



Submission from Community Mental Health Australia (CMHA)

on the Productivity Commission Draft Report Mental Health

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health and peak mental health organisations. Through them CMHA has a direct link and provides a voice for approximately 800 community-based organisations who work with mental health consumers and carers across the nation.

The organisations represented through CMHA are:

1. Mental Health Coalition of South Australia
2. Mental Health Community Coalition of the ACT
3. Mental Health Coordinating Council NSW
4. Mental Health Council of Tasmania
5. Northern Territory Mental Health Coalition
6. Mental Health Victoria
7. Queensland Alliance for Mental Health
8. Western Australian Association for Mental Health

Preface

Despite the damage, trauma and ongoing negative mental health consequences of the recent bushfires, their occurrence has demonstrated once again that unity in adversity is a powerful social binding factor, helping individuals and communities to respond to, and cope with, such adversity¹.

In 1897, Emile Durkheim² noted that suicide rates drop considerably during war and argued this was because higher levels of social integration occur during war. A century of research has confirmed that indeed "Suicide rates decline during wartime... due to greater social cohesion of societies during wartime" *Oxford Textbook of Suicidology & Suicide Prevention: A Global Perspective- 2011*.³

This does not mean that we must create wars and disasters to increase social cohesion. The evidence is clear and compelling⁴ that we can design and implement processes that cultivate positive social identification and community participation in a myriad of ways. These processes are highly efficacious and cost-effective means of preventing and lessening mental ill-health and promoting and developing positive mental health through "relational recovery".⁵

We must put in place these sustainable, community-connecting, mental health protecting processes as part of our [Resilience and Adaptions Strategy](#). For when crises and adversity retreat, unity and comradery can fade, whereas significant post-traumatic mental health effects can sprout years later.

Introduction

Community Mental Health Australia (CMHA) thanks the Productivity Commissions for the opportunity to respond to their Draft Report on Mental Health.

We appreciate the challenge the developers of this Draft Report faced: to collect, organise and analyse a very large amount of information and in a short time frame set out the necessary and sufficient recommendations to achieve a set of acceptable outcomes⁶.

In meeting this challenge, our view is that the Draft Report has been to a significant degree successful. We congratulate the Productivity Commission for this success, but our submission will focus on the several areas where we believe the report has fallen short and needs to be altered and improved.

This submission includes (a) [general comments](#), (b) [commentary on some specific recommendations](#), [Appendix 1](#) presents a suggestion that could secure the implementation of a National Agreement and [Appendix 2](#) presents an example of a comprehensive & integrated national psychosocial program and [Appendix 3](#) is the list of the recommendations made in this submission.

¹ Indeed as has been noted "[The whole World has rallied to support Australia in its time of need.](#)" PRObono Australia, January 10, 2020

² *Suicide: A Study in Sociology*, Emile Durkheim, 1897 (see: [https://en.wikipedia.org/wiki/Suicide_\(Durkheim_book\)](https://en.wikipedia.org/wiki/Suicide_(Durkheim_book)))

³ <https://global.oup.com/academic/product/oxford-textbook-of-suicidology-and-suicide-prevention-a-global-perspective-9780191780547?q=New%20Oxford%20Textbook%20of%20Psychiatry&lang=en&cc=gb>

⁴ *The New Psychology of Health: Unlocking the Social Cure*. Catherine Haslam, Jolanda Jetten, Tegan Cruwys, Genevieve Dingle, Alexander Haslam. 2017

⁵ [Relational recovery: beyond individualism in the recovery approach](#) Rhys Price-Robertson, Angela Obradovic and Brad Morgan, 2016. In *Advances in Mental Health Promotion, Prevention and Early Intervention*, 2017

⁶ Compounded by the fact that "mental health" is not a clear conceptual domain and "mental illness" a multiple entity requiring a variety of different responses and services.

A. General Comments

In our discussions with CMHA's 8 main stakeholders and other organisations working in the sector (such as Mental Health Australia, Mental Illness Fellowship of Australia, Caring Fairly and many others), three critical views have been expressed that will be expanded upon in this submission, these are:

1. The Report has failed to provide a clear overview and recommendations regarding an effective community based mental health strategy that could address many of the key identified problems of the current system (see section below on "About community mental health").
2. Much of the Report and almost all recommendations are too focused on an "individualist paradigm of health and mental health"^{7, 8}
3. The Report is an excellent collection of informational components, but the recommendations made fail capture the significant implication of a number of those components⁹.

Many of the points we wish to make relate to the nine principles set out in the Mental Health 2020 Charter that is discussed in more detail later. The nine principles of the 2020 Charter being:

1. Strike a new National Agreement for Mental
2. Build a mental health system that is truly person led
3. Address the root causes of mental health issues
4. Invest in early intervention and prevention
5. Fund Indigenous mental health, wellbeing and suicide prevention according to need
6. Provide integrated, comprehensive support services and programs
7. Expand community based mental health care
8. Support workforce development
9. Build an evidence based, accountable and responsive system

CMHA's 8 key member organisations, listed on the front page, have or will be submitting their own responses to this Draft Report. We commend and support their comments and recommendations. We have endeavoured to avoid duplication, but where such repetition exists it is indicative of strongly held views founded on extensive experience and evidence.

Box 1 on the following page sets out a collated complimentary set of principles for future community based mental health services extracted from our stakeholder discussions.

⁷ [Social cure, what social cure? The propensity to underestimate the importance of social factors for health](#); Haslam, et al: *Social Science and Medicine*, 2018, V. 198, P14-21

⁸ [Collectivism versus Individualism in Mental Health](#) in *Ethics of Mental Health*, David Cooper, 2017

⁹ For example in Chapter 12, while noting the number of people with Severe Mental Illness (see page 431), and the gap between that number and those people that will be serviced by the NDIS and non-NDIS psychosocial support services, no recommendations are made for adequately addressing that gap.

BOX 1: CMHA Stakeholder Principles

Benefits and Outcomes

A national network of Community Based Services, based upon the principles outlined below, can provide the following measurable benefits to consumers and carers:

1. Provide an *effective alternative*¹ to presentation to EDs for mental health issues and crises
2. "Experience of Service" rated as high by the significant majority of service users
3. "Consumer Rated Outcomes Measures" demonstrate significant sustained improvements
4. Increased economic and social participation

Service Principles

Accessibility

1. Easily located, available and perceived as safe and welcoming in all Australian communities
2. Open initial entry with multiple access points and "no wrong door" approach
3. Proactively connecting and reaching out to isolated people in need
4. No access disadvantages due to age, gender, location, ethnicity, sexuality, gender identity, etc.

Delivery

5. Person-Centred: people with lived experience, their families and support people are central to the process and involved in all decisions
6. Strengths-based and recovery-oriented
7. Focused on prevention and early intervention
8. Wrapped around the needs of the Individual and integrated with the wider health, welfare and justice systems, covering the continuum of mental health care for whole-of-life needs

Workforce

9. An enhanced role for peer workers
10. All workers are qualified to provide high-quality treatment that is strengths-based, culturally appropriate and trauma competent
11. Team-based and interdisciplinary workforce

Quality and Accountability

12. Quality Assured through audited compliance with agreed standards and targets.
13. Human rights are embedded into all aspects of the system
14. Services provide evidence-based treatments which are outcomes-focused to achieve value for money and for individuals and society
15. Consistent approaches to data collection and analysis that facilitate effective undertaking of monitoring, review, quality improvement, evaluation and research

¹ "Effective Alternative" means, one that (a) is frequently used, (b) meets the needs and outcomes required by consumers, carers and families and (c) reduces the demand and usage of EDs and Psychiatric Wards

The Meaning of "Community Mental Health"

Before we make comments on specific recommendations in the Report, there is a matter that first requires clarification. The phrase "Community Mental Health" has at least eight meanings depending upon context, these being:

1. The mental health of the community (where the "community" referred to also depends upon context - from the whole Australian community to small regional area communities to groups that identify by a common characteristic(s) such as the LGBTQIA+ Community)
2. All mental health services delivered in the community (both public, private & not-for profit)
3. Mental health services that are to a considerable extent delivery by the community, that is by peers and/or people that identify with or are part of that local community.
4. Mental health services delivered by the non-government sector (both private and not-for-profit organisation)
5. Mental health service delivered by the not-for-profit sector (i.e. community managed organisations (CMOs), usually registered with ACNC)
6. Public mental health services delivered outside of hospital (i.e. "Specialist Community Mental Health Services", "Ambulatory Community Mental Health Services")
7. Of late Psychosocial Support Services have sometimes been used as a substitute for the term community mental health, which is both helpful and unhelpful.
8. So called "Clinical" verses "Non-Clinical" services

Until new terminologies are adopted that distinguish the above meanings, when claims are made about community mental health services, an explanation as to what is meant is required. For example, when the *Australian Institute of Health and Welfare* use the term "Community Mental Health Services" and provide data about the funding, service distribution and workforce for community mental health services, the AIHW only mean meaning 6 above, i.e. (Public) Community Mental Health Services.

CMHA Recommendation 1: That in the Final Report the Productivity Commission seeks to clarify terminology in the area of "Community Mental Health" and related areas; to disambiguate where necessary and to propose new terminology distinctions where required.

To aid the above, in what follows, we would like to reflect upon the several specific meanings and how they bear upon the critical statement made above that "*The Report has failed to provide a clear overview and recommendations regarding an effective community based mental health strategy that could address many of the key identified problems of the current system*"

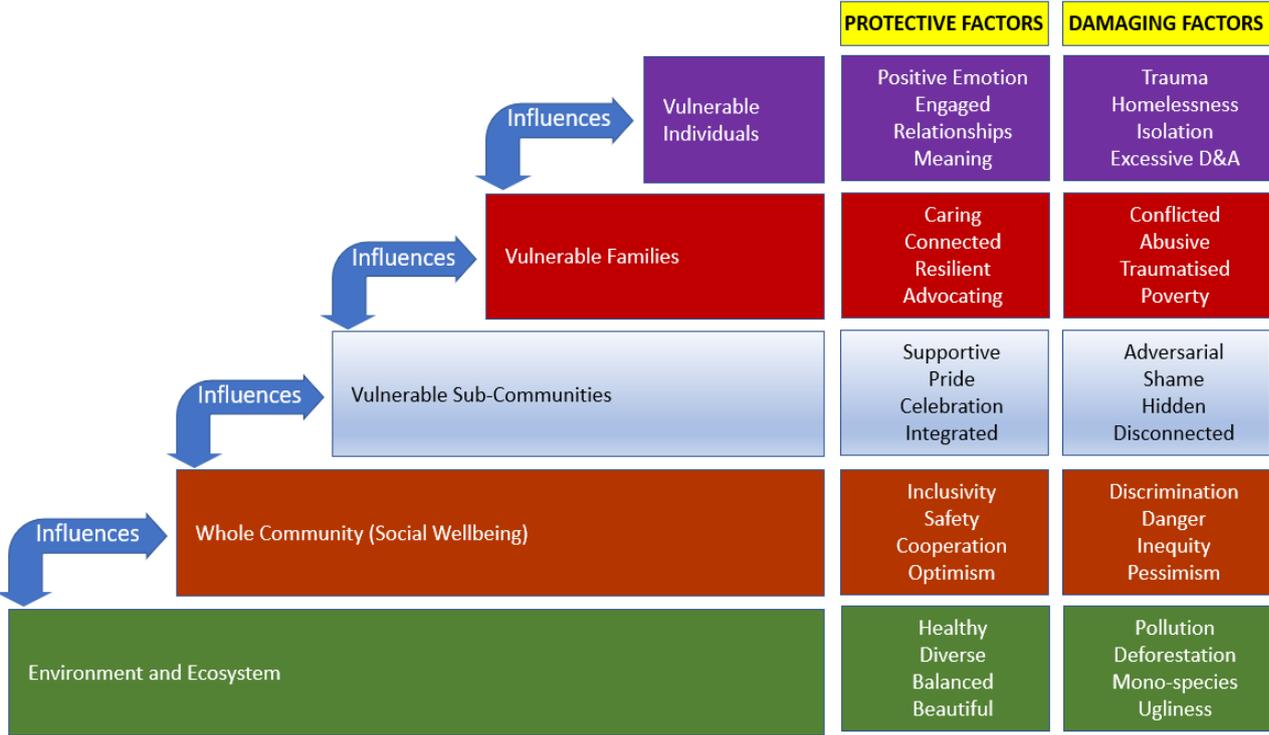
Meaning 1: (Mental Health OF the Community):

The Draft Report makes some recommendations about population mental health as a whole, for example in Recommendation 22.2. (Page 100, Volume 2) it states "*The COAG Health Council should develop a new whole-of-government National Mental Health Strategy to improve population mental health over a generational time frame.*" But there seems an absence of any guiding framework in the

Report that captures the evidence available for the two-way interdependencies of mental health between whole of population, sub-communities, families and individuals^{10, 11, 12}

The appreciation of these interdependencies is implicit in the many statements and recommendations made in the Draft Report about "Social and Emotional Wellbeing" (e.g. *Draft Finding 20.2 — Social And Emotional Wellbeing Of Aboriginal And Torres Strait Islander People*) which are made in relation to both ATSI communities and school based mental health.

As an illustration of what is meant, the following is a variation on the Stepped Care model that could be referred to as the Stepped Independency Model, or Emergent Level Model



The above model embodies both an appreciation of the role of "relational recovery"¹³ and the Social-Ecological Framework for Mental Health¹⁴

CMHA Recommendation 2: That a framework be developed and set out in the Final Report, or a proposal to develop it be recommended, that captures the social ecology of mental health and the two-way interdependencies of mental health between whole of population, sub-communities, families and individuals. Such a framework would complement the Stepped Care Model with its strong focus on individual mental health and treatment.

¹⁰ [Rose's Strategy of Preventive Medicine](#), Geoffrey Rose, 1992
¹¹ [Cooperative behaviour cascades in human social networks](#); James H. Fowler and Nicholas A. Christakis; 2017, Proceedings from the National Academy of Science
¹² [Dynamic spread of happiness in a large social networks](#); British Medical Journal, 2008
¹³ [Relational recovery: beyond individualism in the recovery approach](#) Rhys Price-Robertson, Angela Obradovich and Brad Morgan, 2016. In *Advances in Mental Health Promotion, Prevention and Early Intervention*, 2017
¹⁴ [A socio-ecological framework for mental health and well-being](#); Andrea Reupert; *Advances in Mental Health; Promotion, Prevention and Early Intervention*; Volume 15, 2017 - Issue 2

Meaning 2: Mental Health Services IN the Community

In this sense of the meaning of community mental health services, it is often said that we need to move the “Centre of Gravity¹⁵” of mental health services into the community (i.e. out of hospitals). This desirable objective is of course captured in many places in the Report, for example on Page 23 of the Overview, *“The rate of mental health presentations at Emergency Departments (Eds) has risen by about 70% over the past 15 years, in part due to the lack of community-based alternatives to ED, particularly after hours and in sparsely populated areas”*

The key hypothesis is that by increasing services outside of hospitals and EDs, with a stronger focus on prevention and early intervention, in time the demand for hospital and ED services for mental health issues will decline. The catch-22 that has inhibited such a move has been that in the competition for limited funding there is strong resistance to decreasing the proportion of total mental health budgets that go to Psychiatric services in Hospitals, and there is often strong media pressure to increase funding for more “beds”.

One way out of this catch-22 is for a limited period, increase the total mental health budget and then increase the proportion of that expanded budget that is targeted to community mental health (with contracted outcomes of decreasing demand for hospital services). Once decreased demand is demonstrated adjust expenditure downwards accordingly.

Note that this may take some time as in the initial phase it is likely that increased community mental health services will first be taken up with the considerable current unmet need for such services in the community (e.g. the so-called “missing middle”¹⁶)

CMHA Recommendation 3: That in the Final Report the Productivity Commission clarify the need to increase total expenditure on Mental Health, for at least a limited period, so that sufficient investment can be made in community-based alternatives to Emergency Departments and Hospitalisation for mental health condition to demonstrate their reduced requirement.

Meaning 3: Mental Health Services BY the Community

Talking about one’s own mental health is a very personal thing and exposing one’s vulnerability comes with risks¹⁷. Gaining trust is a key component for engagement with mental health services¹⁸. Trust is also a foundation for many disadvantaged people for the development of hope¹⁹. A significant body of research shows that we are more likely to trust someone (at least initially) who we perceive as more “like us”²⁰. Another way of putting it is that, for better or worse, as one research paper put it bluntly, “humans are tribal”.²¹

¹⁵ [The future of community-centred health services in Australia: lessons from the mental health sector](#), Alan Rosen, Roger Gurr, Paul Fanning, Australian Health Review 34(1) 2009

¹⁶ [Full as Soon as They Are Open](#) – SMH (interview with Ian Hickie), April 3, 2019

¹⁷ [Why We Hide Emotional Pain](#), Leon F Seltzer Psychology Today 2011

¹⁸ [Treatment engagement of individuals experiencing mental illness: review and update](#); Lisa B. Dixon, et al: World Psychiatry. 2016;15(1):13–20.

¹⁹ [The Relationship of Sense of Community and Trust to Hope](#), Leonard A. Jason, Ed Stevens, and John M. Light, Journal of community psychology, 2016

²⁰ [Is actual similarity necessary for attraction? A meta-analysis of actual and perceived similarity](#); R. Matthew Montoya, Ret al; 2008; Journal of Social and Personal Relationships

²¹ [Tribalism is Human Nature](#); Cory J Clark; Brittany S. Liu; Brittany S. Liu, Bo Winegard, Bo Winegard, Peter H Ditto, Peter H Ditto; University of California; 2019

It is for these reasons that having mental health services brokered by and/or in part delivered by people from one's own community significantly improves buy-in and engagement. It is also for these reasons that Peer Workers can be, and are, so needed and effective.

This same logic also applies to organisations. If they are perceived to have come from and/or be part of the local community, they are far more acceptable than outside organisations who may be perceived to have "parachuted in" and who at best have to wait a considerable time until they are recognised and accepted as "part of the community".

In the case of mental ill-health and disorder "help-seeking" is often absent or is a late stage occurrence²². This even more so for disadvantaged individuals and communities. Worldwide 75% of people with mental illness do not seek help and are not connected to a mental health service²³. The difference between true prevalence and treated prevalence is "the treatment gap"²⁴. Embedding mental health service in the community and having them, at least in part, be seen to be delivered by that community can help close that "treatment gap."

Meaning 4: Mental Health Services delivered by the non-government sector - both private and not-for-profit organisations

This is not a common or very helpful usage, though is occasionally used. It distinguishes between those entities where "psychiatric patients" can be involuntarily hospitalised (public system) and those where they cannot (non-public organisations). It thus also speaks to what may be called the "separation of powers" in mental health treatment that is described next.

Meaning 5: Mental Health Services delivered by the not-for-profit sector - i.e. community managed organisations (CMOs), usually registered with ACNC

It is in this sense of "Community Mental Health" there is a perception amongst several stakeholders that the Draft Report has failed to properly capture and set out the key numbers regarding the extent and effectiveness of the sector, including its workforce. Thus, has failed to provide a clear overview and recommendations regarding the community based mental sector and how it could address many of the key identified problems of the current system.

This point is discussed in more detail in the [comments made below](#) in relation to recommendations made about the Workforce Strategy

A Note on "Separation of Powers": For those who have worked on the front lines of mental health in the community sector, it is no surprise to learn that in the eyes of many consumers an advantage of having community managed sector separate from and being seen to be separate from the public mental health sector is that enables a wall of trust to be preserved. For many people with serious mental health issues, who have spent time in hospitals, particularly if this was

²² [Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour](#); Lucy Biddle, Jenny Donovan, Debbie Sharp and David Gunnell: Sociology of Health & Illness, Vol. 29

²³ [Mental Illness Stigma, Help Seeking, and Public Health Programs](#); Claire Henderson, Sara Evans-Lacko, Graham Thornicroft; Am J Public Health. 2013 March

²⁴ [Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: summary of WHO recommendations](#) Dua T, et al PLoS Med. 2011

involuntarily, this was an unpleasant and often traumatic experience that often results in a strong retained sense of mistrust. Community managed mental health sector staff and organisations have the advantage of a “separation of powers” by their identified distance and difference from the public system. Thus, are more easily able to be identified with as “us” (rather than them) and/or at least to operate a bit like the red cross “behind enemy lines”. This may seem almost trite to some, but it is a reality that can be used to positive advantage in engaging mistrustful, socially isolated people in recovery-oriented activities and connections.

Meaning 6: Public Mental health services delivered outside of hospital (i.e. “Specialist Community Mental Health Services”, “Ambulatory Community Mental Health Services”)

As discussed above in relation to this being the usage of the Australian Institute of Health and Welfare (AIHW), this is confusing. For example, if a person was trying to ascertain what is the annual expenditure on “community mental health care services” in Australia, they would see the figure of \$2.2B and conclude that is quite generous and adequate. At the very least the term “Public Community Mental Health Services” should be used when referring to this meaning.

Meaning 7: Psychosocial Support Services

The advantage of this usage is that it does capture what is currently the major focus of many “community managed mental health organisations”, particularly those receiving most of their funding now from PHNs and the NDIS. However, it is not the commonly used terminology in State/Territory commissioned mental health services.

The disadvantage of this usage is that it is still not widely understood. Most people and general media can understand and relate to people having “mental health needs and crises” but much less so with “psychosocial support needs and crisis”. Perhaps, over time this may shift.

In relation to the recommendations regarding Psychosocial Support Services in the Report, it is our view that there are two significant shortfalls in the Report that will be discussed in more detail below in our comments on specific recommendations.

Meaning 8: “Clinical” verses “Non-Clinical” Service Sectors

It is our view that this traditional distinction between the “clinical” verses “non-clinical” service sectors has passed its use-by date. There are now way too many cross overs for this to be useful as a distinction between Sectors, with some community managed organisations providing CBT coaching, mindfulness groups and diet and exercise interventions etc. and some public services providing housing support, peer run social activities, etc.

A cousin of this traditional distinction is between services where the consumers perceives that they are (and may well be) treated as “third person entities”, clinical objects, with the focus of the service on medication and medication compliance (as can happen in busy psychiatric wards, or Clozapine Clinics). This is contrasted with services where people are treated as “first person entities” in collegial non-clinical “person-to-person” settings.

Of course, almost all Commonwealth/State/Territory Government and Mental Health Commission’s Plans and Strategy documents include requirements for all services to be high

quality and person to person, but the reality is that “culture still eats strategy for breakfast”²⁵, and poor to very poor practices still continue in some institutional settings. This is not because there are good and bad people, it is just that some situations inevitably shape poor behaviours²⁶.

This being so, the need to focus on prevention and early intervention to decrease the need for people to have to spend time in psychiatric wards is very well founded and builds upon an historical trajectory to evolve mental health care from its long custodial past²⁷

NOTE: Several of the above meanings of Community Mental Health are intended and implied in Principle 7 in the 2020 Charter which is [EXPAND COMMUNITY BASED MENTAL HEALTH CARE](#): *Ensure there are psychosocial programs and team-based care options to provide community-based care and to avoid hospitalisation wherever possible.*

B. Commentary on Some Specific Recommendation

1. A National Agreement

Comments on Recommendation 22.1, *A National Mental Health & suicide prevention Agreement* and Recommendation 22.2 *A new whole-of-government mental health strategy*

Over the past few months, in anticipation of the release of this Productivity Commission Draft Report, over 100 key mental health sector organisations, facilitated by *Mental Health Australia*, met to discuss and agree upon nine key principles of mental health reform called the *Charter 2020: Time To Fix Mental Health*.

The first of these nine principles is to [STRIKE A NEW NATIONAL AGREEMENT FOR MENTAL HEALTH](#): *An agreement that delivers integration and coordination of mental health services, including agreed objectives, indicators, monitoring arrangements and funding between all levels of government.*

Thus, we fully support Recommendations 22.1 and 22.2 as key recommendations

Our concern is that previous National Mental Health Plans and COAG Agreements have set out similar aims of governance and service integration but have failed to deliver in practice.

The first Key Point in the Draft Report’s Overview states – “Australia’s Mental Health - A generational shift is needed”. [Appendix 1](#) of this submission outlines a suggestion for an additional encompassing Recommendation that would increase the probability of achieving the outcomes specified in the above Recommendations 22.1 and 22.2. If implemented, this proposal would secure in national policy for all parts of government, vertically and horizontally, the interdependence of mental health within a broader set of national Wellbeing factors and measures²⁸.

²⁵As we are only too directly aware from occasional desperate phone calls from scheduled consumers in psychiatric wards; or from the confidential off-the-record reports of shocked new idealist young staff commencing their first terms of duty in a psychiatric wards

²⁶ [Stanford Prison Experiment](#), Phillip Zimbardo

²⁷ [Mental Health Services In Australia](#), Lila P. Vrkleviski, Kathy Eljiz, D Greenfield, *Inquiries Journal*, 2017, VOL. 9

²⁸ <https://www.oecd.org/statistics/measuring-well-being-and-progress.htm>

2. Comprehensive and Integrated System

Comments on Recommendation 5.9, [ensure access to the right level of care](#): *The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate.*

This recommendation is most consistent with principle number six of the nine principles in the *Charter 2020: Time to Fix Mental Health* which is [PROVIDE INTEGRATED, COMPREHENSIVE SUPPORT SERVICES AND PROGRAMS](#): *Full suites of services and programs required to support mental health and ensure intensive, team based and integrated care is available for all those experiencing a mental health crisis, and addressing the needs of people who have traditionally missed out, such as culturally and linguistically diverse, LGBTIQ+ populations, and people living with intellectual disability.*

Our concern is that the current set of Recommendations in the Draft Report are not sufficient to achieve Recommendation 5.9 above. For example:

The Missing Middle

The need to provide [psychosocial support services for the "missing middle"](#) is discussed in several places in the Report (e.g. Section 7.2), but the Report fails to put forward clear recommendations in this regard.

Figure 12.4 on page 431 states that in 2019:

- 775,000 people have severe mental illness (and need psychosocial support services)
- 64,000 will receive psychosocial support services through the NDIS (once full)

The Report notes that there are no clear figures as to how many people are currently being assisted through PHN commissioned psychosocial support services, the best guestimate is between 20,000 to 30,000 people currently being supported through these programs.

Similarly, there are no clear figures as to how many people are currently being assisted through State/Territory psychosocial support type programs. Like the three Commonwealth Programs that were ceased (PHaMs, PiR and D2DL) many of these State/Territory funded programs were also ceased over the past 4 years, in the assumption that the NDIS would absorb all the people they assisted. For example, in Victoria all such programs were ceased.

On page 419 of the Draft Report it states, *"that Department of Health (DoH) estimated that ... approximately 90–95,000 people were receiving psychosocial disability support from Australian, State and Territory Government-funded programs"*. It is unclear though if this number also includes those in the NDIS.

Regardless of the exact numbers it is clear that there is a major gap between the numbers being assisted and the 775,000 people living with severe mental illness.

The significant downsizing of psychosocial and community based mental health services over the past few years, along with the poor pricing in the NDIS (as described in the Report in Box 12.4 on page 450), has been [a significant blow to the viability and sustainability of the community mental health sector](#). Decades of expertise are diminishing, including what has

been the major channel through which the Peer Workforce has emerged and developed. To liken this to the drought in the Australian farming community would not be inappropriate.

Unfortunately, most of the discussion in the Report and all the recommendations revolve around psychosocial services provided through the NDIS and also ensuring that the continuity of support of current non-NDIS psychosocial service provision (commissioned by PHNs) continues. While the need for additional services is noted in several places, no clear recommendation speaks to this serious and outstanding need.

The recommendation that comes closest is Recommendation 12.2 — [guarantee continuity of psychosocial supports](#) *Requirements for continued access to psychosocial support should be changed so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial supports.* The intent of this recommendation needs to be clarified.

CMHA Recommendation 4: That Recommendation 12.2 in the Draft Report ([guarantee continuity of psychosocial supports](#)) be modified and expanded so that it fully addresses the issue of providing psychosocial supports for the “Missing Middle”.

*The Need for Psychosocial Services that provide and foster social connection*²⁹

The Draft Report discusses and makes detailed recommendations about four key “social determinants” of mental health, these being the role of Carers and Families (Chapter 13), Income and Employment (Chapter 14), Housing and Homelessness (Chapter 15) and Justice (Chapter 16). The Report also describes in Finding 20.1 *Social Exclusion is Associated with Poor Mental Health* the importance of social inclusion. The associated Recommendation 20.1 is focused on addressing Stigma through a National Stigma Reduction Strategy.

Psychosocial Support may be said to consist of the following four components³⁰

- a. informational (e.g., advice and referral)
- b. tangible (e.g., financial assistance)
- c. emotional (e.g., nurturance and support)
- d. companionship (e.g., sense of belonging)

The recommendations in the Draft Report seem focused on the practicality of (a) and (b) above but do not seem to embody an appreciation of the need for (c) and (d)

In particular, a significant omission is that the Report makes no recommendations regarding the need for psychosocial services that focus particularly on social connection and inclusion, arguably the most potent social factor effecting mental health³¹ and indeed physical health³².

Such programs do improve outcomes for consumers and embody “Relational Recovery³³” as an effective pathway for “Person Recovery” and “Clinical Recovery”. Social connection is a

²⁹ [Connected: The Surprising Power of Our Social Networks and How They Shape Our Lives](#), Nicholas A. Christakis, 2009

³⁰ https://en.wikipedia.org/wiki/Social_support

³¹ *Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence*: Jerry Tew, Shula Ramon, Mike Slade, Victoria Bird, Jane Melton, and Clair Le Boutillier; British Journal of Social Work, 2017

³² *Social Support and Physical Health: Understanding the Health Consequences of Relationships*. Uchino, B.; New Haven, CT: Yale University Press; 2004

³³ [Relational recovery: beyond individualism in the recovery approach](#) Rhys Price-Robertson, Angela Obradovic and Brad Morgan, 2016. In *Advances in Mental Health Promotion, Prevention and Early Intervention*, 2017

central component of the Clubhouse model³⁴, and was the central component of some of the recently ceased Commonwealth Mental Health programs, particularly the Day to Day Living in the Community program and also PHaMs. These programs were not ceased because they were evaluated and shown not to deliver outcomes for consumers, indeed what research was done demonstrated positive outcomes³⁵, the programs were ceased because it was mistakenly presumed that clients participating in these programs would simply transition to the NDIS and the funding for these programs was needed to fund the NDIS³⁶.

CMHA Recommendation 5: That an Australian wide process be undertaken to co-design a national psychosocial support program that can be individually tailored to different community needs and which supports people living with mental illness to live “contributing lives” in the community with less reliance on unplanned emergency and acute care.

For the purpose of aiding understanding of what is intended above, an example of a type national psychosocial program is given in [Appendix 2](#).

In addition to the above, given the social ecology of mental health issues described above and illustrated in the [Stepped Interdependency Diagram](#), embedding a national psychosocial programs within a broader population wide program that encourages connection and inclusion would be highly desirable.

CMHA Recommendation 6: That a national wellbeing and mental health program for the whole Australian community, be designed and developed. That this program encourages and supports all communities (rural, regional and metropolitan) to develop and engage in activities and projects that foster social connection with a strong inclusion component being essential for their funding. Such a broad approach to social connection and population wide wellbeing becomes an additional Key Reform Area for the Final Report.

Finally, we should note e that CMHA strongly supports draft recommendation 12.1, Extend the contract length for psychosocial supports and also the proposal in Recommendation 12.2 Guarantee Continuity of Psychosocial Supports where it states ... “Should someone choose not to apply for the NDIS, they should be allowed to continue to access support through the national psychosocial support measure, should they require it...”

3. WORKFORCE STRATEGY

The Workforce Strategy is a key success factor in the improvement of Australia’s mental health services as set out in draft [Recommendation 11.1 — the National mental health Workforce Strategy - the forthcoming update of the national mental health workforce strategy should align health workforce skills, availability and location with the need for mental health services.](#)

³⁴ [A Systematic Review of Evidence for the Clubhouse Model of Psychosocial Rehabilitation](#), Colleen McKay, Katie L. Nugent, Matthew Johnsen, William W. Eaton & Charles W. Lidz, *Administration and Policy in Mental Health and Mental Health Services Research* volume 45, pages28–47(2018)

³⁵ [Impact and outcomes of a rural Personal Helpers and Mentors service](#), Debra A. Dunstan, MPsych, PhD, Anna K. Todd, Linda M. Kennedy, Donnah L. Anderson, *Aust. J. Rural Health* (2014) 22, 50–55

³⁶ [CMHA and The University of Sydney NDIS Transitions Final Report September 2019](#)

This is also reflected in Principle 8 of the [2020 Charter, SUPPORT WORKFORCE DEVELOPMENT: Invest in systematic workforce development, including peer workers, volunteers, paid and unpaid carers, community workers and clinicians.](#)

The focus in the report is on Psychiatrists, Psychiatric Nurses and Peer Workers. While all these are important, the Report and its recommendations are silent on what we will call the Community Based Recovery Support Workforce (CBRSW). It has been said (at the Productivity Commission Hearing, Sydney 25 Nov 2019) that because there are no clear figures on the size, qualifications or constitution of this workforce, no recommendations were able to be made.

On page 421 of the Report it does say: *"An accurate estimation of the size of the sector is difficult. A national mental health NGO landscape survey was conducted by the National Health Workforce Planning & Research Collaboration (NHWPRC 2011). It found that in 2009-10, there were 798 organisations providing psychosocial supports nationwide. The total psychosocial support workforce numbered 15-26 000, with many working part-time — equivalent to around 12 000 full-time employees (CMHA 2012). There has been further growth since (figure 12.3)."*

That is the data collated and provided is out of date and extremely minimal given the size and impact of the sector (e.g. with a workforce back in 2009-10 of 15,000 to 26,000, which is several times more than the number (3,369) of psychiatrists in Australia.

This is understandable, in that access to data about the size, activities, workforce and outcomes, etc of this sector is not readily available. While many individual organisations do collect data on their services, staff, activities and outcomes³⁷, there is a sad story of repeated failure over the past two decades of commissioning bodies (i.e. State/Territory and Commonwealth Departments) to ensure that minimum data sets (MDSs) were being properly collected, reported and collated so that essential data could be recorded and evaluated from services that have taken up many hundreds millions of dollar of government expenditure.

This has also meant that the sector has been under appreciated and considerable expertise lost overtime through poor overall sector management and governance by commissioning bodies. This has been particularly highlighted in the transition to the NDIS from the previous Commonwealth funded mental health programs Personal Helpers and Mentors, Partners in Recovery and Support with Day to Day Living³⁸.

It is not now an impossible task to establish the extent of this sector. An audit of the following would be a good start.

- Listing all States/Territory contracted out mental health programs and the organisations they currently contract (approximately 12 remaining in Australia)
- Listing PHN psychosocial programs (approx. 3) and the organisations they contract
- As far as we are aware there is no remaining Commonwealth mental health programs

An optional extra would be listing not-for profit charitable organisations that provide psychosocial services through the NDIS.

³⁷ One small example see the data set out in the [Annual Report 2019 of Flourish Australia](#)

³⁸ [Transitions from PIR, PHaMs and D2DL into the NDIS – Final Report September 2019](#), CMHA

CMHA Recommendation 7: That the Productivity Commission works with the Community Managed Mental Health Sector to collect and collate available data on the CMO workforce and current contracts with State/Territory, PHN and Local Health District funders.

There is existing now a well-established and skilled Community Based Recovery Support Workforce (CBRSW) and it is one that:

1. Needs to be recognised and accounted for in a proper audit of the current resources available to improve Australia's Mental health system
2. Its sustainability and viability need to be urgently assessed, as given the perfect storm of factors described above it is an "endangered species". This is for example reflected in the concern about "thinning markets" in the NDIS, particularly in rural and remote areas
3. The future required numbers, skills and distribution of this CBRS Workforce needs to be set out in and included in the National Mental Health Workforce Strategy

CMHA Recommendation 8: The Productivity Commission advocates for a National Workforce Plan for the Community Based Recovery Support Workforce (or psychosocial support workforce) that includes the Peer Workforce and that covers recruitment, training and development.

4. FUNDING & GOVERNANCE

We commend the Draft Reports analysis of the issues in the area of funding and governance.

We note and concur with the argument that the fragmentation in the system is to a significant degree a reflection of the fragmentation in the sources of funding. Thus, the reasonableness of keeping funding sources and governance as simple as possible (though no simpler³⁹)

We note the strong arguments for and against centralisation verses the localisation of funding and governance. We also note that finding the right balance between centralisation and localisation may be different in different jurisdictions.

We strongly support minimising conflicts of interest or perverse incentives that divert funding away from the broader goals of an over effective mental health system (e.g. always favouring funding for acute crisis services to the detriment of funding prevention initiatives).

We also note that in the field there is a combination of re-structuring fatigue, coupled with the fact that in some jurisdictions (e.g. Western Australia) the current arrangements are working well and thus provides little appetite for significant change.

Given the above and following consultation with our members, CMHA is not able to support either the Renovate or Rebuild models proposed.

³⁹ "Make things as simple as possible, but no simpler" Albert Einstein

Appendix 1

As said above, while we fully support Recommendations 22.1 and 22.2, our concern is that previous National Mental Health Plans and COAG Agreements have set out similar aims of governance and service integration but have failed to deliver in practice.

While previous failure does not necessitate future failure, we wish to propose a radical, broader and longer-term recommendation that if implemented would increase the probability of achieving the outcomes specified in the Recommendation 22.1. *"to integrate services and supports delivered in health and non-health sectors"*

CMHA Recommendation 9: That an investigation be undertaken by appropriate authorities into the viability, advantages and disadvantages of the Australian Government, becoming a Wellbeing Economy Government (WEGo)^{40,41}, as Scotland⁴², New Zealand and Iceland have already done.

If this was done, then the proposed National Agreement (22.1) and Strategy (22.2) would be re-framed within a broad national Wellbeing Economy Policy.

Such an approach captures and holds in national policy for all of parts of government, both vertically and horizontally, the interdependence of mental health within a broader set of national Wellbeing factors and measures⁴³.

These globally recognised outcome measures (with international validity and reliability⁴⁴) would also make a significant contribution to the evaluation and continuous improvement of Australia's mental health system.

Such a proposal would also be consistent with the 200-year evolution of mental health services in Australia⁴⁵. And finally, as with the international effort to address Climate Change, this would position Australia a proactive global citizen, and part of an international effort to improve wellbeing for all.

⁴⁰ <https://www.gov.scot/groups/wellbeing-economy-governments-wego/>

⁴¹ <https://wellbeingeconomy.org/>

⁴² https://www.ted.com/talks/nicola_sturgeon_why_governments_should_prioritize_well_being

⁴³ <https://www.oecd.org/statistics/measuring-well-being-and-progress.htm>

⁴⁴ <https://www.oecd.org/about/secretary-general/the-economy-of-well-being-iceland-september-2019.htm>

⁴⁵ <http://www.inquiriesjournal.com/articles/1654/the-evolution-and-devolution-of-mental-health-services-in-australia>

Appendix 2

An example of a national psychosocial program – The 4 X 4 Model

CMHA Recommendation 5: That an Australian wide process be undertaken to co-design a national psychosocial support program that can be individually tailored to different community needs and which supports people living with mental illness to live “contributing lives” in the community with less reliance on unplanned emergency and acute care.

The following is intended only as an example to clarify what could be included in such a national community based psychosocial program.

The proposed national psychosocial program:

1. Takes international evidence and the most successful components of previous programs^{46, 47}
2. Components are modular/modifiable, allowing communities to design what works for them
3. Target group - people with significant mental health issues who are not NDIS participants⁴⁸.

Entry and Access

1. The program either has no entry requirements (as per the Clubhouse model) or as was the case with the Person Helpers and Mentors (PHaMs) program⁴⁹, after several months of getting to know a person, they can undertake some co-assessment for eligibility or streaming
2. A proactive outreach component to connect with isolated people with mental health issues who would not usually connect with any mental health services (research suggests 75%)
3. The program has multiple “no-wrong doorways” (see below)

Core Components (see details following)

1. Individual Support (one-to-one) support
2. Peer Hubs (multi-function centre-based facility)
3. Proactive Outreach and strong two-way cross-community connections
4. Community Projects Facilitation (social inclusion initiatives)

⁴⁶ [Impact and outcomes of a rural Personal Helpers and Mentors service](#), Debra A. Dunstan, MPsyCh, PhD, Anna K. Todd, Linda M. Kennedy, Donnah L. Anderson, Aust. J. Rural Health (2014) 22, 50–55

⁴⁷ [A Systematic Review of Evidence for the Clubhouse Model of Psychosocial Rehabilitation](#), Colleen McKay, Katie L. Nugent, Matthew Johnsen, William W. Eaton & Charles W. Lidz, *Administration and Policy in Mental Health and Mental Health Services Research* volume 45, pages28–47(2018)

⁴⁸ A strict separation of NDIS and non-NDIS participants is not necessary and indeed taking advantage of all opportunities for increasing social integration of NDIS participants would indicate that enabling them to participate in such a program would be highly desirable. Mechanisms could easily be put in place to prevent funding duplication.

⁴⁹ The PHaMs program used a functional assessment rather than clinical diagnosis to determine eligibility for the service and to assess the impact of a mental health condition on the participant’s life. [The EST looked at nine life areas](#) including: interpersonal relationships, learning, applying knowledge and general demands, communication, working and employment, education, social and community activities, domestic activities, transportation and mobility, and self-care.

Components in Detail

1. *Individual Support (one-to-one) support for*
 - a. Trusted connection (as per the PHaMs program)
 - b. Recovery Coaching (as per the Recovery Coaching model being developed in the NDIS)
 - c. Care coordination (as per the Partners in Recovery program and processes being developed by Local Area Coordinators in the NDIS)
 - d. Advocacy (or support with self-advocacy) to access and getting needed outcomes from required social services, such as housing, justice, education and employment, etc.

2. *Peer Hubs (multi-function centre-based facility) - staffed where possible by local community members with lived experience*

The following different components would probably need separate spaces, particular for (d) below, though these would still be connected and inter-supporting facilities

- a. Social Connection and Activity Centre (as per D2DL and Clubhouse model)
 - b. Psychoeducational Centre (as per the Recovery College Model) with possible additional of availability of individual and group counselling/psychotherapy (as per Headspace)
 - c. Advice about and connection with a variety of allied "social determinate" services (housing, employment, physical health, justice assistance, etc.)
 - d. "Safe Space" alternative to attending hospital EDs⁵⁰ (also as per Trieste Model)
3. *Proactive Outreach and strong two-way cross-community connections*
 - a. Outreach to locate and connect with isolated people living with mental health issues in their homes, community, or homeless situations, to connect them to services, etc.
 - b. Connections to schools and other educational facilities as an potential independent provider of psychoeducation and wellness coaching, and in the opposite direction facilitate transitions to further education and training for people using Peer Hub facilities, etc.
 - c. Connections to workplaces and employer as an potential independent provider of psychoeducation and wellness coaching, and in the opposite direction facilitate transitions to employment (or volunteering) for people using Peer Hub facilities, etc.
 - d. Outreach to a variety of "clinical" health services, such as psychiatric wards, GPs, psychologists, for possible two way "referral" and better care coordination of isolated people living with significant mental illness.

⁵⁰ [Evaluating an Alternative to the Emergency Department for Adults in Mental Health Crisis](#), Heyland & Johnson; Issues Mental Health Nursing 2017 Jul

4. *Community Projects Facilitation (social inclusion initiatives)*

Working in with local organisations, such as local Councils, clubs, etc. to assist with their broad social wellbeing plans and to provide an avenue for participants in the Peer Hubs to become involved as volunteers in wider community activities.

- a. One off projects (e.g. Art Mural, sports event, etc.)
- b. Ongoing projects (e.g. Community Garden, meals on wheels, bush regen volunteers)
- c. Local mental health promotions (e.g. for mental health week, RUOK Day etc.)
- d. Linking with relevant local groups (e.g. social, health and wellbeing groups⁵¹, GROW, AA, NA, Carer Support Groups, etc.)

4 X 4 Model

Individual Support	Peer Hubs	Proactive Outreach	Community Projects
One-to-one Trusted connection	Social Connection and Activity Centre	To isolated people in homes or in community	One off projects
Recovery Coaching	Psychoeducational Centre	To schools and educational organisations	Ongoing projects
Care coordination	"Social Determinant" Assistance Services	To Workplaces	Local mental health promotions
Advocacy	"Safe Space" Alternative to EDs	To "Clinical" Health Services	Linking with relevant local groups

⁵¹ <https://www.lmnc.org.au/page/community-social-health-wellbeing-groups>

Appendix 3

List of Recommendations made in this Report

CMHA Recommendation 1: That in the Final Report the Productivity Commission seeks to clarify terminology in the area of "Community Mental Health" and related areas; to disambiguate where necessary and to propose new terminology distinctions where required.

CMHA Recommendation 2: That a framework be developed and set out in the Final Report, or a proposal to develop it be recommended, that captures the social ecology of mental health and the two-way interdependencies of mental health between whole of population, sub-communities, families and individuals. Such a framework would complement the Stepped Care Model with its strong focus on individual mental health and treatment.

CMHA Recommendation 3: That in the Final Report the Productivity Commission clarify the need to increase total expenditure on Mental Health, for at least a limited period, so that sufficient investment can be made in community-based alternatives to Emergency Departments and Hospitalisation for mental health condition to demonstrate their reduced requirement.

CMHA Recommendation 4: That Recommendation 12.2 in the Draft Report (*guarantee continuity of psychosocial supports*) be modified and expanded so that it fully addresses the issue of providing psychosocial supports for the "Missing Middle".

CMHA Recommendation 5: That an Australian wide process be undertaken to co-design a national psychosocial support program that can be individually tailored to different community needs and which supports people living with mental illness to live "contributing lives" in the community with less reliance on unplanned emergency and acute care.

CMHA Recommendation 6: That a national wellbeing and mental health program for the whole Australian community, be designed and developed. That this program encourages and supports all communities (rural, regional and metropolitan) to develop and engage in activities and projects that foster social connection with a strong inclusion component being essential for their funding. Such a broad approach to social connection and population wide wellbeing becomes an additional Key Reform Area for the Final Report.

CMHA Recommendation 7: That the Productivity Commission works with the Community Managed Mental Health Sector to collect and collate available data on the CMO workforce and current contracts with State/Territory, PHN and Local Health District funders.

CMHA Recommendation 8: The Productivity Commission advocates for a National Workforce Plan for the Community Based Recovery Support Workforce (or psychosocial support workforce) that includes the Peer Workforce and that covers recruitment, training and development.

CMHA Recommendation 9: That an investigation be undertaken by appropriate authorities into the viability, advantages and disadvantages of the Australian Government, becoming a Wellbeing Economy Government (WEGo)^{52,53}, as Scotland⁵⁴, New Zealand and Iceland have already done.

⁵² <https://www.gov.scot/groups/wellbeing-economy-governments-wego/>

⁵³ <https://wellbeingeconomy.org/>

⁵⁴ https://www.ted.com/talks/nicola_sturgeon_why_governments_should_prioritize_well_being