The work of the group should also be about starting to examine measurable targets for improved mental health outcomes, and working with the NMHC on this and the overall monitoring of the reforms progress.

The membership of the cross-government and cross-sector expert reference group could comprise the following members:

- Consumer representatives
- Carer representatives
- The Department of Health
- The Department of Social Services
- Professional groups such as the Australian College of Mental Health Nurses, Royal Australian College of GPs, Royal Australian College of Psychiatrists, and Australian Psychological Society
- Peak mental health groups including Mental Health Australia, Community Mental Health Australia and Mental Illness Fellowship of Australia
- Carers Australia
- Representatives of Aboriginal and Torres Strait Islander groups such as the National Aboriginal Community Controlled Health Organisations

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- Representatives of Culturally and Linguistically Diverse (CALD) groups such as the Federation of Ethnic Communities' Councils of Australia (FECCA)
- Organisation/s able to represent the interests of the PHNs such as the Australian Health and Hospitals Association (AHHA) or representatives of the state and territory PHN networks/alliances.

That the Federal Government establish a cross-government and cross-sector Expert Reference Group to examine and monitor the overlapping health and human services reforms impacting mental health. The Group should comprise representatives of relevant government departments, consumers, carers, relevant professional organisations, peak mental health groups, PHNs, Aboriginal and Torres Strait Islander groups, and CALD groups. The members of the Group should be selected and supported by the sector.

There would be a cost associated with the group in holding meetings and teleconferences, secretariat support and the production of any reports or materials.

Conduct regional Communities of Practice to support NDIS transition

Through the experiences from the implementation of mental health within the NDIS in trial sites, it has become evident that support is required to transition the mental health sector, in particular the community mental health sector to be ready and able to maintain services and support people within the NDIS.

A 2016 piece of work by CMHA led by the Mental Health Coordinating Council (MHCC) New South Wales (NSW), on the impact of the NDIS on the mental health workforce, found that 'an overall perspective from the study that many service providers consider the NDIS to be a 'challenging' environment'.[7] [8] A 2015 report by VICSERV on the NDIS Barwon trial recommended that before full roll-out commenced there needed to be better communication with all stakeholders, and support for organisational readiness at 12 months prior and to shift to a new model of care.[9]

It is acknowledged that the impact of the NDIS on people living with a mental illness and service providers is in its early stages. It is important that the key learnings and issues that emerge from the various reports and studies, particularly those from the community mental health sector – involved on the ground in delivering services as they transition – are incorporated and lead to changes which will ultimately affect the quality of services delivered to consumers.

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[7] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: Mental Health Coordinating Council.

[8] The report was commissioned and funded by the NDIS Sector Development Fund as part of a capacity building project being delivered by Mental Health Australia.

[9] Psychiatric Disability Services of Victoria Inc. Learn and Build in Barwon, The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch Site. Key issues for consumers, families and the Victorian mental health services system. June 2015. Victoria: VICSERV.

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A key issue is therefore facilitating transition for service providers and organisations, and Communities of Practice (CoP) are an effective mechanism to deliver this. Successful CoPs have been undertaken by CMHA member peaks in NDIS trial sites in NSW and WA, and learnings from these can be used in the design of future CoPs.

As states and territories are at different stages of transition, timeframes, and terms of bi-lateral agreements, CoP should be structured regionally rather than as a single national or single state and territory process. There are regional variations in terms of the type of targeted support required, population differences, and issues of distance for regional, rural and remote areas. Regionally based collective support and training is an approach organisations are likely to derive a greater benefit from and also be more cost-effective.

That the NDIS conduct regional CoPs as an effective and efficient mechanism to assist organisations to transition to the NDIS, and to utilise and act on lessons learned in trail sites. Regional CoPs will account for variations in regions including the type of targeted support required, population differences, and issues of distance related to regional, rural and remote areas. They will also be more cost-effective.

This initiative would be cost-neutral by prioritising regional CoPs within existing Department of Social Service's funding for work to support the mental health sector in its pathway to the NDIS.

Develop quality assurance processes specifically tailored for psychosocial support services as a part of the NDIS Quality and Safeguarding Framework

The issue of quality is currently the subject of significant policy activity at the federal and state and territory levels. The MHCC NSW report on the impact of the NDIS on the mental health workforce, found that many survey respondents expressed a fear that quality is being compromised by insufficiently skilled workers being asked to perform work that requires higher level capabilities.[10]

The NDIS pricing structure and its relationship to qualified mental health staffing is having a significant impact, with there seeming to be a misunderstanding between what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation. A model that includes community-based rehabilitation as a necessary part of a high functioning mental health system is essential. The skills and knowledge required are different with the NDIS pricing structure able to fund disability support, while being unclear about its reach into more complex supports.

The NDIS pricing does not officially set mental health sector workers' wages, however, it does have a significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders have noted that pricing was not sufficient to purchase a suitably skilled workforce that engaged in complex 'cognitive behavioural interventions' as well as direct personal care.[11]

[10] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project.* Sydney: Mental Health Coordinating Council.

[11] Ibid

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The VICSERV report on the NDIS Barwon trial concluded that the NDIS wasn't effectively delivering rehabilitation focused services and that these services and disability support services are both important parts of the continuum of care for people living with a mental illness.[12]

In order to maintain and support the community mental health sector workforce and ensure the current quality of service continues through the transition to the NDIS, it is vital that NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services.

The Federal Government develops quality assurance processes specifically tailored for psychosocial support services as a part of the NDIS Quality and Safeguarding Framework, including continuous improvement processes. This should be developed in consultation and partnership with the community mental health sector.

This work can be accommodated within the existing work being undertaken by the Government to develop the NDIS Quality and Safeguarding Framework. There would be costs associated with undertaking consultation processes.

Develop options for funding services for people living with a mental illness who are ineligible for the NDIS and currently access Federally funded programs, ensuring that their rehabilitation and support needs are met whether eligible or not.

As PIR and D2DL funding is transferred to the NDIS it is evident that there will be a proportion of the client base who will move to the NDIS and a proportion who will be ineligible. PIR and D2DL has been largely successful in achieving the aim of the program which is to:

> support people with severe and persistent mental illness with complex needs and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated and integrated way.[13]

Therefore, consideration needs to be given to how people living with a mental illness who need to have collaborative and coordinated care continue to have this provided within a health framework, and developing a mechanism to fund this. A key factor in such a consideration is developing a mechanism which is workable for both the Government and the community mental health sector who would provide PIR and D2DL or like services, such as PHaMs.

Considerations in determining how this would work include:

- Each state and region is in different phase in terms of how the NDIS rollout is progressing.

[12] Psychiatric Disability Services of Victoria Inc. Learn and Build in Barwon, The impact of the National Disability Insurance Scheme on the provision of Mental Health Services in the Barwon Launch Site. Key issues for consumers, families and the Victorian mental health services system. June 2015. Victoria: VICSERV.

[13] Partners in Recovery: coordinated support and flexible funding for people with severe and persistent mental illness with complex needs (PIR) Mental Health, Programs, Department of Health, http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir, Accessed 29 August 2016

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- In the Barwon trial region there was no PIR - what does this mean for people who are now ineligible for the NDIS but haven't had access to a PIR type service and how has this impacted the NDIS?
- Some programs and/or organisations will have differing proportions of ineligible versus eligible clients.
- The impact of the administrative changes, workforce challenges and funding uncertainty will vary according to size and structure of organisation.
- The Department of Health would need to have an appropriate and effective payment system.
- What, if any, would be the role of the National Disability Insurance Agency (NDIA)?

A key issue will be developing options for funding services for people living with a mental illness who are ineligible for the NDIS and currently access PIR and D2DL. It is proposed that a project be undertaken in partnership with the community managed mental health sector, consumers and carers, to develop these options. CMHA is well-placed to undertake this project. CMHA has the access and links to providers to ensure wide and informed input is gathered and presented.

The information gathered would be improved by gaining an understanding of the potential numbers who would access a PIR/D2DL type service funded by the Government through, for example, a snapshot from the NDIS trial sites, and including Department of Social Services programs, primarily PHaMs.

That options be developed for funding services for people living with a mental illness who are ineligible for the NDIS and currently access Federally funded programs, ensuring that their rehabilitation and support needs are met whether eligible or not. These options should be developed in partnership with and therefore supported by the community managed mental health sector, providers, consumers and carers. They will provide the Government with a clear set of options that are suitable, and provide direction on how services could be funded.

It is estimated that the cost for undertaking this work would be approximately $70,000.