



Productivity Commission Inquiry into Mental Health

NSW Mental Health Coordinating Council Submission

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SUMMARY OF RECOMMENDATIONS

1. Workforce

Recommendation:

Funding and policy settings ensure a skilled and experienced community-based mental health sector workforce by ensuring its inclusion in all health/mental health and disability workforce strategies.

2. Integrated Care and Support

Recommendation:

Improve access to and integration of support by ensuring services are provided in the community, by organisations with a strong local presence and the agility to respond to people's needs in the right place, at the right time.

3. The Interface Between Mental Health and Other Human Services

Recommendations:

Undertake a review of the COAG 'Principles to Determine the Responsibilities of the NDIS and Other Service Systems'.

Ensure states and territories continue to provide equal access to mainstream services for people affected by mental health conditions, including but not limited to those with or at risk to develop a psychosocial disability.

4. The Interface Between Mental Health and the NDIS

Recommendations:

Develop national, state and local level operational guidelines that better articulate the interface between trauma-informed recovery oriented treatment/ rehabilitation (i.e., 'clinical') services and disability support services (i.e., whether NDIS funded or not) and embed these in the new NDIS psychosocial disability stream.

Ensure a robust and independent evaluation strategy for the new PHN commissioned National Psychosocial Support and Continuity of Support programs, that is contextualised for the broader PHN mental health reform environment.

Revisit the Productivity Commission recommendation to remove the need to test NDIS eligibility of Commonwealth mental health program clients, in order to have a guarantee of continuity of supports.

Address the emerging gaps created by the transition of Commonwealth mental health services into the NDIS. Clarify and make public how continuity of support for people with psychosocial disabilities who are not eligible for the NDIS will be provided.

5. Priority Service Gaps in NSW

Recommendations:

Support people with mental health conditions to participate in community life through increased accommodation support services (HASI/CLS type supports) that also address physical health needs.

Bridge the gap between acute care and community living through the establishment of additional step up, step down facilities.

Improve co-ordination and access through community mental health one-stop hubs to provide peer support and a range of services in one location.

How can people be enabled to reach their potential in life, have purpose and meaning and contribute to the lives of others? (Productivity Commission, Issues Paper, p.1)

INTRODUCTION

The Mental Health Coordinating Council (MHCC) is the peak body representing mental health non government community managed organisations (NGO/CMOs) in NSW. MHCC is also a founding member of Community Mental Health Australia (CMHA), the alliance of eight state and territory mental health peak bodies, which together represent more than 800 CMOs delivering mental health and related services nationally.

MHCC thanks the Productivity Commission (PC) for the opportunity to make a submission to its inquiry into the role of mental health in supporting social and economic participation and enhancing productivity and growth. MHCC consulted with its membership and our submission focuses on issues for the community managed mental health sector and its delivery of psychosocial care and support services in NSW. The submission also comments on some broader issues concerning the interface between sectors and with the National Disability Insurance Scheme (NDIS), workforce and service gaps. A submission from CMHA will provide a national perspective on behalf of CMO's.

According to the NSW Strategic Framework and Workforce Plan for Mental Health 2018-22, in 2017-18, 1.3 million people in NSW experienced a mental health condition, with 732,000 people experiencing a mild mental health condition, 374,133 people experiencing a moderate mental health condition and 244,000 people experiencing a severe mental health condition. In 2018 -19 the NSW Ministry of Health will invest \$2.1 billion in mental health¹ including \$100 million for mental health reform, demonstrating the NSW Governments response to *Living Well: A Strategic Plan for Mental Health in NSW* ². While this represents the largest amount in NSW history, NSW mental health spending remains below the national average per capita.³

Many people living with mental health conditions are not able to get support when they need it, and too many rely on emergency departments or admission to acute or inpatient facilities because of a lack of services in the community that could intervene early. The most recent data available indicates NSW spends a larger proportion of its mental health budget on acute mental health services than any other state in Australia and directs the lowest per capita amount of any jurisdiction towards community- based and community-managed mental health services. In 2016-17, NSW allocated 7% of its mental health budget to CMOs, compared to the national figure of 13%.⁴

“Adult mental health spaces are clinical and dehumanizing, policy is not connected to the reality of what is happening, that is – what is working and what is not working on the ground.”

Comment from MHCC Member Survey.

The mental health system needs more resources and to shift the emphasis from hospital treatment towards prevention, early intervention and community-based support. There is significant evidence that quality services delivered in the community provide better outcomes for people, carers and their families and this takes pressure off other parts of the health system. A key recommendation of *Living Well* is to improve community-based mental health care in NSW, acknowledging that historically NSW has been overly reliant on hospitals for the delivery of mental health care.

It is possible for people with mental health conditions to live well in the community when they have the right mix of medical, psychosocial rehabilitation and support services. MHCC support increased investment in services in the community which can intervene early and improve the economic and social participation of people with mental health conditions. The following section of our submission provides greater information about the community managed mental health sector in NSW.

COMMUNITY MANAGED ORGANISATIONS

Role and value

Community Managed Organisations (CMOs) provide support for people with mental health conditions and deliver services and programs that embody a trauma-informed, recovery-oriented practice approach. The core activities provided include accommodation support and outreach, employment and education, leisure and recreation, family and carer support, self-help and peer support, helpline, counselling and clinical care services, and promotion, information and advocacy.

These services play a vital role in supporting recovery for people living with enduring mental health conditions, by promoting self-determination, offering greater choice and control and maximising independence and recovery. People are supported to manage self-care, improve social and relationship skills and achieve an improved quality of life including in relation to physical health, social connectedness, secure accommodation, education and employment. Many of the services provided by CMO's are psychosocial rehabilitation services that focus on improving social participation. CMO's also provide education and employment support services which support the economic participation of people with mental health conditions. For example, there is strong evidence that Individual Placement and Support approaches improve economic/employment outcomes, but they are in extremely short supply.

For many years, both in Australia and internationally, mental health reform has emphasised the need to promote a vision for the future that ensures 'mental health is everyone's business'.⁵ The World Health Organisation report, *Promoting Mental Health: Concepts, Emerging Evidence, Practice*⁶ back in 2005 emphasised that everyone has a role and responsibility in mental health and encouraged collaboration across service systems and sectors to make the most positive improvement in people's mental health. This view is still highly relevant today. CMOs are critical to achieving the goals of the *Fifth National Mental Health and Suicide Prevention Plan*⁷ and *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024*.⁸ These plans both envision an expanded role for the community-managed mental health sector.

It is generally accepted by policy makers and practitioners alike, that mental health services are optimally delivered in community settings addressing more than just symptoms of illness. As with general health care, optimal service access and health and social outcomes for people affected by mental health conditions need a 'continuum of care' — a variety of flexible options that meet diverse needs and make the best use of resources across services and systems. There have been major changes to the service delivery environment over the last three years. These changes include mental health reform in NSW, the roll-out of the NDIS and the establishment of Primary Health Networks (PHNs). Providers are increasingly collaborating and forming partnerships to deliver the full range of supports people need including services led and directed by the people using them, delivered through innovative approaches.⁹

In NSW, CMO's are funded through a number of different funding streams. In 2017-2018 in NSW, \$83.1 million was allocated to CMOs to support people living with complex long-term mental illness to live well in the community. This is in addition to \$22.3 million allocated to CMOs to deliver community based mental health related services such as family and carer support, day programs, Aboriginal mental health, translational research and an

enhancement of Lifeline. These NSW Ministry of Health funded community mental health programs include:

1. Community Living Supports (CLS)
2. Family and Carer Mental Health Program
3. Housing and Accommodation Support Initiative (HASI) & Resource and Recovery Support Program (RRSP)
4. HASI Plus
5. LikeMind
6. Ministerial Approved Grants
7. Pathways to Community Living Initiative
8. Suicide Prevention Fund

CMOs also receive Commonwealth funding from a number of programs including Family Mental Health Support Services (FMHSS), Mental Health Respite: Carer Support, Personal Helpers and Mentors (PHaMs), Partners in Recovery (PIR), Individual Placement and Support (IPS) and Headspace.

Whilst the range of CMO services and programs is broad, many of them are provided by large organisations such as: Flourish, New Horizons, Neami National, Mission Australia, the Salvation Army and the Disability Trust, to name a few. These organisations all offer well integrated services across their own diverse mix of programs and have developed strong relationships with several sector providers offering other human services. There are of course a number of smaller specialist services that focus on specific groups or local needs, and whilst some may be less broadly connected, they are often well known because they offer a particular service or work with an identified group of consumers in a particular location.

Many people recover from mental illness and enjoy active, productive lives. However, recovery is not necessarily synonymous with cure. The recovery process refers to both internal and external conditions that facilitate recovery, including implementation of human rights, from both a positive and negative¹ perspective. The value of the services provided by the community managed sector lie in achieving person-centred and integrated approaches to supporting people with mental health difficulties in ways that are chosen by them and that include consideration of social support, employment and housing (i.e. mates, jobs and homes).¹⁰

Outcomes

CMOs are well placed to meet many of the needs and aspirations identified as crucial to keeping people well and improving their social and economic participation. They are constantly finding new ways to demonstrate their value, especially in terms of reducing the burden of cost to the public sector. Outcome frameworks, performance indicators and other types of performance and quality reviews have been developed and implemented to meet the demand for increased accountability from funders, government and local communities.

One of the challenges for CMOs is to find ways of demonstrating outcomes within the limitations of the current contracted measures of success. The literature provides some evidence that articulates the value of the sector in addition to the already well

documented positive outcomes impacting recovery, based on service user satisfaction and evaluation related to 'recovery goals' from both a consumer and service provider perspective. This is demonstrated in detail in '[The NSW Community Managed Mental Health Sector Mapping Report \(MHCC, 2010\)](#)¹¹ and '[Taking Our Place — Community Mental Health Australia: Working together to improve mental health in the community,](#)' (CMHA, 2012)¹².

However, whilst most publicly available program evaluations conducted by CMOs themselves are descriptively detailed, they are not always able to provide rigorous statistical analysis. Many CMOs are insufficiently resourced or do not have the program flexibility to undertake such evaluations. Where support has been provided for rigorous evaluation, the outcomes have been very positive. For example, the University of NSW conducted an evaluation of the NSW Housing and Accommodation Support Initiative (HASI) which demonstrated HASI has provided significant benefits for both those who have received support from the program and the broader NSW community.¹³

Further support is required for research, improved data collection and outcome evaluation of the work undertaken by the CMO sector.¹⁴ MHCC has been working with NSW Health to support enhanced data collection for CMO services through the implementation of the Mental Health NGO -E National Best Endeavours Dataset (NGO-E). The NGO-E has been developed as a national standard for an annual collection of data from CMO services on activity, expenditure and staffing. As part of this work, MHCC have produced two reports. The Stage 1 report discusses the benefits and challenges of CMO data collection; includes a service types and taxonomy use comparison, and an overview of data collection in other states and jurisdictions. The Stage 2 report examines the best practice approach to implementation of collection of the NGO-E, including assessing the feasibility of aligning the current contractual data collection for NSW Health funded services with the NGO-E data requirements to consolidate performance monitoring requirements. This work is ongoing.

MHCC is also undertaking a pilot project of the Community Managed Organisations Your Experience of Service and Carer Experience of Service (CMO YES and CES) survey's in conjunction with NSW Health. The YES and CES surveys were developed nationally to measure consumer and carer experiences of care in mental health services. The YES survey was released for use in public mental health services in 2015. The survey was modified for use in the community managed sector, and in 2017 the CMO YES was released. The NSW YES and CES project will support consistent experience measurement in NSW CMO's to allow services to better understand consumer and carer experiences of service. Services will be provided with a report to assist them to identify what they do well and what they could do better. Services can then use these reports to prioritise areas for improvement.

Based on what is known about consumer and carer outcomes and satisfaction with services, such as what is validated by the HASI program outcomes and evaluation data,¹⁵ there is clear evidence that CMOs play a key role in providing services and supports that keep consumers well in the community and improve their social and economic participation; and that further 'rebalancing an unbalanced system'¹⁶ would lead to substantial cost benefits to the public purse. The next section of this submission focuses on some of the challenges that need to be overcome to ensure a seamless, integrated mental health care and treatment system that is able to meet the needs and aspirations of the community.

CHALLENGES/WHAT NEEDS TO CHANGE

1. Workforce

Recommendation:

Funding and policy settings ensure a skilled and experienced community-based mental health sector workforce by ensuring its inclusion in all health/mental health and disability workforce strategies.

The mental health CMO workforce plays an important role in Australia's mental health system. Estimating the size of the mental health CMO sector is difficult. A 2009 national mental health NGO landscape survey and a 2010 workforce scoping survey provide some data about the mental health CMO workforce.¹⁷ The workforce scoping survey estimated the sectors workforce in 2009/10 to range from 15,000 to 26,000 employees. CMHA conservatively estimate this to be about 12, 000 FTE and there has been further growth since then.¹⁸ Findings indicate that 43 percent of the workforce have a bachelor degree or higher qualification in one of the health disciplines and 34 percent have a vocational (certificate or diploma) level qualification.¹⁹ The peer workforce is playing an increasingly important role in the sector.

The community-based psychosocial rehabilitation sector has championed Australia's approach to providing high quality community mental health services that exemplify a trauma-informed recovery oriented practice approach. Growth of the community-based mental health sector since the COAG mental health reforms were introduced in 2006, along with state and territory program investments, has in the past been paralleled by considerable investments in workforce development. Ten years ago, this workforce was conservatively estimated to be half the size of the public mental health workforce FTE with unique specialist psychosocial rehabilitation skills that support people's recovery and help keep them well in the community.²⁰ While there have been some welcome initiatives in NSW, such as additional funding being made available in 2018/19 to enable community sector workers to achieve Certificate or Diploma level qualifications in mental health, MHCC remain concerned that psychosocial expertise is disappearing as workers are increasingly leaving for employment stability opportunities elsewhere.

The uncertainty and complexity created by mental health sector reform, NDIS implementation and new roles of PHNs in commissioning services is having an impact on the CMO workforce. The NDIS price levels for working with people with complex needs are low and pose challenges to deliver safe and quality services that are economically viable. MHCC notes the recent announcement of a 15 percent funding increase for NDIS core supports but this has not been applied to capacity building supports and the latter is more consistent with recovery oriented approaches. Since the transition to the NDIS, community organisations have lost millions in direct funding, both federally and locally, with funding transitioned to individuals. While MHCC supports the greater choice and control that individualised funding can provide, there is a fundamental mismatch between the NDIS supports and services 'product' that is being purchased and what is known, evidenced-based practice in supporting people's social and economic participation (i.e., recovery outcomes).²¹

The NDIS has resulted in fewer services for many people with serious mental health issues who are ineligible - or choose not to apply - for a funded package of support, and occasionally for those who do have a funded package. It is difficult to estimate the impact of NDIS transition on what was a comparatively well-qualified sector workforce before implementation of the NDIS. The impending 30 June 2019 cessation of Commonwealth mental health programs, even with some recently announced funding extensions through to June 2020, is further eroding this skilled workforce.

Stronger social and economic outcomes for people affected by mental health conditions require a skilled community-based mental health sector workforce. The need to invest in building the capacity of the community mental health sector is critical to long-term sustainability. Current policy and funding directions for both mental health sector reform and NDIS implementation need to ensure an experienced and qualified mental health/ psychosocial disability workforce. Mental health workforce development directions continue to focus on doctors, nurses, other allied health professionals and – more recently – peer workforce development. The workforce within the community sector who are mostly vocationally trained (e.g. Certificate IV in Mental Health Work) are insufficiently recognised. Disability workforce development directions seem to focus on the minimal skills required to support people with physical, sensory and intellectual disability but not with complex health and social issues, as is often the case for people struggling to live with a mental health condition.

2. Integrated Care and Support

Recommendation:

Improve access to and integration of support by ensuring services are provided in the community, by organisations with a strong local presence and the agility to respond to people's needs in the right place, at the right time.

"inter-generational poverty and poor mental health go hand-in-hand. Fund better opportunities for people and provide better opportunities for people living with mental health difficulties to recover and become part of the community."

Comment from MHCC Member Survey.

It could be said that it does not matter who delivers a service as long as it's being delivered by services able to employ similarly trained and qualified practitioners. However, the lens through which people are perceived and the drivers behind service design and approaches may be dissimilar across sectors. The culture of an organisation or agency in whatever sector (whether community, public or private) clearly impacts on what they are best placed to deliver. The key factor is that they support individuals to lead 'a contributing life',²² and hold strongly to recovery values. A holistic approach focused on the person requires the availability of appropriate services and support, the ability for services and sectors to work together to provide integrated care and a respect for and an understanding of the different roles and expertise of service providers. The mental health service system is complex, and it is unfortunate that programs which have established successful partnerships across sectors and made the system easier to navigate such as the Partners in Recovery (PIR) are due to cease.

Joint planning should assist with both addressing service gaps and duplication. In 2018 the National Mental Health Strategy published a [Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services](#). This document provides guidance to both Local Health Networks (LHNs) and Primary Health Networks (PHNs) on the expectations of Commonwealth, state and territory governments and the opportunities associated with the joint development of Integrated Regional Mental Health and Suicide Prevention Plans. The guide explains the intent and role of joint regional planning as a key priority in the *Fifth National Mental Health and Suicide Prevention Plan*. Integration between mental health and other service sectors is complex and provides challenges associated with the reduced level of influence of LHNs and PHNs beyond health.

Transitions from public services to community managed services should be an increased area of focus as there can often be poor discharge planning and inadequate risk assessment processes. The collaboration and partnerships between public and CMO services need to be strengthened. Good practice often depends on individual relationships, knowledge and experience. Frequently, services in rural and remote areas collaborate better than in metropolitan areas because they have better knowledge of what services exist in their local area and the people working in them.

Vestiges of prejudice across the professions as to the skills and competencies attributable to workers in the CMO sector still exist, despite evidence to the contrary (as identified in MHCC's Sector Mapping Report, 2010).²³ Public sector professionals often perceive the sector's role as support only rather than psychosocial support and rehabilitation, despite the evidence of large numbers of highly qualified individuals employed by CMOs. Many CMO professionals have Certificate 4 or degree level qualifications. The casualisation of the workforce occurring as a consequence of the roll-out of the NDIS, is further contributing to this perception.

"LikeMind is an amazing service which provides a holistic approach through service delivery integration that meets an individual's goals, including social inclusion."

Comment from MHCC Member survey.

The pilot of the LikeMind integrated service model in NSW, while still being evaluated, is demonstrating good outcomes in improving integrated care and making the system easier to navigate. The centres co-locate various community health services and consumers have access to a range of clinical and non-clinical services including mental health care, alcohol and other drug services, physical health care, vocational and accommodation support services. Expansion of this model is one of MHCC's priorities for addressing service gaps, outlined later in this submission.

The mental health system is under increasing pressure and there are too many people who cannot get the support and services they need when and where they need it. This impacts on the capacity to provide integrated care in a timely way. According to the Australasian College of Emergency Medicine (ACEM) people living with mental health conditions disproportionately experience access block compared to people presenting with other emergency conditions. ACEM conclude "it is likely that many mental health presentations to emergency departments occur as a result of chronic underfunding in community treatment settings."²⁴

Readmission rates to hospital, and people coming before the Mental Health Review Tribunal demonstrates that people engaged with CMO programs and services, stay well for longer periods of time; have more chance of completing their educational goals, gaining and sustaining employment and experiencing social participation and achieving a 'contributing life'. A more seamless mental health service system requires a greater investment in services and programs provided in the community by organisations with a strong local presence and the agility to respond to people's needs in the right place at the right time. Section 5 outlines MHCC priorities for investment in NSW.

"Better access for individuals and their families, less waiting times and more funding for community inclusion activities."

Comment from MHCC Member survey.

3. The Interface Between Mental Health and Other Human Services

Recommendations:

Undertake a review of the COAG 'Principles to Determine the Responsibilities of the NDIS and Other Service Systems'.

Ensure states and territories continue to provide equal access to mainstream services for people affected by mental health conditions, including but not limited to those with or at risk to develop a psychosocial disability.

Improving the economic and social participation of people affected by a mental health condition requires a collaborative response from all levels of government, extending well beyond the health/mental health sectors to other service systems such as housing, transport, health, justice and education. Formalised agreements to strengthen coordinated care between the various parts of the human services sector that focus on community inclusion are needed.

For example, principles to determine the responsibilities of the NDIS and other mainstream service systems were agreed by COAG in 2015.²⁵ These require urgent review for greater clarity about who should be funding and delivering what and to whom, to enhance integrated/coordinated care, reduce governance/jurisdictional ambiguities and potential/actual cost-shifting. NSW has developed enhanced operational guidelines linked to the COAG principles and this exemplifies improved practice in better understanding who should be funding and delivering what and to whom.²⁶

Governments should articulate and publish which programs they are rolling into the NDIS and how they will support people with disability who are not covered by the NDIS. While the NSW Government has made a very wise decision in not rolling state funded mental health programs into the NDIS, it has largely withdrawn from disability support service provision, which means gaps are emerging that threaten the social and economic participation of people with mental health conditions

Many people with 'complex needs' - people who need considerable social and health support which typically includes mental health conditions - have no option but to present to emergency departments and too often inappropriately reside in acute psychiatric

hospital beds. The interface between mainstream mental health, housing and justice is a particularly important nexus for enhancing the social and economic participation of people affected by mental health conditions.

MHCC supports the recent Productivity Commission recommendation to develop a new National Disability Agreement to facilitate jurisdictional cooperation, enhance accountability and clarify roles and responsibilities, but this will not occur until beyond 2020. In the interim, it is essential that states and territories continue to provide equal access to mainstream services for people affected by mental health conditions, including but not limited to those with or at risk to develop a psychosocial disability, especially given the challenges often experienced by them in accessing and navigating mainstream and other community services and supports.

4. The Interface Between Mental Health and the NDIS

Recommendations:

Develop national, state and local level operational guidelines that better articulate the interface between trauma-informed recovery oriented treatment/ rehabilitation (i.e., 'clinical') services and disability support services (i.e., whether NDIS funded or not) and embed these in the new NDIS psychosocial disability stream.

Ensure a robust and independent evaluation strategy for the new PHN commissioned National Psychosocial Support and Continuity of Support programs, that is contextualised for the broader PHN mental health reform environment.

Revisit the Productivity Commission recommendation to remove the need to test NDIS eligibility of Commonwealth mental health program clients, in order to have a guarantee of continuity of supports.

Address the emerging gaps created by the transition of Commonwealth mental health services into the NDIS. Clarify and make public how continuity of support for people with psychosocial disabilities who are not eligible for the NDIS will be provided.

The mainstream mental health and NDIS interface is critical to enhancing the social and economic participation of people affected by mental health conditions. This is true both for people accessing a funded package of supports and for people ineligible, or choosing not to apply, for NDIS funded supports. The NDIS is about more than funded support and includes the 'Tier 2' Information Linkages and Capacity-building (ILC) program. The ILC is about enhancing community inclusion for all people with disabilities, including psychosocial disability.

'Non-clinical' mental health (i.e., rehabilitation and recovery) services sit awkwardly within the NDIS. Part of the issue is the blurred line between mental healthcare and disability support as indicated by the crossover between the key terms, mental illness and psychosocial disability. Differences in language and practice approaches mean that NDIS implementation is hindering psychosocial rehabilitation/support programs because traditional disability support approaches often support client maintenance and dependence rather than recovery and independence.

The current estimate based on the Productivity Commission's modelling is that 64,000 people will be eligible for NDIS funded support for their psychosocial disability. As at the end of December 2018 there were just 18,700 people nationally and 7,225 people in NSW with a 'primary' psychosocial disability accessing NDIS funded support.

The NDIS was never intended to replace mainstream mental health services. There needs to be a greater understanding as to what national, state/territory and local/regional non-acute mental health programs are available, whether a person is receiving NDIS funded supports or not. MHCC strongly support the NSW Government decision not to roll-in state funded mental health programs into the NDIS and the Government has also moved to expand capacity and the evaluation framework that sits around them.

In October 2018, the NDIA announced development of a new NDIS access and planning stream for psychosocial disability and this is understood to having been trialled in Tasmania and South Australia from late 2018. The decision to introduce the new stream came after recommendations by Mental Health Australia following consultation with people with lived experience of mental illness, their families and carers, advocates and service providers.

Little is known publicly about the trials at this time. However, NSW Health has been working on a state-wide protocol/pathway for access to NDIS funded support, HASI/CLS programs or both given a person's unique and individual needs at any point in time in their recovery journey.

Primary Health Networks (PHNs)

The future of Commonwealth mental health programs such as Partners in Recovery (PIR), Personal Helpers and Mentors Service (PHaMS), the Day to Day Living (D2DL) Program and Mental Health Respite: Carers Assist has been of significant concern. As illustrated by the access numbers provided above, the transition of these program clients into the NDIS – along with the incremental rollout across states and territories - has not been a priority for the NDIA thus limiting opportunities for people who have been accessing these services to date.

Obtaining data related to client transitions has proven challenging and the community sector has voiced long-term concerns that significant service gaps have emerged for people with psychosocial disability who do not qualify for an NDIS funded package.²⁷ The 'Mind the Gap' report, compiled by the University of Sydney and Community Mental Health Australia, describes qualitative research that highlights problems with the current state of the NDIS for people with psychosocial disability. These include eligibility criteria that exclude many, slow uptake and engagement due to a disconnect between the notion of 'disability' and 'mental health', and inadequate involvement models for carers and families.

This work is now being extended through a project being undertaken by CMHA, the University of Sydney and National Mental Health Commission to explore NDIS access for people receiving Commonwealth mental health programs. An interim report released in December 2018 suggests that the numbers of people not accessing NDIS funded packages will be much higher than the government currently anticipates. The report is based upon data provided by 22 organisations in five states and territories with data from over 3,000 individuals currently using PIR, PHaMs or D2DL programs. The preliminary data evidences low proportions of people applying for NDIS packages and high proportions of people being assessed as ineligible. A second report is expected in April 2019.

The gap issue is further complicated by the requirement that Commonwealth mental health program clients must apply to have their NDIS eligibility tested to have guarantee of continuity of supports and access services. Removal of the need to test eligibility was a Productivity Commission recommendation not supported by the Government. MHCC believe this recommendation should be revisited.

There has been a commitment made by all governments to provide continuity of support for people with psychosocial disabilities who are not eligible for the NDIS. However, there is a need to clarify and make public how they intend to provide these services and address the emerging gaps created by the transition of existing services into the NDIS. The Federal Government last year announced National Psychosocial Support (NPS) and Continuity of Support (CoS) programs to address concerns that some people with severe mental health issues were slipping through the NDIS net and committed \$80 million over four years, to be matched by the states and territories, for 31 PHNs to commission support services.

The NPS program was intended to commence in January 2019 and most PHNs are still engaged in commissioning and establishment activity. Emerging program models appear to be diverse. The CoS program is \$92.6M over four years and will assist 8,800 people currently receiving Commonwealth mental health program clients (under) estimated to be ineligible for the NDIS or alternately may be an estimate only of those that may 'choose' to test their NDIS eligibility and be found ineligible. The CoS program is to commence July 2019 and its interface, if any, with the NPS is not known.

These new programs, along with PHN roles in developing regional national mental health and suicide prevention reviews/plans and commissioning other primary mental health care services/programs, mean that the broader system and policy landscape remains in a state of flux. It will probably take some years before the implications of the NDIS for acute psychiatric treatment services and supports is understood, thus requiring formal evaluation to identify programs for future scale up.

PHNs cannot achieve their role as commissioners of primary care mental health services and as a system integrator to achieve mental health reform on their own - all stakeholders within the complex mental health and social care system have a role to play. This must include learning from the experience of the mental health and NDIS interface at the local level along with enhanced access to mainstream and community services and supports for all people with, or at risks of developing a psychosocial disability.

5. Priority Service Gaps in NSW

Recommendations:

Support people with mental health conditions to participate in community life through increased accommodation support services (HASI/CLS type supports) that also address physical health needs.

Bridge the gap between acute care and community living through the establishment of additional step up, step down facilities.

Improve co-ordination and access through community mental health one-stop hubs to provide peer support and a range of services in one location.

It has been estimated that nationally almost 230 000 people living with severe mental health conditions will continue to require support after the national rollout of the NDIS.²⁸ Based on population distribution, this represents more than 60,000 people in NSW alone. The National Mental Health Services Planning Framework indicates that these people will require community based- supports such as individual or group support or non-acute residential services rather than acute or inpatient services.²⁹ CMO services which support people with mental health conditions to manage self-care, improve social and relationship skills, sustain secure accommodation and access education and employment will be vital.

There have been many previous reports that have highlighted areas of need for mental health services and there are many areas that would benefit from additional funding including suicide prevention, youth mental health, rural and remote service provision and culturally appropriate services for Aboriginal and Torres Strait Islander people. At the end of 2018, MHCC worked with its members including service providers, consumers and carers to prioritise three areas for investment in NSW based on identified need, improved outcomes and maximising expenditure savings. These are outlined in the report **“Mental Health Matters, Future Investment Priorities for NSW”**.³⁰ KPMG undertook the research for the report and analysed the return on investment. The report identifies the following three priorities for investment and further details are provided below:

- Increased accommodation support services for people with mental health conditions (HASI/CLS type supports) that also address physical health needs
- Step-up, step-down facilities to bridge the gap between acute care and community living
- Community mental health one stop hubs to provide peer support and a range of services in one location

Accommodation and Support Services

Often, people living with severe mental health conditions require support with other aspects of their lives, including physical health and accommodation support. There is increasing demand for Specialist Homelessness Support (SHS) services from people living with mental health conditions in NSW. SHS services are those that target specific priority groups, such as people experiencing mental health and co-existing difficulties. The number of people seeking specialist accommodation support with mental health issues has increased by an average of 14.8 percent per year since 2012.³¹

The NSW Government funds community-based psychosocial support services for adults with mental health conditions through the Housing and Accommodation Support Initiative (HASI) and the Community Living Supports (CLS) program. Findings of an evaluation conducted by the University of New South Wales in 2012 demonstrated that HASI has provided significant benefits for those who have received support from the program as well as the broader NSW community.³² These include a 24 percent reduction in mental health related hospital admissions following HASI supports, a 51 percent reduction in emergency departments presentations following two years of participation and an estimated \$30 million in savings each year compared to an allocated budget of \$118 million for four years from 2006 to 2010.

Accommodation support assists people living with mental health conditions to participate in the community, experience an improved quality of life, prevent homelessness and assist in recovery. However, based on the increasing number of people living with mental

health conditions experiencing homelessness, it is clear that further efforts are necessary to boost these types of service. According to research undertaken by KPMG for MHCC, investment in additional HASI type services will return \$1.20 per every dollar invested in the short term.³³ There is also a significant opportunity to leverage the success and impact of HASI and CLS services to deliver targeted physical health support services to people living with mental health conditions in NSW. This will support the achievement of national and state-level targets to better integrate and prioritise physical health care for this group of people whilst utilising existing infrastructure and models of care with proven outcomes.

Step-Up, Step-Down Services

Step-Up, Step-Down (SUSD) services enable people to receive supports in a pleasant, low stimulus, homelike environment where clinical self-care and recovery-based interventions are delivered in partnership between the health sector and the CMO sector. They provide a 'step-down' function whereby people in acute psychiatric inpatient units can be discharged earlier into the SUSD and assisted to return home in a gradual and very supported way and provide a 'step-up' function whereby a person at risk of psychiatric admission can either be referred or self-refer into the SUSD.

There is strong evidence that this model of care can impact the overall health system by enabling better management of acute bed pressure, reducing demand for psychiatric admission and presentations at ED and, most importantly, assist the person to develop capability to self-manage episodes of mental ill health. When it is done well, in addition to the impacts on the health system mentioned above, over time people who use the SUSD can demonstrate that their acute episodes are responded to earlier, last for less time and that there are longer periods of wellness in between episodes. SUSD programmes deliver much higher levels of consumer satisfaction and voluntary engagement than do psychiatric inpatient units.

Previous studies in NSW indicate that the risk of suicide for current or former mental health clients is 10 times that of the general population of the state. However, this increases to 100 times that of the general population around the time of discharge from inpatient care.³⁴

These services are designed to limit the number of mental-health related emergency department presentations and hospital admissions. This in turn reduces the system costs attributed to inpatient hospitalisations, which may be diverted to other required referrals, and the associated burden such incidents have on other related services, including ambulance and police services.

The SUSD model is operated across Australia, however not all states have the same access to this service, with only a handful of such facilities available in NSW. The evaluations of services operated in other states, particularly Victoria and WA demonstrate positive results for both individuals and the health system. An evaluation of Western Australia's Joondalup SUSD service found that the intervention saved approximately 0.28 potential years of life for each person, with mortality rates among users of the service nearly 4 times lower than control 'people who did not receive the same services'³⁵.

In research undertaken for MHCC, KPMG estimate the cost of step-up, step-down interventions as \$9,300 per person (excluding capital components) however additional investment in such services would yield financial savings of \$9,480 per person through reduced hospitalisation rates, shorter hospital stays and reduced emergency department

presentations. This suggests that additional investment in step-up, step-down facilities would pay for itself. In NSW it is estimated that approximately 9,500 people with mental health conditions may be suitable for these services.

Improved Community Access to Mental Health Support

Navigating the mental health service system has been identified as a barrier to service access. People with mental health conditions need effective and efficient coordination of care through established partnerships between multiple services. As the number of people living with mental health conditions continues to rise, alternative service options to hospitals and residential care must be considered. Integrated community-based mental health hubs offer a new way for people experiencing mild-to-moderate mental health difficulties to access the care they need streamlined in a 'one-stop-shop'. This already operates successfully through the similar Headspace model for young people.

These community-based mental health 'hubs' are being established worldwide in an effort to improve community access to a diverse range of mental health support. People with low to moderate mental health needs, including those experiencing first episodes, often require additional support to access and engage with mental health supports. Integrated hubs also support locally-led approaches to building and embedding awareness, knowledge and capacity for improved mental health outcomes for individuals. In addition to community-based mental health hubs, the peer support workforce also provides invaluable support for people in the community who require connection to the mental health service system.

The NSW Government, in partnership with CMO's, have implemented the LikeMind pilot in four locations across the state. As mentioned earlier in this submission, LikeMind is an integrated service model designed to support adults experiencing moderate to enduring mental health conditions. The model involves the co-location of various community health services, both public and CMO operated, in one central location. Consumers have access to a range of clinical and non-clinical services including mental health care, alcohol and other drug services, physical health care and programs, and vocational and accommodation support services. The care and support provided is streamlined across all service types and determined by the specific needs of the consumer and the local demographic.

While the initiatives and services that have been implemented within NSW and across Australia to date are a positive step, these services need to be implemented on a scale that meets everyone's needs, regardless of the community they live in. A significant proportion of the NSW population living with mental health conditions are not accessing available community support services. In 2011, 65% of people with mental health issues did not receive any formal support for their condition.³⁶ Integrated mental health care hubs and peer support offer a significant opportunity to improve the level of community access to mental health services. Through these hubs and peer support services, people experiencing mild to moderate mental health distress would have access to streamlined and coordinated care in one location, as well as other related services such as legal support.

CONCLUSION

“Please step away from a top-down approach, and listen to the communities experiencing inter-generational mental health and social issues. What is needed is more person and community-centred support and carer that would assist individuals achieve their mental health and social goals.”

Comment from MHCC Member survey.

The Productivity Commission Inquiry into Mental Health provides an important opportunity to consider what reform and change is needed to ensure a seamless, integrated mental health care and treatment system that meets the needs and aspirations of the community. Many people living with mental health conditions do not get the support they need; they characteristically encounter stigma and discrimination; have a lower average life expectancy and experience poorer physical health than the community in general as well as higher rates of unemployment, poverty and disadvantage. Australia can and must do better than this.

The mental health system in Australia is complex and involves different levels of government funding and public, private and non-government service delivery. MHCC's submission presents a perspective to the inquiry on behalf of the NSW community managed mental health sector. Despite this being a national inquiry, MHCC believes a state based perspective is of value both because many of the issues are similar across all the jurisdictions and the inquiry is considering the role of all levels of government.

MHCC notes the Productivity Commission intend “to give the greatest consideration to where there are the largest potential improvements in population mental health, participation and contribution over the long term” and identifies four groups - people with mild or moderate mental illness, young people, disadvantaged groups and suicide prevention.

Many community managed mental health organisations work with the fifth group the Commission has also referenced - “people with severe, persistent and complex mental illness”. While MHCC do not disagree with the importance of consideration of the four areas identified, we agree with the CMHA submission that people severely impaired by a mental health condition require the same consideration in the inquiry's deliberations, given they have the highest mortality, morbidity and unemployment rates and account for a disproportionately high amount of human services.

MHCC's submission focuses on five areas – workforce; integrated care and support; interface between mental health and other human services; interface between mental health and the NDIS; and priority service gaps. We believe reform is required in these areas so people living with mental health conditions can get the support and services they need to enhance their economic and social participation and improve their quality of life. MHCC acknowledges there are other areas and many issues that also require attention and our recommendations are not exhaustive – however they reflect the expertise and experience of the community managed mental health sector in NSW. MHCC is happy to provide any further information or advice the Productivity Commission may require as it undertakes this review.

Endnotes

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