Productivity Commission Inquiry into Mental Health: Draft Report

Mental Health Coordinating Council Submission

mhcc
mental health coordinating council

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Introduction

The Mental Health Coordinating Council (MHCC) is the peak body for community based mental health organisations (CMOs) in New South Wales. The purpose of the Council is to support a strong and sustainable community-managed mental health sector that provides effective health, psychosocial and wellbeing programs and services to the people of NSW. MHCC provides policy leadership, promotes legislative reform and systemic change and provides resources and training to assist community organisations to deliver quality and effective services. The MHCC Learning and Development arm is a widely respected registered training organisation delivering nationally accredited mental health training and professional development courses.

MHCC provided a submission to the Productivity Commission (PC) Issues Paper in April 2019 and presented to the PC public hearings held in Sydney. The PC mental health inquiry makes possible 'once in a generation' reform of the mental health service system across Australia with the clear objective of ensuring people living with mental health conditions get the support and services they need to live full and contributing lives in the communities of their choice. MHCC believe substantial systemic reform is necessary to create a different kind of mental health system – one that is reflective of a trauma-informed recovery-oriented (TIRO) approach to care, treatment and support; promotes a human rights perspective that aligns with the United Nations Convention on the Rights of People with a Disability (UNCRPD); and which maximises self-determination and social inclusion promoting a co-design imperative in every aspect of service design and development.

MHCC commends the PC for its comprehensive Draft Report. There is much in the Report that MHCC supports particularly the focus on putting consumers at the centre of service delivery, recognising the social determinants of mental health and documenting the significant cost of mental illness. The Report acknowledges the major gap in mental health services between primary and acute care - the "missing middle" and provides analysis of the shortfall in both psychosocial support services and specialised clinical care provided in the community. However, the Draft Report refers to the role of psychosocial supports as generally complementing community based clinical services and while they do this, they are much more than this. They are standalone services which play a vital role in supporting recovery for people with enduring mental health conditions working with people over the long term to address more than just the symptoms of illness and are often the key to people living well in the community.

The PC final Report should include recommendations that outline:

- A clear plan to expand community-based support mental health support services and the provision of additional funding to enable this to occur
- The role of community managed mental health organisations in addressing the current service gaps through the provision of psychosocial rehabilitation and support services.

MHCC hope this submission will contribute to achieving these outcomes by providing a better understanding of the services provided by CMOs in NSW and the workforce which delivers those services. The submission also comments on the recommendations in the Draft Report that are particularly relevant to our members and the community managed mental health sector more broadly.

The CMO Sector – Psychosocial Support and Rehabilitation Services

Following the release of the PC Draft Report, there has been much discussion about what is psychosocial support. MHCC recommend the following definition of 'Psychosocial Rehabilitation and Support' be included in the Productivity Commission's final report to Government.[1]

"**Psychosocial rehabilitation and support** programs and services promote personal recovery, successful community integration and an improved quality of life for persons living with mental health conditions. They are founded in an approach that embodies the values and principles of a trauma-informed recovery-oriented culture and practice approach. Psychosocial rehabilitation is designed to target the specific difficulties that arise when people have a severe and enduring mental health conditions. Psychosocial rehabilitation services and supports are collaborative, person directed, and individualised, and an essential element of the human services spectrum. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice and include a wide continuum of services and supports."

The CMO Sector in NSW

In NSW psychosocial rehabilitation and support services are largely provided by CMOs. Core activities include accommodation support and outreach, employment and education, leisure and recreation, family and carer support, self-help and peer support, helplines, counselling, rehabilitation and clinical care services, online programs as well as promotion, information and advocacy.

Evidence clearly demonstrates that people accessing CMO rehabilitation and support programs and services, stay well for longer; have more chance of completing their educational goals, gaining and sustaining employment and experiencing social participation and achieving a 'contributing life'. This greatly impacts both on admission and readmission rates to hospital thus reducing the need for more acute services in mental health facilities. The findings from an evaluation of the NSW Housing and Accommodation Support Initiative (HASI) conducted by the University of NSW demonstrated that HASI has provided significant benefits to those who receive support from the program as the broader NSW community.[2]

It is important to note that CMOs are not a service system as such but a collection of individually funded organisations. Some CMOs provide commissioned services and programs through PHNs whilst others provide a range of services and/or individual packages funded by state or Commonwealth agencies.

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[1] Mental Health Coordinating Council 2020, Mental Health Rights Manual, 5th Edition. (To be published).

[2] Social Policy Research Centre 2012, *Evaluation of the Housing and Accommodation Support Initiative (HASI): Final Report*, ARTD Consultants, University of New South Wales for NSW Health and Housing NSW. Available at: https://www.health.nsw.gov.au/mentalhealth/resources/Pages/hasi-final-report.aspx

In NSW the Ministry of Health fund community mental health programs including Community Living Supports (CLS); Housing and Accommodation Support Initiative (HASI); Family and Carer Mental Health Program; LikeMind: Pathways to Community Living Initiative; Suicide Prevention Fund.

The value of services provided by the CMO sector lie in achieving person-centred and directed integrated approaches to supporting people in ways that are chosen by them. This includes holistic consideration of social supports, physical health needs, employment and housing.

MHCC (2010) has identified three types of CMOs providing mental health services and support:

> ***Type 1:*** solely involved in the provision of mental health services
>
> ***Type 2:*** provide other types of services as well as mental health services (e.g. alcohol and other drug services (AOD)
>
> ***Type 3:*** do not provide services specific to addressing mental health conditions but provide other support services which persons living with mental health difficulties are most likely to require (e.g. probation and parole, social housing, employment).

In a recent survey of NSW CMO's undertaken by MHCC [3], 56% of respondents indicated that they were categorised as Type 2, that is '*Providing mental health programs in addition to other programs/services'* while 21% identified as Type 1 and 23% as type 3.

For this survey an increasingly accepted and standardised taxonomy of service types was adopted - the *Mental health non-government organisation establishments National Best Endeavours Data Set* (MH NGOE NBEDS)[4].

The MHNGOE NBEDS identifies 18 service type options. The survey results indicated that respondents were providing a broad range of mental health services. The most prevalent type of service offered by CMOs was an 'Intake/assessment/triage service', and the least prevalent service was 'Service integration infrastructure' (Table 1).

See table following page.

[3] Ridoutt, L & Cowles, C 2019, *The NSW CMO Mental Health Workforce: Findings from the 2019 MHCC Workforce Survey,* MHCC: Sydney.

[4] Metadata Online Registry, Accessed 20.01.2020, Available at: https://meteor.aihw.gov.au/content/index.phtml/itemId/494729

Table 1: Types of mental health services delivered by respondent CMOs in NSW (n = 48)

Mental health services provided by CMOs	Number of CMOs	Proportion of total CMOs
Counselling-face-to-face	22	44.9
Counselling[5], support, information and referral-telephone	20	40.8
Counselling, support, information and referral-online	9	18.4
Intake/Assessment/Triage for referral to other service	27	55.1
Self-help-online	6	12.2
Group support activities	26	55.3
Mutual support and self-help	14	29.8
Staffed residential services	14	29.8
Personalised support-linked to housing	17	36.2
Personalised support-other	21	44.7
Family and carer support	25	53.2
Individual advocacy	21	44.7
Care coordination	21	44.7
Service integration infrastructure	6	12.2
Education, employment and training	21	44.7
Sector development and representation	15	31.9
Mental health promotion	26	55.3
Mental illness prevention	20	40.8

Gaps in service access and equity

MHCC strongly agree with the findings in the Report that point to the lack of community-based services to adequately support the "missing middle", and that this raises serious issues regarding equity of access across Australia. People report poor experiences due to a high level of unmet need and inadequate access and equity to services; a workforce that is overwhelmed with the demand for services; service confusion and duplication as a result of a myriad of commissioning bodies and siloed funding streams; and poor planning and coordination between different levels of government and service providers.

[5] Ridoutt, L & Cowles, C 2019, pg.16, "55.3% of respondents offered at least one form of counselling service".

Our earlier submission provided details of specific service gaps in NSW based on the report **Mental Health Matters, Future Investment Priorities for NSW**[6]. The Report identifies the following priorities for investment:

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

KPMG's analysis of the return on investment for the first two service types identified a short-term ROI of 1, indicating additional investment in these types of service would pay for themselves.

MHCC believe the PC list of what could "start now" to improve peoples' experiences with mental health care [7] should include expanding community-based psychosocial rehabilitation and support services to keep people well in the community and reduce their need for acute services. This will require both additional funding and addressing workforce challenges, which are outlined in the next sector.

CMO Sector – Workforce

Psychosocial rehabilitation and support services have historically been delivered by a skilled and qualified workforce with specialist capability and competence to practice in ways that promote recovery, as well as help to prevent relapse, psychiatric crises and suicide risk. The community-based psychosocial rehabilitation and support service workforce collaborates alongside other specialist mental health and primary health care service providers in delivering treatment, rehabilitation and support services.

However, the workforce providing psychosocial rehabilitation and support services (i.e., 'non-clinical' or non-acute services), and the organisations that employ them, are not always well understood. To better understand the size, nature and context of the NSW community managed mental health sector workforce MHCC undertook a 2019 NSW CMO mental health workforce survey [8]. At the request of the Productivity Commission, the Report is provided as an attachment to this submission. A literature review is also available from MHCC's website.

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[6] Mental Health Coordinating Council 2019, *Mental Health Matters, Future Investment* Priorities for NSW, MHCC, Sydney, Australia. Available at : http://www.mhcc.org.au/publication/mental-health-matters-future-investment-priorities-for-nsw/

[7] Productivity Commission 2019, *Mental Health Draft Report, Overview and Recommendations,* Volume 1: p.16.

[8] Ridoutt, L & Cowles, C 2019, *The NSW CMO Mental Health Workforce: Findings from the 2019 MHCC Workforce Survey*, MHCC, Sydney.

In summary, the NSW CMO mental health workforce survey found that:

- the size of the mental health workforce is approximately 4,745 paid workers (this includes both direct care and managers/ administrators) as well as 4,160 volunteers.

- In terms of full-time equivalents (FTE), the paid workforce was 3,464 representing close to one-quarter of the total mental health workforce in NSW in 2016-2017 of 14,182 FTE (this includes public and private sector employed workers based on the AIHW National Mental Health Establishments Database and Private Health Establishments Collection).

- the workforce was female dominated (70%) and nearly two-thirds of the workforce were under 45 years of age.

- the workforce was primarily Mental Health Support Workers (63%) and there were also significant numbers of allied health workers including nurses (12%) and Peer Workers (11.3%).

- almost half of the workforce (49%) was employed on a temporary contract or on a casual (hourly rate of pay) basis, and there was a high level of part-time employment.

- qualifications of the main workforce categories were a mixture of levels ranging from no qualification to an undergraduate degree. The predominant qualification was a relevant Certificate III or Certificate IV in, for example, Mental Health Work or Mental Health Peer Work. The emerging peer worker workforce appeared to generally have a lower level of nationally recognised qualification compared to the mental health support worker workforce.

The survey also found that there were a limited number of long-term (greater than three months) vacancies identified by surveyed CMOs (only an estimated 2% vacancy rate). However, MHCC member organisations consistently report increasing challenges in both recruiting and retaining suitably skilled and capable staff. Retention was not explored in the survey but member organisations report increasing rates of staff turnover.

A literature review exploring what we know about the CMO mental health workforce informed survey development.[9] It highlighted the increasing complexity of the psychosocial rehabilitation and support sector and the lack of related workforce data. The government last scoped the workforce nationally in 2009/10.[10]

A rudimentary estimate of workforce growth in the CMO sector can be made by taking as the baseline the midpoint of the NHWPRC range estimate for workforce size (4,100), and the estimate from this survey as the end point (4, 745) which provides a workforce growth estimate of 1.9% per annum.[11]

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[9] Ridoutt, L.& Cowles, C 2019, *What we know about the CMO Mental Health Workforce – A literature review,* MHCC, Sydney.

[10] National Health Workforce Planning and Research Collaboration 2011, *Mental Health Non-Government Organisation Workforce Project Final Report,* Health Workforce Australia, Adelaide.

[11] Ridoutt, L.& Cowles, C 2019, *What we know about the CMO Mental Health Workforce – A literature review,* MHCC, Sydney.

The NSW 2019 workforce survey focused on current workforce supply. MHCC anticipates growth in future workforce demand given policy and funding directions. Funding and policy settings that ensure a skilled and experienced community-based mental health sector and its workforce are essential. Good workforce planning needs investment in both forward demand estimates and related skill/capability development and deployment. MHCC strongly support the Productivity Commission's recommendation for five-year contracts for CMOs funded to supply mental health services that allow for strategic workforce planning and development. Short-term contracts and increasing casualisation can result in unstable or temporary employment for workers and reduce the quality and effectiveness of services.

MHCC also reiterate the recommendation we made in our earlier submission to the Productivity Commission that funding and policy settings to ensure a skilled and experienced community-based mental health psychosocial rehabilitation and support sector and its workforce in all health/mental health and disability workforce strategies are needed. This, along with addressing shortages for community-based acute care services, is essential to addressing the 'missing middle' between acute and primary care services.

Comments on Draft Recommendations

This next section comments on individual recommendations in the Draft Report.

Part 11 – Reorienting health services to consumers

Draft Recommendation 5.9 - Ensure Access to the right level of care

The stepped-care model inadequately identifies where psychosocial rehabilitation and support services operate. They should be situated across all levels of care (Overview, p.18 diagram). It should clearly show how these services should be optimally integrated across all levels of need and demonstrate that it is underpinned by a trauma-informed recovery-oriented approach that is consistent across service contexts.

The proposals for low intensity support should include recognition of the benefits of providing mental health hubs; such as LikeMind which is a service funded by the NSW Ministry of Health. The service provides support for adults with mental health concerns, as well as their families and carers. They establish partnerships across sectors and bring together existing community services in one accessible community space offering an integrated hub of co-located information and support services. Comprised of a range of locally relevant psychosocial and clinical services they are informed by the social determinants of health that meet peoples' recovery needs and goals in one place.

The PC recommends 'Step U/Step Down' (SUSD) programs as part of a strategy to meet the objectives of the stepped-care model. However, In NSW, these services are few and far between and operational only since 2017. Doubling subacute beds in the community, as the PC proposes, will in no way meet the considerable need identified in NSW. At the very least one SUSD program should be established in every LHD in NSW.

One example of a Step-Up Step-Down program in NSW is Eurella, a collaborative partnership between Sydney LHD and New Horizons (a CMO). It opened in June 2017 and is based on the Prevention and Recovery Care (PARC) model which originated in Victoria. Key features of the model are: 10 beds; length of stay less than 28 days; providing step-down (residential support services following discharge from hospital) and step-up (increased support and potentially diverting consumers from hospitalisation) care; 24 hour staffing 7 days per week; based on a mixed CMO and LHD clinical staffing model.

The first 12 months of service data demonstrates increasing occupancy, fidelity to intended scope, favourable clinical outcomes and a functioning partnership model. There were no significant incidents within the first year of use. Step-down referrals came from Concord and the Professor Marie Bashir Centre (PMBC). Step-up referrals came from Community Mental Health Teams across the LHD and Assertive Outreach teams. Nine out of 10 consumers had a primary diagnosis of Schizophrenia and 1 out of 10 had Bipolar Affective Disorder. Average lengths of stay were 22 days.

From the evaluation conducted over the first 12 months of operations, the achievements of Eurella centred on the successful functioning of the unique partnership between SLHD and New Horizons. Eurella utilised three outcome measures: The Health of the Nation Outcome Scales (HoNOS), a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning; the K10 which is a self-report measure of psychological distress; and the Living Skills Profile LSP16 which is a clinician tool which assesses basic life skills and general functioning. The YES Survey which is the Your Experience of Service consumer completed questionnaire was used to improve and respond to the quality of consumers' experience.

Consumers valued their stays at Eurella, reporting that they benefited from the support staff provide and would likely return if needed. Data showed that Eurella functioned well within its intended scope for the first 12 months of operations, although data collection requires greater numbers and a longer period of time, particularly since there are an increasing number of consumers repeatedly being admitted to Eurella due to high support needs who usually require frequent hospitalisations and receive high level community care.

Draft Recommendation 5.2 – Assessment and referral practices in line with consumer treatment need

MHCC agree with improving integrated regional planning and service delivery.

Where MBS services are used, it is vital that they are accountable. A mechanism should be established that assists GPs refer appropriately in a way that matches a person's needs and improves their understanding as to whether the particular practitioner they identify uses a specific therapeutic model or models that will effectively correspond to a consumer's needs.

MHCC draw the PC's attention to Youth Community Living Support Services (YCLSS). The YCLSS is a community mental health service for young people aged 16 to 24, living in the South West Sydney and Northern NSW regions of NSW. The program aims to improve the lives of young people experiencing severe mental health difficulties, giving them the best chance at recovery where they are surrounded by their existing support network of friends, family and carers.

YCLSS is funded by the NSW Ministry of Health and delivered in a partnership between Wellways, the Northern NSW Local Health District Mental Health Service and the South West Sydney Local Health District Mental Health Service. This is an important development in the youth space that meets complex needs and evidence has shown extremely good outcomes. We urge the PC to support growth of such services so that the risk of young people ending up in adult psychiatric services is circumvented.

Draft Recommendation 6.1 – Supported on-line treatment options

It is vital to understand and acknowledge that there is no 'one size fits all' model of therapy. For example, although Internet Cognitive Behaviour Therapy (ICBT) is a promising treatment option for several disorders, it can only be regarded as a well-established treatment for depression, panic disorder, anxiety and social phobia. It therefore follows that ICBT is as effective as conventional CBT for the respective clinical disorders, that is, if conventional CBT works then ICBT works. The effectiveness of the intervention and the limited therapist time required suggest that the treatment is highly cost effective for well-established indications. Other studies internationally demonstrate quite similar outcomes [12]. Whilst proven valuable in the contexts mentioned, the model is often quite inappropriate for many other presentations, particularly therapy for people who have experienced long-term interpersonal trauma – which by and large needs to be highly relational, and therefore face to face, of open-ended duration.

This recommendation must be backed by an evidence-base concerning the effectiveness of online services that meet specific areas of need and that demonstrate an understanding of needs for culturally diverse people. It is not just about translating an online program into another language. Programs need to be specifically co-designed by professionals of that culture with expertise that meets the cultural context and mores. Experience has shown that culturally diverse people may well prefer in the first instance, to use face to face culturally aligned professionals.

Draft Recommendation 5.4 – MBS Rebated Psychological Therapy

MHCC support the recommendation that Government commission an evaluation of MBS rebated psychological services. Whilst MBS rebated psychological services provide an important much needed addition to services in the community for people experiencing a range of difficulties, including mental health conditions it is a concern that no accountability mechanism had been built in.

MHCC draw the PC's attention to comments provided by Sebastian Rosenberg, Brain and Mind Centre, University of Sydney and Fellow at the Centre for Mental Health Research, Australian National University and Professor Ian Hickie, Co-Director at the Brain and Mind Centre, University of Sydney, which outline a decline in the number of new clients in the Better Access Program.
They suggest that it may be that these services have become a referral avenue for people previously accessing the services of psychologists and psychiatrics practicing "talking-therapies" privately, rather than providing services to those previously unable to afford such services. It should be acknowledged that the government did review the session numbers and make possible more sessions for people with severe and ongoing mental health needs.

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[12] Andersson, G Cuijpers, P Carlbring, P Riper, H & Hedman, E 2014, *Guided Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: a systematic review and meta-analysis, World Psychiatry 2014;13:288–295.*

Nevertheless, for many people experiencing complex and co-existing difficulties the limited amount of sessions available can be harmful rather than therapeutic. To commence intense work requires a great deal of time to build trust and rapport, in order to start the 'real work of therapy'. This is true particularly in relation to people with lived experience of trauma, where short-term therapy has the potential to lead to increased distress, when sessions need to be continued and unlimited sessions are unavailable.

Well targeted referrals can be a challenging. There is no 'one size fits all' model of therapy and a GP needs to have extensive knowledge of the difficulties both emotional and functional to make an effective referral. An inappropriate referral may deter a consumer from engaging with any other therapist now or in the future. These are just some of the identified problems with the scheme, and we urge the PC to review the NMHC's findings.

The Draft Report also recommends that MBS psychological services be expanded to meet the needs of people living with mental health conditions presenting with more complex needs; and that lower needs be addressed though online services and other initiatives. This recommendation does not adequately recognise that people with more complex difficulties characteristically need care coordination. When psychological/ therapeutic or behavioural supports are necessary, they can be referred as required to the MBS scheme. However, care coordination services need to be able to refer to psychosocial rehabilitation as well as support services. This is to provide services that can more assertively respond where functionality is negatively impacting on a person's efforts to live a better life in the community. This requires a greater investment in community-based psychosocial rehabilitation and support services. Care co-ordination can only be effective if such services exist and can be accessed when and where they are needed.

Draft Recommendation 7.1 - Planning regional hospital and community mental health services

MHCC support using an evidence-based framework such as the National Mental Health Services Planning Framework (NMHSPF) to ensure funding levels are matched to the level of need. However, the NMHSPF must adequately benchmark optimal community health service delivery.

We comment further that the NMHSPF needs to assess current needs whilst making a judgement on a transition realignment of service delivery from acute to community-based services. Some initial expenditure is necessary to undertake trials and evaluations to assess what improved outcomes could be achieved across service contexts. This includes assessment of the impact that more housing stock and enhanced housing and homelessness support programs could make to the number of hospital presentations and lengths of stay across a diverse Australian landscape.

Draft Recommendation 8.1 – Alternatives to hospital emergency departments for people with acute mental illness

MHCC support the provision of more and improved alternatives to hospital emergency departments.

MHCC ask the PC to consider the review of the Psychiatric Emergency Care Centres (PECCs) which are the specialist 6 bed short stay mental health units co-located in an Emergency Department (ED). The length of stay in the PECC is up to 48 hours, providing an opportunity for assessment, close observation, and treatment to support clinical stabilisation. Follow-up on discharge from these units is often provided by the Acute Care Team. Patients are also linked into services identified by the treating team to ensure ongoing follow up and support.

PECCs in NSW were generally rolled out somewhat differently than had been originally envisaged. Many patients in PECCs are triaged in the usual way in ED settings, and may later be diverted to a PECC if they do not get assessed as requiring to be scheduled. This model needs to be reviewed and considered in the context of a collaborative model with 24/7 community-based centres that would only refer to PECCs where appropriate.

MHCC believe a great deal could be achieved by establishing community-based intense service delivery centres. These could provide an opportunity for de-escalation in a trauma-informed recovery-oriented environment with armchairs, coffee and food, someone to talk to, sensory spaces, comfortable and private de-escalation rooms and access to a diversity of workers including peer support and AOD workers.

It would require collaborative work between the police, paramedics and community services to be able to provide intense clinical and social care and a wrap around 24/7 crisis and referral service.

An independent review process should be undertaken which encompasses a codesign and development process between consumers, carers, clinicians, mental health and peer workers and CMOs to design and develop a community-based collaborative model that could offer an alternative and addition to EDs and PECCs.

Elsewhere in this submission MHCC have also raised the need for step-up step-down services which could also assist in reducing the number of people with a mental health condition presenting to emergency departments.

Draft Recommendation 11.1 – The National Mental Health Workforce Strategy

In this recommendation and the following draft recommendations (11.2 - increase the number of psychiatrists; 11.3 – more specialist mental health nurses and 11.4 – strengthen the peer workforce) the PC Report recommends strategies to increase the number of psychiatrists and mental health nurses. It also has a focus on strengthening the peer workforce. These are both important initiatives, however, workforce development needs must include the community mental health workforce more broadly, which in NSW is nearly one-quarter of the total mental health workforce. The sector is under significant strain due a range of reforms including the NDIS and the transition from national to regional commissioning through the PHN's.

MHCC have previously raised the pressing need for a community-based workforce skilled and capable of providing psychosocial rehabilitation and support needs across the spectrum of the stepped-care model.

As mentioned earlier, psychosocial community-based rehabilitation is a defined intervention designed to work with the specific difficulties that arise when people have a severe and enduring mental health conditions using the principles and framework that supports a person's journey of recovery.

In addition to core recovery capability, the workforce requires:

- a sound understanding of the diversity of mental health conditions and co-existing conditions including the interface with physical health, trauma and developmental difficulties, alongside the impact of mental health conditions on activities and participation;
- an understanding of evidence-based approaches to assisting people build skills, find employment, maintain a home and build social networks;
- sound understanding of rehabilitation models and related skills;
- a commitment to working with, supporting and including families, carers and support persons; and
- an advanced understanding of trauma-informed recovery-oriented values and principles, as well as recovery processes.

The community managed mental health sector prioritises psychosocial rehabilitation and support services that progress recovery, engender hope and support people to thrive. The sector has developed a workforce that is appropriately qualified and skilled to deliver these services, and that brings with it a culture and values that are reflected in the National Practice Standards for the Mental Health Workforce. However, the workforce needs to grow, whilst maintaining and improving its outcomes and outputs and meeting access and equity demands. This is especially pressing in rural, regional and remote communities where people resources are limited particularly in relation to Aboriginal mental health workers.

The reform environment has created several challenges for the sector supporting people living with psychosocial disability, the quality of supports available, and meeting occupational health and safety obligations to staff.

These include:

- Difficulty in being able to afford time for essentials such as practice supervision, training, development, collaboration and innovation, and routine administration, due to funding constraints
- Workplace health and safety concerns when providers are unable to fund two support workers – i.e. staff working in isolation and in uncontrolled environments such as people's homes, etc.,
- Providers shifting to an increasingly casualised workforce and the impact this has on being able to provide a consistent worker for individuals who seek or benefit from this;

- Difficulties in retaining the highly skilled workforce who are currently employed and who have experience working with complex clients;

- Accommodating different levels of complexity and reflecting the costs of providing reasonable and necessary levels of care.

Part 111 - Reorientating surrounding services to people

Draft Recommendation 10.2 - Online navigation platforms to support referral pathways
MHCC support in principle online navigation platforms to enhance referral pathways.

However, there are some issues that need to be considered:

- Privacy issues e.g., in relation to schools and other service providers and agencies;

- Where an assessment occurs and how appropriate referrals will be conducted together with the confidentiality of the information be contained in the portal;

- Review the HealthPathways portal (an online health information portal for GPs, to be used at the point of care) to determine if it is a suitable mechanism for mental health information, who will have access and what the long-term impacts of that might be.

Draft Recommendation 10.3 – Single care plans for some consumers
Single care plans may provide for more integrated care. However, privacy and confidentially issues must be considered.

A statement of rights should be developed that clearly sets out the permissions for shared-care, and states where and when certain directives must be observed in order to respect a person's wishes. Further, a portal is only as robust as those entering the data, particularly in relation to medication, diagnoses and social histories. Files can hold much out of data information that can become a millstone around a person's neck; and greatly impact a person's ability to exercise 'dignity of risk'.

The current recommendation designs single care plans to be managed in clinical settings, by clinicians working on behalf of their patients. The implications for professional/practitioner role delineation arising from a single care plan must be considered, especially with regards to how non-health services might be included. Organisations outside of the traditional health system will also need to be supported to have the capacity to participate in the necessary data sharing systems.

There are examples of poor communicators of risk assessments between public mental health services and CMOs. There are a range of issues with discharge planning for example, when circumstances change quickly and people are discharged without the paperwork having been adequately completed, either because of staff shifts or change-over issues. This may also impact on consumers exercising choice regarding who they would like to deliver a service, especially when services are thin on the ground or do not exist at all.

Draft Recommendation 10.4 - Care Coordination Services
Care-coordination is a vital part of insuring that a person living with mental health conditions has access to a range of services that meet their needs and goals. It is vital that the person at the centre of the plan is supported to participate in decisions and discussions as to what is to be achieved. Supported Decision –Making (SDM), is an essential workforce skill and competence in the mental health space. People may have varying degrees of capacity to give informed consent, and make decisions about care, treatment and supports. They should have access to mental health workers who have skills to assist a person maximise self-determination and independence, including even if a person is under a Guardianship or another Order, including Community Treatment Orders (CTOs).

Matters for consideration are: how consumers can best participate and (where possible) direct care planning; and be able to give voice to their 'will and preference' as well as express their recovery goals? A cultural shift is often required across roles and professional disciplines so that everyone is on the same page; and that care coordination of single plans does not translate into symptom management plans.

Several other issues also require consideration. Firstly, how can and will such services be assessed and benchmarked, and where will the consumer experience sit in terms of benchmarking.

The **Your Experience of Service (YES/CMO)** questionnaire, which is designed to gather information from consumers about 'their experiences of care', aims to help mental health services work with consumers to build better services. The second pilot, CES, will similarly gather evidence from carers of people using mental health CMO services. The YES questionnaire was developed with mental health consumers based on recovery principles described in the 2010 National Standards for Mental Health Services.

The YES questionnaire data is confidential and does not include personal identifiers, such as a medical record number. Services will receive feedback combined under a specific service type. Feedback will help organisations identify what they do well and areas for improvement. NSW CMO's are currently piloting the YES questionnaire. This pilot is expected to run for a year-and-a-half ending June 2020.

Draft Recommendation 12.1 - Extend the contract length for psychosocial supports
MHCC strongly supports the recommendation to move funding cycles from one to five years. It is likely there will be ongoing growth in CMO workforce. In the 2019 MHCC workforce survey most organisations surveyed identified that an increase in workforce numbers with higher skill levels will be required.

Good workforce planning needs investment in both forward demand estimates and related skill/capability development. Five-year funding contracts will allow for strategic workforce planning and development. The current short-term contracts that are so prevalent can result in unstable or temporary employment for workers and reduce the quality and effectiveness of services.

Draft Recommendation 12.2 – Guaranteed continuity of psychosocial supports
MHCC support this recommendation. It is worth noting that CMOs include psychosocial rehabilitation services that may not be duplicated in a NDIS context. The NDIS does not replicate mainstream services and sets itself up to provide services to enhance mainstream services rather than substitute them.

The NSW Government made the sensible decision not to roll into the NDIS its mental health programs. This is to ensure that people can continue to access these specialist psychosocial support and rehabilitation services from mainstream providers.

Draft Recommendation 13.3 – Family-focused and carer inclusive practice
MHCC support the recommendation that proposes greater consideration be given to family and carer needs in their role of contributing to the mental health of consumers.

MHCC draw to the attention of the PC a model of care called 'Open Dialogue'. Developed in Finland, Open Dialogue has been taken up in countries around the world, including much of the rest of Scandinavia, Germany and several states in America. It has raised considerable interest in Australia.
Open Dialogue is a model of mental health care which involves a consistent family and social network approach where all treatment is carried out via a whole system and network meetings, which always include the consumer.

In the UK, the USA and Scandinavia all healthcare staff involved in Open Dialogue are trained in family therapy and related psychological skills. The Open Dialogue approach is very much a recovery, strength-based program approach, which several NH Trusts in the UK have now established. Some of the results from international non-randomised trials are striking. For example, 72 per cent of those with first episode psychosis treated via an Open Dialogue approach returned to work or study within two years, despite significantly lower rates of medication and hospitalisation compared to treatment as usual. More about the origins of Open Dialogue, and the work being conducted in the UK, is available at www.developingopendialogue.com

Whilst recognising that many consumers with complex and co-existing mental health conditions are very socially isolated and have no family, carers or support networks, MHCC propose that this model lends itself to broad-based application and is particularly helpful to younger adults who still have family and social networks.

Draft Recommendation 15.1 – Housing security for people with mental illness & Draft Recommendation 15.2 – Support people to find and maintain housing
MHCC strongly support these recommendations.

Too many people languish long-term in mental health facilities (despite assessments reporting that that are well enough to be discharged). This is due to a lack of appropriate housing and support services to help them maintain a quality of life that will promote their recovery in the community.

Sometimes, because of the shortage of suitable accommodation, people are discharged to unsuitable housing, such as boarding houses, motels and caravan parks. This compounds the fact that they may also have poor access to the support services necessary to minimise the risk of readmission. If more housing and services were made available, this would reduce the bed blockages that many facilities experience.

Pathways to Community Living Initiative (PCLI) is a NSW program that is making some inroads into finding suitable homes for people who have been staying too long in hospital. The PCLI is a coordinated state-wide approach to supporting people with severe and persistent mental illness, who have been in hospital for more than twelve months, to re-establish their lives in the community.

The PCLI program adopts a rights-based, recovery-oriented approach that places the quality of life and unique needs and wishes of the consumer at the forefront. PCLI works with the consumer, their family or carer to find the best option for community-based living. Such programs should be expanded to offer stable housing to those who have also had long stays in hospital for over 6 months.

At June 2019, four years into this initiative, the initial evaluation findings by the Australian Health Services Research Institute from the University of Wollongong are that this is a major reform program that is transforming people's lives and contributing to practice change in mental health hospitals. PCLI Evaluation Report 1 details the significant work by Local Health Districts (LHDs) to ensure person-centred and successful transitions are making a difference to the lives of patients and their families.

There are two other important NSW initiatives which are relevant to this recommendation - Housing and Accommodation Support Initiative (HASI) & Community Living Supports (CLS). HASI support helps people to achieve their own, unique goals. The types of support people receive depends on their individual needs and what they want to achieve. People in the program often get help with: daily living skills like shopping, looking after finances, cooking or catching public transport; remembering appointments, medications and other treatments; meeting people in the local community and participating in social, leisure or sporting activities; learning new skills; accessing education or help to get a job; moving from a hospital or a prison back to home; accessing other supports like alcohol and other drug services and the National Disability Insurance Scheme (NDIS). The level of support is flexible. Some people might need only a few hours of support a week while some HASI consumers might get more than 5 hours support a day.

HASI providers and mental health services work closely with the Department of Family and Community Services (FACS) because many HASI participants live in social housing. However, a person is not automatically eligible for public or community housing just because they are a HASI participant. The normal application process and eligibility criteria for social housing apply. CLS is a more recent addition to the service program.

Evaluation of the HASI and CLS programs provide evidence of the effectiveness of these programs in keeping people well in the community and improving quality of life. Findings from an evaluation conducted by the University of New South Wales in 2012 demonstrate that HASI has provided significant benefits for those who have received support from the program as well as the broader NSW community. This evaluation demonstrated a 24% reduction in mental-health related hospital admissions following HASI supports; a 51% reduction in emergency department presentations following two years of participation and an estimated $30 million in savings each year (in 09-10 dollars) compared to an allocated budget of $118 million for 4 years from 2006 to 2010. The beauty of these initiatives is that they represent secure stable housing that people can call home. This level of security really helps people remain well in the community, with levels of support that can be altered according to need that may fluctuate over time. People are not expected to leave this accommodation because they are maintaining good health or have found employment for example.

According to an analysis by KPMG undertaken for MHCC, investment in additional HASI type services will return a $1.20 per every dollar invested in the short term. MHCC's report, Mental Health Matters[13] estimates there are an additional 4,907 people in NSW in need of a HASI/CLS type service, based on the gap between the number of people accessing Specialist Homelessness Support (SHS) services who were identifies as needing mental health services and those who received access to this care.

Draft Recommendation 16.2 – Mental healthcare standards in correctional facilities

MHCC support the mental health standards applying to correctional facilities in line with that of the community in general.

Draft Recommendation 16.3 – mental healthcare in correctional facilities and on release

In addition to this recommendation, there needs to be improved access to community mental health programs for correctional patients so that they can better transition back into the community and not be lost to services.

Over the years, it has proved problematic for CMOs to gain access to inmates experiencing mental health difficulties in gaol. An added barrier is that amongst the CMO workforce there are limitations in terms of the numbers of workers with the skills and confidence to work with this group of people who often demonstrate a very complex mix of mental health and personality disorders, trauma histories, co-existing substance misuse as well as developmental and acquired cognitive impairments. Such workers are a very important and necessary addition to the CMO workforce that should be considered in any community workforce strategy in terms of education, training and remuneration levels.

Draft Recommendation 16.6 – Legal Representation at Mental Health Review Tribunal hearings

MHCC strongly support access to legal services at all types of hearings that arise from the interface with the *Mental Health Act 2007* (NSW). Consumers have poor access to legal assistance unless the matter relates to Involuntary Orders (s371a, b) or first CTOs. The Mental Health Legal Advocacy Service will make a judgement on future orders and some other matters such as ECT, but generally this would be unusual.

Draft Recommendation 16.7 – Non-legal advocacy services

MHCC support this recommendation and propose the suitability of the peer workforce to be upskilled to provide Supported Decision-Making (SDM). Scholarships should be provided to the sector to ensure that this is available. Scholarships are also required to provide training to Peer Workers as well as Mental Health workers. MHCC have recognised the importance of these skills and has developed two products that speak to this knowledge and skills gap.

[13] Mental Health Coordinating Council 2019, *Mental Health Matters, Future Investment* Priorities for NSW, MHCC, Sydney, Australia. Available at : http://www.mhcc.org.au/publication/mental-health-matters-future-investment-priorities-for-nsw/

MHCC has provided a submission to the Ageing and Disability Commission: Advocacy Review which addresses the need for the NSW Government to maintain its support of specialist advocacy services across the disability sector. In its submission MHCC provided perspectives on the purpose, functions and future needs for disability advocacy across the state. This included comments on the principles that should apply and ways in which to address the emerging needs of people living with disabilities in a dynamic service systems environment.

Part 1V – Early intervention and prevention

Draft Recommendation 20.1 – National Stigma Reduction Strategy

MHCC strongly support a national stigma reduction strategy being undertaken. The extremely successful campaign that was conducted and continues in Scotland is worth noting. The campaign ' SEE Me – End mental health discrimination and stigma' involved some very moving videos shown on YouTube and TV and a raft of resources that address issues across contexts.

Draft Recommendation 20.2 – Awareness of Mental Illness in the Insurance Sector.

MHCC support this recommendation.

KPMG have conducted research into this matter and released 'The impact of Psychosocial factors on mental Health and their implication in Life Insurance' which speaks to the "growing recognition of the social and economic impact of mental health conditions".

This study has instigated important policy considerations across many organisations, industry and government. KPMG reported that the life insurance industry is a sector experiencing an increase in mental health income replacement claims. The most widely acknowledged social and individual impact of mental health difficulties for adults are the flow-on effects (financial, familial and social) of unemployment. This paper describes the results of a systematic review of the relevant literature relating to the development of mental health conditions based on the biopsychosocial model of healthcare.

Draft Recommendation 21.3 – Approach to Suicide Prevention

The NSW Government is investing approximately $87 million over the next three years into eight new suicide prevention initiatives, to support the implementation of the Strategic Framework for Suicide Prevention in NSW 2018-2023. One of these is the Alternatives to Emergency Department Presentations initiative. Over the next three years, $25.1 million is being invested to open twenty new Alternatives to Emergency Department Presentations services around NSW. These services will provide a safe alternative to presenting to an emergency department for people with suicidal thinking, who are in distress or crisis. These types of services have been shown to reduce the pressure on busy emergency departments and admissions to mental health inpatient units.

LHDs will work with people with lived experience of suicide to establish these services, which will have a strong peer work focus. The services will offer a safe and appropriate environment for people to connect to support. It is expected that CMOs will play an important role in providing these services and collaborating with other organisations that provide online suicide and crisis counselling such as Lifeline and first responders as a first referral point in the community. Evidence from evaluations of this systems approach together with the Toward Zero Suicide Strategy also being rolled out in NSW should provide good evidence as to what could become a national strategy for reducing suicide in Australia in a cross-government approach across a range of human services. MHCC support these initiatives.

Part V – Pulling together the reforms

Draft Recommendation 22.1 – A National Mental Health and Suicide Prevention Agreement

MHCC support the recommendation for a National Mental Health Agreement to codify responsibilities for the delivery of and funding of mental health services and suicide prevention activities. The lack of clarity about how both tiers of government share responsibility for funding and delivering mental health services needs to be addressed and MHCC believe this recommendation is a foundation reform on which other reforms can build.

MHCC support the proposal for COAG Health Council to be the responsible body for developing the agreement. However, we do raise some concerns about "separating funding and governance arrangements of mental health from those of physical health" (second dot point). While supporting the desire to strengthen the accountability of individual jurisdictions for mental health outcomes, separating governance arrangements for physical and mental health poses risks for integrated care, the potential loss of shared learnings across both areas and could see mental health isolated from broader Government commitments for health improvements.

Consideration also needs to be given as to how this agreement will relate to the five-year Fifth Mental Health Plan which was recently endorsed by COAG.

Draft Recommendation 22.3 – Enhancing consumer and carer participation; 22.4 – Establishing targets for outcomes; and 22.5 – Building a stronger evaluation culture

MHCC support these three recommendations.

Draft Recommendation 23.1– Review proposed activity-based funding classification for mental health care

The Draft Report suggests activity- based funding could be applied to community mental health services. MHCC question how this is workable in terms of responding to episodic need and critical incidents.

Draft Recommendation 23.2 - Responsibility for psychosocial and carer Support Services

MHCC support this recommendation in principle, but there are issues which need to be considered. For example, CMOs may be providing the same services to two groups of people from different funding sources – those eligible for the NDIS and those ineligible – with potentially different staff working at different rates of pay.

Draft Recommendation 23.3 – Structural reform is necessary, two models proposed "Renovate" or "Rebuild"

MHCC agree that structural reform is necessary and support the need to incentivise governments to invest in the services that best meet the needs of people living with mental health conditions, their families, carers and support persons. We raise the following concerns regarding the "Rebuild" model:

- Such a major and complex change would take significant time to implement resulting in enormous uncertainty and may detract from the capacity to make other necessary improvements to service delivery.
- Establishing separate mental health specific commissioning bodies may impact negatively on systemic capacity to further drive integrated care for people with mental health issues. The role of GP 's has not been fully considered.
- It is not clear how community mental health services and psychosocial services fit into the regional model of care. How would consumers and carers be supported to engage with these structures, and would people be able to self-refer?
- There are significant challenges in ensuring state and territory governments accurately determine their expenditure on 'in scope' services that would be transferred to the Regional Commissioning Authority (RCA).
- It is not clear which level of government would bear responsibility for ensuring the RCA has sufficient funds to meet the required demand for services.

The "Renovate model" is a more gradual approach to reform, with the accompanying risk that it may not result in the necessary level of change required to "fix the mental health system". However, if accompanied by the necessary leadership, additional funding, alongside the implementation of many of the other reforms outlined in this report, it could provide a workable model.

To this end, MHCC make the additional comments regarding our current experience of working with PHNs, which should be taken into account if the "Renovate Model" is implemented. Community mental health organisations have worked hard to develop good collaborative relationships with PHNs since they were established. The CMO sector has significant service delivery and partnership experience and there are ways in which PHNs could work more effectively with CMOs and achieve better outcomes by moving away from a 'commissioner versus provider' model. Evidence has shown that co-commissioning models work best where CMOs (together with people with lived experience, family and carers) are partners in identifying and shaping the response through a co-design and development approach, and by collaborating to evaluate agreed measures and outcomes.

A lack of consistency in approach to commissioning by PHNs has impacted on the resourcing of CMOs, who characteristically have to deal with multiple PHNs, different KPIs, numerous outcome measures, contracts, length of contracts, overheads and budget parameters (e.g. indirect v direct costs), with associated negative productivity and efficiency impacts (which Draft Recommendation 25.6 addresses).

PHNs could benefit from better understanding the community mental health sector workforce including the qualifications and unique knowledge, skills and competencies our staff demonstrate in supporting people experiencing complex mental health issues; including the large and growing peer workforce trained and employed by the sector.

Draft Recommendation 24.3 – The National Housing & Homelessness Agreement
MHCC support this recommendation.

Draft Recommendation 25.1 –A data linkage strategy for mental health data, Draft Recommendation 25.2 – Routine National surveys of mental health, Draft Recommendation 25.3 - Strategies to fill data gap
MHCC support these recommendations. There is a pressing need to improve mental health data collection, particularly about the CMO sector.

Draft Recommendation 25.4 – Strengthening monitoring and reporting; Draft Recommendation 25.5 – Reporting service performance data by region; Draft Recommendation 25.6 – Standardised regional reporting requirements; Draft Recommendation 25.7 – Principle for conducting program evaluations

MHCC support these four recommendations.

Other concerns

The PC have made clear that that the mental health needs of older people would remain outside of its deliberations. Nevertheless, MHCC emphasise that this will exacerbate the substantial gap that exists for older people across multiple service systems. The Age Care Commission Inquiry is also silent about the mental health needs of older Australians. Therefore, we highlight this as an area of concern especially because of an increasingly growing ageing population nationally.

It is vital that in the important recommendations proposed by the PC regarding for example, early intervention, that mental health matters be considered across the lifespan to include older persons. Likewise, that in relation to education and employment and the interface between clinical and psychosocial that the needs of older persons be considered. Certainly, many of MHCC's member services are already working in this space.

The PC's considerations regarding a whole of government approach to economic outcomes leaves out the huge contribution that older people make in terms of informal care, and to the community in general. It is about participation more than employment and their contribution to creating a cohesive society.

Mental health care is not undertaken by the age care sector, and to leave out the psychosocial needs of older persons and the cross-government partnerships vital to ensuring a coordinated approach across the sectors, is in our view problematic. By way of an example, MHCC draw attention to HASI and CLS services which several MHCC members facilitate. These services do not mandate an upper age limit and they continue to work with and support many clients in the older age bracket.

Some recently established services employ staff specifically skilled and trained to work with older clients to provide quality improvement for this cohort. We therefore urge the PC to consider these questions in their further review of service gaps that could be addressed in their final report to government.

MHCC thank the PC for the opportunity to provide input into this Inquiry and express their willingness to be further consulted on any matter discussed in this submission.