



MENTAL ILLNESS
FELLOWSHIP
of Australia Inc

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Submission to the Productivity Commission

Inquiry:

Mental Health in Australia

Contents

About Mental Illness Fellowship of Australia 4

Submission Outline 5

Need for Better Mental Health Data 6

 Population estimates for people with severe mental illness 7

 Burden of disease 10

Investment in Mental Health 11

 NDIS Service Gaps 13

A Program to meet the commitments of the Fifth National Mental Health and Suicide Prevention Plan..... 15

 Eligibility 15

 A National Psychosocial Recovery Program is Needed 16

 Features of the National Psychosocial Recovery Program 18

 1. Delivery of individual and group psychosocial support services through a recovery-oriented model 18

 2. Stepped Care model 19

 3. Assertive Outreach 21

 4. Inclusion of families, friends and carers 22

 5. Integration of services supporting carers and families 23

Planning under the National Psychosocial Recovery Program 24

 Support for joint PHN/LHD planning 24

 Support for strengthening the National Mental Health Services Planning Framework..... 25

Funding for the National Psychosocial Recovery Program 25

 Support for a National Psychosocial Recovery Program 26

Addressing Stigma 27

 The impact of stigma 27

 Barriers to seeking help 28

 National Anti-Stigma Strategy 29

Recommendations 30

Appendix A 31

Group Support Services 31

Appendix B 33

 Strengthening Primary Health Networks..... 33

Contact..... 35

Written by 35

Disclaimer..... 35

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 (formerly Schizophrenia Fellowship of NSW);
- **selectability** (a merger of SOLAS and Mental Illness Fellowship of Northern Queensland);
and
- Skylight Mental Health (formerly Mental Illness Fellowship of South Australia).

Submission Outline

In this submission, MIFA will:

1. Point to the need for the Productivity Commission to **obtain better mental health data** to improve our population estimates of people with severe mental illness to inform decisions about mental health investments and service need.
2. Advocate for **greater investment in** mental health services based on the burden of disease.
3. Propose the implementation of a national program – the **National Psychosocial Recovery Program** – for the group of 225,000 people with severe mental illness who are not eligible for support under the National Disability Insurance Scheme. MIFA proposes that, through this program, governments will be able to meet their commitments under the Fifth National Mental Health and Suicide Prevention Plan.

In describing the National Psychosocial Recovery Program, MIFA will:

- define the cohort of people who will be eligible for the program;
 - identify why this program is needed;
 - describe the features of the program;
 - describe the planning under the program;
 - describe the method of funding for the program; and
 - describe support already received for the program, both from within the mental health sector and from within government.
4. Urge the Productivity Commission to address **the impact of stigma** on people with lived experience of mental illness by implementing a national anti-stigma strategy.
 5. Make **recommendations** to the Productivity Commission based on the content of this submission.

Need for Better Mental Health Data

At present, we are unable to easily quantify the economic impacts of all mental ill-health in Australia as there is an alarming lack of mental health data. The lack of a consistently applied national dataset for mental ill-health makes it challenging to quantify the number of people who are experiencing severe mental illness in Australia from year to year and the impact of this.

MIFA notes the population estimates contained in the Productivity Commission Issues Paper for this inquiry. In this paper, it is stated that approximately 800,000 people experienced severe mental illness over the 12-month period leading up to 31 March 2018. Of these people, it is estimated that 500,000 people experienced episodic mental ill-health, 200,000 people experienced persistent mental ill-health and 100,000 people experienced complex and persistent mental ill-health.

The following table was included in the 2012 Productivity Commission Report on the National Disability Insurance Scheme (NDIS)¹:

NDIS Scope of Services

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

It is timely that the Productivity Commission review and update this information. This will enable governments and the mental health sector to have a clear understanding of how many people

¹ Australian Government Actuary, *National Disability Insurance Scheme Costings – Review by the Australian Government Actuary*, Canberra, 2012, p. 13-14.

are experiencing severe mental illness each year in Australia and the clinical and non-clinical supports that are required.

As part of the Productivity Commission review, MIFA recommends that this information is updated to take the following considerations into account:

- To take account of population growth.
- To take account of new research or accepted numbers/definitions for mental illness categories.
- To review the assumptions made at the time in relation to the expectations of the non-NDIS service system. Does the non-NDIS system have the capability or current resources to deliver the clinical, disability or social inclusion programs identified? Are the services that are not included in the NDIS system currently available, given that some services are ceasing so that funds can be channelled into the NDIS?
- A revised table needs to identify how care needs not included in the NDIS should be provided in the future. The table should identify which program and level of government will have responsibility for meeting non-NDIS care needs.

Population estimates for people with severe mental illness

Based on the information currently available, MIFA contends that the population estimates for mental health needs in Australia are as follows:

- **3.8 million**² people of all ages experience mental illness in Australia each year.
- **690,000**^{3,4,5} people have a severe mental health issue.
- Between 280,000⁶ to **290,000**⁷ 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

² 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

³ National Mental Health Commission (NMHC) *Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services*, 2014, p. 46.

⁴ *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.

⁵ 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>.

⁶ 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.

⁷ People aged 12-64, McGrath, D. (2016). *Op. cit.*

mental illness (up to 690,000 people) will require some level of ‘disability support’ at some point in their lifetime.^{8,9}

- There is uncertainty about how many of those people will be eligible for 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).^{10,11} This number has now been updated by the NDIA to **64,000**.¹² However, recent modelling by the Department of Health based on the (unpublished) National Mental Health Services Planning Framework suggests that **91,916 people** with “severe and complex disorders”¹³ would be eligible.

Based on these population estimates, MIFA’s **Diagram of Need** identifies the different cohorts of people experiencing severe mental illness and the population estimates for each group. It goes further and explains the funding arrangements, both past and present, and identifies gaps in current funding arrangements. The **Diagram of Need** describes the following groups of people:

- **690,000 people** with severe mental illness;
- **290,000 people** with psychosocial disability with reduced functional capacity; and
- a conservative estimate of **65,000 people** with psychosocial disability and substantially reduced functional capacity who meet the eligibility requirements under the NDIS.

This classification of people with severe mental illness, as outlined in the **Diagram of Need**, will be referred to throughout this submission. The **Diagram of Need** is provided below.

⁸ National Mental Health Commission. *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services*. 2014, p.46.

⁹ 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.

¹⁰ 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.

¹¹ Detail of Australian Government modelling reported on p14, Australian Government Actuary (AGA). *NDIS Costings – Review by the Australian Government Actuary*. Op cit. 2012.

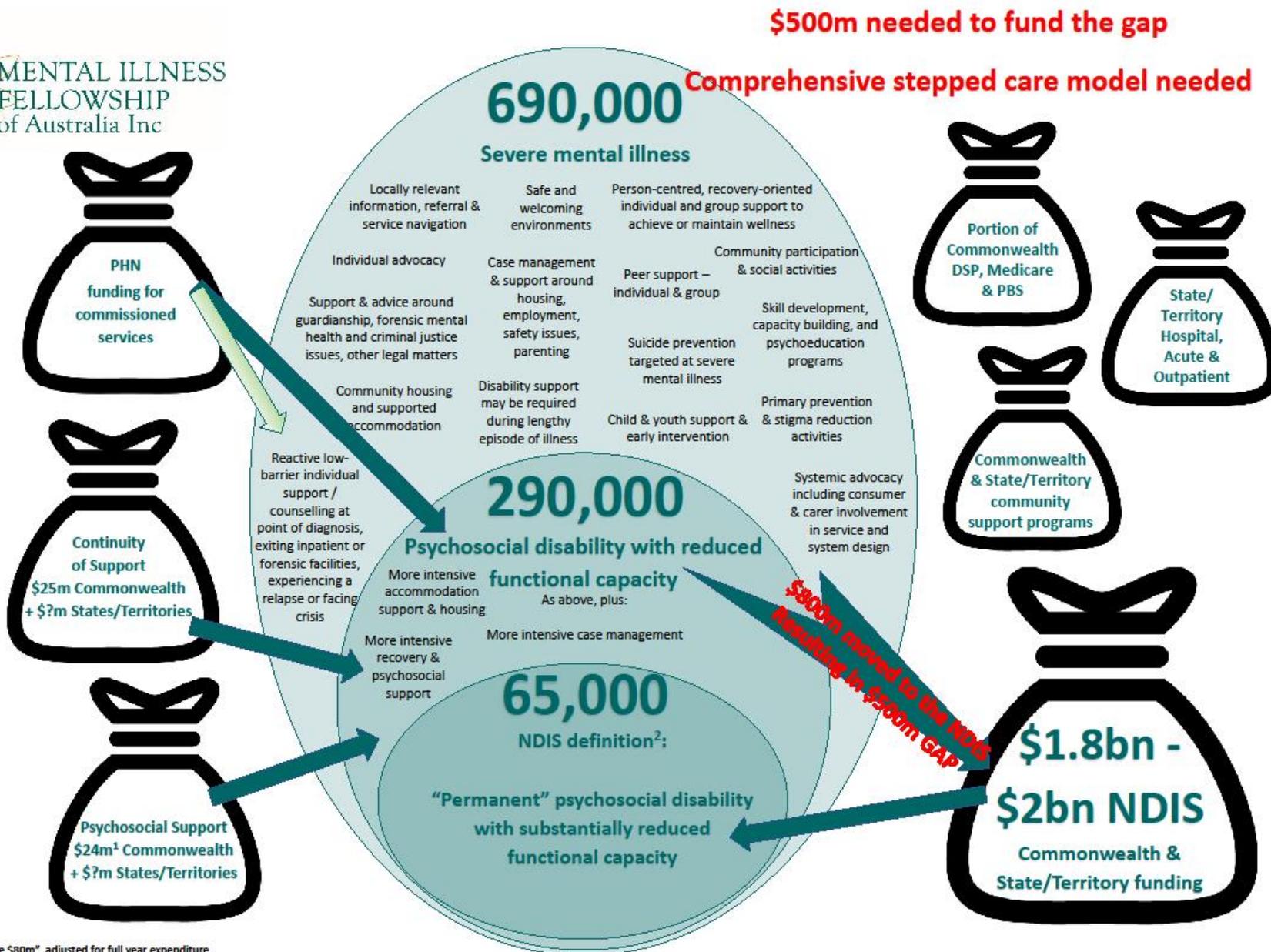
¹² NDIA Annual report 2015-16, Available at: <https://www.ndis.gov.au/medias/documents/ha5/h04/8798853726238/NDI7040-AnnualReport2016-vFaccessible.pdf>, p. 26.

¹³ 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.

DIAGRAM OF NEED



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¹Known as “the \$80m”, adjusted for full year expenditure

²Original Productivity Commission definition: people with “severe, persistent and complex” psychiatric needs

Burden of disease

The Australian Institute of Health and Welfare reports that mental illness accounts for 12% of the burden of disease in Australia.¹⁴ People experiencing 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.¹⁵ The cost to the primary care sector is great. Approximately 75% of mental health care is provided in the primary care sector.¹⁶

The annual costs of psychosis 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.¹⁷ This research revealed that psychosis costs Australian society \$4.91 billion annually and the Australian government almost \$3.52 billion annually.¹⁸ 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.¹⁹ 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 annum²⁰ and people living with schizophrenia accessing health services are estimated to cost \$50,000 per person annually.²¹ From these figures

¹⁴ 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.

¹⁵ 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).

¹⁶ 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.

¹⁷ 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.

¹⁸ Ibid at pp.169-182.

¹⁹ Ibid at pp. 169-182.

²⁰ 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.

²¹ 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.

we can see that the expenditure on serious mental illness is disproportionately low compared to the burden of disease.

Investment in Mental Health

MIFA remains concerned at the significant underinvestment in mental health across Commonwealth and State and Territory governments. Spending on mental health accounts for 7.8% of health expenditure across jurisdictions,²² while causing 12% of the burden of disease.²³ In the 2016-2017 financial year, Australia spent \$180.7 billion (\$7,400 per person) on health,²⁴ whilst \$9.1 billion (\$375 per person) was spent on mental health.²⁵ While what is considered an adequate investment may not precisely correlate with burden, this serves to demonstrate the deficit in funding which has characterised mental health spending in Australia.

The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan)²⁶ commits all governments to work together to achieve integration in planning and service delivery at a regional level. Priority Area 3 of the Fifth Plan states that many of the people with severe and complex mental illness do not receive the supports they need. MIFA believes that there needs to be a significant new funding commitment from the Commonwealth and State/Territory Governments to meet the costs associated with supporting people with severe mental illness over and above the levels already committed under existing funding programs.

²² Australian Institute of Health and Welfare (2016). *Australian Burden of Disease Study: impact and causes of illness and death in Australia*, Available at: <https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-death-2011/contents/highlights>, 2011. Accessed: 22 February 2019.

²³ 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.

²⁴ Australian Institute of Health and Welfare. *Health Expenditure Australia: 2016-2017*. Available at <https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure-australia-2016-17/contents/summary>. Accessed: 3 April 2019.

²⁵ 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/report-contents/expenditure-on-mental-health-related-services>. Accessed: 3 April 2019.

²⁶ *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.

States and Territories currently provide over 70% of community mental health funding²⁷ and 62.1% of overall mental health funding.²⁸ Under the Fifth Plan, governments will establish a sustainable service system that provides the right amount of tailored clinical and community supports, at the right time, for people with severe and complex mental illness. Under Priority Area 3 of the Fifth Plan, the Commonwealth Government has committed to and is responsible for providing an integrated, culturally competent and sustainable service system.²⁹ MIFA advocates that the Commonwealth Government should follow through with these funding commitments.

The lack of investment is evident in the everyday experiences of those accessing services, particularly those with severe mental illness. Current investment in mental health is characterised by short-term and inadequate clinical supports. There is major underinvestment in the non-clinical community supports that complement clinical supports and maintain recovery. There is also little to no investment in service integration or case coordination on a systemic or individual level. This results in poor quality services and poorer outcomes for people with serious mental illness.

To address these inadequacies, MIFA advocates that there must be a planned and nationally consistent approach to investment in mental health services to ensure funding is secured over the long-term. Where extensive cost modelling and regional planning is pending, interim adequate funding must be directed into programs that:

- support those not eligible for the NDIS and provide similar services to the Personal Helpers and Mentors program (PHaMs) and the Partners in Recovery program (PIR), including Continuity of Support, to those in programs set for transition;
- support people in ways not possible under the NDIS, such as providing flexible entry and crisis-responsive services; and
- support people who are considered eligible to apply for the NDIS, during the period of waiting for their application to be resolved.

²⁷ Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health, Senate Estimates 30 May 2017, Community Affairs Legislation Committee: p. 7.

²⁸ Productivity Commission, *Report on Government Services: 13. Mental Health Management*. Available at: <http://www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/mental-health-management/rogs-2017-volumee-chapter13.pdf>, 2017: p. 3.

²⁹ *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. Accessed 2 April 2019: p. 29.

Such programs are best provided by services that have visibility, mental health-specific expertise, and pre-existing community connections.

NDIS Service Gaps

One of the enduring national policy deadlocks for many years now has been the problem created by the restricted eligibility of the NDIS and the transfer of funding to the NDIS from Commonwealth funded programs like PIR, PHaMs and the Day to Day Living Program (D2DL). MIFA is concerned about the 225,000 people who were eligible to receive supports under these Commonwealth programs, and various State/Territory psychosocial programs, who will not meet the eligibility criteria to receive supports under the NDIS. The transfer of funds from these Commonwealth funded programs into the NDIS has meant that only 65,000 people of the 290,000 people with psychosocial disability will be eligible for support under the NDIS, resulting in a gap of 225,000 people who will miss out.

Whilst the introduction of the NDIS has provided significant additional supports to some individuals with psychosocial disability to date, it has been far from smooth. Unfortunately, the transition has resulted in separating out cohorts of people into yet more service frameworks, resulting in an even more fragmented and siloed system.³⁰ MIFA notes that while the NDIS is not the focus of this inquiry, it is critical that we do not overlook the issues that have arisen from the NDIS transition.

Unfortunately, many of the issues identified in previous inquiries remain, including low eligibility and slow transition rates. Recent research conducted by Community Mental Health Australia (CMHA) and The University of Sydney (December 2018) has shown that low proportions of people from the PIR, PHaMs and D2DL programs are applying for NDIS packages and high proportions of people are being assessed as ineligible.³¹ These concerns were mirrored in a recent study of NDIS service providers, where concerns for gaps in eligibility and assessment processes, and concerns for ongoing service delivery for those with serious mental illness outside of the NDIS were recorded.³² Further research is being conducted by CMHA and The University of Sydney to review

³⁰ See MIFA's Diagram of Need document at page 9 of this submission.

³¹ Community Mental Health Australia and The University of Sydney, 'Commonwealth Mental Health Programs Monitoring Project: Tracking transitions from PIR, PHaMs and D2DL into the NDIS', December 2018, at p. 15.

³² Furst, M. A., Salinas-Perez, J.A. & Salvador-Carulla, L. 'Organisational impact of the National Disability Insurance Scheme transition on mental health care providers: the experience in the Australian Capital Territory'. *Australasian Psychiatry*, 2018, 00(0): pp. 1-5 at p. 4.

whether the introduction of the Psychosocial Disability Stream will provide a better pathway for supporting those individuals applying for support under the NDIS.³³

Areas requiring improvement continue to arise as the scheme unfolds. An emerging issue is the number of NDIS applications that are now stalling in the system, resulting in protracted decisions about the eligibility of participants. This is a high priority area that requires immediate attention. Whilst we acknowledge that the NDIA and Government are working together to address this and other issues, MIFA believes it is unlikely that all people will have their NDIS eligibility tested and determined by the time that funded programs are due to cease. This is of great concern to MIFA, our members and to consumers and carers.

³³ View the announcement of the new NDIS Psychosocial Disability Stream: NDIS, “Government announces improved NDIS mental health support”, 10 October 2018, available at <https://www.ndis.gov.au/news/400-government-announces-improved-ndis-mental-health-support>. Accessed on 5 April 2019.

A Program to meet the commitments of the Fifth National Mental Health and Suicide Prevention Plan

MIFA advocates that we need to meet the commitments of the Fifth Plan by planning for the needs of the 225,000 people with psychosocial disability with reduced functional capacity who are not eligible for the NDIS.

The Fifth Mental Health and Suicide Prevention Plan commits Commonwealth and State/Territory Governments to:

negotiate agreements that prioritise coordinated treatment and supports for people with severe and complex mental illness. This will include planning for the community mental health support needs of people who do not qualify to receive supports under the NDIS, including fulfilment of agreed continuity of support provisions and ensuring any mainstream capacity is not lost for the broader population as a result of transition to the NDIS.³⁴

In this submission, MIFA outlines how we can provide a program of coordinated mental health treatments and supports for people with severe mental illness who are not eligible to receive supports under the NDIS. MIFA proposes **addressing the gap** in the current suite of mental health programs and supports through the introduction of a **National Psychosocial Recovery Program** in Australia for the cohort of 225,000 people with psychosocial disability with reduced functional capacity who are not eligible for the NDIS.

Eligibility

MIFA's **Diagram of Need** assessment identifies a group of 225,000 people with psychosocial disability with reduced functional capacity. These people are not eligible to receive support under the NDIS, as they do not meet the NDIS eligibility criteria.

This group of 225,000 people with psychosocial disability with reduced functional capacity will be eligible to receive support under the proposed National Psychosocial Recovery Program.

³⁴ National Mental Health Strategy. *The 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. Accessed: 4 April 2019, p. 28.

A National Psychosocial Recovery Program is Needed

MIFA believes that funding needs to be provided to support all people with a severe mental illness. Additional community-managed services are required for the total cohort of 690,000 people with severe mental illness, and especially the 225,000 people with psychosocial disability with reduced functional capacity who are not eligible for the NDIS. The withdrawal of PHaMs and PIR for this cohort has severely impacted on their capacity to live well as contributing members of the community.

To complement the systems created by the NDIS, MIFA advocates that a long-term, cost-effective and recovery-oriented national psychosocial support program is needed to support the mental health needs of the 225,000 people with severe mental illness in Australia who are not eligible to receive support under the NDIS.

The introduction of the NDIS and the withdrawal of community-based mental health services has created a gap in Australia's service infrastructure that needs to be addressed. The group of 225,000 people with severe mental illness who are not eligible for support under the NDIS need to be identified as a group of people eligible for psychosocial support services. MIFA advocates that a National Psychosocial Recovery Program, designed specifically to meet the needs of this cohort, is the 'missing piece' in the institutional frameworks that support people with severe mental illness.

MIFA has identified **"The Missing Piece"** to describe the proposed National Psychosocial Recovery Program (see below).

The Missing Piece

A National Psychosocial Recovery Program - NPRP

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WHY.....

- The 5th Mental Health and Suicide Prevention Plan commits Commonwealth and State/Territory Governments to “negotiate agreements that prioritise coordinated treatment and supports for people with severe and complex mental illness. This will include planning for the community mental health support needs of people who do not qualify to receive supports under the NDIS, including fulfilment of agreed continuity of support provisions and ensuring any mainstream capacity is not lost for the broader population as a result of transition to the NDIS”.

WHO.....

- 225,000 people with severe and complex mental illness
- Needing psychosocial support and cross-program community supports
- Not eligible for the NDIS

WHAT.....

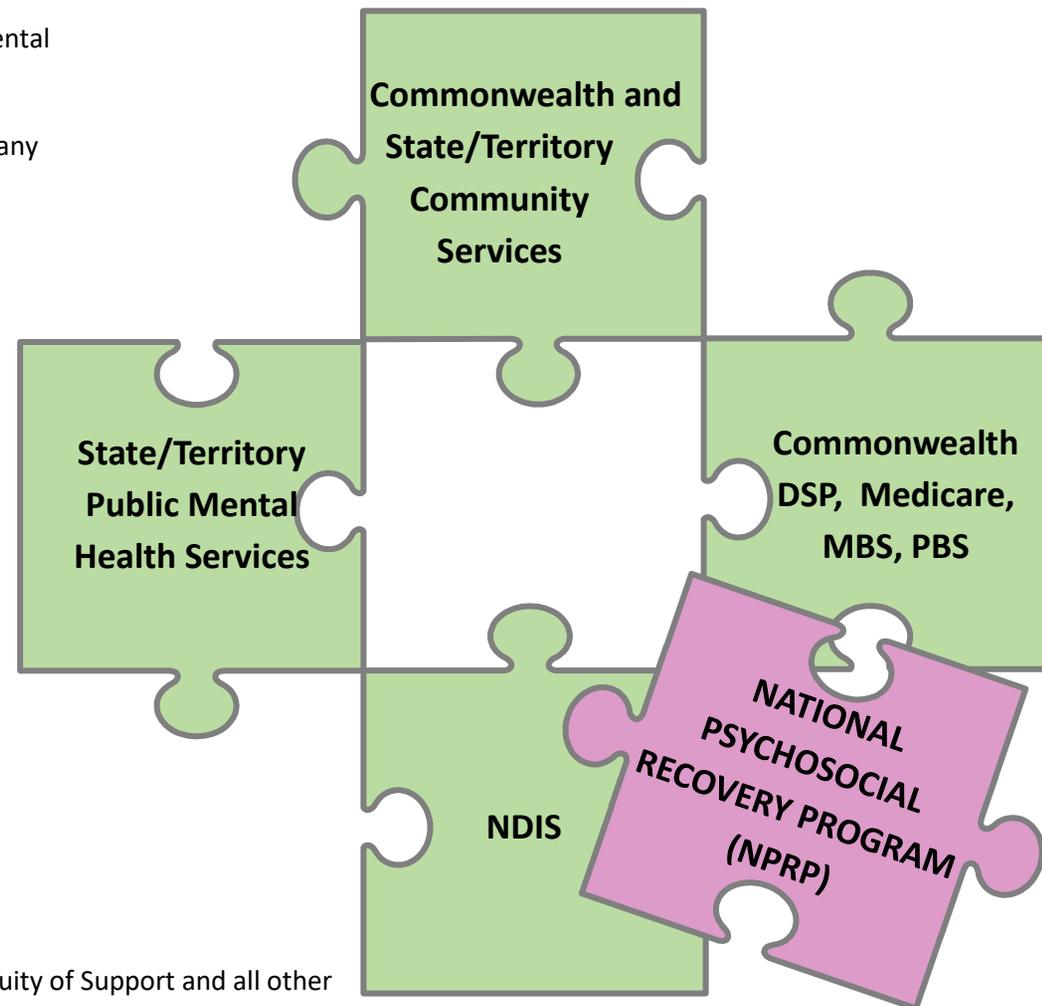
- Individual and group recovery-oriented psychosocial support services
- Build on Australia’s world class recovery model which thrived under 10 plus years of government support
- Carer support services
- Assertive outreach
- Stepped care/person-centred model
- Sector coordination and integration

HOW.....

- Regional allocation
- Based on joint PHN/LHD planning
- Flexible/integrated funding
- No hard boundaries around funding source/level of government

COST.....

- Cost neutral in first year
- Fold in existing Commonwealth and State/Territory commitments for Continuity of Support and all other psychosocial support programs
- Future expansion of funding based on identified needs from regional planning



Features of the National Psychosocial Recovery Program

MIFA proposes that the National Psychosocial Recovery Program involves significant investment in a spectrum of flexible and recovery-oriented clinical supports and non-clinical community-based 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.

The program shall have the following features:

- 1. delivery of individual and group psychosocial support services through a recovery-oriented model;**
- 2. stepped care 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 services supporting carers and families.**

MIFA proposes that this program build on Australia's world class recovery model, which thrived under more than a decade of government support.

Supporting individuals with psychosocial disability with reduced functional capacity is complex. Under this program, **flexible and responsive services** will be needed for people with episodic mental health needs. At times, people may require significant support. At other times, people may only require light-touch quality support. The program will 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.

1. Delivery of individual and group psychosocial support services through a recovery-oriented model

The National Psychosocial Recovery Program will involve the delivery of individual and group psychosocial support services through a recovery-oriented model. MIFA supports a recovery-oriented approach to mental health treatments and supports, believing that all people living with mental illness can recover a better quality of life. In brief, recovery has been defined as:

*an approach to mental health care that promotes self-direction, self-determination and self-management, in the context of individualised, holistic and person-centred support, provided by mental health professionals. Recovery aims to empower consumers as they progress on non-linear journeys of self-discovery, healing and personal development. In order to achieve this, recovery practice often employs strengths-based approaches, partnerships and intensive consumer involvement in the delivery and continuous improvement of services.*³⁵

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 National Psychosocial Recovery Program.

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 through a centre-based Clubhouse model (see Appendix A – Group Support Services).

2. Stepped Care model

MIFA advocates that the National Psychosocial Recovery Program needs to involve a stepped care and person-centred recovery model. ‘Stepped care’ is:³⁶

a term used to describe service systems in which the primary care team is central, but where other levels of professional service are then added proportionately to the severity and complexity of the clinical scenario. Thus, effective primary medical care is linked with the appropriate and timely use of specialist resources.

³⁵ Department of Health Victoria. *Recovery-oriented practice literature review*, 2011: p. 19.

³⁶ 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): at 403-404.

There is international support for the cost effectiveness of stepped care models.^{37,38,39} In Australia, access to appropriate and integrated care at all levels of need in a stepped care model is central to the Fifth Plan through the adoption of coordinated treatments and supports.⁴⁰

Stepped care requires coordinated access to the broader community services sector. Many different support services are vitally important to mental health support, including access to housing, legal support, healthcare, cultural support, domestic violence support, employment support, social services and income support. MIFA endorses the view of the Productivity Commission outlined in the Issues Paper⁴¹ that there are many service areas that can fundamentally improve mental health. Stepped care should link people with severe mental illness to the mix of community support services necessary to meet their specific needs as and when needed. Different service systems working together, with a high degree of service integration and collaboration, to support the needs of individuals with severe mental illness needs to be a feature of the National Psychosocial Recovery Program.

MIFA advocates that the coordination of treatments and supports in this way would be supported through a collaborative care approach. A collaborative care approach aligns with existing policy directions, shows a strong return on investment and produces better outcomes for people experiencing mental illness.⁴² This approach involves building a team of health professionals around the person to manage their mental and physical health needs. The team is led by a care manager who works in partnership with the person's GP, psychiatrist and/or psychiatric nurse and other health professionals.⁴³ Under the National Psychosocial Recovery Program, this same model could be extended to include professionals from a range of different community support services, as determined by the needs of the individual.

³⁷ Katon W, Von Korff M, Lin E, Simon G. Rethinking practitioner roles in chronic illness: the specialist, primary care physician, and the practice nurse. *Gen Hosp Psychiatry* 2001; 23: pp. 138-144.

³⁸ Von Korff M, Katon W, Unutzer J, et al. Improving depression care: barriers, solutions, and research needs. *J Fam Pract* 2001; 50: E1.

³⁹ Lin EH, VonKorff M, Russo J, et al. Can depression treatment in primary care reduce disability? A stepped care approach. *Arch Fam Med* 2000; 9: pp. 1052-1058.

⁴⁰ Australian Government Department of Health. *The Fifth National Mental Health and Suicide Prevention Plan 2017*. Australian Government. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan>. 2017. Accessed: 18 February 2019.

⁴¹ Productivity Commission. *The Social and Economic Benefits of Improving Mental Health: Productivity Commission Issues Paper*. Australian Government: January 2019: p. 3.

⁴² KPMG and Mental Health Australia. *Investing to Save*. KPMG. 2018. Available at https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf. Accessed 5 April 2019: pp. 60-62.

⁴³ Ibid at 60.

This approach is supported by research on the social determinants of mental health.^{44,45} Not only is it essential for different support services to work together, it is also critical that this level of collaboration and consultation occurs at a governance level amongst public policy decision-makers. MIFA advocates that the latest research and information on the social determinants of mental health needs to be considered when developing the National Psychosocial Recovery Program. It is critical that various sectors work together at a governance level to recognise the important social and economic conditions implicated in major health inequalities that are shaping the overall burden of disease in Australia. This requires adopting governance structures that promote collaborative and shared decision-making at the highest levels of government.

3. *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 health care 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.⁴⁶ Typically, assertive outreach is designed to reach individuals with whom mainstream mental health services have found it difficult to engage.⁴⁷ 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.⁴⁸

In Australia, we already have 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 play an active role behind the scenes to ensure that their clients have access to the full range of services that they need. 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

⁴⁴ World Health Organization and Calouste Gulbenkian Foundation. *Social determinants of mental health*. Geneva, World Health Organization, 2014: at p. 6.

⁴⁵ Fisher, M. and Baum, F. “The social determinants of mental health: implications for research and health promotion”. *The Royal Australian College and New Zealand College of Psychiatrists*, 2010. Available at <http://www.sdoha.org.au/SD%20of%20mental%20health-1.pdf>. Accessed: 4 April 2019.

⁴⁶ National Forum for Assertive Outreach, “What is Assertive Outreach?”. Available at http://www.nfao.org/About_AO/About_AO.html. Accessed: 3 April 2019.

⁴⁷ Ibid.

⁴⁸ Ibid.

Recovery Program, promoting engagement with hard to reach individuals and people who may experience barriers to accessing services.

4. *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 people with a lived experience of mood disorders,⁴⁹ psychotic disorders^{50,51} and bi-polar disorder.^{52,53} 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

⁴⁹ 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.

⁵⁰ 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.

⁵¹ 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.

⁵² 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.

⁵³ Miklowitz, D.J. and Goldstein, M.J. Behavioral family treatment for patients with bipolar affective disorder. *Behavior Modification*, 1990, 14(4): pp.457-489.

and services.^{54,55} In particular, young people can experience immense benefits from the engagement of their family and social circle in their treatment.⁵⁶

5. *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.⁵⁷ 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).⁵⁸ 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.⁵⁹ In particular, young carers require adequate supports to promote their own health, mental health and wellbeing.⁶⁰ Mental health carers have different respite and support needs compared to other carers, due in part to the unpredictability and episodic nature of mental illness.

Despite the growing evidence base of the important role they play,⁶¹ supports for mental health carers in Australia are weakening. The Mental Health Respite: Carer Support (MHR:CS) program

⁵⁴ 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.

⁵⁵ Falloon, I.R.H. Family interventions for mental disorders: efficacy and effectiveness. *World Psychiatry*, 2003. 2(1): p. 20-28.

⁵⁶ 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.

⁵⁷ 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.

⁵⁸ 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.

⁵⁹ 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.

⁶⁰ Carers Australia, *Young Carers*. Available at <http://carersaustralia.com.au/about-carers/young-carers2/>. Accessed: 5 April 2019.

⁶¹ 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.

was funded at \$60.7m⁶² and supported 29,141 people in 2015-16⁶³. This funding ceases on 30 June 2019. MIFA believes that this funding should be quarantined to provide for carers. Both carers and respite service providers have expressed support for this program in the past, supporting the delivery of “flexible, creative, peer-led services which are developed collaboratively with carers in direct response to their expressed needs”.⁶⁴

MIFA advocates investment in a nationally consistent mental health carers support program, including specialist support for young carers of people with a mental health issue. Rather than dismantling the infrastructure, workforce capacity and institutional memory in existing carer programs, MIFA advocates that these services could be provided under dedicated, quarantined and nationally consistent Information, Linkages and Capacity Building (ILC) funding for mental health carer support programs. Alternatively, these services could be provided as a separate specialist mental health element of the proposed National Integrated Carer Support Service, expanded to include planned carer respite.

Planning under the National Psychosocial Recovery Program

MIFA proposes that funding for the National Psychosocial Recovery Program is allocated regionally based on the joint Primary Health Network (PHN) and Local Health Districts (LHD) planning. MIFA proposes that funding for the program is flexible, with no hard boundaries around the funding source or level of government.

Support for joint PHN/LHD planning

MIFA supports the **joint mental health planning** being undertaken by PHNs and LHDs together, as provided for in the Fifth Plan.⁶⁵ The development of 31 regional mental health plans will optimise the assessment of demand and supply of services appropriate to the region. 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

⁶² Ms Margaret McKinnon, Group Manager, NDIS Market Reform, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee: p. 13.

⁶³ Ibid at p. 13.

⁶⁴ Department of Social Services. ‘Mental Health Respite: Carer Support (MHR:CS)’. Available at: <https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability/mental-health-respite-carer-support-mhr:cs>. Last updated 21 December 2018. Accessed: 2 April 2019: p. 5.

⁶⁵ National Mental Health Strategy. *The Fifth National Mental Health and Suicide Prevention Plan, National Mental Health Strategy*, 2017, p. 19.

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 for PHNs to commission mental health services through flexible funding packages⁶⁶ under the National Psychosocial Recovery Program. To do this well, MIFA advocates strengthening the role of the PHNs in 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 their work. MIFA is currently involved in a working party convened by Mental Health Australia and the PHN Cooperative to strengthen PHN mental health commissioning (see Appendix B – Strengthening Primary Health Networks).

To support joint mental health planning, PHNs must be positioned to work closely with the NDIA, Local Hospital Networks (LHNs), 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.⁶⁷ 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.

⁶⁶ 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.pdf 2018. Accessed: 2 April 2019, p. 62.

⁶⁷ *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.

Future expansion of the National Psychosocial Recovery Program will be based on the identified needs of each PHN, which result from the regional planning process. This will provide an enabling environment for regional action in mental health planning⁶⁸ that will allow funds to be allocated according to regional need.

Support for a National Psychosocial Recovery Program

MIFA's "Diagram of Need" analysis and "The Missing Piece" proposed solution have received positive feedback from the mental health sector. MIFA presented these at a recent Mental Health Australia Policy Forum. Mental Health Australia has endorsed MIFA's leadership in progressing this matter further.

MIFA also presented these at the Department of Health's Mental Health Reform Stakeholder Working Group. At the meeting, the Department of Health agreed to set up a small working party of departmental and stakeholder representatives to progress the National Psychosocial Recovery Program model.

⁶⁸ National Mental Health Strategy. *The Fifth National Mental Health and Suicide Prevention Plan, National Mental Health Strategy*. 2017: p. 19.

Addressing Stigma

MIFA advocates that it is imperative that the Productivity Commission consider the impact of stigma on people experiencing mental illness in any discussion about mental health sector reform. People with mental illness face stigma and discrimination in a variety of settings, which can have an adverse economic impact on individuals and the community. Stigma and discrimination regarding mental health issues have been found to negatively impact on employment, income and healthcare costs.⁶⁹ Interventions that reduce stigma may therefore also be economically beneficial.⁷⁰

The serious impact of stigma needs to be considered when designing services under the National Psychosocial Recovery Program. People with mental illness, particularly those experiencing psychotic disorders, report feeling similar levels of stigma from health professionals as from the general community.⁷¹ MIFA contends that stigma may have an impact on access to services, consumer engagement, and may even impact on service delivery and the strength of the collaborative relationships that are developed between health care professionals, mental health professionals and professionals from other community support services. As such, we need to support action to combat stigma at the national level.

The impact of stigma

Stigma is identified by people with mental illness and their carers as one of the greatest deterrents to their full citizenship within our society. It often includes elements of self-stigma where people affected by mental illness accept the stereotypes and the consequent discrimination aimed at them. MIFA believes that it is our responsibility to work collaboratively to challenge inaccurate or prejudicial beliefs and replace them with evidence-based information.

The impact of stigma is serious. In a SANE Australia survey (2006),⁷² 74% of respondents living with mental illness had experienced stigma. Approximately 40% of people living with a psychotic illness had experienced stigma or discrimination within the past year alone. Respondents said that a reduction in stigma would help them to feel better about themselves, manage their illness better, return to work or study and participate in social activities. Sadly, stigma can lead to social

⁶⁹ Sharac, J., McCrone, P., Clement, S., and Thornicroft, G. "The economic impact of mental health stigma and discrimination: A systematic review", *Epidemiology and Psychiatric Sciences*, 2010, 19(3): pp. 223-232.

⁷⁰ Ibid at 223.

⁷¹ SANE Australia. *A life without stigma: A SANE Report*. SANE Australia, 2013: p. 7.

⁷² Study cited in SANE Australia. *A life without stigma: A SANE Report*. SANE Australia, 2013: p. 5.

withdrawal and isolation. In a SANE Australia Research Bulletin, it was found that 52% of respondents did not feel part of their local community.⁷³

Barriers to seeking help

Stigma stops people asking for help and getting the support and treatment they need. Research indicates that around 54% of people with mental ill-health do not seek help⁷⁴. This presents a significant issue for service system planning and policy. Over half of people with mental ill-health do not present to services and a significant proportion struggle to self-advocate. It follows that resources must be dedicated to supporting help-seeking behaviour and reducing barriers for access.

There are several barriers specific to people with psychosocial disability that impact on their willingness to seek help and engage with services. These barriers can result in significant disengagement from the services system. Barriers include:

- lack of trust in service systems due to previous poor experience with services;
- functional impairments in psychosocial disability, which can include confused thinking, delusions and paranoia, or lack of awareness of their own condition;
- the burden of stigma, shame and fear of disclosure in the context of mental illness;
- difficulties with literacy, concentration and appointment-keeping, which may affect a person's ability to engage with services; and
- the impact of the disability symptoms themselves, such that those with anxiety and trauma may require significant support to attend appointments where they are exposed to strangers and may feel threatened, judged or vulnerable.

People with psychosocial disability require significant support and assertive outreach from services who have deep understanding of the system. The best strategies go beyond public campaigns and information provision, and into dedicated assertive outreach and assertive engagement processes. These services need to be integrated with other kinds of supports, so that a 'no wrong door' policy exists where people prefer to connect to a previously known health service. This 'no wrong door' policy needs to be a feature of the National Psychosocial Recovery Program to ensure timely, flexible and low-barrier entry to the program.

⁷³ SANE Australia. *The SANE Guide to Reducing Stigma*. Available at <https://www.sane.org/images/PDFs/SANE-Guide-to-Reducing-Stigma.pdf>. 2014, Accessed: 3 April 2019, p. 18.

⁷⁴ Whiteford HA, Buckingham WJ, Harris MG, et al. Estimating treatment rates for mental disorders in Australia. *Australian Health Review* 2014; 38(1): pp. 80-85.

National Anti-Stigma Strategy

MIFA contends that it is critical for the Productivity Commission to consider the implementation of a national anti-stigma strategy based on what works. SANE Australia has highlighted the importance of tackling stigma and discrimination through a national anti-stigma strategy:⁷⁵

A strategy to tackle stigma and discrimination associated with mental illness is vital, and should be a non-negotiable component of mental health policies and plans. It should be as non-negotiable as treatment and support programs. It is essential if we are to help people with mental illness live a contributing life. This strategy will also benefit recruitment of people to work in mental health services in both clinical and non-clinical roles.

...

Australia now needs a national, long-term strategy and campaign to reduce the stigma and discrimination associated with mental illness, with a particular focus on psychotic illness. The strategy must be consistent with national and state mental health plans and strategies, the social inclusion agenda and the forward workplan of the National Mental Health Commission.

Based on the evidence, SANE Australia has identified the essential components of an Australian anti-stigma strategy.⁷⁶ MIFA endorses this approach.

⁷⁵ SANE Australia. *A life without stigma: A SANE Report*. SANE Australia, 2013, p. 27.

⁷⁶ The full Anti-Stigma Strategy is available from SANE Australia. *A life without stigma: A SANE Report*. SANE Australia, 2013, p. 27.

Recommendations

MIFA is pleased to make the following recommendations to the Productivity Commission based on the contents of this submission.

It is recommended that:

1. The Productivity Commission obtain better mental health data to improve population estimates of people with severe mental illness and better inform decisions about mental health investments.
2. The Productivity Commission support a planned and nationally consistent approach to investment in mental health services, with reference to the burden of disease, to ensure appropriate funding is secured over the long-term.
3. The Productivity Commission identifies the level of funding needed to support all people with a severe mental illness, allocated by need, service type and level of government responsibility.
4. The Productivity Commission agrees that there is currently a gap in the suite of mental health programs and recommends a National Psychosocial Recovery Program for the cohort of 225,000 people with psychosocial disability with reduced functional capacity who are not eligible for support under the NDIS.
5. The Productivity Commission supports investment in a nationally consistent mental health carers support program, including specialist support for young carers of people with a mental health issue.
6. The Productivity Commission addresses the impact of stigma on people with lived experience of mental illness through recommending the implementation of a national anti-stigma strategy.

Appendix A

Group Support Services

The Clubhouse model is a centre-based service that provides a supportive, non-clinical environment where people with lived experience of mental illness can reconnect with the community through participation in a range of recovery-oriented activities and programs. Clubhouses offer a community of hope. The impact of the Clubhouse model is well documented.⁷⁷ As an example, MIFA provides this case study from One Door Mental Health in New South Wales on the value of centre-based services.

Case Study from One Door Mental Health: Centre-based services⁷⁸

One Door would like to bring the value of centre-based services for those living with a mental illness to the attention of the Productivity Commission. Centre-based services take many forms throughout Australia including D2DL centres (transitioning to the NDIS) and Clubhouses. The centre-based service model provides the opportunity for people living with a mental illness to form a community with peers, empowerment through joint management, the ability to gain practical skills (such as pre-employment training and computer skills) and all-important social interaction. In fact, international research shows that Clubhouses: have a 42% employment rate for members;⁷⁹ reduce incarceration in the criminal justice system;⁸⁰ facilitate recovery-oriented practice;⁸¹ support improvement in education and social domain outcomes;⁸² and support improvement in quality of life, particularly with the social and financial aspects of their lives.⁸³ Importantly, Clubhouses are low barrier to entry and flexible in access, as members can essentially come and go as often or as little as they want or are able to.

⁷⁷ For the evidence, see Clubhouse International, 'Our Impact'. Available at <http://clubhouse-intl.org/our-impact/overview/>. Accessed: 3 April 2019.

⁷⁸ Extracted from One Door Mental Health's Submission to the Productivity Commission for this inquiry.

⁷⁹ Response to Question On Notice by Joint Standing Committee on NDIS Inquiry into Psychosocial Services, Wide Bay PIR, Available at: <http://www.aph.gov.au/DocumentStore.ashx?id=e1a87e9d-ef8e-4573-ac9d-edeb1f15b79f>

⁸⁰ Ibid.

⁸¹ Raeburn, T., Schmied, V., Hungerford, C. and Cleary, M. The use of social environment in a psychosocial clubhouse to facilitate recovery-oriented practice. *BJPsych Open*, 2016, 2(2): pp.173-178.

⁸² McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W. and Lidz, C.W. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, 2018, 45(1): pp.28-47.

⁸³ McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W., & Lidz, C.W. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, 2016: pp. 1-20.

Centre-based services are cost effective. For example, those who attend Clubhouses for three days or more per week have a mean one-year mental health care cost of US \$5,697, compared to \$14,765 for those who attended less often.⁸⁴ Further, funding of a year of holistic recovery services that are delivered to Clubhouse members has the same cost as a two-week psychiatric hospital stay.⁸⁵

Unfortunately, centre-based services are poorly funded and, as such, access is restricted to those areas fortunate enough to have one. The problem is compounded by the introduction of the NDIS and the transition of funding for centre-based services. The NDIS model does not provide the financial stability required for a provider to cover fixed costs such as rent, electricity, rates and water that are necessary for a centre-based service. This could be somewhat alleviated by allowing centre-based services to require a 50% deposit from an NDIS package to access the service, and then charge on a per use basis after this. However, the NDIS model is still not fundamentally compatible with the concept of a low barrier to entry service with access available as much or as little as a person is able to.

⁸⁴ Hwang, S., Woody, J. and Eaton, W.W. Analysis of the association of clubhouse membership with overall costs of care for mental health treatment. *Community mental health journal*, 2017, 53(1), pp.102-106.

⁸⁵ Ibid.

Appendix B

Strengthening Primary Health Networks

Recently, some concerns have arisen in the mental health sector about the performance of PHNs. Firstly, there is some concern that PHNs may not have the internal capacity to undertake the comprehensive public health planning and commissioning approach required of them. **PHNs require additional resourcing to ensure they have the internal capacity to undertake regional mapping, properly commission resources, and network across the full range of mental health services.**

Secondly, there is some concern that PHNs are operating in an inconsistent manner across Australia. **It is essential to invest in governance and accountability mechanisms to coordinate and monitor PHN activity.** This would ensure PHN activity is consistent and coordinated across Australia, enabling better collection of national datasets and use of national expertise and learnings to support PHN policy initiatives. Such mechanisms could include extending the terms of reference and resources devoted to the Primary Health Network Mental Health Advisory Panel⁸⁶.

Thirdly, there is concern about the lack of non-clinical focus and understanding amongst PHNs. As PHNs evolved out of Medicare Locals and, prior to that, General Practice alliances, they also risk having excessive focus on primary health, at the exclusion of the broader community sector. PHNs need to move away from a clinical focus and commission psychosocial community-managed supports that are fully integrated with the service system. Such a refocus could occur through a change to the PHN guidelines.⁸⁷ **MIFA urges that PHN guidelines are changed to allow PHNs to commission psychosocial supports.**

Lastly, an integrated mental health system requires national planning and cost modelling to develop a model for sustainable long-term investment in mental health, with cross-government and bipartisan support. Regional planning and coordination are important and must be supported by adequate investment in services. The Council of Australian Governments (COAG) has a primary role in managing boundary issues between the NDIS and mainstream systems, and between State/Territory and Federal mental health programs, ensuring adequate and equitable

⁸⁶ Terms of Reference for the Primary Health Network Advisory Panel on Mental Health. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-health-advisory-panel>

⁸⁷ Department of Health, *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care*. Available at: [http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/\\$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF](http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/1PHN%20Guidance%20-%20Stepped%20Care.PDF), 2016, p. 6.

investment in mental health services across governments. **This requires resourcing and investment in national modelling, cross-governmental agreements to commit long-term investments, and governance structures to ensure the Fifth Plan is properly implemented.**

In response to these concerns about the performance and capability of PHNs nationally, Mental Health Australia and the PHN Cooperative have established a National Working Party, of which MIFA is a member. This Working Party aims to develop and implement a plan for national engagement on PHN mental health commissioning to enhance national collaboration, ensure effective working relationships between PHNs and national stakeholders, and improve commissioning of psychosocial and community-managed supports. MIFA eagerly awaits the outcome of this process and will continue to advocate for reforms to ensure a robust, consistent and well-resourced PHN system in Australia to support the needs of people with severe mental illness. In the meantime, MIFA argues that greater investment in PHN resourcing is needed to address the concerns identified above.

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Disclaimer

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