



Community Mental Health Australia Submission on the Fifth National Mental Health Plan

Introduction

CMHA is a coalition of the eight state and territory peak community mental health organisations. 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.

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. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

CMHA advocates for and promotes evidence-based, good practice and capacity building for community based mental health services, and collaborates with consumers and carers through a lived experience partnership. CMHA does this at the national level, and at the state and local level.

CMHA would like to thank the Australian Government for the opportunity to comment on the Fifth National Mental Health Plan (the Plan). CMHA's submission to the Plan will provide some general overall comments on the Plan, including the direction and focus, and will provide comments on the Priority Areas, including proposed recommendations.

General Overall Comments

Overall CMHA believes the Plan represents a retrograde step in establishing a vision for the direction of mental health policy in Australia and is concerned that along with the focus of the Primary Health Networks (PHNs) and the direction of the National Disability Insurance Scheme (NDIS), there is an increasing emphasis on the clinical and acute treatment of mental health and a move away from recovery focussed community-based mental health services.

Mental health is undergoing significant changes particularly in terms of the transfer 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 transferring to the responsibility of the PHNs, where program funding will go into a mental health funding pool from which PHNs will

commission services for their PHN area based on needs assessments and planning they have undertaken. It should be noted that the National Mental Health Commission Report of the National Review of Mental Health Programmes and Services recommended relocating a minimum of \$1 billion in forward estimates over 5 years to not only primary health but also community-based psychosocial and community mental health services¹. Shifting funding to the community managed mental health sector has also been advocated for in past National Mental Health Plans.

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

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.²

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. It is vital that the national policy direction recognises the various factors impacting mental health and set the direction for addressing the issues that emerge and encouraging evidence-based practice which actually delivers the recovery oriented services that consumers and the families and carers need.

The current draft of the Plan unfortunately does not set this vision or direction and, as noted earlier, is a step backwards in encouraging recovery focused services and a holistic, whole of person approach. The delivery of services is almost entirely focused on PHNs (and Local Hospital Networks (LHNs)) and there is no strong role articulated for the consumers, carers and the wider community. While CMHA agrees that regional planning and delivery of services through the PHNs is a good mechanism, a significant unacknowledged issue is the directive from Government that PHNs shouldn't commission psychosocial services.

The Plan does not address the gap that will be created for people living with a mental illness who are not eligible for the NDIS and will not receive services from PHNs. CMHA continually reinforces the point that both properly funded state and territory and federal mental health programs are required, with a

¹ National Mental Health Commission, 2014. The National Review of Mental Health Programmes and Services. Sydney: NMHC.

² 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.

strong focus on community-based rehabilitation. The Plan must address this gap that will occur otherwise it ignores what is actually happening on the ground, including via programs the Federal Government is actually funding.

The Plan does not include any information or discussion about the NDIS, and to do so, completely ignores what is actually impacting the overall provision of mental health services across the country. To adopt an approach that this is a 'Health' plan and that a cross-government approach has not been adopted because past plans shows it is too difficult to gain agreement across Ministers, renders the Plan almost meaningless. The NDIS is and will continue to have a major impact on the way mental health is funded into the future and it must be included in this Plan. The Plan also ignores programs that are occurring within the Health portfolio, such as Health Care Homes, which will also impact on mental health.

Mental health cannot be addressed if national policy ignores all the factors in a person's life which is necessary for them to actually recover and lead contributing lives. Housing, employment, physical health and disability are among the factors which are a part of a person becoming and remaining well. By ignoring them and saying we have to address health, disability, housing etc. in separate ways, reinforces the siloed approach which the community-managed mental health sector has fought against and which past National Plans have moved away from. The Plan actually includes very good content around the range of issues which impacts people's lives, but then this is not reflected in the priority area and actions.

The oversight of the Plan is currently proposed via approach which has Government and the Council of Australian Governments (COAG) monitoring the implementation and progress of the Plan, along with a number of intergovernmental advisory groups or committees. This is not the approach which should be taken as it offers no independent oversight and offers no guarantees of involving stakeholders outside of government. The monitoring of the Plan should be undertaken by the National Mental Health Commission (the Commission), which is reported publicly and responded to formally by the Government. Currently the Plan articulates no role for the Commission.

A further significant gap is that there is limited to no discussion about workforce in the Plan. Regardless of how the services or direction are implemented, for example via PHNs, LHNs or other mechanisms, addressing the workforce is central as nothing will get delivered if there isn't a workforce to deliver it. An ongoing policy void has been the lack of a National Mental Health Workforce Strategy and the development of a strategy should be included as a task in the Plan.

Lastly a major missing piece of the Plan is the lack of inclusion of targets and timelines. A Plan to address mental health over the next five years is meaningless without these included. Governments must be held to account for their delivery of services, as the community managed mental health sector and all mental health services are. The targets and timelines for this Plan should be reference to the past plans and the work of the Commission in developing the Review of Mental Health Programs and Services.

CMHA was concerned to see that the background briefing for participants attending the Plan consultations stated with regards to the priority areas that ‘As governments have already agreed on the priority areas....these are not likely to be adjusted. However gaps in priority areas will be noted’. The Plan in its current form is not providing the direction needed at a national level and there needs to be a significant review not just ‘noting’ of the entire Plan for it to be supported by the sector.

Recommendation 1: The Plan must include the role and impact of the NDIS, and any Health or other portfolio programs or funding that include mental health.

Recommendation 2: The National Mental Health Commission must be responsible for monitoring the implementation and progress of the Plan. This should be publicly reported and responded to formally by the Government.

Recommendation 3: The Plan must include targets and timelines which can be referenced back to past plans and the work of the National Mental Health Commission in the Review of Mental Health Programs and Services.

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

As noted earlier, while CMHA agrees that regional planning and delivery of services through the PHNs is a good mechanism, a significant unacknowledged issue is the directive from Government that PHNs shouldn’t commission psychosocial services. The current focus from the Government for the PHNs is very clinically focused and while it promotes a stepped care approach, it is focused on the top tier not the full spectrum of care.

Across the Plan, it consistently states that ‘Governments will work with’ or ‘Governments will work to’ but offers no detail about how they will actually do this. It also often states or refers to the difficulty and complexity in getting different portfolios and levels of government to work together. The two statements therefore seem to be suggesting that ‘we’ll try to work together but really it’s too difficult’ offers no assurances that the ‘how’ has even been considered, little alone discussed and the lack of detail in the Plan, makes any actions stating this quite meaningless.

CMHA believes this whole priority area must consider the needs for PHNs to be able to commission psychosocial services if that’s what their needs assessments and plans show is needed. Significantly there is no discussion about the role of community-managed mental health services in the plan. While the plan notes that this is a national plan and therefore there isn’t a discussion about state services, including the role of the LHNs means state and territory planning will be a part of this plan, and community-managed services are central to the delivery of the plan and services by PHNs.

Recommendation 5: The Plan must include PHNs being able to commission psychosocial services, if that is what their needs assessment and plans show is required, and discuss this as a part of service delivery.

Recommendation 6: The role of the community-managed mental health service sector is articulated in the plan including their role in the delivery of services in conjunction with PHNs.

Priority Area 2 – Coordinated treatment and supports for people with severe and complex mental illness

As mentioned above, a significant gap in this priority area and the overall plan is not addressing the gap that will be created for people living with a mental illness who are not eligible for the NDIS and will not receive services from PHNs. There is an action stating 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, but nothing about how this should be addressed. There is also the action stating that PHNs and LHNs will ‘work with’ the community sector but again not how.

As with much of the vast majority of the Plan, there is little detail about a vision as to how the ‘working with’ will occur. The key issue is that it shouldn’t be about working with but actually stating that these other sector, in particularly the community managed sector, must be leading the process of implementation and that Government’s agree that these services must continue to be funded and work alongside the reforms being implemented.

CMHA believes that the Federal Government must continue to fund a flexible, low barrier to entry service (as per Partners in Recovery, Day to Day Living and Personal Helpers and Mentors (PHaMs)) that sits outside of the NDIS for people who need ongoing community and coordination support. This must be addressed in the Plan.

Recommendation 7: That the Plan discuss and address the gap that will be created in service delivery for people not eligible for the NDIS and who won’t receive PHN commissioned services. This includes the Federal Government continuing to fund a flexible, low barrier to entry service.

Priority Area 3 – Suicide Prevention

A key area missing in this priority area is the role of community in suicide prevention and communities leading response. There is other work occurring in this area and the Plan must articulate how other strategies in suicide prevention work with the Plan, in particular programs and services that work now and are successful.

The Plan states that ‘There is currently no nationally consistent approach to follow-up care after suicide attempt’. However, there are factors that are identified in work such as the Systems Based Approach to Suicide Prevention which outline the key factors in preventing suicide and working with people after,

which are based on internationally proven models.³ Therefore there is work occurring in this space and what is working and what is best practice should be included in the Plan and help formulate the actions.

Action 6 states that, once again, Governments will work together to renew efforts to develop a nationally agreed approach to suicide prevention. This action should not 'renew' but governments should actually complete this action and have a timeframe associated with it. This also applies to other actions in this priority area which talk about working with PHNs to get consistent approaches and to strengthen data collections. The key issue with this is that as PHNs are all approaching commissioning and suicide prevention in different ways, having a consistent approach and collecting consistent data won't be likely. It would be preferable for PHNs to all have nationally consistent outcomes measures which are reported against. Even if different approaches are taken, this would assist in actually looking at consistent outcomes and data.

Recommendation 8: The Plan should include an examination of existing successful approaches or programs in suicide prevention.

Recommendation 9: The PHNs should have nationally consistent outcomes measures.

Recommendation 10: There should be a timeline and target for governments achieving a nationally agreed approach to suicide prevention.

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

The central issues with this priority is that Aboriginal and Torres Strait Islander people should be leading this priority not included as a service provider that might be included. The Aboriginal Community Controlled Health Organisations should be leading the implementation of any approaches.

There was originally funding quantified for Aboriginal and Torres Strait Islander suicide prevention which has been transferred to the PHNs mental health funding pool. This should be specifically used for Aboriginal and Torres Strait Islander people and there should be a national PHN outcome measure which this is reported against.

As for other actions, it states that 'Governments will renew efforts to develop a nationally agreed approach to suicide prevention'. Again it shouldn't be renewing efforts but actually achieving a national approach and having a timeline and target for this.

There is also an existing National Aboriginal and Torres Strait Islander Suicide Prevention Strategy which is in operation and under which programs are funded. There is no discussion about this in the Plan, and

³ Black Dog Institute and Centre for Research and Excellence in Suicide Prevention, A World-Class Integrated Approach to Suicide Prevention.

<https://cresp.edu.au/sites/default/files/newsevents/events/BDICRESP%20Systems-Based%20Approach%20to%20Suicide%20Prevention.pdf>. Accessed 17 November 2016

the Plan should be referring to what is already being funded, particularly where it is being led by Aboriginal and Torres Strait Islander communities.

Recommendation 11: Aboriginal and Torres Strait Islander people should be leading suicide prevention and mental health approaches, and the Aboriginal Community Controlled Health Organisations should be leading the implementation of any approaches.

Recommendation 12: There should be a timeline and target for achieving a national approach to suicide prevention for Aboriginal and Torres Strait Islander people.

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

A key party of this priority area is considering other initiatives which are already occurring, including in the Health portfolio, and will impact on mental health.

The Department of Health is developing the National Strategic Framework for Chronic Conditions is moving away from a disease-specific approach and looking at a broad range of chronic conditions by recognising that there are often similar underlying principles for the prevention and management of many chronic conditions.⁴ Mental health has been identified as a target area.

There is also the Health Care Homes which is aimed at improving the provision of care for people with chronic and complex conditions and is being implemented through the PHNs.⁵ Mental health has also been identified as a particular needs group.

This priority is an area where the workforce should be included as a focus, as ensuring all health professionals who provide a service to someone living with a mental illness have an understanding of mental health and chronic health will be important. The Plan doesn't address this now.

As with the entire Plan, it seems to be siloing services again, which the sector continues to emphasise is not how services are or should be provided to people living with a mental illness. By not looking at what is even happening in the Health portfolio, little alone other portfolios, the Plan ignores areas where mental health is currently being considered or should be.

Recommendation 13: The Plan must consider other programs and initiatives that are occurring in the Health and other portfolios that are relevant to mental health.

Priority Area 6 – Stigma and discrimination

As per other areas of the Plan, the key part missing for this priority is detail on how actions will be achieved. Action 19 regarding governments broadening efforts to reduce stigma and discrimination for

⁴ National Strategic Framework for Chronic Conditions, The Department of Health, <https://www.health.gov.au/internet/main/publishing.nsf/Content/nsfcc>. Accessed 16 November 2016.

⁵ Health Care Homes: Reform of the Primary Health Care System, The Department of Health, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes>. Accessed 16 November 2016.

people with severe mental illness does not state how this will be achieved. CMHA agrees that this is needed, however there needs to be targets, timelines and detail as to how this should occur. This is the same for other actions in this priority area.

Priority Area 7 – Safety and quality in mental health care

The content of this priority area is generally good, however, the main issue to note for this priority is that CMHA understands consumers and carers have raised concerns about amendments to the National Standards for Mental Health Services. Therefore, this Plan should emphasise that any actions in this priority should not result in any reduction of rights for consumers and carers, and that governments should also be supporting this.

There is also a statement in this priority area that legislation is an important framework for the human rights of consumers and that while uniform mental health legislation would be ideal, there are barriers to this across a federated system. It must be noted that while it is difficult it has occurred in a range of other areas, such as industrial relations and with the national register of health practitioners, so it is actually possible to achieve.

Recommendation 14: The Plan should note that the rights of consumers and carers in safety and quality standards must not be reduced and governments should support this.

Monitoring and Reporting on Reform Progress

As stated earlier in this submission, the oversight of the Plan is currently proposed via approach which has Government and COAG monitoring the implementation and progress of the Plan, along with a number of intergovernmental advisory groups or committees. This is not the approach which should be taken as it offers no independent oversight and offers no guarantees of involving stakeholders outside of government. The monitoring of the Plan should be undertaken by the Commission.

With regards to monitoring and performance measures, community managed mental health is an area where there is incomplete and poor data, and the sector has continually called for the development of thorough and complete data. Disappointingly the Plan does not address this, and the community managed mental health sector continues to be left out of these sorts of considerations.

As past plans and consultation on these plans has seen, an ongoing issue is the lack of outcomes measures. This would have seemed to have been the time to actually work with the sector to develop theses, with the PHNs being used as the primary mechanism for rolling out programs and services. This would also be possible through the NDIS.

The potential indicators listed are worthy, but again they provide very little in the way of actually seeing if approaches and services are achieving actual outcomes.

The Plan has little focus on the work of the community managed mental health sector. There is a need to improve the collection and reporting of activity and outcomes of this sector.

Recommendation 15: The Plan must discuss and provide a target and timeframe for the development of thorough and complete data for the community managed mental health sector and outcomes measures. The Plan should prioritise the following activities:

- *national collection and reporting of the Non-Government Organisation Establishment (NGOE) Data Set Specification as an NGOE National Minimum Data Set; and*
- *work with CMHA to deliver a targeted roll out of the Your Experience of Service (YES) community managed organisation (CMO) Version, Living in the Community Questionnaire (LCQ) and mental health carer experience survey (CES) (when completed) with the community managed mental health sector.*

Summary and Recommendations

Overall CMHA believes the Plan represents a retrograde step in establishing a vision for the direction of mental health policy in Australia and is concerned that there is an increasing emphasis on the clinical and acute treatment of mental health and a move away from recovery focussed community-based mental health services. The Plan actually includes very good content around the range of issues which impacts people's lives, but then this is not reflected in the priority area and actions.

The delivery of services is almost entirely focused on PHNs (and LHNs) and there is no strong role articulated for the consumers, carers and the wider community. While CMHA agrees that regional planning and delivery of services through the PHNs is a good mechanism, a significant unacknowledged issue is the directive from Government that PHNs shouldn't commission psychosocial services.

The Plan does not address the gap that will be created for people living with a mental illness who are not eligible for the NDIS and will not receive services from PHNs. The Plan does not include any information or discussion about the NDIS, and to do so, completely ignores what is actually impacting the overall provision of mental health services across the country. Other significant gaps in the Plan include a lack of consideration about workforce, and no inclusion of targets and timelines.

The Plan in its current form is not providing the direction needed at a national level and there needs to be a significant review of the Plan for it to be progressed. It would be extremely disappointing for the sector if this didn't occur.

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

Recommendation 1: The Plan must include the role and impact of the NDIS, and any Health or other portfolio programs or funding that include mental health.

Recommendation 2: The National Mental Health Commission must be responsible for monitoring the implementation and progress of the Plan. This should be publicly reported and responded to formally by the Government.

Recommendation 3: The Plan must include targets and timelines which can be referenced back to past plans and the work of the National Mental Health Commission in the Review of Mental Health Programs and Services.

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 Plan must include PHNs being able to commission psychosocial services, if that is what their needs assessment and plans show is required, and discuss this as a part of service delivery.

Recommendation 6: The role of the community-managed mental health service sector is articulated in the plan including their role in the delivery of services in conjunction with PHNs.

Recommendation 7: That the Plan discuss and address the gap that will be created in service delivery for people not eligible for the NDIS and who won't receive PHN commissioned services. This includes the Federal Government continuing to fund a flexible, low barrier to entry service.

Recommendation 8: The Plan should include an examination of existing successful approaches or programs in suicide prevention.

Recommendation 9: The PHNs should have nationally consistent outcomes measures.

Recommendation 10: There should be a timeline and target for governments achieving a nationally agreed approach to suicide prevention.

Recommendation 11: Aboriginal and Torres Strait Islander people should be leading suicide prevention and mental health approaches, and the Aboriginal Community Controlled Health Organisations should be leading the implementation of any approaches.

Recommendation 12: There should be a timeline and target for achieving a national approach to suicide prevention for Aboriginal and Torres Strait Islander people.

Recommendation 13: The Plan must consider other programs and initiatives that are occurring in the Health and other portfolios that are relevant to mental health.

Recommendation 14: The Plan should note that the rights of consumers and carers in safety and quality standards must not be reduced and governments should support this.

Recommendation 15: The Plan must discuss and provide a target and timeframe for the development of thorough and complete data for the community managed mental health sector and outcomes measures. The Plan should prioritise the following activities:

- *national collection and reporting of the Non-Government Organisation Establishment (NGOE) Data Set Specification as an NGOE National Minimum Data Set; and*



- *work with Community Mental Health Australia to deliver a targeted roll out of Your Experience of Service (YES) community managed organisation (CMO) Version, Living in the Community Questionnaire (LCQ) and mental health carer experience survey (CES) (when completed) with the community managed mental health sector.*