Mental Health Australia

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Submission to the Department of Health – Priorities for Mental Health Reform

SEPTEMBER 2015

Contents

1. Introduction

The second half of 2015 is a crucial time for Australia's mental health sector. During this period the mental health sector is expecting:

- A comprehensive response by the Commonwealth Government to the National Mental Health Commission's Review of Mental Health Programmes and Services ('the NMHC's Review' or 'the Review');
- Multilateral agreement by all state/territory and Commonwealth governments on the *Fifth National Mental Health Plan;* and
- Bilateral agreements between most states/territories and the Commonwealth detailing the transition of existing programmes (including mental health programmes) into the National Disability Insurance Scheme (NDIS).

Mental health reform has been on hold since November 2013, when the Government announced the NMHC review. Since that time, there have been no significant policy or funding announcements on mental health, with the exception of temporary extensions of existing contracts. For example, in May 2014 and June 2015 contracts with NGO providers for Commonwealth-funded mental health programmes were extended for six or 12 months, but with no funding commitments made beyond that term. These short-term funding extensions created unprecedented and ongoing uncertainty for the people who use these programmes and the mental health workforce who deliver them.

There are several other important processes in train with major implications for mental health reform, including the Reform of the Federation White Paper process, the review of primary health care and the review of the Medicare Benefits Schedule.

These processes must align if we are to avoid reinforcing the fragmentation and discoordination the NMHC recently identified as being at the core of system failure.

This submission conveys the views of Mental Health Australia's member organisations on some of the major areas of reform proposed by the Review. It is intended to supplement the recommendations in the *Blueprint for Action on Mental Health* by addressing two key sets of issues:

- The Department of Health's questions for consultation, recently circulated to participants at the Department's stakeholder workshop on 6 August 2015
- Key recommendations in the Review that have drawn comment from Mental Health Australia's member organisations.

1.1 Mental Health Australia's role in reform

Government commitment to reform is absolutely necessary, but on its own will not be enough to drive sustainable improvements in mental health outcomes. Past efforts at mental health reform in Australia have foundered on the task of putting priorities into action. There has been no shortage of well-intentioned policy and plans. The failure has been in implementation.

Successful implementation of any reform agenda will require the mobilisation of the whole mental health sector. Mental Health Australia is well placed to facilitate and assist in this work.[1]

Successful reform in mental health will require many small steps towards longer-term goals. It will require various parties to work together in new ways. It will require problem solving and goodwill when interests conflict. It will require locally-driven solutions to address the particular challenges that have prevented adequate progress to date. Previous reform processes have not invested adequately in these change management imperatives – to their detriment.

Mental Health Australia is ready to work with Government, our member organisations and other stakeholders to secure the success of mental health reform over the course of the next decade. If appropriately resourced by Government, Mental Health Australia can continue to support positive change and even expand this work. This would involve building the capacity of the sector to engage in reform, helping Government to negotiate the risks associated with planning transition and managing change.[2]

By tapping into Mental Health Australia's diverse membership and broad networks, reform is much more likely to deliver sustained improvements in mental health outcomes – ultimately benefiting all governments and the community.

[1] Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector. It was established in 1997 as the first independent peak body in Australia to represent the full spectrum of mental health stakeholders and issues. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies. Information about Mental Health Australia's span of influence is at Attachment 1.

[2] In a separate submission to the Department of Health in March 2015, Mental Health Australia proposed ten projects to support reform which are consistent with the comments and recommendations in this submission.

2. Key messages for Government

Throughout 2014, we consulted widely among our networks to identify reform priorities and communicate these to the NMHC. These discussions led to our *Blueprint for Action on Mental Health* (attachment 2), a set of 45 recommendations that formed Mental Health Australia's fourth and final submission to the Review on behalf of the broader sector in November 2014. The *Blueprint* is the standard by which Mental Health Australia will assess government decisions on mental health. Its recommendations remain current and pressing, and have the endorsement of the broader non-government mental health sector.

It is encouraging there is so much consistency and congruence between the *Blueprint* and the NMHC Review. Both reports acknowledge there are few easy fixes available to improve Australia's mental health arrangements. Each recognises fundamental systemic changes are required if we are to see long-term improvements in mental health.

More recently, Mental Health Australia held a consultation forum on 5 August 2015. Representatives of around 60 non-government organisations came together at short notice, to provide input to the Department regarding the recommendations in the Review. Members and stakeholders reached overriding consensus on the following messages for government.

- Government must embrace the sector as partners. **The reform process must be a true partnership between governments, consumers, carers, providers, clinicians and other experts**. The current focus on policy must be matched by an even stronger focus in future on its implementation and only partnership will guarantee the success of implementation.
- **We must invest in strong community based mental health services outside the NDIS**. While the NDIS will deliver much-needed support for a relatively small population, there will be a larger population of people with moderate to severe mental illness whose needs fluctuate over time, and whose circumstances are not suited to the NDIS model. **Consistent with the Review's recommendations,[3] programmes currently in scope for the NDIS should not be cashed out**, but should instead continue to be delivered through existing funding mechanisms until the NDIA demonstrates it is better able to meet the needs of the population that each programme serves. These programmes include (at a Commonwealth level) Partners in

[3] Recommendation 3(2): 'Do not cash out existing mental health and other associated programmes (e.g. carer and respite programmes) into the NDIS until there is evidence as to eligibility for people with a psychosocial disability, and clarity about ongoing support for those who are eligible for Tier 2 support.'

Recovery (PIR), Personal Helpers and Mentors, Day to Day Living in the Community and Targeted Community Care: Mental Health Respite.

- Our members anticipate substantial risks in the proposed role of Primary Health Networks (PHNs) as the regional architecture for mental health services. While welcoming initiatives to promote better local integration and control, there is, as yet, little to reassure mental health stakeholders the governance arrangements in PHNs sufficiently reflect the diversity of services for mental health consumers and carers and guarantee minimum standards of care. Without such diversity, there is anxiety that the full range of interventions available beyond the hospital campus or the GP clinic may be undervalued. In addition, mechanisms must be in place to share lessons and strategies at the national level, and to ensure transparency and accountability at different levels of the changing mental health system. **There is much to be done before the broader mental health sector can embrace the central role for PHNs envisaged by the Review**.

- There is also a clear risk of delays further reducing sector capacity as an unintended consequence of ongoing delays in securing funding. Given the cumulative impact of the ongoing funding uncertainty – impacts such as reduced access to services and loss of workforce – it is important the Government takes active steps in the near term to provide security for people who rely on services and programmes for support, and security for the workforce who will be needed to deliver the services and programmes of the future. **As a matter of urgency, the Commonwealth Government should adopt and implement a Transition Plan aimed at minimising any further reduction in sector capacity or service access.**

- **Government commitment to reform is absolutely necessary, but on its own will not be enough to drive sustainable improvements in mental health outcomes.** Past efforts at mental health reform in Australia have foundered on the task of putting priorities into action. There has been no shortage of well-intentioned policy and plans. The failure has been in implementation. Successful implementation of any reform agenda will require the mobilisation of the whole mental health sector. Mental Health Australia is well placed to facilitate and assist in this work.

Building on these key messages, the sections that follow provide further detail in response to specific questions recently circulated to stakeholders by the Department of Health.

3. Promotion, prevention and early intervention

Australia's health funding system is disproportionately skewed towards acute care and crisis management, with this imbalance perhaps most evident in mental health. Mental Health Australia supports the NMHC Review's recommendation that the balance of investment be recalibrated away from hospitals and acute services to promotion, prevention and early intervention (PPEI). In keeping with the Review's recommendations, this need not mean a reduction in funding for acute care, but rather a staged redirection of growth funding.

Promotion, prevention and early intervention across the life cycle

Promotion, prevention and early intervention should not just be focussed on children and young people. Instead, PPEI needs to occur throughout a person's life, as well as in the early stages of illness being identified. In particular, promotion and prevention could be focussed on key points of risk in a person's life, such as marriage, the birth of new children, having teenagers, divorce, losing a job, etc.

In this context, programmes like the National Perinatal Depression Initiative, which was specifically focussed on PPEI, need to be funded and expanded.

Integrating mental health expertise into other health system interactions and improving mental health awareness of frontline human services workers

Children and young people engage with a variety of different health services, including local council health centres, school-based health programmes, as well as private GP practices. This provides significant opportunities to integrate mental health PPEI into the broader health system. Protocols around immunisations, the Healthy Kids Check, and state-based development checks should be updated to include a clear focus on mental health issues.

The benefits of integrating mental health with the school system have been shown in Queensland. The Ed-Linq programme aims to support collaboration across sectors to enhance the early detection and treatment of mental illness affecting school-aged children and young people, by ensuring school staff know how to identify when a student is at risk of, or is experiencing, mental illness.

Using savings generated in the Disability Support Pension and the NDIS

The NMHC Review observed that the majority of Commonwealth mental health funding is directed at the Disability Support Pension (DSP) and carer payments (60 per cent), and a

further 11 per cent for hospital funding. This suggests savings and efficiencies are more likely to be found in these areas, not in the six per cent spent on programmes delivered by NGOs. The Review argued governments' collective response should be directed at minimising those 'acute' costs through prevention and early intervention. Mental Health Australia strongly endorses these arguments.

Recent changes to DSP arrangements (unrelated to the NMHC Review's recommendations) mean government-employed doctors (rather than the claimant's personal GP) now assess new DSP claims and reviews of existing DSP claimants. This approach is designed to reduce DSP expenditure and encourage more people into work. Government announcements indicate there has already had been a significant reduction in DSP approvals following these changes.[4] Mental Health Australia's rough estimate is the new approach could save the government in excess of $800 million per year,[5] of which approximately $250 million per year can be attributed to mental health.[6] There is a clear case for re-investing these savings into the mental health system, particularly PPEI.

Similar arguments can be made with respect to the NDIS, which is designed to support people to participate in the community, including in paid employment where possible. Indeed, such arguments were at the heart of the Productivity Commission's economic and policy rationale for such a major investment in disability services, and is a key tenant of the insurance model.

The NMHC's Review makes the same case regarding savings generated by successful investments in the mental health system. Applying the same logic: any attributable savings in the NDIS, or other systems associated with successful NDIS supports (e.g. in acute psychiatric hospital services), could reasonably be reinvested in PPEI. Such services might be delivered through Information, Linkages and Capacity Building (ILC) or through services in the community funded beyond the NDIS.

RECOMMENDATIONS

The Commonwealth Government should:

- track reductions in DSP and NDIS expenditure attributable to people with mental illness, and then re-invest any savings in prevention, early intervention and other services that help reduce the risk of people with mental illness and/or psychosocial disability becoming eligible for the NDIS when their circumstances worsen. This aligns with NMHC recommendations 7 & 12.
- improve and expand the planning and delivery of e-mental health, as set out in recommendations 11-16 of Mental Health Australia's *Blueprint*.[7] This aligns with NMHC recommendations 10, 11 & 25;
- assess mental health impacts on a whole-of-government basis and recognise cross-portfolio returns on investments, as set out in recommendation 30 of Mental Health Australia's *Blueprint*.[8] This aligns with NMHC recommendation 7.

4 http://www.yourlifechoices.com.au/news/14423/20150714/dsp-approval-rates-hit-new-low

5 49299 people x $648.40 per fortnight (couple each payment) = $831m p.a. Some people will receive less than $648.40 per fortnight, due to income or assets. Others will receive more, as singles can receive up to $860.20 p/fn.

6 http://www.theaustralian.com.au/national-affairs/mentally-ill-may-lose-disability-support-pension-welfare-head-patrick-mcclure-suggests/story-fn59niix-1226971977282

[7] The *Blueprint* is available at http://mhaustralia.org/submission/blueprint-action-mental-health and is at attachment 2 to this Submission.

- finalise and adopt the National Mental Health Service Planning Framework (NMHSPF), which should provide guidance on more appropriate levels of investment for mental health promotion and prevention, as compared with acute hospital-based services. This aligns with NMHC recommendation 8.
- continue to focus on reducing stigma, which the NMHC has identified as leading to lower rates of help-seeking and treatment. This aligns with NMHC recommendation 11.
- improve mental health training for frontline workers across human service delivery - not just health - including, education, justice and housing. This aligns with NHMC recommendations 11, 19, 22 & 23.

[8] Recommendation 30: Treasury and/or Finance Departments of all governments should use existing internal processes such as new policy proposals and Regulation Impact Statements to identify the potential impacts of policy changes on mental health outcomes, including impacts that may be significant across portfolios and jurisdictional boundaries. Treasury and/or Finance Departments of all governments should also reconfigure their Budget rules in order to allow Ministers to account for savings in one portfolio as a result of investment in another portfolio, and to better recognise longer-term down-stream savings that stem from government investments in areas such as psychosocial services, employment supports and securing stable housing.

4. Primary mental health care

Mental Health Australia and its members recognise that, conceptually, there could be significant benefits to a strong, regional model, as proposed in the NMHC Review. The importance and benefits of a localised model have been highlighted in a recent review of PIR programmes across Victoria (attachment 3). However, our members anticipate substantial risks in adopting the Review's recommendations on the role of PHNs as the principal architecture for planning and funding mental health services, without significant safeguards to ensure access to the full range of services is not unintentionally lost in a period of transition and change.

While the sector supports initiatives to promote better local integration, there is little to reassure stakeholders that governance arrangements in every PHN are sufficient to reflect the diversity of services mental health consumers and carers need. For example, there is no specific requirement for PHNs to include mental health or broader social service providers on their Boards, Clinical Councils or Community Advisory Committees. The Victorian PIR review found that cross-sectoral partnerships, especially with mainstream services (such as education, housing, transport and employment) are vital to successful system change in the interests of mental health consumers and carers, and it takes time to develop these trusting relationships and effective referral pathways.

Non-government mental health stakeholders worry that putting PHNs at the heart of mental health reform without appropriate governance arrangements, accommodating the full range of relevant services for mental health consumers and carers, may inadvertently shift resources from community-based services to more clinically focussed medical services. Stakeholders are also concerned about the disruption that pooling funds through PHNs may cause for programmes which are currently delivered successfully (though not necessarily at the right scale) through the community mental health sector. At this early stage in the PHN initiative, there is much to be done to ensure the central role for PHNs envisaged by the Review.

RECOMMENDATIONS

The Commonwealth Government should:

- require that all PHNs:
    - include mental health and other community-based service providers (working in housing, employment, disability, social work, local police etc) on their Boards, Clinical Councils and/or Community Advisory Committees;
    - demonstrate how they include the input of people with lived experience of mental illness in planning and commissioning services for mental health

consumers and carers; and

    - demonstrate the impact of their work outside the clinical health arena, including service access, use and satisfaction by mental health consumers and carers.

- guarantee that mental health services and funding are not diminished, or diverted to other areas of PHN responsibility, and report accordingly.
- introduce strong mental health KPIs for PHNs, consistent with the national targets and indicators recommended by the Council of Australian Governments (COAG) Expert Reference Group in 2013.
- ensure appropriate national standards and reporting processes for co-ordinating the 31 PHNs, to avoid duplication of effort, ensure an overarching, national view and to engage directly with mental health stakeholders at local, regional, state/territory and national levels.
- trial pooled funding, with a transparent, independent evaluation to be completed and any recommendations adopted, before wider rollout.
- consult further with the sector on the PHN performance framework.
- invest in the capacity of the community-managed mental health sector to:
    - engage effectively with any new service and funding arrangements arising out of the PHN initiative, such as through robust referral pathways well beyond the clinical system;
    - identify and collect data associated with client and system outcomes, so as to better demonstrate improvements in performance and identify success factors;
    - remain financially viable in a period of transition so as to ensure continuity of, and growth in, service availability.

5. Suicide prevention

Suicide prevention cuts across mental health, alcohol and drug policy, and broader social policy. Risk factors for suicide include the impact of mental illness, suicide bereavement, lack of access to timely professional support, interpersonal relationship problems, pressures of work, drug and alcohol misuse, experiencing abuse or sexual assault and many more. Mental illness and suicide bereavement are particularly important factors, but are by no means the only contributors to suicide.

Misunderstanding, stigma, and judgemental attitudes are a key barrier to help-seeking. They are pervasive and severely undermine people's willingness to talk about their suicidal thoughts and feelings. Attempted suicide is the single biggest risk factor to eventually dying by suicide, so by understanding how we can help and support people both before and after attempted suicide, we can work towards making a significant reduction in the suicide rate in Australia.

A key problem in this area, like the broader mental health and health fields, is a lack of translation from research into practice.

There are a number of examples of co-ordinated, regional, approaches to tackle suicide. The European Alliance Against Depression initiative included providing 'emergency cards' for people with emerging suicide risk, offering them immediate access to any service they need. This initiative has helped reduced the suicide rate in these areas by 25 per cent. The WA Mental Health Commission established regional Community Coordinators, to identify and map existing suicide prevention activities and determine the need for new initiatives. These initiatives suggest that much can be done to improve suicide prevention efforts at the local level. However, such local action will require national leadership, both from the Commonwealth Government and from the National Coalition for Suicide Prevention, led by Suicide Prevention Australia.

RECOMMENDATIONS

The Commonwealth Government should continue to have a strong and active role in suicide prevention, including:

- adopting strong suicide prevention targets at a national level, linked to indicators at regional levels. This aligns with NMHC recommendations 4 & 19.
- urgently establishing nationally consistent routine data collections for suicides and suicide attempts. This aligns with NMHC recommendation 19.
- supporting improved suicide awareness training for frontline staff likely to come into contact with vulnerable people, as well as general population literacy. This aligns with

NMHC recommendation 19.

- a continuing focus on reducing stigma, particularly in communities with higher suicide rates. This aligns with NMHC recommendation 11.
- supporting community-based suicide post-vention. This aligns with NMHC recommendation 19.
- supporting helpline funding and administration, as set out in recommendation 16 of Mental Health Australia's *Blueprint*.[9] This aligns with NMHC recommendations 19 & 24.
- supporting translational research, such as the proposed national mental health research and clearinghouse hub,[10] to identify and promote successful approaches, both internationally and at a local level. This aligns with NMHC recommendation 20.
- supporting the National Coalition for Suicide Prevention's efforts to establish co-ordinated and evaluated suicide prevention activities in key locations across Australia.

[9] Recommendation 16: The Commonwealth should support a nationally-coordinated system of helplines for mental health support, crisis intervention and suicide prevention, by providing ongoing funding for administration and operations, national telephony infrastructure and targeted ongoing work to develop referral pathways and integration between helplines and other supports and services. Implementation of this proposal should be consumer- and carer-driven and led from within the community-sector, in partnership with private and public mental health stakeholders.

[10] http://mhaustralia.org/sites/default/files/civicrm/persist/contribute/files/Project%20proposal%20-%20Mental%20Health%20Australia%20and%20National%20Institute%20for%20Mental%20Health%20Research.pdf

6. Fifth National Mental Health Plan

Both the NMHC and Mental Health Australia have called for clarity and certainty on Commonwealth/state responsibilities in mental health. Unfortunately, the current Reform of the Federation process creates significant uncertainties regarding roles and responsibilities in mental health. The Fifth National Mental Health Plan should allow for more detailed work, involving the government and NGO sector, to plan and implement coordinated action once roles and responsibilities are more clearly defined by COAG.

When the Government released the Review, the Minister for Health set three criteria for success – any long-term approach to mental health had to be "co-ordinated", "binding" and "national".

RECOMMENDATIONS

All governments should ensure that any mental health agreement is:

1. **"Co-ordinated" and "national."** The Fourth National Mental Health Plan explicitly recognised the need for a whole-of-government approach, extending beyond the mental health sector. However, the Fourth Plan was only endorsed by health ministers, rather than First Ministers or COAG.

   Mental Health Australia calls on First Ministers to endorse the new national agreement on mental health – not health ministers or bureaucrats. The agreement should recognise and articulate a clear and ongoing role for people with lived experience of mental illness and their carers. It should also recognise the clinical, NGO and private sectors as genuine partners in planning, implementation and evaluation.
2. **Funded.** Governments must allocate sufficient funding to implement the agreement successfully and ensure outcomes and expenditure are regularly and transparently reported.
3. **Meaningful.** The agreement needs to contain genuine accountability and reporting mechanisms, including specific, realistic, measurable actions. Without accountability no agreement can be considered "binding". Accountability measures should include, at a minimum:
   a. adopting and reporting on the targets and indicators recommended by the Expert Reference Group that reported to COAG in September 2013;
   b. a stronger NMHC tasked with collating and reporting both Commonwealth and state/territory data on COAG-endorsed targets and indicators, and with

improving national approaches to data collection; and

c. improved governance arrangements, including enhanced co-ordination between the COAG Disability Reform Council, the COAG Health Council and the mental health sector, through regular joint meetings and joint working groups of officials across portfolios.

4. **An improvement.** The agreement should guarantee access to community support services for all Australians with lived experience of mental illness and their carers. This would take us much further towards the "no wrong door" policy that governments have agreed in principle, but to date is rarely achieved in practice.

This aligns with NMHC recommendation 2.

7. Support for people with severe illness – ambiguity of responsibility

The NMHC Review called on the Government to 'urgently clarify the eligibility criteria' for the NDIS, as well as making recommendations about:

- ensuring people with lived experience and carers are involved in sector consultation about the future of the NDIS;
- including respite for carers in NDIS package arrangements;
- ensuring carers are involved in the planning process, and provided with separate support to develop their own goals and identify their support needs; and
- conducting detailed modelling on the interaction between clinical mental health supports, community supports, and the NDIS.

Mental Health Australia strongly supports these recommendations, and points to our recent analysis of the draft National Mental Health Service Planning Framework (attachment 4) as a starting place.. The Review reinforces Mental Health Australia's ongoing concerns about the uncertain future for the mental health sector as we near the NDIS transition period.

Funding for services prior to NDIS acceptance and plan approval

There is significant concern that some of the most disadvantaged people, who are likely to be eligible for the NDIS, will 'fall through the gaps' because there will not be adequate outreach programmes to identify and support them through the process of recognising the NDIS could be of benefit for them, and applying to enter the Scheme.

This kind of support – which ideally would include assertive outreach based on a recovery paradigm – cannot practically be part of a NDIS Individually Funded Package, as the support is needed before a person (potentially) becomes a participant. The ILC Framework recognised that pre-planning support is 'in-scope' for ILC-funded services. However, the Framework does not clarify the level of support that may be available for people with complex needs before entry into the NDIS.

The Department of Social Services have recognised there will be some people who require active assistance to become NDIS participants, but it is not clear how this will occur.

RECOMMENDATION

All governments should provide sufficient funding, through ILC, or other systems, to provide comprehensive outreach and support for people with complex needs to help determine their eligibility, identify their goals and aspirations, become NDIS participants and provide pre-planning support, and/or help them access a range of other services necessary for recovery. This aligns with NMHC recommendation 3.

Clear commitment to a strong and vibrant community mental health system outside the NDIS

A significant contributor to the confusion and uncertainty in the sector is the lack of official recognition that the vast majority of people with severe disabilities associated with mental illness will not be eligible for an Individually Funded Package. Estimates of the number of Australians with severe mental illness vary, but based on Mental Health Australia's commissioned analysis of the draft National Mental Health Service Planning Framework (attachment 4), we believe approximately 289,000 people with a severe mental illness will need individualised "NDIS-like" community supports in any 12-month period. This is five times the estimated number of people with psychosocial disability forecast to be eligible for the NDIS.

It is currently unclear which levels and which parts of government, if anybody, have ultimate responsibility for servicing this group of people. Funding arrangements and jurisdictional responsibility appear to be split across future NDIS ILC supports, existing Commonwealth programmes across Health and DSS, and existing state/territory programmes across multiple portfolios. No one framework ensures policy accountability for this residual group and there is no policy entity to be held accountable. This is an unacceptable situation and cannot continue.

Just 10 months from the NDIS transition period, it is still not clear to what extent the Commonwealth, states and territories will continue to fund a community mental health system outside the NDIS. The mental health sector – NGOs, clinicians, consumers, carers and family members – need a clear commitment that the community mental health system will be maintained, and indeed strengthened, so it can continue to provide support to people with mental illness.

RECOMMENDATION

All governments should publicly commit to maintaining and strengthening the community mental health system outside the NDIS. This aligns with all of the NMHC recommendations.

The Commonwealth Government should not cash out mental health programmes currently in scope for the NDIS, but should instead continue to deliver these through existing funding mechanisms until the NDIA demonstrates it is better able to meet the needs of the population that each programme serves. These programmes include PIR, Personal Helpers and Mentors, Day to Day Living in the Community and Targeted Community Care: Mental Health Respite. This aligns with NMHC recommendation 3.

Surety for all people with severe mental illness – a guarantee of access

Community support services should be available for all Australians with a psychosocial disability and/or severe mental illness, including individuals who do not meet the access criteria for the NDIS.

Potentially, anyone who presents to the NDIA and meets the relevant criteria for access to the broader mental health "system", but does not meet the access criteria for the NDIS, could have their details provided to a nominated officer, who would broker referral arrangements and initiate contact with an appropriate service provider. This arrangement would require a screening tool or set of tools, and a clear service map linking funded service providers to target groups. These instruments do not yet exist in any systematic way – although there is much good work done at local levels already. Such good work must not be lost.

Tracking arrangements are also required to meet the existing continuity of support requirements agreed by governments. Data on individuals who are referred by the NDIA could and should be aggregated and publically reported, with information regarding entry into community support also reported. This would ensure there is accountability for governments, rather than contestation across portfolios about where responsibility lies. It would also provide more reliable estimates for future planning across systems.

RECOMMENDATION

All governments should guarantee access to community support services for all Australians with a psychosocial disability and/or severe mental illness, including individuals who do not meet the access criteria for the NDIS. This aligns with NMHC recommendation 4.

8. Support for people with severe mental illness – NGO sector capacity during NDIS transition

There is nothing in the Review recommending immediate changes to contracts, grants or other funding arrangements currently supporting non-government organisations working in mental health. Nevertheless, there is a clear risk of a government response that further reduces sector capacity as an unintended consequence of ongoing delays in securing Government funding. This would compound the problems the Review tries to solve. Given the cumulative impact of the ongoing funding uncertainty – impacts such as reduced access to services and loss of workforce – it is important the Government takes active steps in the near term to provide security of funding, thereby guaranteeing access to important services while reforms are considered and rolled out over time.

RECOMMENDATION

The Commonwealth Government should, as a matter of urgency, adopt and implement a Transition Plan aimed at minimising any further reduction in sector capacity or service access. The Transition Plan should cover all Commonwealth-funded programmes, including programmes in scope for the NDIS.

- For Commonwealth mental health programmes not in scope for the NDIS, extend contracts with NGOs until 30 June 2017 and include provision for automatic renewal of contracts for 12 months should decisions about that programme/service not be made by 31 December 2016.
- For Commonwealth mental health programmes notionally in scope for the NDIS, acknowledge the unique contribution each programme currently makes to Australia's mental health service mix by:
  - » Ensuring the services currently available through in-scope programmes to the broader population of mental health consumers and carers continue to be available from 1 July 2016 until policy settings and detailed jurisdiction implementation plans are fully developed and announced.
  - » Providing short- and medium-term certainty for future NDIS providers who

currently provide community-based mental health services, and who may be adversely affected by uncertainties in the lead-up to the NDIS Transition Period, by extending contracts under those programmes up to 30 June 2018.

- Including measures to avoid the unintended consequences of NDIS rollout observed in trial sites, consistent with lessons from NDIS trial sites (or the lack thereof) to date.

These align with NMHC recommendation 3.

Continuity of services during transition

Prior to the end of 2015, governments must make unambiguous decisions about the future of programmes and services that are notionally in scope for the NDIS, as well as decisions about the level of funding available for ILC and other support services in adjacent systems.

It is important to note this is not a notional problem of the future, but a real problem today. Organisations providing services contracted to 30 June 2016 are already facing problems maintaining their workforce. Realistically, a staff member replaced today can only be offered a contract of approximately 10 months given the current uncertainty about future funding. This is a real barrier to service continuity during transition and is becoming more urgent by the day.

All governments have recognised the importance of assisting service providers to transition some programmes from block funding to individualised funding. While the NDIS is rolling out, there is a risk of significant fluctuations in provider income, as plans are developed and approved and the market is created. Consequently, some essential services may not be available for people who need them. Until proper transition plans are developed and published, widespread uncertainty and confusion will continue – with ongoing and major impacts on community mental health services and the workforce that deliver them.

Mental Health Australia believes the Commonwealth Government should guarantee that, for three years, existing Health- and DSS-funded service providers in programmes being rolled into the NDIS, will receive at least the same amount, indexed for inflation, that they received immediately prior to NDIS rollout.[11]

As the NDIS is forecast to roughly triple expenditure on mental health and disability services, such a funding guarantee should not be a significant concern to governments, but would provide the sector with the certainty it needs to survive over the transition period. This approach would avoid the need to change transition schedules or bilateral agreements, while ensuring service providers have the certainty they need to invest in the future. This investment in sector capacity would pay longer-term dividends for both governments and NDIS participants by shielding future suppliers of NDIS-funded services from unnecessary disruption during a period of policy uncertainty.

[11] This is not the first policy area where governments have moved from block funding to some form of individualised funding. In 2011, governments agreed all hospital services should transition from block funding to activity based funding (ABF). The Commonwealth "guaranteed" no state would be worse off in the short term, agreeing that if a state's ABF-based funding was less than the amount they would have received under the previous system, the Commonwealth would provide top-up funding during the transition (see clauses 15, A67 & A68 of the *National Health Reform Agreement*).

RECOMMENDATION

The Commonwealth Government should provide a funding guarantee to existing community-managed mental health service providers for three years following the commencement of the NDIS in their jurisdiction or locality. This aligns with NMHC recommendation 3.

9. Broader considerations

9.1 Supporting change management

The Review noted that current funding arrangements support a focus on activity and inputs rather than outcomes. This has been the case for too long and has worsened in recent years. Mental Health Australia's recent consultations indicate systemic problems in the way all governments commission and contract services across the human services sector, both in mental health and beyond. Such problems include:

- siloed decision making by government agencies without adequate reference to guiding strategies or overarching policy goals that often work to exclude local organisations bringing important social capital to the table, in favour of larger corporate entities who have scale and cash resources;
- short-term contracts and funding insecurity that undermine service providers' capacity to plan ahead, and which impact adversely on workforce retention and continuity of services for consumers and carers;
- onerous tendering, compliance and reporting requirements - red tape - that contribute little to the achievement of policy or project goals;
- lack of consistency in reporting and data requirements and failure to make best use of the data collected;
- inequitable conditions such as the right for governments to terminate contracts without due care; and
- failure to include community sector input into programme and project design.

There are many reasons why these failures must be of concern to governments. They undermine the quality, coherence and effectiveness of the services government can buy. They undermine the non-government supply chain on which governments increasingly depend to deliver community services.

These problems were well-documented by the Productivity Commission (PC) in its 2010 inquiry into the contribution of the not-for-profit sector. Mental Health Australia's commissioned research, soon to be released, explains why reforms to commissioning and contracting practices, in line with the PC's recommendations, must be in place for the community mental health sector to grow, thrive, and take pressure off other service systems.

The Review recognised the importance of building NGO capacity and capabilities. This requires further cross-government work, carried out in partnership with the non-government sector.

Change management – a genuine partnership

Successful implementation of this reform agenda will require the mobilisation of the whole mental health sector, and a genuine partnership between the sector and government.

RECOMMENDATION

All governments should, at a minimum:

- reintroduce consumer, carer and non-government sector representation on the Mental Health, Drug and Alcohol Principal Committee (MHDAPC) and other relevant working groups. This aligns with NMHC recommendation 2.
- continue to provide targeted funding for organisations within the mental health sector that assist government to navigate and overcome implementation challenges, including by building capacity, consulting across the sector and identifying areas for system improvement, as well as information dissemination, policy translation and ongoing advice to government on sector-specific issues. This aligns with NMHC recommendation 9.
- support the ongoing engagement of consumers and carers in all levels of policy making and implementation. This aligns with NMHC recommendation 2.
- articulate a clear and central role for consumers, carers and NGOs in the 5th Plan. This aligns with NMHC recommendation 2.

9.2 Workforce

In addition to broader support for mental health workforce development, Mental Health Australia agrees the peer workforce must play a central role in the future mental health system and endorses NMHC recommendations 19, 21 and 22.

RECOMMENDATION

The Commonwealth Government should:

- adopt recommendation 5 in Mental Health Australia's *Blueprint*[12] and Health Workforce Australia's Mental Health Peer Workforce Study, many of which directly relate to workforce planning and infrastructure.
- adopt the NMHC recommendations on peer workforce development guidelines and data sets, which will support workforce planning.
- support mental health services to embed peer workers in their organisation.[13]

[12] Recommendation 5: The Commonwealth should provide funding and support to develop a trained professional mental health peer workforce, as well as incentives to integrate peer workers into all mental health services, multi-disciplinary teams and accident, emergency and other first responder services. This includes developing and implementing a national mental health and psychosocial support peer workforce development framework, as recommended by Health the National Mental Health Commission.

[13] In the United Kingdom, the Implementing Recovery through Organisational Change programme (ImROC) identified that many organisations required extensive support to introduce peer workers. Issues identified included a lack of understanding of the peer worker

9.3 The needs of Aboriginal and Torres Strait Islander people

Mental Health Australia endorses the NMHC Review's recommendations on Aboriginal and Torres Strait Islander mental health. We note the Government committed to consult the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) in the development of the Government's response to the NMHC Review.

RECOMMENDATION

The Commonwealth Government should support appropriate data development to ensure adequate measurement regarding mental health amongst diverse populations, including Aboriginal and Torres Strait Islander peoples.

position works; the value of peer work and perceived lack of 'legitimacy'; and stigma associated with being identified as someone with a mental illness. Both the Western Australian Association for Mental Health (WAAMH) and ImROC have developed extensive resources to support the implementation of peer work in services.

10. List of attachments

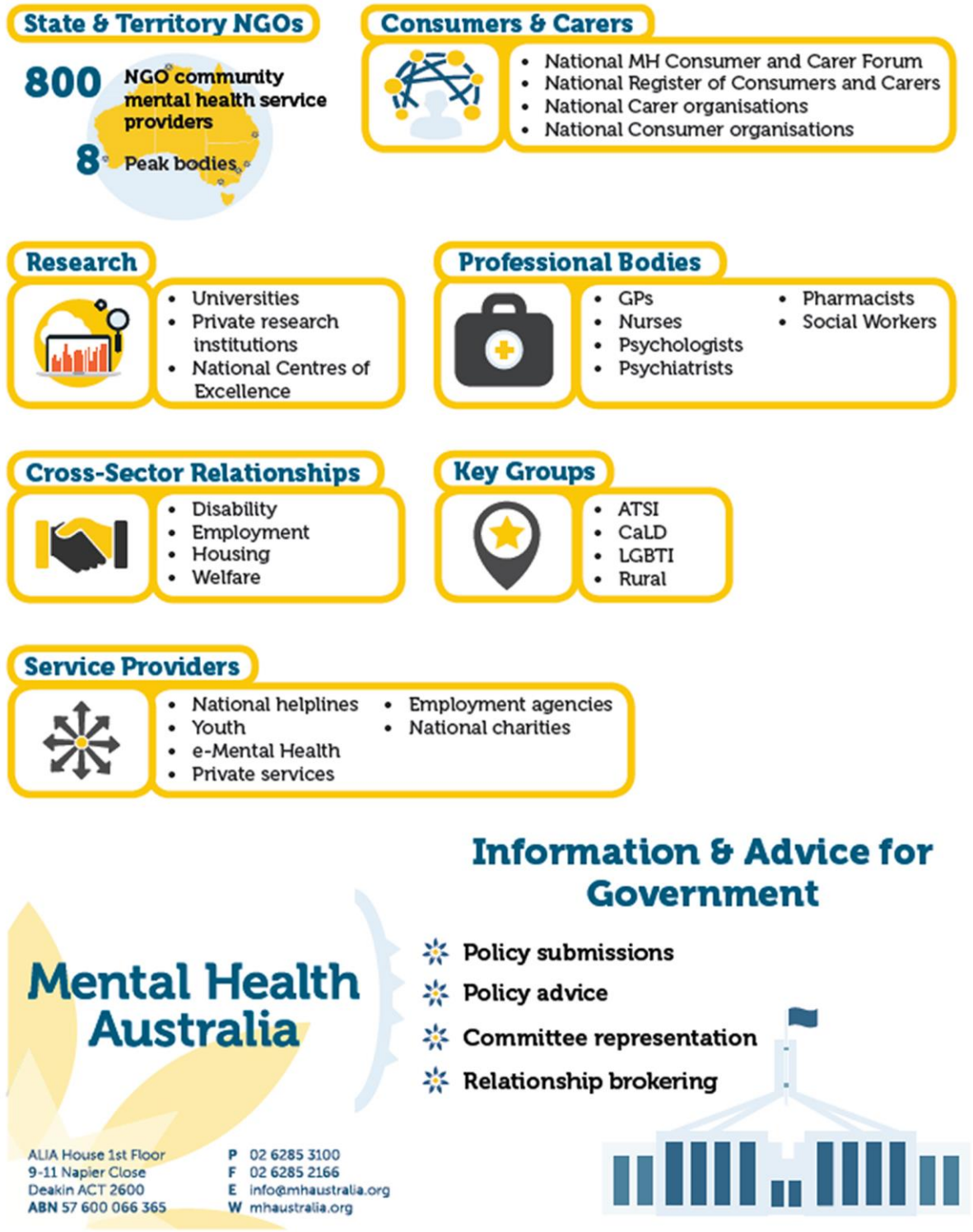
Mental Health Australia's Span of Influence

Blueprint for Action on Mental Health

Victorian Partners in Recovery – White Paper preview

The implementation and operation of the psychiatric disability elements of the National Disability Insurance Scheme: A recommended set of approaches

Attachment 1 – Mental Health Australia's Span of Influence



Mental Health Australia

Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

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