



# SUBMISSION

To the National Mental Health  
Commission's Review of Existing  
Mental Health Programs and Services

June 2014

*Mentally healthy people, mentally healthy communities*

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# 1 INTRODUCTION

This is the third submission from the Mental Health Council of Australia (MHCA) to the National Mental Health Commission (NMHC) to inform the NMHC's current review of mental health programs. The MHCA's first submission was made in November 2013 (see Appendix A) and the second in April 2014 (see Appendix B).

The recommendations presented in earlier MHCA submissions remain critical to the task of achieving lasting mental health reform to improve consumer and carer outcomes. This submission makes recommendations which replicate or expand on earlier recommendations.

This submission builds on previous submissions by:

- Describing the characteristics of a high-performing mental health system, emphasising the interdependency of clinical, psychosocial and other issues which contribute to the capacity of individuals to lead a contributing life;
- Discussing some broader contextual factors which are critical to improving outcomes in the long-term, with reference to the National Commission of Audit, the 2014-15 Federal Budget, the McClure Review of Australia's Welfare System, the Federation White Paper, and the National Disability Insurance Scheme;
- Considering the challenges in achieving better coordination and integration within and across systems that people with mental health issues may encounter;
- Describing the practical steps required to lay the structural foundations for reform; and
- Identifying other immediate priorities for action which are consistent with a long-term vision for reform.

## CHARTING A LONG-TERM REFORM AGENDA

In considering priorities for action on mental health, it is important to remember that there is no such thing in Australia as a mental health 'system' per se. Instead, the mental health 'system' is shorthand for the many systems and services that consumers and carers may encounter over a lifetime. For the most part, these services and systems are poorly integrated, overseen by different parts of government, based on widely differing organising principles, and not working towards a common goal for improved outcomes.

This means that major gains can be made by ensuring that the right governance conditions are in place, improving coordination within and across governments and service providers, and addressing gaps in services. If we can take these steps, we will truly be able to say we have a cohesive 'system' which meets the needs of consumers and carers. By contrast, if governments only tinker with the present system, but have no vision for a better system in the future or the path to reform, then improvements in outcomes will inevitably be piecemeal and fortuitous rather than far-reaching and deliberate.

The terms of reference for the NMHC Review indicate that the Review will make recommendations to government relating to existing programs and services. While this is necessary and useful, the MHCA believes that sustainable reform depends on program- or sector-specific and structural issues being addressed in parallel, driven by a consistent and

widely endorsed vision for change. Such reforms will necessarily be complex, and require sustained effort over the long-term. The Commonwealth Government is uniquely placed to take a leadership role in this regard.

After years of substantial spending by the Commonwealth and states, and increased rates of help seeking, mental health outcomes are not improving at the pace they should be. It is critical that the NMHC's Review charts a path to reform over the next ten years and beyond that realigns priorities, builds the capacity of the mental health sector, and refocuses spending to align with a shared vision for a high-performing system. The key characteristics of such a system include:

1. Full and meaningful participation by people with mental illness and the people who care for them;
2. Priority given to mental health promotion, prevention and early intervention;
3. Recovery orientation;
4. Seamless integration and coordination of policies, services and programs (both within the health system and across systems such as employment, housing and education); and
5. Accessibility, effectiveness, efficiency and accountability for measureable consumer and carer outcomes.

One of the chief hallmarks of a high-performing system is that most of the activity that would contribute to better outcomes actually takes place outside the health system – that as many people as possible receive the right help early, thereby reducing demand for services for people in crisis. Nevertheless, in the short term there are many things that would improve the performance of the health system in meeting the needs of people with mental illness, and these are an immediate priority. In the longer term, we need to lay the foundations for improvements in how other systems can contribute to better outcomes.

Importantly, structural reforms would not necessarily involve major new spending by government – in fact, significant progress can be made on a number of important fronts at little cost.<sup>1</sup> On a similar note, the MHCA concurs with the conclusion of the NMHC's second *National Report Card on Mental Health and Suicide Prevention*, which described mental health as an 'invest-to-save' issue and highlighted the major productivity and participation gains that are possible through a concerted effort to build individual and community resilience. In this respect, investments today (including modest adjustments to existing investments) can deliver substantial cost savings to government in the long term. Some ideas for how to find savings in the mental health system are presented in Section 3.

This submission focusses on opportunities for reform that draw on an emerging vision of a mental health 'system' which better matches services with community need, taking account of the major gaps and other shortcomings which presently exist. The MHCA hopes to complement the work of the NMHC by identifying a host of factors which undermine the

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<sup>1</sup> The *MHCA Submission to the 2014-15 Federal Budget*, February 2014 includes a range of recommendations which would have little or no cost to the Australian Government. It can be found at: <http://mhca.org.au/submission/mhca-submission-2014-2015-federal-budget>

effectiveness of existing programs, and which will shape the ability of governments to help people with mental illness and their families lead a contributing life. The submission also highlights the structural impediments to achieving better outcomes and makes recommendations about how more appropriate governance and incentive arrangements might be put in place over time – bearing in mind the need to do this in logical, evidence-based fashion with due regard to the positive features of the present ‘system’ and the goodwill of consumers, carers and service providers.

## THE FIRST STEP IN MENTAL HEALTH REFORM

Mental health is not a closed system; it reaches into every part of our society, our economy, our personal and professional lives. It also has a profound economic dimension: not only do governments spend some \$28 billion per year dealing with the impact of mental illness,<sup>2</sup> but the gains that can be made in productivity and participation terms are even greater. Responsibility for mental health outcomes does not reside in one domain or with one level of government. It is imperative that actions to improve mental health are far-reaching and tied to a collective vision rather than haphazard and incremental. With this in mind, the MHCA argues that the greatest priority for mental health reform, and the first step towards a long-term vision, is for governments to endorse and collectively commit to a common set of whole-of-life targets for improved consumer and carer outcomes, underpinned by indicators that will reflect our shared progress towards that vision.

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<sup>2</sup> A recent analysis estimated direct health expenditure in Australia at over \$13.8 billion per year, with direct non-health expenditure of at least \$14.8 billion per year: Medibank and Nous Group (2013) *The Case for Mental Health Reform in Australia: a Review of Expenditure and System Design*.

## 2 CHARACTERISTICS OF A HIGH-PERFORMING MENTAL HEALTH SYSTEM

A high-performing mental health system must be underpinned by recognition of fundamental human rights and freedoms. The principles of recovery, access and equity should apply to all elements of the system.

Critically, this system must ensure that all people have the right to live a meaningful and contributing life, and enable person-centric approaches that maximise individual and community capacity and autonomy. This is in contrast to the current situation, where policy and service delivery are too often driven by the priorities of policy makers, funding agencies and service providers, rather than being based on the whole-of-life needs of consumers and carers.

There are many existing statements of government policy which articulate the key features that should characterise a high-performing mental health system. Some notable examples are provided at Appendix C, and the MHCA endorses all of these. Indeed, if any one of these statements of policy ambition were implemented in full, we would see tangible improvements in consumer and carer outcomes. At the same time, it is also clear that solutions to one problem are often dependent on solutions to others.

Achieving a mental health system with these characteristics will require a carefully managed process of change over the long-term, with changes made in the short-term measured against this vision. The changes required will range from detailed matters of implementation and service delivery through to complex and multi-faceted reforms to structural elements both within and outside health and mental health. Any changes to programs, services, funding or government responsibilities need to be considered in light of the complex interdependencies and potential unintended consequences within and between mental health and other systems. The remainder of this section outlines several areas of such complexity, with specific priorities for short-term action and longer-term structural reforms identified in Sections 4 and 5.

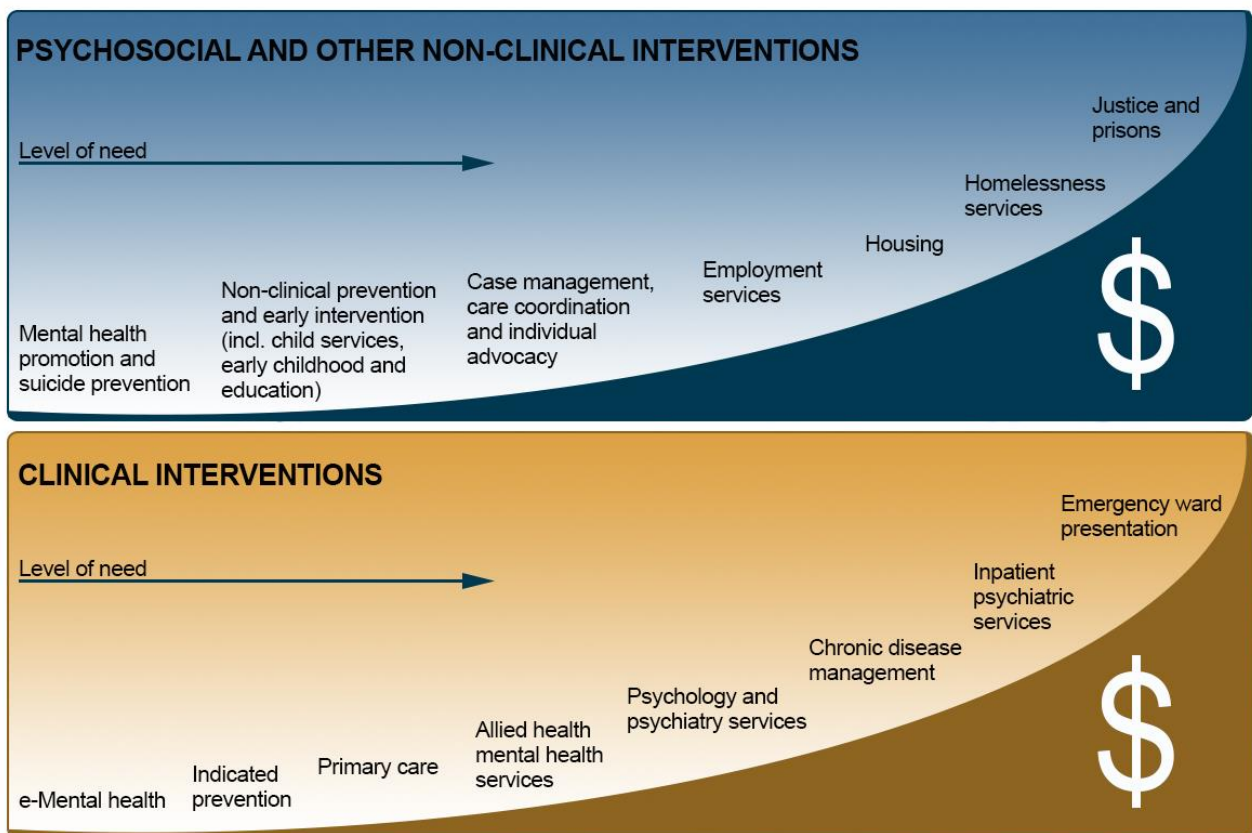
### MATCHING CONSUMER AND CARER NEEDS WITH THE RIGHT ASSISTANCE

Our current service systems often focus on a relatively narrow aspect of a person's life, whether that be on their medical symptoms and treatment, their housing situation or their personal finances. This is despite the fact that in the life of an individual various support needs are likely to be interconnected or, more accurately, interdependent. Providing support in one domain is at best inefficient and at worst ineffective if important needs in other domains are left unaddressed. An obvious example is where homelessness or insecure housing exacerbates clinical symptoms, but nonetheless requires non-clinical solutions.

If we are to optimise the support that people receive when they approach various support systems, those systems must also be interconnected and interdependent. Ensuring appropriate triaging (to identify and prioritise needs and provide support) and clear pathways through various support services – both clinical and otherwise – is the greatest challenge of the reform process, but also the one that holds the most promise for improved consumer and

carer outcomes. An excellent example of how these systems can work more closely together is provided by the GP Access Program in South Australia.<sup>3</sup>

The diagram below illustrates the increasing costs to government and individuals as levels of need increase for clinical and for psychosocial and other non-clinical interventions. It will not be enough to resolve clinical questions if psychosocial supports are not provided in a coordinated and integrated way; likewise, it will not be enough to resolve the psychosocial questions if clinical support is ad hoc or unavailable. Rather, these systems must complement each other. Ensuring integration across these systems, and matching interventions to a person’s needs from multiple perspectives, will ultimately lead to substantial improvements in both the effectiveness of the mental health ‘system’ and the value for money that it delivers.



<sup>3</sup> GP Access supports and assists people with a mental illness to (1) manage their mental illness and prevent further deterioration or development of disability; (2) fully and actively participate in the community including pursuing social, recreational, training, educational, volunteering and employment opportunities; access suitable independent housing (private rental, Housing Associations, Housing SA); (3) increase independent living skills through the development and maintenance of general housekeeping skills (e.g., cooking, cleaning, budgeting, shopping); (4) improve self-management of mental and physical health needs by accessing specialist services and allied health (able to complement other GP initiatives such as Access to Allied Psychological Services and Mental Health Care Plans); and (5) consider every aspect associated with their psychosocial needs: accommodation; independent living skills; employment; community links; health issues; finances and overall wellbeing.

### How can primary care and psychosocial support systems complement each other?

- There would be no wrong door – entry at any point in the system will see consumers efficiently directed to the support they require.
- A well-defined model of stepped care will:
  - Assist consumers, through appropriate triaging upon assessment, to find the best level of care they require, from self-help and online interventions through to intensive, complex support.
  - Ensure low-cost interventions (such as web based interventions and psycho-education) are provided to most in order to make talking therapies and more intensive supports available to more people who need them.
  - Provide services at the earliest opportunity rather than requiring crises to manifest.
  - Ensure that pathways through the support system (including to system exit) are clearly defined and agreed.
- Consumers, carers, clinicians and other workers would have access to information regarding supports available from various specialists and care providers (building on models like Healthpathways in NSW).<sup>4</sup>
- Models of collaborative care will be implemented to ensure all providers – including peer workers, case managers, mental health nurses, GPs, psychologists, psychiatrists, housing workers, case managers, employment support workers and others – provide care that is well coordinated and optimises the role played by each.
- Incentives will be provided to support collaboration – not just between clinicians, but between consumers, carers, clinicians and services providing psychosocial supports.
- Duration or intensity of care and support will be based on routine reassessment and review rather than on arbitrary caps on service offerings.
- Medicare will support the treatment of mental illness in ways which recognise the ongoing nature of people’s needs, as for chronic physical conditions.
- Consumers will determine priorities for access to support for accommodation, self-care, social and economic participation, and education as required.

## PROMOTION, PREVENTION AND EARLY INTERVENTION

Effective mental health prevention initiatives should be in place at primary, secondary and tertiary levels of prevention. Some of these initiatives will be aimed at providing equitable access to mainstream services and entitlements, while others might be specifically targeted at mental health services.

While there are many potential settings for mental health prevention activities, priority should be given to initiatives that can be incorporated in settings with the greatest reach and influence over large population groups. For example, general practice currently provides a widely accessible setting for mental illness prevention and early intervention.

For young people, prevention and early intervention will be most effective in very early childhood (commencing with pre-natal care) and in childcare, pre-school and school settings. Primary and secondary curricula should promote the development of emotional resilience

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<sup>4</sup> More information about the Healthpathways model can be found at [www.hnehealth.nsw.gov.au/innovation\\_support/programs\\_for\\_20102011/health\\_pathways](http://www.hnehealth.nsw.gov.au/innovation_support/programs_for_20102011/health_pathways).



and other factors that help prevent mental illness, and provide education and other resources for parents, teachers and students in fostering good mental health and seeking help for psychological stress and mental illness. Mental health training should also be incorporated into accreditation and professional development courses for all staff within educational settings. Initiatives such as Headspace and Early Psychosis Prevention and Intervention Centres provide coordinated and integrated services to adolescents experiencing mental illness with the aim of preventing the development of more severe conditions.

For adults, promotion and prevention initiatives should be incorporated into workplace settings. While many workplaces already feature early intervention strategies (such as Employment Assistance Programs), practices and training to prevent the emergence of mental distress and illness should also be in place. Such initiatives should include at a minimum, employee training in mental health and wellbeing, but may also include initiatives to improve job design and work-life balance, and to reduce workplace stress and to improve organisational culture.

Mental health promotion and prevention should also be incorporated into residential aged care facilities, with a focus on differentiating depression and other mental health needs from early signs of dementia.

There is strong evidence that targeted interventions in the first few years of life can substantially improve outcomes over a lifetime, including both physical and mental health outcomes. Existing initiatives such as maternal and child health nurse home visits and child health checks provide governments with practical channels for promoting good mental health early in life.

Underpinning any targeted promotion and prevention activity should be a funded, coordinated national strategy for improving community awareness, understanding and attitudes in relation to mental illness. To avoid duplication and to increase efficiency there is a clear role for the Commonwealth in leading and coordinating this work.

**How can we change the balance in services away from acute care towards promotion, prevention and early intervention?**

The National Mental Health Service Planning Framework (NMHSPF) is the most comprehensive planning tool currently available in relation to mental health, developed through an exhaustive process of consultation with the mental health sector. The NMHSPF will assist governments to identify the level of need for both clinical and community services and make investments accordingly. Through careful use, the NMHSPF could drive investment in community-based services which, over the long term, should ease demand on acute and crisis-driven services – a goal that many stakeholders share but is difficult to achieve in practice.

The MHCA therefore reiterates Recommendation 4 from our previous submission to the NMHC: that Commonwealth and State/Territory Governments agree to release the latest version of the NMHSPF and to work with stakeholders to develop plans to support its ongoing development and implementation.

## INTEGRATION AND COORDINATION

As demonstrated by the many previous reviews and reports into mental health reform, there is no shortage of ideas and detailed suggestions about improving mental health in Australia. However, the successful implementation of these many ideas is often undermined or obstructed by systems well beyond mental health as narrowly conceived. As already noted, the mental health ‘system’ as perceived by many in the Australian community (i.e. services staffed by clinical mental health professionals such as psychiatrists, psychologists and mental health nurses) is just one part of a much larger set of arrangements.

Poor integration and coordination is widely cited by a range of stakeholders (including governments) as leading to ineffective and inefficient service provision, and a key source of frustration and poor outcomes for mental health consumers and carers. By way of recent example, the National Commission of Audit noted that ‘Australia should move toward a more integrated health services system where people are looked after on a “whole of life” not “episode by episode” basis’ – an observation echoed and supported by the mental health sector<sup>5</sup>.

Before solutions and best-practice initiatives can be identified, however, it should be noted that ‘integration and coordination’ means different things from different perspectives – as described below. Nevertheless, some of the steps towards better integration would deliver benefits from multiple viewpoints; some potential responses in the short- and longer-term are outlined in Sections 4 and 5.

### What does integration and coordination really mean?

**For consumers** it means not having to tell your story over and over; it means no wrong door and being able to access the right mix of services at the right time; it means consistency in a minimum level of service standards; and it means help to participate to the maximum extent possible in society, in the economy, and in decisions which affect you. It also refers to the view that a high-performing mental health system should be able to respond to an individual’s needs across the full spectrum of mental illness and match services appropriately.

**For service providers** it means less red tape getting in the way of good service delivery; flexibility to provide the right service at the right time; accurate and comprehensive understanding of referral pathways available at a local level; it means flows of information that is relevant, accurate and readily available; and collaborative and respectful relationships amongst all professions and workforces involved in supporting good mental health and recovery.

**For funders of services** it means that consumer and carer outcomes are being supported through a network of services that together represent the best value for money; that data and other evidence is readily available and is informing ongoing evaluations and service improvements in order to ensure that services are appropriate, well-targeted and good value for money.

From a **policy design perspective**, integrated services may refer to funding models – such as pooled funding distributed on a regional basis – or the ‘mainstreaming’ of mental health, whereby mental health outcomes are an explicit priority across a range of service areas (such as in education, workplaces, housing and homelessness, and the justice system). Alternatively, it may mean consistency of process (such as consistent/aligned data collections, eligibility criteria, assessment forms and triage processes), and/or sensible delineation of roles and responsibilities with adequate safeguards to prevent people falling through the cracks.

<sup>5</sup> National Commission of Audit, *Phase One Report*, page 107.

### 3 THE ROLE OF GOVERNMENT IN MENTAL HEALTH

The National Commission of Audit (CoA) recommended that analysis of mental health programs be deferred to the NMHC Review<sup>6, 7</sup>. With this in mind, the MHCA takes this opportunity to consider other issues raised by the CoA which may have direct or indirect impacts on mental health, particularly in relation to the role of government, and the Commonwealth Government in particular, with respect to mental health policy and service delivery.

#### THE MENTAL HEALTH MARKET

The CoA has much to say about the role of markets in Australian society, including in service delivery<sup>8</sup>. Similarly, the recent Review of Medicare Locals refers to an overarching principle that government 'should only provide services where there is demonstrable market failure, significant economies of scale or absence of services'.

One such area of market failure recognised by the CoA is in disadvantage, with the CoA suggesting in broad terms, that 'Government should protect the truly disadvantaged and target public assistance to those most in need'. Without a definition of 'true' disadvantage, it is not clear which groups in society should receive help; however, it is obvious that many people with mental illness would fall into this category, regardless of what definition is used. It is therefore reasonable to conclude that there is a compelling case for government(s) to take concerted action to reduce the social and economic impacts of mental illness and promote better mental health at a population level.

With these observations in mind, the MHCA suggests that the mental health arena has over time been characterised by market failure, underinvestment and a chronic absence of services (with certain notable exceptions). While the move towards an individualised funding model may deliver a better quality of life for some people with psychosocial disability under the National Disability Insurance Scheme, under current policy settings this will only assist a minority of people who experience mental illness.

Government is by far the largest purchaser of services for people with mental illness (despite the choice that consumers sometimes exercise on what service they access). This is appropriate, but it means that governments have collective responsibility for purchasing the

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<sup>6</sup> *National Commission of Audit, Phase One Report*: Recommendation 40 – 'Mental health services are characterised by overlapping funding and service delivery responsibilities and a lack of coordination across jurisdictions. The Commission supports the proposed review by the National Mental Health Commission and recommends that the review pay particular attention to removing the significant duplication between the Commonwealth and the States that currently exists in mental health services.'

<sup>7</sup> Although it is noted that the CoA's proposal for a Medicare co-payment could have significant implications for mental health consumers' access to services and supports.

<sup>8</sup> For example, *National Commission of Audit, Phase One Report*, page 11: 'There are instances when markets cannot do what is needed and governments have to intervene. In doing so they must strike the right balance. Government interventions should be justified on the basis that they produce net sustainable benefits that improve the wellbeing of the community. There is a need to be aware also of the potential for government interventions to crowd out the private and non-government sectors from activities that they may be more capable of providing.'

right mix of services based on community need. In an environment where Commonwealth, State and Territory responsibilities are unclear, government decision-making results in programs and services that are often funded on an ad hoc, fragmented basis, or in response to pressures which do not align with community needs, meaning that government responses can be inappropriate or have unintended consequences. For example, some areas of mental health are characterised by duplication (with many providers operating where a small number of providers would make more sense – say in e-mental health) or by the complete absence of services (where there are insufficient incentives for market entry – say in rural and remote areas). It is therefore reasonable to conclude that the mental health ‘marketplace’ is not currently delivering value for the community.

From another perspective, mental health is not an area well-suited to market-based interventions. A well-functioning market requires, among other things, equal access to information and informed consumer choice. In mental health, there is often a stark information asymmetry between providers of mental health services (who hold detailed clinical knowledge, for example) and potential consumers of those services (who do not necessarily always understand what they are ‘purchasing’ or why, or even if they have a choice). Providers frequently respond to price signals from governments and other funders rather than responding to the needs of consumers and carers. In addition, the notion of an informed consumer can be complex where someone may have cognitive difficulties, confusion regarding the risks and benefits of different service options, and limited options which do not necessarily correspond with their actual needs. With these reflections in mind, the MHCA argues that governments must think carefully before using market mechanisms to coordinate and deliver mental health services of one kind or another.

## COMMONWEALTH AND STATE/TERRITORY ROLES

The CoA proposed that the Commonwealth essentially cease developing policy and funding services in areas where States and Territories have responsibility. This is recommended on the basis of ‘the principle of ‘subsidiarity’<sup>9</sup>... that policy and service delivery is as far as is practicable delivered by the level of government closest to the people receiving those services’. According to this principle, State and Territory governments would be best placed to design, deliver and fund mental health services, as they are better able to detect and respond to change in local needs.

Whilst acknowledging the important and ongoing role for States and Territories in mental health, the MHCA believes that there is a very strong case for continued Commonwealth involvement in certain key respects. This case is reinforced by decades of failed policy in mental health, responsibility for which must be shared by all governments.

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<sup>9</sup> *National Commission of Audit, Phase One Report*: Recommendation 7 – ‘The Commission recommends that a comprehensive review of the roles and responsibilities between the Commonwealth and State governments be undertaken, informed by: (a) the principle of ‘subsidiarity’ so that policy and service delivery is as far as is practicable delivered by the level of government closest to the people receiving those services.’

The value of a national role in mental health policy is also evidenced by several recent achievements that would not have been possible without bipartisan support and leadership at a federal level. These include:

- The National Framework for Recovery-Oriented Mental Health Services<sup>10</sup>, recently released, is the first attempt to translate the whole-of-life needs of consumers and carers into a service delivery context.
- The National Mental Health Service Planning Framework (NMHSPF) which enables governments to identify the level of need for both clinical and community services and make investments accordingly. The NMHSPF will, for the first time, make clear the substantial gap between the level of need in the community and what is funded in each jurisdiction. As explained above, it is critical that the NMHSPF be released as soon as possible.
- The establishment of the NMHC and its National Report Cards on Mental Health and Suicide Prevention, the findings and recommendations of which are broadly endorsed by the mental health sector.
- A very broad range of mental health and related stakeholders coming to a consensus on a framework for targets and indicators to drive long-term mental health reform. It is now up to governments to endorse – and resource – this framework.

Despite these landmark initiatives, there is clearly much more work to be done. The MHCA therefore supports the CoA's recommendation that the respective roles and responsibilities of the Commonwealth and States/Territories in the context of a federal system be reviewed, both for mental health<sup>11</sup> and more broadly<sup>12</sup>. We note the opportunity presented by the upcoming Federation White Paper to tackle these issues, and refer the NMHC to Recommendations 6 and 9 of our previous submission<sup>13</sup>, which refer to jurisdictional roles and responsibilities. Indeed, addressing federal financial arrangements at a broader level is a precondition for achieving coordinated and effective national action on mental health.

In the meantime, the MHCA proposes that the Commonwealth provide national leadership and hold responsibility for areas of mental health in which national consistency is critical. This would include, for example, minimum standards of service delivery, workforce accreditation, and data specifications. It should also ensure monitoring and reporting on those standards and against agreed outcome measures through an independent (or jointly

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<sup>10</sup> Available online at

[www.ahmac.gov.au/cms\\_documents/National%20Mental%20Health%20Recovery%20Framework%202013-Policy&theory.PDF](http://www.ahmac.gov.au/cms_documents/National%20Mental%20Health%20Recovery%20Framework%202013-Policy&theory.PDF)

<sup>11</sup> *National Commission of Audit, Phase One Report*: Recommendation 40 – (see above at footnote 6).

<sup>12</sup> *National Commission of Audit, Phase One Report*: Recommendation 6 – Budget reporting and the Charter of Budget Honesty; Recommendation 7 – Reforming the Federation: Clarifying Roles and Responsibilities; Recommendation 8 – Reforming the Federation: Addressing vertical fiscal imbalance; Recommendation 9 – Reforming the Federation: Arrangements for addressing horizontal fiscal equalisation; Recommendation 10 – Reforming the Federation: Reduced tied grants to the States; Recommendation 11 – Reforming the Federation: Reducing the administrative burden.

<sup>13</sup> *MHCA submission to NMHC Review, April 2014*: Recommendation 6 – 'That the NMHC consider and define the optimal roles and responsibilities of Commonwealth and State/Territory Governments in relation to mental health. Recommendation 9 – 'That COAG develop and agree to a new National Agreement for Mental Health as a nationally unifying and authoritative strategy for mental health reform over the longer-term.'

'owned' by the Commonwealth and States and Territories) national mental health 'watch-dog', to which all jurisdictions would be required to regularly provide data as a condition for ongoing funding. The Commonwealth should also take the lead in areas that do not require or recognise state boundaries, such as where nationally-consistent information technology platforms and quality standards are used or required.

## FINANCIAL INCENTIVES

Funding is a key factor motivating the behaviour of individuals, services and governments alike, and is therefore an effective lever for change available to both Commonwealth and State/Territory governments.

Some of the channels through which funding can have impacts include:

- Conditions placed on cash and in-kind supports for individuals (e.g. social security payments);
- Conditions placed upon funding for services (e.g. specific contract terms, as well as associated processes such as contract management);
- Direct and indirect incentives embedded in funding for public and non-government services (e.g. hospital funding and Medicare), including incentives for collaboration and partnership<sup>14</sup>; and
- Conditions placed upon funding provided from the Commonwealth to States/Territories, such as measurement and reporting on outcomes.

The MHCA therefore recommends that detailed consideration of the consequences of different funding and payment arrangements is needed if future reform efforts are to succeed.

Within governments, there also are Budget Rules regarding the accounting treatment of investments and down-stream savings, which in turn can influence political and policy decision-making:

- Only savings that are directly attributable to a specific policy change are accounted for in budget bottom lines, with any indirect savings regarded as 'fortuitous underspends'.
- Where expenditure on demand-driven programs was lower than forecast, those savings are not specifically identified through a budget measure (which must be published), but are returned to consolidated revenue via an 'estimates variation'.<sup>15</sup>

With commitments to bring budgets back to surplus, these rules weaken the already tenuous incentives to take longer-term policy action. The rules also create perverse incentives

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<sup>14</sup> The Commission of Audit recommended close examination of the effectiveness of Medicare Benefits Schedule items (*National Commission of Audit, Phase One Report: Recommendation 17(f)*). Such a review could provide useful lessons for mental health, particularly if it takes into account structural barriers to better integration and coordination.

<sup>15</sup> The actual Budget Rules in place in any given year are generally cabinet-in-confidence. However, the MHCA understands that the principles outlined here apply by convention regardless of the government of the day.

whereby ministers and line departments are unlikely to make investments in one portfolio, only for the financial benefits to be reaped in another.

Nevertheless, there are various ways in which government decisions can be informed by cross-portfolio considerations. For example, proposals involving additional regulation need to be accompanied by a Regulatory Impact Statement<sup>16</sup>; similarly, initiatives to close the gap in Indigenous outcomes are developed with reference to needs across agencies and across jurisdictions. These and other options should be considered to ensure that mental health is given cross-portfolio priority at the highest levels of government decision-making.

As Professor Allan Fels AO explained in the NMHC's second National Report Card on Mental Health and Suicide Prevention, mental health is an 'invest-to-save' issue. All governments have a financial interest in minimising the prevalence and impact of mental illness in the community, and the importance of responding to mental illness as early as possible is a principle on which the entire mental health sector is united. However, it appears there are a lack of or inadequately-targeted incentives (across a number of inter-jurisdictional and other funding arrangements) to encourage investment in mental health promotion, prevention and early intervention. The MHCA also notes that the CoA provided no advice on how the Commonwealth might maximise its return on investment in prevention and early intervention, notwithstanding significant evidence to support the business case.

The MHCA anticipates that the McClure Review of the Welfare System is likely to recommend an investment approach to mental illness prevention and early intervention, approaches which could be applied to other areas of government responsibility. The MHCA urges the NMHC to take account of the likely impact of different options for welfare reform that the McClure Review is expected to outline, including innovative approaches for using evidence to guide investment to improve long-term outcomes for consumers.

To better understand the long-run economic returns associated with preventative action on mental health, the MHCA has commissioned independent modelling on the potential economic benefits of investment in mental health promotion, prevention and early intervention. We anticipate being able to share the findings from this study in the second half of 2014.

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<sup>16</sup> A Regulatory Impact Statement (RIS) is a document prepared by the department, agency, statutory authority or board responsible for a regulatory proposal, following consultation with affected parties. It formalises and provides evidence of the key steps taken during the development of the proposal, and includes an assessment of the costs and benefits of each option. Preparation of a RIS ensures that all relevant information is documented, and that the decision-making processes are made explicit and transparent.

## How can we find cost savings within the mental health system?

Over time, the mental health system must shift its focus and emphasis from tertiary and acute care to primary care and prevention. This will not be an easy or quick transition.

Currently, our clinical systems are not well coordinated and largely fail to appropriately triage at the point of entry to the system. This means that some consumers miss out on services they need, some gain access to high intensity and expensive resources that are unnecessary, and many consumers get access to services that are inadequate for their needs at that time. Further, the progress of many consumers is not consistently monitored so that services can be appropriately added or removed during their recovery journey.

This situation is mirrored in the poor availability and fragmentation of psychosocial supports. Too often, people are required to be in crisis to have any chance of gaining access to any supports at all. If they are lucky enough to get support then housing, employment, financial and social needs are likely to be addressed by different agencies and programs with poorly articulated links to each other and with little or no coordination.

Finally, our existing systems for providing clinical support and our systems for providing psychosocial support are largely disconnected from each other – to the detriment of both. Clinical supports provided in isolation from psychosocial support will frequently fail, resulting in people cycling or returning to the clinical system repeatedly. Similarly, psychosocial supports provided in the absence (or ignorance) of necessary clinical supports can be equally ineffectual and expensive.

A high performing mental health system will provide integrated, coordinated and appropriately triaged supports across the clinical and psychosocial domains based on the recovery needs of each individual by:

- Moving consumers from hospital-based care towards community-based care, early intervention through primary care, self-managed care, and prevention strategies.
- Implementing a 'stepped care' model for mental health services which better matches the level and intensity of care with individual and family needs and responds to the episodic nature of mental illness.
- Identifying and promoting low-cost and scalable interventions, such as e-mental health initiatives, which provide excellent value for money across the continuum of need.
- Ensuring that resources are directed at all parts of the spectrum of need – from mild to severe – with specific groups along this continuum receiving the right targeted interventions.
- Appropriately balancing psychosocial and other non-biomedical needs with clinical options to assist people to lead a contribution life.
- Ensuring an effective triage and referral service at all points of entry, with:
  - Initial referral to appropriate less intensive services, with options to step-down and step-up to less or more intensive services if/when needed
  - Clearer and simpler decision-making criteria for triage and referral pathways
  - Team-based care including both biomedical and psychosocial assistance
  - Integrated care systems for people with chronic and complex conditions.
- Ensuring the appropriate and efficient use of the available mental health workforce to the top of their scopes of practice.



## 4 STRUCTURAL FOUNDATIONS FOR LONG-TERM REFORM

Previous reform efforts have laid out aspirational plans for the future of mental health services and programs, but insufficient consideration has been given to the governance and structural arrangements that might best support such reform. In this section we address some of the areas of structural changes that will need to be considered if any new reform agenda is to be more successful than previous attempts.

### TARGETS AND INDICATORS

A critical factor in successful reform is a coherent and meaningful framework to both guide reform planning and transparently track progress in reform efforts. For too long, the lack of clearly defined targets and indicators has seen national mental health reform lag behind many other significant reform processes.

As consistently recommended by the MHCA<sup>17</sup>, all governments – including the Commonwealth – should endorse and resource targets and indicators that will drive long-term mental health reform as a matter of urgency. Endorsing these targets is a high-priority and value-for-money initiative that will lay the foundations for future reform.

Following extensive research and consultations, a framework for national mental health targets and indicators (‘the Framework’) was recommended to government by the COAG Mental Health Reform Working Group’s Expert Reference Group (ERG) in September 2013. The MHCA understands there may now be interest in options for a stepped approach to this framework.

It should be noted that while the Framework represents a majority consensus view, some differences of opinion remain, particularly regarding relative priorities. While the MHCA supports the Framework in its current form (recognising the practical challenges of implementing particular elements within the Framework), we propose that targets and indicators corresponding to the four elements of a high-performing mental health system should have the highest priority. With this in mind, we propose that measures of and meaningful targets towards the following (identified by the ERG and presented to COAG) are of particular importance:

- The size and distribution of the peer workforce
- Consumer and carer satisfaction with services

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<sup>17</sup> *MHCA Submission to NMHC Review*, April 2014: Recommendation 3 – ‘That Australian and State/Territory Governments adopt outcome-based, whole-of-life targets that are ambitious and achievable over the long term and are tracked through indicators that measure progress towards those targets. These indicators should include, as a priority, nationally consistent measures of consumer and carer experiences. Information systems should be developed to allow the efficient and timely collection, analysis and publication of these data.’

*MHCA Submission to the 2014-15 Federal Budget*, February 2014: Recommendation 4 – ‘The Australian Government should endorse, and seek endorsement by state and territory governments, national mental health targets and indicators at the next meeting of the Council of Australian Governments.’

- The physical health of people with mental illness, especially serious and persistent mental illness
- Unstable housing and homelessness, especially with reference to people with mental illness in hospital
- Social and economic participation
- Rates of mental illness and service access among high risk groups
- Rates of suicide and self-harm.

Should a staged approach be adopted, we recommend that governments outline a process for moving towards a complete implementation of the Framework in the longer term.

## COMMONWEALTH-STATE/TERRITORY ARRANGEMENTS

There needs to be a close review of the appropriate split of roles, responsibilities and relationships between Commonwealth and State/Territory governments in relation to mental health, including its social determinants and its broader impacts on government expenditures. This is consistent with the MHCA's April 2014 submission to the NMHC Review<sup>18</sup>.

Reforming the Federation was a focus of the Commission of Audit reports, both in a general sense<sup>19</sup> and specifically in relation to mental health<sup>20</sup>. There also is an opportunity for the NMHC's findings in this regard to inform the Commonwealth's upcoming Federation White Paper.

Some of the barriers associated with the Commonwealth-State/Territory divide that affect mental health outcomes are shared by other sectors and stakeholder groups, but other barriers are unique to mental health. With this in mind, the MHCA believes it would be valuable for the Commonwealth Department of Prime Minister and Cabinet (which has carriage of the Federation White Paper) to initiate a stream of work which examines in some detail these unique barriers, as informed through consultations with State/Territory officials, state mental health services and state-funded non-government services, as well as the relevant national counterparts.

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<sup>18</sup> *MHCA Submission to NMHC Review*, April 2014: Recommendation 6 – 'That the NMHC consider and define the optimal roles and responsibilities of Commonwealth and State/Territory Governments in relation to mental health.' Recommendation 9 – 'That COAG develop and agree to a new National Agreement for Mental Health as a nationally unifying and authoritative strategy for mental health reform over the longer-term.'

<sup>19</sup> *National Commission of Audit, Phase One Report*: Recommendation 7 – Reforming the Federation: Clarifying Roles and Responsibilities, Recommendation 8 – Reforming the Federation: Addressing vertical fiscal imbalance, Recommendation 9 – Reforming the Federation: Arrangements for addressing horizontal fiscal equalisation, Recommendation 10 – Reforming the Federation: Reduced tied grants to the States, Recommendation 11 – Reforming the Federation: Reducing the administrative burden.

<sup>20</sup> *National Commission of Audit, Phase One Report*: Recommendation 40 – (see above at footnote 6).

## INCENTIVES, PATHWAYS AND STAKEHOLDER ROLES IN MENTAL HEALTH

A close analysis is needed of funding and other incentives that affect pathways of care and the delivery and operation of services. This work would consider:

- Grants arrangements, procurement processes and contracting requirements imposed by funding bodies<sup>21</sup>);
- Incentives around publicly funded systems and programs (including, for example, hospital-based services, Medicare Benefit Schedule items<sup>22</sup>, and a large number of programs in non-health portfolios, especially the Department of Social Services);
- Incentives and barriers to provision of different types of services, such as through online delivery<sup>23</sup>; and
- The market roles of various public, private and non-government sectors, bodies and stakeholders, and options for future arrangements, with reference to:
  - Increasing the contestability of funding;
  - Providing longer term funding certainty to maximise return on investment; and
  - Harnessing the benefits of collaboration and partnership.

This stream of work would need to be closely aligned with reform processes regarding Commonwealth-State/Territory relations, as well as with the development of policy or reform options regarding the way in which social services (through public, private and not-for-profit sectors) are funded, regulated and otherwise supported. It should also draw on the National

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<sup>21</sup> *National Commission of Audit, Phase One Report: Recommendation 49 – Grants Programmes:* ‘The Commission recommends significant changes be made to the administration of the Commonwealth’s grant programmes including by: (a) establishing a central register within the Department of Finance of all grants programmes with complete transparency on all grants awarded; (b) reducing red tape for grant recipients by applying contemporary risk-based approaches to grant management, (c) decreasing the number of existing grant programmes by abolishing, merging or consolidating existing grants programmes; (d) addressing the proliferation of new grant programmes by introducing a rigorous grant assessment process at the approval stage; and (e) ensuring all grants have measurable outcomes which are regularly assessed.’  
*Recommendation 59 – Outsourcing, competitive tendering and procurement:* ‘The Commission recommends that the Government: (a) re-establish competitive tendering and outsourcing guidelines that reflect contemporary and best practice contract management processes; (b) base procurement decisions on value for money at all times by abolishing Procurement Connected Policies; (c) taking a more strategic and professional approach to procurement and contract management; (d) make greater use of standardised contracts for procurement; and (e) develop a whole-of-government user charging framework that improves efficiency, accountability and transparency.’

<sup>22</sup> *National Commission of Audit, Phase One Report: Recommendation 17(f) – ‘reviewing the Medicare Benefits Schedule to identify and remove ineffective items, replace expensive items with less expensive alternatives where available and investigate options for cost recovery for applications to list items on the schedule.’*

<sup>23</sup> *MHCA Submission to NMHC Review, April 2014: Recommendation 4 – ‘That Australian and State/Territory Governments agree to release the latest version of the National Mental Health Service Planning Framework (NMHSPF) and support its ongoing development so that future reforms and service planning be informed by the NMHSPF and its subsequent iterations.’*

Mental Health Planning Framework, as per Recommendation 4 of the MHCA's previous submission<sup>24</sup>.

## REPORTING AND ACCOUNTABILITY

The Commonwealth's 2014-15 Budget flagged the possibility of a new Health Productivity and Performance Commission, pending negotiation with States and Territories. If this body is established, it will be critical that it includes a mental health focus and has structures in place to enable regular and formal opportunities for consultation with and input from community-managed organisations. It should also address the very real risk of overreliance on the efficient pricing of hospital services to the detriment of community-based services, which can often deliver better value for money and reduce demand for hospital services.

Reporting on mental health targets and indicators could be vastly improved by coordinating around a consistent set of high level policy objectives, articulated through a consistent and nationally endorsed framework of mental health targets and indicators. A focus on high-level outcomes will help shape and focus down-stream efforts, bringing both increased efficiency and effectiveness in terms of meaningful data that can be tracked over time and inform ongoing policy development.

As outlined at Recommendation 7 of the MHCA's April 2014 Submission<sup>25</sup>, the efficiency of reporting would be vastly improved by compatibility of information systems and data sets used by service providers in private, public and non-government sectors.

## GROWING THE PEER WORKFORCE

The role of a professional, well-integrated and supported peer workforce has been consistently identified in past reviews and consultation processes as the way to move from theory to practice in maximizing consumer and carer participation in decisions that affect them. A stronger and more highly valued peer workforce would be an efficient and self-sustaining mechanism to address the stigma in services that is so often at the heart of poor outcomes and experiences of care. Providing appropriate employment opportunities for people with lived experience of mental illness would also assist in harnessing their potential to make a major contribution to the Australian economy and social fabric – a potential that is so often unrealised at present – and in turn ease pressures on the social security system.

The MHCA therefore reiterates Recommendation 1 of its previous submission to the NMHC: that the Australian Government work with consumers and carers, agencies across governments, professional groups and non-government organisations to develop and fund a national peer workforce strategy.

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<sup>24</sup> *MHCA Submission to NMHC Review, April 2014: Recommendation 4 – (see above, at footnote 23)*

<sup>25</sup> *MHCA Submission to NMHC Review, April 2014: Recommendation 7 – 'That the NMHC consider the potential efficiencies in improving information management systems regarding mental health, including consistency in system standards and interoperability and data exchange between systems (including but not limited to personally controlled electronic health records).'*

## BUILDING SECTOR CAPACITY

Careful management of change is a critical factor for both short and long term reforms (as per Recommendation 10 of the MHCA's April 2014 submission to the NMHC)<sup>26</sup>. Neglecting this aspect for reform has previously led to implementation difficulties and failure to convert otherwise good policy into practice.

Many of the policy reforms suggested in this paper will require careful change management processes, including:

- Constructive communication and collaboration with stakeholders affected by policy reforms – including service providers, and consumers and carers; and
- Support for the sectors and stakeholders affected by change, by building capacity to contribute, respond and adapt to policy reforms.

Some specific areas for building sector capacity also include:

- Encouraging collaborative practice to deliver better whole-of-life outcomes in increasingly competitive markets;
- Information management, data design and collection regarding outcomes measurement (consistent with Recommendation 7 of the MHCA's April 2014 submission<sup>27</sup>); and
- Utilising and designing mechanisms for culture change.

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<sup>26</sup> *MHCA Submission to NMHC Review, April 2014: Recommendation 10 – ‘That government responses to the outcomes of the NMHC’s review should occur over a period of carefully managed transition.’*

<sup>27</sup> *MHCA Submission to NMHC Review, April 2014: Recommendation 7 – ‘That the NMHC consider the potential efficiencies in improving information management systems regarding mental health, including consistency in system standards and interoperability and data exchange between systems (including but not limited to personally controlled electronic health records).’*

## 5 LOOKING BEYOND TRADITIONAL BOUNDARIES

Many of the recommendations above describe how to improve integration and coordination across programs and services not traditionally thought of as the 'mental health system'. These will help to address 'boundary issues' between mental health and other relevant systems. In addition, we need to implement specific changes *within* other systems to better support people with mental illness. A significant proportion of people with mental illness encounter programs and services not traditionally associated with mental health, including housing and homelessness, physical health, disability and employment services. Immediate priorities for action in each of these areas are set out below.

### PHYSICAL HEALTH

People with mental illness often miss out on adequate physical care in both hospital and primary care settings. In both these contexts, physical health problems are often regarded by mental health clinicians as secondary considerations to mental health issues. Consumers are also increasingly drawing attention to the major physical health impacts of antipsychotic medications and demanding more informed choice over treatment options.

There is a range of ways that governments could address these issues:

- Adopting system-wide, outcome-based targets and indicators that relate specifically to the physical health of people with mental illness;
- Providing enhanced access to additional physical health services for people with serious and persistent mental illness and/or complex needs;
- Promoting collaborative care models, including consideration of the role of peer workers in clinical mental health and physical health care settings; and
- Examining in detail the myriad pathways through the mainstream health and mental health systems that consumers currently take and considering options for improving those pathways through better coordination between and within services (including by improving connections between clinical and psychosocial services and supports, as noted above).

### DISABILITY

The implementation of the National Disability Insurance Scheme (NDIS) presents both great opportunities and major risks for people with mental illness, carers and mental health services. These challenges are described in detail in the MHCA's position paper on *Mental Health and the National Disability Insurance Scheme*<sup>28</sup>.

Commonwealth and State/Territory Governments should undertake or support the following as a matter of urgency:

- Mapping programs, services and target populations that are in scope for the NDIS in each jurisdiction, as set out in bilateral agreements between the Commonwealth and States/Territories, and identifying where service gaps are likely to emerge as the NDIS is rolled out;

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<sup>28</sup> Available online at: [http://mhca.org.au/sites/default/files/docs/mhca\\_position\\_paper\\_-\\_ndis.pdf](http://mhca.org.au/sites/default/files/docs/mhca_position_paper_-_ndis.pdf)

- Quarantining, tracking and publicly reporting on mental health/psychosocial disability funding within the NDIS;
- Estimating numbers and describing the characteristics of Tier 3 and Tier 2 participants based on an expert-informed and iterative analysis of the National Mental Health Service Planning Framework;
- Designing a system of services and supports for Tier 2 participants that intervenes early to reduce future need for Tier 3 supports or crisis intervention, which – consistent with insurance principles – would invest up-front to reduce future costs;
- Ensuring that the process of assessment and planning for Tier 3 participants is:
  - Delivered by a workforce with sufficient skills and experience working with people with psychosocial disability;
  - Based on tools and protocols which are appropriate for people with psychosocial disability associated with mental illness;
  - Takes into account the challenges of point-in-time assessment for someone with episodic needs;
  - Captures the insights of trusted people, including carers and service providers, into the circumstances and support needs of participants with psychosocial disability;
- Ensuring a smooth transition from the current service system to the NDIS over several years, avoiding unintended consequences associated with the move to new arrangements, by:
  - Continuing to fund in-scope and other existing services on a block-purchasing basis, especially services which are currently accessed by people likely to be ineligible for a Tier 3 support packages, until such time as the architecture of the scheme is better developed and understood;
  - Working to retain and enhance the positive features of existing community-based mental health services, including contemporary, best-practice approaches to service design and delivery which aim to foster recovery, a highly specialised and growing workforce, and maximum involvement by consumers and carers in decisions which affect them.

## EMPLOYMENT

Some recommendations to promote mental health in the workplace are set out above in Section 2, under Promotion, Prevention and Early Intervention.

In addition to promoting workplace mental health, there should be adequate support when people with mental illness are unable to work, including adequate financial support and specialist employment services. It is critical that the Government's response to the McClure Review of the Welfare System includes reforms that appropriately recognise the significant impacts of mental illness on functional capacity to work, including the fluctuating and unpredictable nature of those impacts. Many people with mental illness receiving the Disability Support Pension want to work (or work more), but we currently have neither a welfare system which encourages entry into the labour market nor employer attitudes that sufficiently value the contribution people experiencing mental illness can make in well-

structured jobs. We expect the McClure Review will canvas these issues in considerable detail.

## HOUSING AND HOMELESSNESS

Patients in acute hospital-based mental health services often stay longer than necessary simply because they have nowhere else to stay. Blockages in the acute mental health care system are therefore often a symptom of a broader housing problem, not under-resourcing of acute care. Ironically, COAG's 'no exits into homelessness' commitment may be exacerbating these problems. At the same time as clinical workers are asked to refrain from discharging people onto the streets, governments have not made the investments necessary to better integrate hospital and homelessness services and to expand housing options.

There should be a focus on initiatives that address the challenges in providing homelessness services to people with mental illness, along with those that provide support for people with mental illness to access and remain in public, private and social housing.

- 'Housing first' initiatives (where access to support is available 24 hours a day but engagement is not compulsory and the only condition of tenancy is that rent is paid) have been found to keep people with serious and persistent mental illness housed for longer periods with fewer hospitalisations.
- A renewed focus by mental health services, correctional settings and hospitals to achieve COAG's 'no exits into homelessness' commitment, including greater accountability and reporting on discharge and referral practices.

There is a clear role for the Commonwealth negotiating with State and Territory governments to guarantee a proportion of transferred housing stock is secured for people with mental illness and adequate support provided for those people to maintain their tenancy<sup>29</sup>. While the Commission of Audit recommended responsibility in these areas should sit with States/Territories<sup>30</sup>, it is the MHCA's view that the Commonwealth has both a moral and structural responsibility for taking concerted action to reduce homelessness, including among people with mental illness who fall through the gaps in existing service systems.

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<sup>29</sup> See Recommendation 12, MHCA 2014-15 Budget Submission: The Australian Government should negotiate with state and territory governments to guarantee a proportion of transferred housing stock will be secured for people with mental illness and psychosocial disability and adequate support provided for those people to maintain their tenancy and access a range of social supports.

<sup>30</sup> Recommendation 38, National Commission of Audit, Phase One report: Housing affordability and homelessness prevention are primarily the responsibility of State and Territory governments. The Commission recommends the Commonwealth: (a) limit its involvement in housing to providing Rent Assistance payments; (b) extend Rent Assistance to public housing tenants, provided State governments commence charging market rates of rent; and (c) fund the increase in aggregate Rent Assistance payments by re-directing Commonwealth funding from existing agreements with the States for Affordable Housing and Homelessness and the National Rental Affordability Scheme.



Professor Allan Fels AO  
Chair, National Mental Health Commission  
PO Box 4023  
Parkville VICTORIA 3052

## Re: Review of mental health programmes

Dear Professor Fels,

Following the release of Terms of Reference, I am writing to offer our support and assistance to the National Mental Health Commission's Review of Mental Health Services and Programmes. In doing so, I also wish to highlight a number of issues that the Mental Health Council of Australia believes must be given high priority throughout the course of the review.

From your previous report cards it is clear that you are already aware Australia's mental health system is too often failing those who rely on it for assistance. We invest too much at the acute end, and too little in early intervention and prevention. We routinely fail to monitor the outcomes that we expect from our investments.

Your review marks a unique opportunity to address these historic failures, and to re-orient our investments so as to build, over time, a world's best mental health system for the future.

The failings of the system have been known for a long time now, and numerous reports have already articulated these failings in sombre detail. While we must certainly acknowledge these failings, we hope that your review will provide an opportunity to articulate a clear vision of the mental health system that will be desirable for the future.

It is the view of the Mental Health Council of Australia that we must advance on a number of fronts if we are to achieve this vision;

1. Firstly, the review must set out a vision for what an optimal mental health system should look like in Australia. As we have said before; a system that is focused on meaningful participation; that prioritises promotion, prevention and early intervention; that is recovery oriented; that is seamlessly integrated across services and programs; and, that is accessible, effective and efficient
2. Secondly, the review should set out recommendations that detail the radical reforms that will be required to move us from where we are now toward our shared vision. The history is already littered with incremental, ad hoc and stop gap measures and this is not what Australia needs now.

3. Finally, a priority task will be to identify major gaps in our existing services, and investments that are not currently yielding us the best outcomes. It is clear that some people currently entering the system could be diverted from future high cost services with appropriate investment in early intervention and prevention. It is also clear that people who have entered the system with complex needs would be better served by much closer integration across existing programs

Against a well-documented backdrop of inadequate and poorly targeted investment in the current mental health system, it is an important principle that any inefficiencies or savings identified by the review be recommended for reinvestment within the mental health system. Further, in an environment where services are often scant, there should be no diminution of services that people currently rely on.

The review is also asked to consider transparency and accountability in mental health investment. As the Commission has previously identified in its National Report Cards on Mental Health and Suicide Prevention, national targets and indicators for mental health reform are critical foundations for transparency and accountability, and are also useful mechanisms for monitoring the efficiency and effectiveness of the system. The work that the Commission has already facilitated on indicators and targets has significant buy-in from across the sector and it is our hope that the review will reinforce their importance.

A further task for the review is to identify future funding priorities in mental health across Australia. With this in mind I urge you to make full use of the opportunity presented by the recent development of the National Mental Health Service Planning Framework. While still incomplete, I understand this is the most comprehensive evidence-based planning tool currently available, and could be appropriately adapted to guide the review's investigations.

In terms of specific programmatic considerations, I note there are a number of planned but not yet implemented shifts in mental health policy and funding that will require careful consideration by the review. This particularly relates to the National Disability Insurance Scheme (NDIS) for people with mental illness and psychosocial disability.

As you are aware, the Mental Health Council of Australia has strong concerns that the NDIS may considerably reduce essential supports for large numbers of current and future mental health consumers and carers. On current estimates, individualised support through the NDIS will be available to only a relatively small proportion of people with psychosocial disability. Further, decisions around programmes and funding identified as in-scope for the NDIS are likely to lead to significant decreases in service availability for the vast majority of people with mental illness who do not gain access to NDIS support. This is likely to see increased, rather than decreased, demands on broader service systems, including additional presentations at emergency departments, increased reliance on crisis accommodation and higher contacts with the criminal justice system. Such a result is clearly neither efficient nor sustainable in the longer-term.

To deliver an accurate and nuanced assessment of mental health programmes, it is imperative that the review examines the service upheavals that will stem from the implementation of the NDIS. Consistent with the principles stated above, it also follows that funding for existing mental health programmes that are 'in-scope' for the NDIS, including Partners in Recovery, should remain available (at least during the transition period and

possibly beyond) in order to address the considerable levels of existing and unmet need for mental health services and supports, both currently and in future.

Finally, I am sure you will be aware of a number of other review processes that are likely to have a direct impact for people with experience of mental illness, and the mental health sector more broadly. The review of the welfare system being conducted by Patrick McClure is considering the payments system and strategies aimed specifically at increasing workforce participation amongst people with experience of mental illness. The Federal Government's upcoming White Paper on Commonwealth-State financial arrangements will be considering jurisdictional splits in funding and service delivery responsibilities, which has direct implications for governance, funding and operation of mental health services. In order to minimise the risks of duplication of effort and inconsistency in content, it would be prudent for the review to engage with these other processes as soon as possible.

Noting the relatively short timeframes for the Commission's work, and noting the successful collaboration we have had on previous projects, I am pleased to offer the assistance of the Mental Health Council of Australia in contributing to the review wherever possible. I note Mr David Butt has generously agreed to attend a forthcoming meeting of our Board and that this meeting might present an opportunity for us to consider future cooperation on this important work.

I would be pleased to discuss these issues with you at your convenience.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Frank Quinlan', written in a cursive style.

Frank Quinlan  
CEO

14 February 2014



Mental Health  
Council of Australia

# MENTAL HEALTH COUNCIL OF AUSTRALIA SUBMISSION

To the National Mental Health  
Commission's Review of Existing  
Mental Health Programmes and  
Services

April 2014

*Mentally healthy people, mentally healthy communities*

The Mental Health Council of Australia (MHCA) welcomes the opportunity to make a submission to the National Mental Health Commission's (NMHC) review of mental health programmes and services. The MHCA is currently developing its long-term vision for national mental health reform, in collaboration with our members, consumers and carers, and other key stakeholders. We hope to articulate this vision over the course of the NMHC's review and beyond.

In this submission, the MHCA has attempted to identify structural and systemic levers for reform, while still being practical and achievable in a reasonable timeframe. The recommendations below are based on the MHCA's vision of a world-class mental health 'system' characterised by several fundamental features to drive better consumer and carer outcomes: prevention and early intervention, a recovery focus, service integration, and increased participation and inclusion of mental health consumers and carers. We look forward to a process of constructive engagement with mental health commissions and governments to make this vision a reality.

## RECOMMENDATION 1

**That the Australian Government work with consumers and carers, agencies across governments, professional groups and non-government organisations to develop and fund a national peer workforce strategy.**

To build more effective services for consumers and carers, it is important to move beyond well-established theories of recovery towards approaches that incorporate recovery in practice. The role of a professional, well-integrated and supported peer workforce has been consistently identified in past reviews and consultation processes as the way to move from theory to practice in this regard. A stronger and more highly valued peer workforce would be an efficient and self-sustaining mechanism to address the stigma in services that is so often at the heart of poor outcomes and experiences of care. Providing appropriate employment opportunities for people with lived experience of mental illness would also assist in harnessing their potential to make a major contribution to the Australian economy and social fabric – a potential that is so often unrealised at present.

## RECOMMENDATION 2

**That the NMHC closely examine financial and other structural incentives that may be perpetuating investment in acute and hospital-based care, restricting investment in recovery-based approaches, and preventing efficient and effective early intervention and prevention services, particularly services based in the community, from thriving and growing.**

For example, some services (such as those funded under the National Disability Insurance Scheme) require that a consumer have a 'permanent impairment' before they can access services. In many contexts, less expensive, and potentially better fit-for-purpose, non-clinical supports, such as in housing, employment support and assistance in navigating other service systems, should be preferentially favoured over expensive clinical supports. A systematic and population-based approach to prevention and early intervention should be

promoted, including through the implementation of population-specific, evidence-based strategies in a variety of settings, commencing in early childhood and primary and secondary school curriculums and including youth friendly settings, workplaces, and aged care services and facilities.

## RECOMMENDATION 3

**That Australian and State/Territory Governments adopt outcome-based, whole-of-life targets that are ambitious and achievable over the long term and are tracked through indicators that measure progress towards those targets. These indicators should include, as a priority, nationally consistent measures of consumer and carer experiences. Information systems should be developed to allow the efficient and timely collection, analysis and publication of these data.**

The MHCA broadly endorses the framework for targets and indicators recommended to COAG by its Expert Reference Group. Experience has shown that outcome frameworks can drive progress and provide a direction for reform that is shared consistently at national, state/territory, local and service levels (for example, the Closing the Gap in Indigenous Disadvantage strategy). Outcomes reporting can drive reform by enhancing accountability on the part of funders and service providers, and provides a way to incentivise and measure the impact of reforms in specific areas.

In addition, measures of consumer and carer experiences and satisfaction would provide an important mechanism for promoting recovery principles and embed consumer and carer perspectives in service design and delivery. Collection of such information should be required from all services that interact regularly with people with mental illness, regardless of funder type, and be monitored and reported upon regularly.

## RECOMMENDATION 4

**That Australian and State/Territory Governments agree to release the latest version of the National Mental Health Service Planning Framework (NMHSPF) and support its ongoing development so that future reforms and service planning be informed by the NMHSPF and its subsequent iterations.**

Arising out of the Fourth National Mental Health Plan, the NMHSPF is the most comprehensive planning tool currently available in relation to mental health, developed through a comprehensive process of consultation with the mental health sector.

Through careful use, the NMHSPF could drive investment in mental health promotion, prevention and early intervention, which over the long term should ease demand on acute and crisis-driven services – a goal that many stakeholders share but is difficult to achieve in practice.

If the NMHSPF is not released in the near future, there is a risk of undermining the substantial contribution that many stakeholders made to its development and consequent loss of goodwill towards the jurisdictions involved.

## RECOMMENDATION 5

**That the NMHC carefully consider the practicalities and implications of applying Activity Based Funding (ABF) to community-based mental health services funded outside of the hospital system.**

If applied appropriately, ABF may have the potential to improve transparency and efficiency in mental health services through standardising reporting, clarifying where money is spent, and enabling benchmarking and comparison of different approaches and outcomes. It could also be a driver for innovative service models that can demonstrate better outcomes. Supported by appropriate infrastructure and training, accurate and comprehensive ABF models would also recognise and properly fund the important role of the community sector in relieving pressure on hospitals. Without these and other ways of allocating resources efficiently, we risk perpetuating the hospital-centric nature of the mental health 'system', for example through perverse incentives for states and territories to prioritise services they already provide at the expense of more efficient and more effective services.

## RECOMMENDATION 6

**That the NMHC consider and define the optimal roles and responsibilities of Commonwealth and State/Territory Governments in relation to mental health.**

Services available to consumers and carers are currently provided through a maze of fragmented and often ad hoc programs and service streams, with little national coordination or clear lines of accountability for outcomes. At a broad level, State/Territory Governments should have responsibility for service planning and delivery to ensure local needs are being met, and also for service management, including contracting and procurement with a focus on outcomes rather than activity.

For its part, the Commonwealth should provide national leadership and hold responsibility for areas in which national consistency is critical. This would include, for example, minimum standards of service delivery, workforce accreditation, and data specifications. It should also ensure monitoring and reporting on those standards and against agreed outcome measures through an independent national mental health 'watch-dog', to which jurisdictions would be required to regularly provide data as a condition for ongoing funding. The Commonwealth should also take the lead in areas that do not require or recognise state boundaries, such as where nationally-consistent information technology platforms and quality standards are used or required.

## RECOMMENDATION 7

**That the NMHC consider the potential efficiencies in improving information management systems regarding mental health, including consistency in system standards and interoperability and data exchange between systems (including but not limited to personally controlled electronic health records).**

Service providers consistently report considerable duplication and inefficiency across services and programs in the collection, management and reporting of information, requiring significant resources in terms of both time and financial investment. Consumers and carers

also express frustration that existing systems are not accessible to or controlled by consumers, or portable between services. A better coordinated approach to data management, including for recording service history and outcomes information, would facilitate service integration and coordination. While issues around privacy and confidentiality would need careful consideration, a more coordinated approach would ultimately increase the effectiveness of services and provide better insight into progress towards better outcomes for consumers and carers.

## RECOMMENDATION 8

**That the NMHC consider how better use of information technology could deliver more diverse and more effectively targeted services, and better manage demand for services.**

Wide penetration of web technology provides significant potential to provide effective and efficient services in ways that go beyond traditional service models. Interactive online services, internet resources, mobile apps and other avenues for self-managed care should be openly accessible, given that they are easily scalable and therefore have capacity to meet virtually unlimited levels of demand.

Improving the effectiveness and awareness of such services, integrating them into service models and pathways, and using them as a first line of care where possible, could deliver significant efficiencies through early intervention. Importantly, such services need to be aligned with other pathways to care to ensure that people with higher-level needs are quickly identified and referred to more appropriate services. Such approaches would also help to efficiently divert demand from more expensive services, so that clinical and other professional services can target their specialist skills towards those consumers who would benefit most.

## RECOMMENDATION 9

**That COAG develop and agree to a new National Agreement for Mental Health as a nationally unifying and authoritative strategy for mental health reform over the longer-term.**

A new National Agreement should be the primary mechanism for a sustained and coordinated approach to mental health in Australia. It would have much the same role, structure, authority and operation as the National Indigenous Reform Agreement (NIRA). That is, it would:

- commit all governments to the achievement of high-level objectives and outcomes in mental health;
- provide an authoritative mechanism for specific targets and indicators for reform;
- enshrine key principles such as the centrality of the recovery framework, consumer and carer engagement, and prevention and early intervention;
- clearly set out the roles and responsibilities of each level of government;
- shift incentives towards more effective, evidence based outcomes;



- explicitly state that achieving mental health outcomes requires coordinated and integrated efforts across all jurisdictions, all portfolios and all sectors (including in physical health, early childhood, education, employment and housing); and
- guide planning and implementation of reforms over the longer-term (including, for example, by reference to minimum service standards).

Also consistent with the NIRA model, a Specific Purpose Payment would not necessarily be attached to a new National Agreement for Mental Health. Instead, jurisdictions would be accountable for progressing mental health outcomes in various service contexts and across portfolios, leveraging existing streams of funding (including existing Specific Purpose Payments), and activity across mainstream social services.

As with other COAG agreements, the specific activities to be pursued under a new National Agreement would be outlined in detail in individual State and Territory Implementation Plans. The National Agreement would also guide the content of any bilateral or multi-lateral arrangements between the Commonwealth and States/Territories in relation to specific reforms. For example, National Partnership Agreements could provide reward funding for jurisdictions that achieve certain milestones in progressing towards agreed mental health targets, or provide incentives for jurisdictions to explore more efficient and sustainable models of funding for non-government organisations across all social service areas, with trials or pilots conducted on a regional-basis.

## RECOMMENDATION 10

**That government responses to the outcomes of the NMHC’s review should occur over a period of carefully managed transition.**

This submission has identified a number of complex, high-level, system-wide options for reform that are likely to drive progress towards a better mental health system and ultimately towards better outcomes for consumers and carers. These options are not quick fixes, and will require sustained effort and commitment from governments and non-government organisations across the health, mental health and social services sectors, as well as from consumers and carers.

The NMHC’s review is taking place in a period of great uncertainty, particularly given the potential impact of the National Disability Insurance Scheme on the service landscape. It will be important to learn from the lessons of implementing psychosocial disability support through the NDIS, and ensure that any future directions are consistent with efforts to improve those processes.

Any decisions made in the near term should be consistent with a long-term vision, ensure that service capability is maintained, and, especially, should provide continuity of support for mental health consumers and carers. Importantly, this means that:

- any savings identified in the course of the NMHC’s review should be reinvested within the mental health system; and
- the recommendations of the NMHC’s review should stipulate that there be no overall reduction in services for people with experience of mental illness compared with the status quo.

# APPENDIX C

## PRINCIPLES TO UNDERPIN GOOD MENTAL HEALTH, AS DRAWN FROM KEY POLICY DOCUMENTS

The **National framework for recovery-oriented mental health services** domains are:

- Promoting a culture and language of hope and optimism
- Person-first and holistic approaches
- Supporting personal recovery, including autonomy and self-determination, collaboration, strengths-focus and personal responsibility
- Organisational commitment and workforce development
- Action on social inclusion and the social determinants of health, mental health and wellbeing.

The **Contributing Life Framework**, as presented in the NMHC's national mental health report cards:

- Thriving, not just surviving
- Connections with family, friends, culture and community
- Ensuring effective support, care and treatment
- Something meaningful to do, something to look forward to
- Feeling safe, stable and secure
- Preventing suicide

Domains of the **National Mental Health Targets and Indicators**, presented by the COAG Expert Reference Group on Mental Health

- good mental health and wellbeing;
- good physical health;
- living meaningful and contributing lives;
- positive experiences of support, care and treatment;
- fewer experiences of avoidable harm; and
- fewer experiences of stigma and discrimination.

The principles underpinning the **National Summit on Addressing the Premature Death of People with a Mental Illness**, held on 24 May 2013, include that

- People with serious mental illness should have the same expectations of a rich and contributing life as the general population. This includes having good mental health, physical health and wellbeing as well as the same access to timely and quality health care and the other supports and services critical to a contributing life.

- To achieve these improvements, there is need for the active engagement of all relevant portfolios across governments, noting the importance of a rehabilitation and recovery framework.
- Any action to reverse this trend must be informed by the experience and knowledge of individuals living with mental illness and also that of their families and carers.

The vision presented by the **COAG Expert Reference Group on Mental Health** in its report on National Mental Health Targets and Indicators is that in Australia in 10 years' time there will be:

- Reduced prevalence of mental illness and suicide
- Increased understanding of and improved attitudes towards mental illness resulting in changed behaviour
- Increased funding allocated to, and spent on, mental health in particular community services, promotion, prevention and early intervention, as a percentage of GDP (to be determined by the Productivity Commission). An interim target is that the proportion of funding on mental health from the health budget should be at least 13% which is equal to the burden of disease

Regarding the **United Nations Convention on the Rights of People with Disability**, Disability Discrimination Commission, Greame Innes AM, has commented:

*Importantly, the Convention makes a significant shift away from the medical model of disability towards a social model of disability. This demands the development of different solutions to redress the current situation.*

*The Convention recognises that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.*

The **Mental Health Statement on Rights and Responsibilities** (1991 and revised in 2012) addresses eight domains where rights and responsibilities are relevant to mental health: Part I: Inherent dignity and equal protection

- Part II: Non-discrimination and social inclusion
- Part III: The promotion of mental health and the prevention of mental illness
- Part IV: The rights and responsibilities of individuals who seek assessment, support, care, treatment, rehabilitation and recovery, regarding:
  - High-quality, integrated, recovery-focused and accountable services
  - The right to mental health care
  - Involuntary admission and treatment
  - Children and young people
- Part V: Rights and responsibilities of carers and support persons

- Part VI: Rights and responsibilities of people who provide service
- Part VII: Rights and responsibilities of the community
- Part VIII: Governance, including
  - Standards and accountability
  - Mental health legislation
  - Mental health and forensic matters

The logo is a stylized white flower with eight petals and a dark blue center, set against a light blue background.

Mental Health  
Council of Australia

*Mentally healthy people, mentally healthy communities*