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# Submission to the Productivity Commission Inquiry: Mental Health in Australia Draft Report

# Contents

# About Mental Illness Fellowship of Australia

Mental Illness Fellowship of Australia (MIFA) is a federation of long-standing member organisations, established in 1986. Our members deliver specialist services for individuals living with severe mental ill-health and their carers, friends and families, out of nearly 60 'front doors' in metropolitan and regional areas, to over 20,000 people each year. Our membership has a strong focus on building community, valuing peer support and lived experience, and supporting recovery.

We know from experience that recovery of a better quality of life is possible for everyone affected by mental illness. We work with individuals and families in their journey to recover mental health, physical health, social connectedness and equal opportunity in all aspects of life. We have substantial experience delivering specialist, place-based, community-building programs to those experiencing mental illness, and over 55% of our workforce has a lived experience as a consumer or carer. As such, we feel we are well placed to assist the Productivity Commission in its inquiry into mental health in Australia, and we welcome the opportunity to provide our input.

MIFA's current member organisations, operating across Australia, are:

- BRIDGES Health & Community Care;
- Mental Health Foundation ACT;
- Mental Illness Fellowship Australia (NT) Inc;
- Mental Illness Fellowship of Western Australia;
- One Door Mental Health;
- select**ability**; and
- Skylight Mental Health.

# Introduction

This submission focuses on the needs of people living with severe mental illness, and particularly the role of psychosocial support services in supporting the recovery of people living with severe mental illness. The Australian Institute of Health and Welfare reports that mental illness accounts for 12% of the burden of disease in Australia.[1] People living with severe mental illness account for a small percentage of the population and yet the burden of disease placed on the economy is significant. In Australia, 60% of all health-related disability costs in people aged 15 to 34 years of age are attributable to mental health problems and 27% of all years lived with disability are attributable to mental disorders.[2] The cost to the primary care sector is great. Approximately 75% of mental health care is provided in the primary care sector.[3]

The annual costs of severe mental illness in Australia are very high and broad ranging. In the second Australian National Survey of Psychosis, the costs of psychosis were assessed and broken down into health sector costs, other sector costs and productivity losses.[4] This research revealed that psychosis costs Australian society $4.91 billion annually and the Australian government almost $3.52 billion annually.[5] The costs of psychosis to society are estimated to be $77,297 per individual annually. This consists of $21,714 in medical costs, $40,941 in lost productivity and $14,642 in costs to other sectors.[6] Health sector costs for people with psychosis were 3.9 times higher than those of the average Australian.

The burden of disease differs depending on the type of mental illness. The average cost per person for bi-polar disorder is $13,013 per annum[7] and people living with schizophrenia accessing health services are estimated to cost $50,000 per person annually.[8] From these figures we can see that the expenditure on serious mental illness is disproportionately low compared to the burden of disease.

The Productivity Commission's Draft Report encompasses the full spectrum of mental health conditions in Australia. In relation to severe mental illness, the draft report makes a number of observations and recommendations. These include provisions for clinical care, psychosocial support and social determinants of health interventions. This submission provides additional and stronger recommendations for psychosocial support services, as it is our contention that the Draft Report does not adequately provide for psychosocial support within its reform scenarios.

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[1] Australian Institute of Health and Welfare, *Mental Health Services in Australia*. Available at: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/mental-health-resources/expenditure-on-mental-health-related-services, 2017. Accessed 22 February 2019.

[2] Mathers C, Vos T, Stevenson C. The burden of disease and injury in Australia. Canberra: Australian Institute of Health and Welfare, 1999. (AIHW Catalogue No. PHE 17).

[3] Hickie, I., Groom, G.L., McGorry, P. D., Davenport, T.A. and Luscombe, G.M. "Australian mental health reform: time for real outcomes", *Health Care,* 2005, 182(8): pp. 401-406.

[4] Neil, A.L., Carr, V.J., Mihalopoulos, C., Mackinnon, A. and Morgan, V.A., Costs of psychosis in 2010: Findings from the second Australian National Survey of Psychosis. *Australian & New Zealand Journal of Psychiatry*, 2014. 48(2): pp. 169-182.

[5] Ibid at pp.169-182.

[6] Ibid at pp. 169-182.

[7] Harper, David, Achieving Cost Savings in Bipolar Disorder – A Preliminary Evaluation, http://www.bipolaraustralia.org.au/wp-content/uploads/2018/03/Cost-Savings-in-Bipolar-Disorder.pdf, 2017. Accessed: 22 March 2019.

[8] Mental Health Australia and KPMG. *Invest to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*. KPMG. 2018. Available at: https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf. Accessed: 22 February 2019.

## People living with severe mental illness

Based on published information, MIFA contended in its submission to the PC Inquiry, that the population estimates for mental health needs in Australia are as follows:

- **3.8 million**[9] people of all ages experience mental illness in Australia each year.
- **690,000**[10,11,12] people have a severe mental health issue.
- Between 280,000[13] to **290,000**[14] people with severe mental illness require some level of psychosocial community support and rehabilitation (or 'disability support') for a primary psychosocial disability each year. It is likely the entire cohort of people with severe mental illness (up to 690,000 people) will require some level of 'disability support' at some point in their lifetime.[15,16]
- Regarding the NDIS, the original Productivity Commission numbers, based on Australian Government modelling, indicated 57,000 people were in scope (that is, 0.4% of the adult population or around 12% of those with severe mental illness).[17,18] This number has now been updated by the NDIA to **64,000**.[19] Further modelling by the Department of Health based on the (unpublished) National Mental Health Services Planning Framework suggested that **91,916 people** with "severe and complex disorders"[20] could be eligible. As at January 2020, there are only 32,000 people receiving support through the NDIS for primary psychosocial disability, 50% of the target.

[9] Based on National Mental Health Services Planning Framework (unpublished), adjusted to 2015 Australian population, in McGrath, D. *The Implementation and operation of the Psychiatric Disability Elements of the National Disability Insurance Scheme: A Recommended Set of Approaches*, Available at: http://www.pc.gov.au/__data/assets/pdf_file/0008/215864/sub0155-ndis-costs-attachment.pdf, 2016.

[10] National Mental Health Commission (NMHC) *Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services,* 2014, p. 46.

[11] *Fifth National Mental Health and Suicide Prevention Plan*. Available at: http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf, 2017, p.27.

[12] NDIA, Additional document to JSC on NDIS Inquiry into NDIS and Psychosocial disability. 2017. Available at: http://www.aph.gov.au/DocumentStore.ashx?id=e381f4e0-5784-422a-9397-a2c244da509d.

[13] People aged 0-64. Department of Health. Submission 175 to PC Review of NDIS Costs Issues Paper. 2017. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0003/216066/sub0175-ndis-costs.pdf.

[14] People aged 12-64, McGrath, D. (2016). *Op. cit*.

[15] National Mental Health Commission. *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.* 2014, p.46.

[16] Australian Government Actuary. *NDIS Costings – Review by the Australian Government Actuary.* 2012. Available at: https://static.treasury.gov.au/uploads/sites/1/2017/06/doc1.pdf, p.14.

[17] Productivity Commission (PC). Appendix M: The intersection with mental health. *Disability Care and Support: Productivity Commission Inquiry Report*, 54(2), Canberra. 2011. Available at: https://www.pc.gov.au/inquiries/completed/disability-support/report/37-disability-support-appendixm.pdf, p.4.

[18] Detail of Australian Government modelling reported on p14, Australian Government Actuary (AGA). *NDIS Costings – Review by the Australian Government Actuary.* Op cit. 2012.

[19] *NDIA Annual Report 2015-16,* Available at: https://www.ndis.gov.au/medias/documents/ha5/h04/8798853726238/NDI7040-AnnualReport2016-vFaccessible.pdf, p. 26.

[20] Department of Health, Submission 175 to PC Costs Issues Paper. 2017. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0003/216066/sub0175-ndis-costs.pdf.

Based on the findings in the Draft Report, the number of people with complex care needs is noted as 350,000 people, of which 190,000 to 250,000 people have episodic or persistent severe mental illness and have significant complex needs arising from their illness.

As previously stated, modelling for the NDIS estimates that 64,000 people will be eligible for the NDIS, or between 25% and 33% of the group with significant complex needs. However, currently, only 32,000 people, or 12 to 16% of that group are receiving support through the NDIS.

Regarding psychosocial support services outside the NDIS, there are 10,000 people still in Commonwealth-funded transition and Continuity of Support, and a further 3,000 Commonwealth-funded people in the National Psychosocial Support Measure. Assuming a further 20,000 are in State/Territory programs, that amounts to about 65,000 people receiving psychosocial support either through the NDIS or outside the NDIS. That amounts to 26% to 34% of people with significant complex needs. This indicates a current level of **unmet need for psychosocial support for 125,000 to 185,000 people**. Even allowing for the NDIS to double the number of people with psychosocial disability within the scheme, this still leaves 93,000 to 153,000 people in need of psychosocial support services.

**Recommendation 1**

That the Productivity Commission Report confirms the number of people living with severe mental illness who have significant complex needs arising from their illness. MIFA estimates this group to be 190,000 to 250,000 people, with:

- 64,000 expected to be supported through the NDIS;
- 33,000 estimated to be in receipt of existing Commonwealth or State/Territory psychosocial support outside the NDIS; and
- 93,000 to 153,000 with no psychosocial support.

## Psychosocial support for people living with severe mental illness

MIFA contends that psychosocial support is highly effective in contributing to the recovery and wellbeing of people living with severe mental illness, thereby improving quality of life. Psychosocial support also reduces Government expenditure in all areas of mental health and social support, including clinical care, acute hospital care, homelessness and incarceration.

MIFA contends that the scope and nature of psychosocial supports are not fully understood within the Draft Report, and that the role of psychosocial support is not adequately reflected in reform scenarios.

The model of stepped care on page 18 of Volume 1 of the Draft Report includes psychosocial supports as part of the Complex Care step. Page 25 states, "*even with the best clinical treatment*, episodic or persisting mental illness can result in the need for psychosocial and other supports, such as stable accommodation, income and vocational support, to assist the person to live as independently as possible in the community". This implies two things:

1. psychosocial supports are secondary to clinical treatments; and
2. psychosocial supports are limited to social and community supports, such as stable accommodation, income and vocational support.

A better understanding of 'psychosocial supports', and its role in a future mental health system, is needed. Psychosocial supports are critical for a person's recovery, on a number of levels:

- At a personal level, psychosocial supports are a necessary pre-condition to the effectiveness of clinical care. Psychosocial supports provided by a trained and experienced support worker contribute to the person's understanding of their individual strengths and resilience. Psychosocial supports build a person's hope and optimism, and empower people to have agency over their lives, to understand that they have choices, and to exercise control over their lives.
- At an interpersonal level, psychosocial supports build relationships with family and friends. These relationships are often fractured and people can become isolated. Without support from family and friends, clinical care often fails.
- Furthermore, the emerging concept of relational recovery points to family or social relationships as central, decisive determinants and enablers for recovery. It places the locus of deficit, and therefore the focus of intervention, in the space between people and their social environment, rather than the space between their ears. It is primarily community focused, has family life at its heart and deals with the real world.
- Finally, at a community level, psychosocial supports connect people to stable accommodation, income and vocational support, connect people into clubs, social activities, and other activities that lead to social inclusion, participation and contribution to family and community life.

So psychosocial supports are critically essential to recovery *in their own right*. They are not an add-on to clinical care and are not simply concerned with the domains of the social determinants of health.

There is a strong message coming out of the available evidence and advocacy from the mental health sector that the most effective responses to people with severe mental illness and psychosocial disability are those that are flexible, holistic, integrated, supportive of recovery outcomes, and delivered within a recovery-oriented framework.[21] One of the most commonly cited definitions of recovery is the one articulated by William Anthony:

> [Recovery is] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.[22]

In Australia, the National Framework for Recovery-Oriented Practice articulates a number of components of mental health care that:

- recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues;
- maximises self-determination and self-management of mental health and wellbeing; and
- assists families to understand the challenges and opportunities arising from their family member's experiences.

There are five main domains of recovery-oriented practice, including:

[21] McGrath, D, *Support for people with psychosocial disabilities participating in the NDIS: Literature Review.* Mental Health Australia. 2018, pp. 1-59.
[22] Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), pp. 11–23 at p.

1. Promoting a culture and language of hope and optimism: ensuring a service culture and language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism.
2. Person first and holistic: putting people who experience mental health issues first and at the centre of practice and service delivery; viewing a person's life situation holistically.
3. Supporting personal recovery: ensuring personally defined and led recovery is at the heart of practice, rather than treating personal recovery as an additional task.
4. Organisational commitment and workforce development: environments and culture that are conducive to recovery and a workforce that is appropriately skilled, equipped, supported and resourced for recovery-oriented practice.
5. Action on social inclusion and the social determinants of health, mental health and wellbeing: upholding the human rights of people experiencing mental health issues and challenging stigma and discrimination; advocating to address the poor and unequal living circumstances that adversely impact on recovery.

There is much discussion in the literature around the application of the term recovery and its associated outcomes, most notably regarding the realms of 'clinical' and 'personal' recovery. About recovery outcomes, David McGrath writes:[23]

> Recovery is broadly defined as 'living as well as possible' (South London and Maudsley NHS Foundation Trust 2010), with minimal symptoms of mental ill health (Slade et al. 2012). As a concept, it introduces notions such as hope, empowerment and aspirations to inspire the consumer to attain a 'meaningful life' (Anthony 1993, Corrigan 2006, Slade et al. 2012).
>
> Application of this is about identifying realistic and practical strategies to help consumers cope with and reduce disability using evidence-based interventions (Corrigan 2006).
>
> 'Clinical' recovery includes criteria in areas such as remission, stabilisation of symptoms, psychosocial rehabilitation, improved vocational activities, additional social connections and independent living (Bellack 2006, Kopelowicz et al. 2005, Liberman et al. 2002). It is largely biomedical in nature, focused primarily on illness and impact on functioning.
>
> In contrast to clinical recovery, 'personal' recovery has been described as a process or continuum that is subjectively defined by the individual and is 'rated' by the person who is experiencing the mental health difficulties who is considered the expert on their recovery. It is derived from consumer oriented literature, case studies and qualitative surveys. Rather than being focused on biomedical understanding of illness and disability, the focus is on strengths or improvement measures such as mental health and wellbeing outcomes.
> …
> Influenced by consumer oriented literature and advocacy, the concept of personal recovery is more frequently being prioritised over clinical recovery and is becoming embedded into contemporary policy and service provision.
> …
> Consistent with the shift towards 'personal' recovery and assisting individuals to find a meaningful life, it is important to align the principles of recovery to a set of processes

[23] McGrath, D, *Support for people with psychosocial disabilities participating in the NDIS: Literature Review.* Mental Health Australia. 2018, pp. 1-59 at pp. 10-11.

> and outcomes that could articulate to additional supports for people with psychosocial disability.
>
> A systematic review conducted by Slade et al explored the evidence base in order to identify key recovery processes and pro-recovery interventions. The result was the identification of five key domains that capture the recovery journey, processes and stages with recommendations for ten empirically supported and targeted pro-recovery interventions.

The key components of the recovery framework, collectively described by the acronym CHIME, include:

- Connectedness;
- Hope and optimism;
- Identity;
- Meaning and purpose; and
- Empowerment.

On the concept of translating recovery domains into practice, David McGrath writes:[24]

> In a paper discussing psychosocial disability and the NDIS, Paul O'Halloran suggests that the conceptualisation of recovery should be inclusive of all thematic elements including personal, clinical and functional dimensions of recovery. O'Halloran suggests that outcomes are optimised when consumers and families have choice about and access to whatever aspects of recovery are needed and preferred. Similar to Slade, he suggests framing support determination in the context of recovery needs, outlining a number of recovery dimensions, including:
>
> - Recovering hope;
> - Redefining self and reframing illness;
> - Meaningful activity;
> - Overcoming stigma;
> - Assuming control;
> - Empowerment and citizenship;
> - Managing symptoms and disability; and
> - Being supported.

[24] McGrath, D, *Support for people with psychosocial disabilities participating in the NDIS: Literature Review.* Mental Health Australia. 2018, pp. 1-59 at pp. 11-12.

**Recommendation 2**

That the Productivity Commission Report includes a discussion on the critical and essential role of psychosocial supports delivered through a recovery-oriented framework, particularly in relation to the personal recovery of people living with severe mental illness. This discussion should reflect a contemporary understanding of the role of psychosocial supports in the theory and practice of recovery, and relational recovery.

**Recommendation 3**

That the reference to psychosocial supports in the stepped care model on page 18 be amended to: "Psychosocial supports provided by qualified support workers and peer workers within a recovery-oriented framework".

## The demand for psychosocial support services for people living with severe mental illness

The following table was produced in the context of the Productivity Commission's recommendations for the establishment of the NDIS. The aim of the table was to identify the types of services for people living with severe mental illness and complex care needs, and whether those services were included or not within the NDIS. The assumption surely was that those services not included within the NDIS were necessary and would be met from other non-NDIS services. Programs such as PHaMs and PIR, and their State/Territory equivalents, existed at the time. However, those programs have been closed down, leaving a gap in those non-NDIS services. While, as stated earlier in this submission, up to 33,000 people may be receiving support through Continuity of Care or new measures, there remains a gap in the provision of those services. MIFA asserts that the Productivity Commission Inquiry is the appropriate vehicle to revisit the assumptions made at the time of the establishment of the NDIS, and to redress the disruption of the mental health system resulting from this unintended consequence of the NDIS.

**Table 1. NDIS Scope of Services (PC NDIS establishment)**

| Description | Care Needs | NDIS Coverage |
|---|---|---|
| Episodic mental illness<br>**(est. 321,000 people)** | Clinical services both during episodes of illness and to maintain remission between episodes<br>Disability support services may occasionally be required, particularly during a lengthy episode of illness | Not included<br>Not included |
| Severe and persistent mental illness but can manage own access to support systems<br>**(est. 103,000 people)** | Clinical services<br>Social inclusion programs | Not included<br>Not included |
| Complex needs requiring coordinated services from multiple agencies<br>**(est. 56,000 people)** | One on one support from a carer (paid)<br>Supported accommodation, where appropriate<br>Social inclusion program<br>Clinical services | Included<br>Included<br>Included<br>Not included |

A category is included in the table for people with 'Severe and persistent mental illness but can manage own access to support systems'. Given the juxtaposition of this cohort between the broader cohort and the NDIS cohort, it is reasonable to assume that this group is consistent with the group of 190,000 to 250,000 people with episodic or persistent severe mental illness who have significant complex needs arising from their illness. It is timely to update this information so that a new table is produced which:

- updates the numbers and definitions; and
- identifies how the non-NDIS care needs should be provided in the future.

With respect to identifying how the non-NDIS care needs should be provided in the future, we suggest that the Productivity Commission use the following adaptation from the Draft Report analysis:

| **Description** | **Care Needs** | **NDIS Coverage** | **PC Mental Health Inquiry** |
|---|---|---|---|
| Complex Care **(350,000 people)** | Clinical care using a combination of GP care, psychiatrists, mental health nurses and allied health | Not included | Adequately discussed |
| | Inpatient services | Not included | Adequately discussed |
| | ***Psychosocial supports provided by qualified support workers and peer workers within a recovery-oriented framework*** | Not included | ***Refer to MIFA's recommendations for additional consideration in the Inquiry*** |
| | Single care plan and care team | Not included | Adequately discussed |
| | Care Co-ordinator | Not included | Adequately discussed |
| Episodic or persistent severe mental illness with significant complex needs **(190 000 - 250 000 people)** | Clinical care using a combination of GP care, psychiatrists, mental health nurses and allied health | Not included | Adequately discussed |
| | Inpatient services | Not included | Adequately discussed |
| | ***Psychosocial supports provided by qualified support workers and peer workers within a recovery-oriented framework*** | Not included | ***Refer to MIFA's recommendations for additional consideration in the Inquiry*** |
| | Single care plan and care team | Not included | Adequately discussed |
| | Care Co-ordinator | Not included | Adequately discussed |
| NDIS eligible **(64,000 people)** | One on one support from a carer (paid) | Included | |
| | Supported accommodation, where appropriate | Included | |
| | Social inclusion programs | Included | |
| | Clinical services | Not included | |

It is essential that there is up-to-date and accurate data about the demand for psychosocial support services for this cohort. This needs to be articulated into a table like that suggested above.

**Recommendation 4**

That the Productivity Commission establishes the expected demand for psychosocial support services, the extent to which this demand should be met, and the estimated future investment needed in psychosocial support services.

## The delivery of psychosocial support services for people living with severe mental illness

MIFA proposes that the Productivity Commission Inquiry establishes a National Psychosocial Recovery Program to channel significant investment in a spectrum of community-based, recovery-oriented psychosocial supports. MIFA believes that Australia can lead the world in this development and that it is appropriate and necessary to create a nationally-funded program for this cohort of people. MIFA argues that we need greater investment in capacity building of non-clinical, recovery-oriented and specialised community-based mental health programs as an integral part of the reform of the mental health system.

The National Psychosocial Recovery Program should have the following features:

1. delivery of individual and group psychosocial support services through a recovery-oriented model;
2. person-centred model, including service integration and case coordination of broader community services, and collaborative care;
3. assertive outreach;
4. inclusion of families, friends and carers; and
5. integration of specialist services supporting carers and families.

MIFA proposes that the National Psychosocial Recovery Program build on Australia's world class recovery model, which thrived under more than a decade of government support. Flexible and responsive services are needed for people whose mental health needs are episodic. At times, people may require significant support. At other times, people may only require light-touch quality support. The reformed program must offer flexible, low-barrier entry criteria, with flexibility in the type, range and length of supports offered. It is important that access and support is timely and crisis-responsive.

In the absence of this type of support, people's needs will escalate to more expensive, crisis-driven support. Stability in housing, employment, family and community connectedness, and adherence to medication regimes will suffer. People will present to State and Territory emergency departments when other community-based options are no longer available, further burdening the health system.

There are already several world class, recovery-oriented programs, well known for their effectiveness in the mental health sector. Rather than dismantling the infrastructure, workforce capacity and institutional memory in existing programs, MIFA argues that the principles and lessons learned through programs like PIR, D2DL and PHaMs should be retained under the banner of a National Psychosocial Recovery Program to meet the needs of people with severe mental illness.

In addition to the delivery of individual support services, there is great value in promoting access to

group support services. MIFA advocates that group support services play a vital role in providing non-clinical, recovery-oriented supports. Therapeutic group programs support wellness for a diverse range of individuals living with mental illness in the community. MIFA draws on the experience of our member organisations to point to the effectiveness of group support services in delivering best outcomes for people with severe mental illness.

## Assertive Outreach

MIFA advocates that the National Psychosocial Recovery Program needs to include assertive outreach to people with severe mental illness and complex needs. In an assertive outreach model, a specialised team of recovery professionals deliver intensive, highly coordinated and flexible services and supports to individuals with longer term needs who are living in the community. Services are delivered by multi-disciplinary teams who provide a wide range of interventions, including psychosocial interventions and intensive practical supports.[25] Typically, assertive outreach is designed to reach individuals with whom mainstream mental health services have found it difficult to engage.[26] International research has shown that an assertive outreach model for people with severe mental illness can have a large positive impact on engagement, housing and hospital admission rates.[27]

In Australia, we have worked within an established and effective assertive outreach model in the PIR program. PIR is regarded by many in the sector as the best existing model providing specialist outreach for people with severe mental illness. In this model, Support Facilitators played an active role to ensure that their clients have access to the full range of services that they needed. This is known as the 'systems change' model in PIR. MIFA advocates that the assertive outreach component of the PIR program needs to be a feature of the National Psychosocial Recovery Program, promoting engagement with hard to reach individuals and people who may experience barriers to accessing services.

## Inclusion of families, friends and carers

MIFA believes that families, friends and carers are key partners in recovery. As such, MIFA advocates that families, friends and carers of the person with lived experience of mental illness be actively engaged in the recovery process. Inclusion of families, friends and carers of people with severe mental illness will be an important part of delivering recovery-oriented supports to people under the National Psychosocial Recovery Program.

It is important to recognise that, most often, it is a family member, friend or carer who first perceives changes in a person's behaviour, indicating the development of mental illness. It is often a family member, friend or carer who refers an individual in mental distress to a mental health professional. Mental illness also has broader impacts on the physical and psychological wellbeing of families, friends and carers in their own right.

Involving family, friends and carers can have direct and indirect benefits for people experiencing mental illness. Engaging family, friends and carers has been shown to produce positive benefits for

[25] National Forum for Assertive Outreach, "What is Assertive Outreach?". Available at http://www.nfao.org/About_AO/About_AO.html. Accessed: 3 April 2019.

[26] Ibid.

[27] Ibid.

people with a lived experience of mood disorders,[28] psychotic disorders[29,30] and bi-polar disorder.[31,32] Where family, friends and carers are informed about mental illness generally, and about the specific illness a person is experiencing, they can provide better support, care and understanding. This can lead to: improved wellbeing for both the consumer and family, friends and carers; reduced stress; reduced burden of care; and improved understanding of treatments and services.[33,34] In particular, young people can experience immense benefits from the engagement of their family and social circle in their treatment.[35]

## Integration of services supporting carers and families

MIFA advocates that the National Psychosocial Recovery Program needs to include the provision of dedicated carer support services. Mental health carers play a vital role in supporting individuals with severe mental illness and promoting ongoing recovery. Mental health carers also make a significant contribution to the Australian economy.[36] The involvement of carers in the service delivery process is fundamentally important to the delivery of appropriate, responsive and high-quality services.

Mental health carers need a range of supports, including information, referral, peer support groups, counselling and one-on-one support. This is particularly important as often carers are the first to reach out. Carers can be instrumental in encouraging consumers to access services (noting that around 54% of people with mental ill-health do not seek help).[37] Research has demonstrated that carers often experience poor physical health, financial difficulties, isolation and their own mental health issues as a direct result of their caring responsibilities.[38] In particular, young carers require adequate supports to promote their own health, mental health and wellbeing.[39] Mental health carers have different

[28] Dadds, M.R., Heard, P.M. and Rapee, R.M. The role of family intervention in the treatment of child anxiety disorders: Some preliminary findings. *Behaviour Change*, 1992, 9(3): pp.171-177.

[29] Mullen, A., Murray, L. & Happell, B. Multiple family group interventions in first episode psychosis: enhancing knowledge and understanding. *International Journal of Mental Health Nursing*, 2002. 11(4): pp. 225-232.

[30] Pitschel-Walz, G., et al. The effect of family interventions on relapse and rehospitalisation in schizophrenia - a meta-analysis. *Schizophrenia Bulletin*, 2001. 27(1): pp. 73-92.

[31] Simoneau, T.L., Miklowitz, D.J., Richards, J.A., Saleem, R. and George, E.L., Bipolar disorder and family communication: effects of a psychoeducational treatment program. *Journal of Abnormal Psychology*, 1999 108(4), p.588.

[32] Miklowitz, D.J. and Goldstein, M.J. Behavioral family treatment for patients with bipolar affective disorder. *Behavior Modification*, 1990, *14*(4): pp.457-489.

[33] Ohaeri, J. The burden of caregiving in families with a mental illness: a review of 2002. Current Opinion in Psychiatry, 2003. 16(4): pp. 457-465.

[34] Falloon, I.R.H. Family interventions for mental disorders: efficacy and effectiveness. World Psychiatry, 2003. 2(1): p. 20-28.

[35] Headspace. *Position Paper – Inclusion of Family and Friends.* Available at https://headspace.org.au/assets/Uploads/Corporate/inclusion-of-family-and-friends-ext-approved-september-2012.pdf, 2012. Accessed: 29 January 2018.

[36] Diminic S., Hielscher E., Yi Lee Y., Harris M., Schess J., Kealton J. & Whiteford H. *The economic value of informal mental health caring in Australia: summary report.* 2016. The University of Queensland.

[37] Whiteford, H., Buckingham W., Harris, M. et al. 'Estimating treatment rates for mental disorders in Australia.' *Australian Health Review*, 2014, 38(1): pp. 80-85.

[38] Mental Health Council of Australia. 'Mental Health Respite: Carer Support Consultation Report'. Available at https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Mental_Health_Respite_-_Carer_Support_Consultation_Report.pdf. 2012. Accessed: 2 April 2019, at p. 3.

[39] Carers Australia, *Young Carers.* Available at http://carersaustralia.com.au/about-carers/young-carers2/. Accessed: 5 April 2019.

respite and support needs compared to other carers, due in part to the unpredictability and episodic nature of mental illness.

## Eligibility for psychosocial support services for people living with severe mental illness under a National Psychosocial Recovery Program

The proposed National Psychosocial Recovery Program should target people affected by severe mental illness, whose capacity to participate in the social and economic life of their community is severely impacted by their mental illness, whether or not they have a current formal clinical diagnosis.

MIFA recommends eligibility criteria similar to the previous PHaMs program:

- be aged 16 years or more;
- have a mental illness;
- experience severe functional impairment because of their mental illness; and
- be willing to participate in the service voluntarily and able to make an informed decision to participate.

**Recommendation 5**

That the Productivity Commission recommend the establishment of a National Psychosocial Recovery Program to deliver psychosocial support services to people living with severe mental illness.

**Recommendation 6**

That the Productivity Commission establish the target group, service delivery principles, and eligibility criteria for the National Psychosocial Recovery Program.

## A person-centred model of mental health care

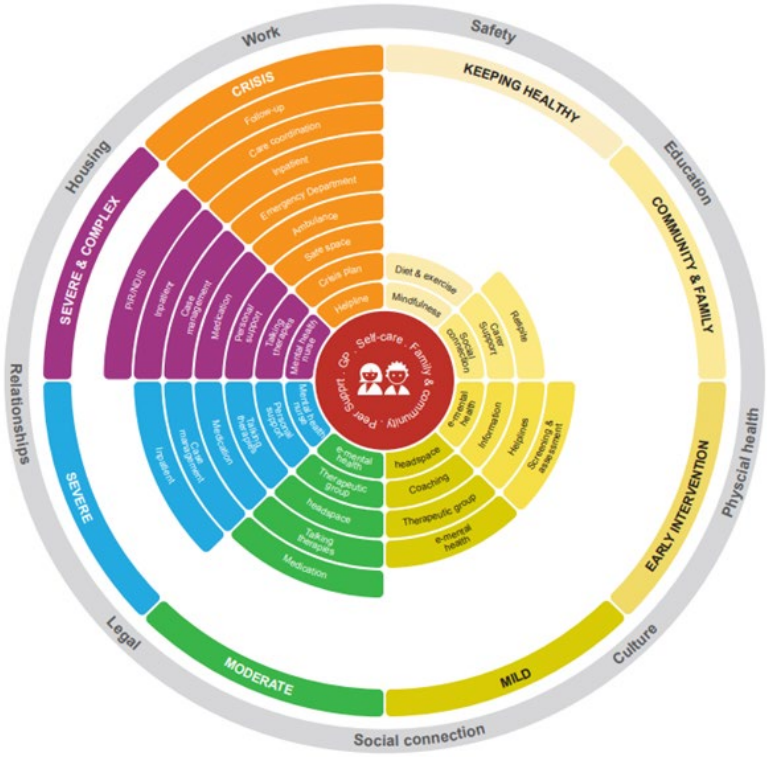
The Draft Report discusses a Stepped Care model of mental health care. This model is very useful for identifying the number of people in each step, the characteristics of people in each step in terms of the level of severity of their mental health condition, and the types of support/care required in each step. This is also essential for planning for the services required, the respective workforce needs, and the overall investment required of Government.

The stepped care model is not appropriate for understanding how an individual interacts with the service system. Individuals needs change as a result of the episodic nature of their condition, the support provided by family and friends, access to clinical care and psychosocial supports, and crises which may develop from time to time. For example, a person with moderate intensity care needs may require urgent additional support as a result of an episode requiring acute hospital admission. On discharge, the person may have lost their job and housing tenancy, and fractured their family relationships as a result of their episode. Even though they may return to moderate intensity needs after discharge, they would require additional urgent support in avoiding homelessness and securing housing, re-establishing family relationships, and securing income support or employment.

There needs to be person-centred model to articulate the way in which an individual interacts with the service system, as their needs change. Rather than seeing the person move up or down the steps, this model must see the person in the centre of the model, with the service system changing and adapting with the changing needs of the individual. In other words, the person stays where they are, and the system changes around them.

This will require a process of urgent reassessment of need, referral to relevant services, and quick response from the relevant service type.

One model which applies some of this approach has been developed by Brisbane North PHN:



# Planning, funding and commissioning for psychosocial support services for people living with severe mental illness

MIFA proposes that funding for the National Psychosocial Recovery Program is allocated regionally based on regional planning conducted jointly by all relevant stakeholders, including the Primary Health Network (PHN), Local Health Districts (LHD, consumers and carers, service providers, and the broader social services sectors. MIFA proposes that a single planning, funding and commissioning model is established.

Depending on the size of planning regions, diverse geographic regions will require sub-regional plans to adequately plan for the variation of regional settings and demographics. In this way, plans should organically take account of regional, rural and remote needs, including the mental health needs of Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people with complex needs. Planning of relevant service responses that are best suited to the region or sub-region of the PHN should occur.

There is a clear opportunity to commission mental health services through flexible funding packages[40] under the National Psychosocial Recovery Program. To do this well, MIFA advocates strengthening the capability of system planning for mental health. This includes strengthening: mapping services, and conducting consultative needs, gaps and accessibility analyses; networking and coordinating service delivery across sectors; and embedding consumer co-production/co-design into this work.

To optimise joint mental health planning, there must be close cooperation with the NDIA, State/Territory Departments, Commonwealth Departments, private hospital and general practice, and allied health private practitioners.

## Support for strengthening the National Mental Health Services Planning Framework

To complement regional planning, work is needed to strengthen the National Mental Health Services Planning Framework.[41] Firstly, a thorough review of the assumptions underpinning the Framework is needed, in line with our earlier recommendation to refine the data on numbers and definitions of people with a severe mental illness. Secondly, a review of the assumptions about the type and ratio of service types per unit of population is needed. Thirdly, there is a need to review the assumptions of the cost of service types. Finally, the technology of the Framework should be improved to provide ready access and ease of use for all stakeholders who need to refer to the Framework.

## Funding for the National Psychosocial Recovery Program

MIFA proposes that the National Psychosocial Recovery Program will be **cost neutral** in the first year of operation. Funding for the Program will result from folding in existing Commonwealth and State/Territory commitments for Continuity of Support and all other psychosocial support programs into one funding source.

Future expansion of the National Psychosocial Recovery Program will be based on the identified needs of each region, which will result from the regional planning process. This will provide an enabling

[40] Mental Health Australia and KPMG. *Investing to Save*. Available at https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf2018. Accessed: 2 April 2019, p. 62.

[41] *Introduction to the NMHSPH*, https://nmhspf.org.au/wp-content/uploads/2019/01/Introduction-to-the-National-Mental-Health-Service-Planning-Framework_2019.pdf, 2019. Accessed: 5 April 2019.

environment for regional action in mental health planning[42] that will allow funds to be allocated according to regional need.

## Commissioning model

MIFA is open to further discussion with Government and the sector around a preferred commissioning model. MIFA's view is that a commissioning structure should include the following principles:

- be sufficiently regional to be able to focus on the communities covered by the region, ie to avoid regional areas that encompass both large metro communities and regional communities. There needs to be a focal point of commonality across the region, and a capacity to focus on those communities' unique needs, rather that a one-size-fits-all approach to encompass diverse community characterises.
- Include all levels of government, consumers and cares, service providers, the NDIA, private practitioners, and the broader social services sectors
- be consumer and carer led with genuine co-design
- get the governance right – whether PHNs or new RCA's have the lead, what's important is that there is clear governance rules with principles of accountability, transparency, integrity, fairness, independence from vested interests, inclusivity, skill and responsibility for outcomes.

**Recommendation 7**

That the Productivity Commission recommend a suitable mechanism for regional planning, national funding and regional commissioning of a National Psychosocial Recovery Program to deliver psychosocial support services to people living with severe mental illness.

[42] National Mental Health Strategy. *The Fifth National Mental Health and Suicide Prevention Plan, National Mental Health Strategy.* 2017: p. 19.

# Summary of Recommendations

**Recommendation 1**

That the Productivity Commission Report confirms the number of people living with severe mental illness who have significant complex needs arising from their illness. MIFA estimates this group to be 190,000 to 250,000 people, with:

- 64,000 expected to be supported through the NDIS;
- 33,000 estimated to be in receipt of existing Commonwealth or State/Territory psychosocial support outside the NDIS; and
- 93,000 to 153,000 with no psychosocial support.

**Recommendation 2**

That the Productivity Commission Report includes a discussion on the critical and essential role of psychosocial supports delivered through a recovery-oriented framework, particularly in relation to the personal recovery of people living with severe mental illness. This discussion should reflect a contemporary understanding of the role of psychosocial supports in the theory and practice of recovery, and relational recovery.

**Recommendation 3**

That the reference to psychosocial supports in the stepped care model on page 18 be amended to: "Psychosocial supports provided by qualified support workers and peer workers within a recovery-oriented framework".

**Recommendation 4**

That the Productivity Commission establishes the expected demand for psychosocial support services, the extent to which this demand should be met, and the estimated future investment needed in psychosocial support services.

**Recommendation 5**

That the Productivity Commission recommend the establishment of a National Psychosocial Recovery Program to deliver psychosocial support services to people living with severe mental illness.

**Recommendation 6**

That the Productivity Commission establish the target group, service delivery principles, and eligibility criteria for the National Psychosocial Recovery Program.

**Recommendation 7**

That the Productivity Commission recommend a suitable mechanism for regional planning, national funding and regional commissioning of a National Psychosocial Recovery Program to deliver psychosocial support services to people living with severe mental illness.









## Written by

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## Disclaimer

This submission represents the position of MIFA. The views of MIFA members may vary.

## Contact

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