Mental Illness Fellowship of Australia

Submission in response to the
Draft Fifth National Mental Health Plan

December 2016

1. About Mental Illness Fellowship of Australia

For more than 30 years the Mental Illness Fellowship of Australia (MIFA) has provided a federated structure for many of Australia's leading providers of community mental health services, particularly in the support of individuals and families affected by severe mental illness. MIFA member organisations deliver services through more than 150 'front doors' in most parts of Australia. On any given day they are supporting up to 30,000 individuals and families, with around 2000 staff and more than 1500 trained volunteers. MIFA's motto is 'Succeeding Together' embracing the consumers, families, volunteers, staff, management and boards who share a common purpose to improve the quality of life of people affected by mental illness

MIFA's federated structure provides for coordinated advocacy at the local and national levels, and for mutually supportive business development. This collective strength has given MIFA members a strong voice in mental health policy and improved opportunities for identifying and seeking out new resources.

2. MIFA Member Oganisations

MIFA's member organisations operate is a total of 80 locations and in every State and Territory of Australia. They include:

- *SOLAS* – based on Townsville, services across North Queensland
- *Mental Illness Fellowship North Queensland* – based in Townsville, services in North and Central Queensland
- *Bridges* – based in Bundaberg, services from Gladstone to Sunshine Coast
- *Mental Illness Fellowship Qld* – based in Brisbane, services throughout Brisbane, Southern and Central Qld
- *Aftercare* – based in Sydney, services in Queensland, NSW, Victoria and WA
- *Schizophrenia Fellowship NSW* – based in Sydney, services across NSW
- *Mental Health Foundation ACT* – based in Canberra
- *Mental Health Carers Tasmania* – based in Hobart, services across Tasmania
- *Mental Illness Fellowship SA* – based in Adelaide, services across most of SA including APY Lands
- *Mental Illness Fellowship of WA* – based in Perth, services across South of WA
- *Mental Illness Fellowship of Australia NT* – based in Darwin, services in Darwin and Alice Springs

3. MIFA's Vision, Mission, Strategies and Priorities

Vision

Australians have the best possible mental health and quality of life.

Mission

MIFA's core strength is to work with people affected by severe mental illness, their families, friends and other networks to deliver effective, quality supports.

MIFA advocates for positive changes in all areas of social and public policy that impact on the quality of life of people affected as well as families and friends.

Strategies

- Improving the quality of public mental health policy
- Maximise the effectiveness of the MIFA Network in delivering additional benefits to individuals and families
- Develop national projects that deliver innovation and build community capacity

4. MIFA's Common Focus

As a group of long-standing membership based organisations, MIFA currently has more than 150 'front doors' across Australia. It is building a national network that delivers local solutions based on the common strengths of its member organisations.

- MIFA knows from experience that recovery of a better quality of life is possible for everyone affected by mental illness
- MIFA works with and alongside participants and members of its member organisations in every program, whether as staff, managers, peers, volunteers or board members
- Peers—consumers, carers, families, friends—are at the heart of all MIFA's program design, governance, delivery and evaluation
- MIFA works closely with families, carers and friends as well as the person with a mental illness, including those who are hard to reach
- MIFA's objectives are holistic – the organisation works to assist individuals and families in their journey to recover mental health, physical health, social connectedness and equal opportunity in all aspects of life.
- MIFA educates and advocates to help build a community where people with mental illness are accepted and valued, and where carers are supported and validated
- MIFA's national federation strengthens its efforts to be innovative and reflective in all of its practices -- and to become well-enough known to ensure no-one misses out on available help

- MIFA gives priority to persuading funders, policy makers, politicians and potential corporate sponsors to invest in community resources which reflect these common strengths
- MIFA doesn't do it all, nor does it want to – its collaborations with other service providers ensure that the 'front doors' will always lead to the best local services

5. Executive summary

MIFA's view is that the Plan fails to set out a comprehensive plan for addressing the mental health needs of the 690,000 people with severe to complex needs in Australia (refer table below from the National Mental Health Commission).

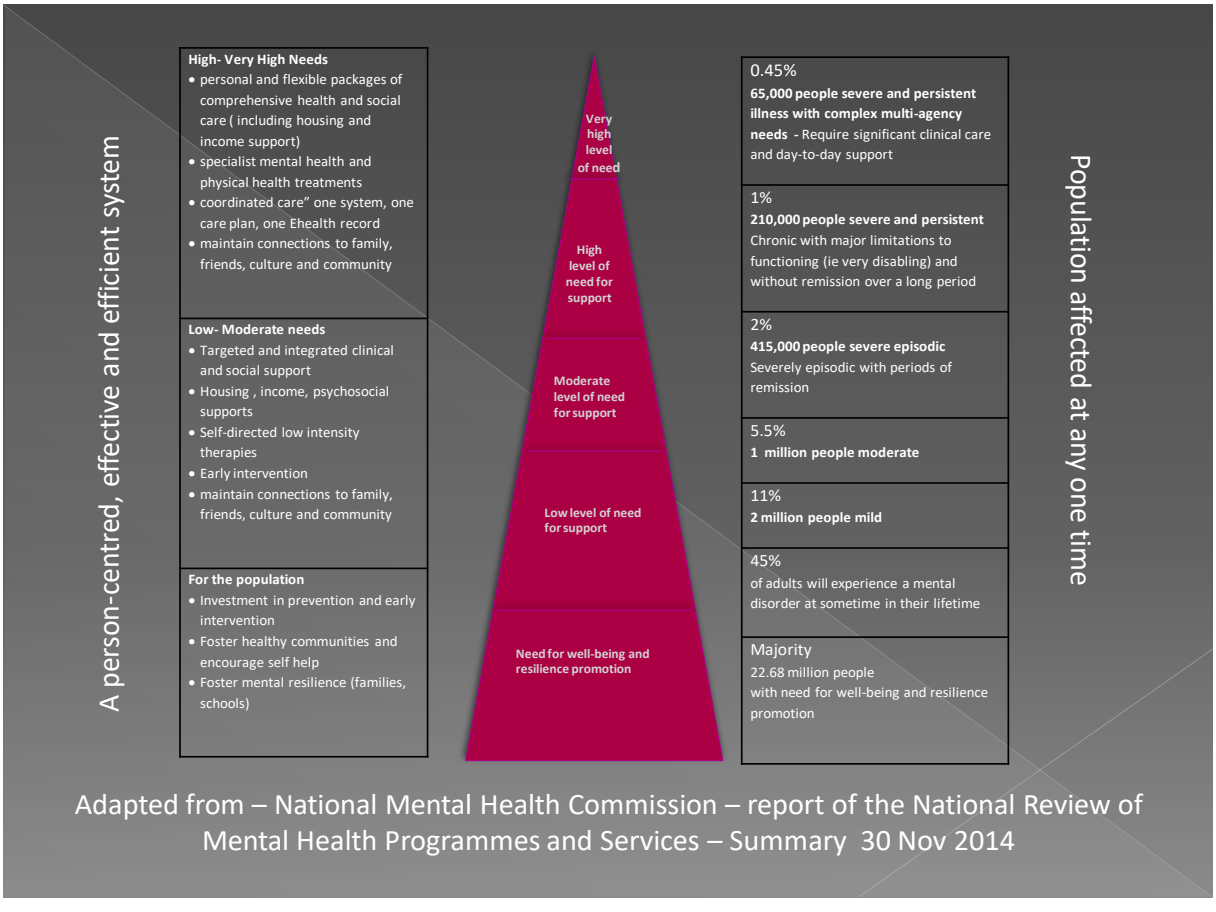
Current mental health reforms including the National Disability Insurance Scheme (NDIS) and the Primary Health Networks (PHNs) will target some aspects of this need. People supported through these reforms will be a small proportion of the overall number, and will need to meet the eligibility criteria for the NDIS and the clinical focus of the PHNs. State/Territory Governments will vary in the range and scope of services they provide to the overall cohort.

MIFA is concerned about the several hundred thousand people who have been eligible for Commonwealth programs such as Partners in Recovery, PHaMs and Day to Day Living, and various State/Territory psycho-social programs, who won't be eligible for the NDIS. MIFA supports the access to the NDIS, for all people targeted by those programs, however we are concerned that many will not meet the eligibility criteria. Flexible and responsive services will still be needed for people with episodic needs, and who rely on light-touch quality support when they need it. In the absence of this 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/Territory emergency departments when other community-based options are no longer available.

The Plan must include all Commonwealth and State/Territory commitments to address the needs of the 690,000, with clear articulation of roles, responsibilities and accountabilities for their contributions to the Plan.

MIFA supports the concept of regional planning. Regional planning mechanisms must integrate PHNs and local State/Territory health and hospital services as recommended, but should also include the regional NDIA office, to ensure that all government programs are working together effectively.

MIFA is concerned about the significant clinical focus of the PHNs. The reforms developed to PHNs require an integrated approach, with an emphasis on recovery focussed community-based mental health services as required. MIFA supports the approach of many PHNs in consulting and researching community needs and priorities, with an overlay of evidence-based responses. Where the regional needs and the evidence requires a recovery focussed community-based mental health solution, PHNs should be allowed to implement this.



6. **Specific comments on, and recommendations for, identified priority areas**

Priority area 1: integrated regional planning and service delivery

Investment in capacity building of "non-clinical" specialised community mental health support programs

The introduction of the NDIS has seen a drastic removal of funding for community mental health programs ahead of approval of NDIS packages for individuals using the services and the implementation of funds through Information, Capacity and Linkages building (ILC) programs.

MIFA anticipates that there will be a net reduction in investment in community psychosocial supports which has the potential to result in the closure of programs and services. Capacity building through meaningful block funding investment in "non-clinical" specialised community mental health support programs is needed to sustain current levels of support and continue to delivery integrated services.

Currently several community mental health programs are unable to take more participants resulting already in the development of large waiting lists. Timely access to mental health services is critical to successful treatment of people with a severe mental illness, and is necessary to reduce psychiatric hospitalisations and the risk of suicide.

Capacity building of community mental health supports can also reduce waiting lists for in-patient care, specialist psychiatric and psychosocial interventions. Timeliness is a key quality indicator in calls for improvement to the mental health care system- the 5th National Mental Health Plan should commit to a specific target of reduction in waiting times for critical services and programs.

Recognition of the clinical value of community mental health programs

Mental health reform should aim to improve a person's quality of life. This requires that policy frameworks move away from a focus on what are considered "clinical" services. Classification of services into clinical versus non-clinical devalues non-clinical services.

Many services currently classified as "non-clinical" specialised community mental health support programs, result in statistically significant improvements in clinical outcomes. For example, Schizophrenia Fellowship NSW (SF NSW) delivers programs that have seen significant ($p<0.01$) improvements in functional, personal, clinical and social domains as measured by Recovery Assessment Scale- Domains and Stages (RAS-DS) (Hancock, N., Scanlan, J.N., Bundy, A.C., & Honey, A. (2016). Recovery Assessment Scale – Domains & Stages (RAS-DS) Manual- Version 2. Sydney; University of Sydney)

Longer funding contract lengths

Stability in the mental health sector could also be achieved by increasing the length of funding contracts. In our experience, and as identified by the Productivity Commissions Review of Human Services (Productivity Commission 2016, Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Study Report, Canberra.), short contract lengths and tendering processes creates competition in a sector that has typically relied on collaboration. This breakdown in partnerships could be somewhat alleviated by increasing contract length and thereby reducing the number of "competitive events".

Contracts covering 5 years with clearly defined KPIs should be established. For those services able to satisfactorily meet the KPIs, funding should be automatically renewed. A value-add of this proposal is increased workforce stability, which the NFP sector often struggles with due to the inability to attract and maintain quality staff given constant funding instability.

Recommendations:

- Investment in capacity building for community mental health programs.
- Further block funding of key successful community mental health programs commenced under the Howard Government COAG reforms.
- Commitment to a specific reduction target in waiting times for crucial psychiatric and psychosocial services.
- Recognition of the clinical value of community mental health programs.
- Increase the length of funding contracts to a 5 x 5 year model.

Priority area 2: coordinated treatment and supports for people with severe and complex mental illness

Assurance of action for emerging gaps following the implementation of the NDIS

Community mental health service provision is a key foundation for promotion, prevention, early intervention and support towards recovery for those living with a mental illness. Not-for-profit (NFP) organisations such as MIFA member organisations are driven by their vision to see the most vulnerable people included and participating in meaningful life.

Changes in policy and funding in Health and Social Services are not mutually exclusive and integration between the two is of fundamental importance to the ability of our organisation and other CMOs to support people in their recovery journey. However, the interface with the NDIS and the 5th national mental health plan is not clear.

With the transition of funding for many mental health programs such as PHaMs, D2DL and PIR to the NDIS, a real gap is emerging. Without restoration of a portion of block funding, it is likely that these programs will be unable to be delivered to those who do not receive and NDIS package.

These programs keep people well and participating in the community. They reduce hospitalisations, reduce emergency department visits, reduce chronic disease burden, improve employment outcomes and improve the wellbeing of entire families.

MIFA supports monitoring and reporting on emerging policy issues and gaps relating to the implementation of the NDIS by the Mental Health Drug and Alcohol Principle Committee. However, assurances are needed that once gaps are identified, Health Ministers will intervene to address these gaps. This will create a sense of security in a sector that is currently experiencing a great deal of instability.

Include mental health advanced care directives in multi-agency care plans

It is MIFA's view that advanced care directives should be included, as a matter of priority, in multi-agency care plans. Through an advanced care plan, a person is able to give guidance to healthcare professionals on their preferences and view of treatment should they lose capacity.

This is particularly useful for severe episodic mental illness, when often a person has previous experience of what treatment was or was not successful in their recovery.

People with a severe episodic mental illness should be encouraged, while able, to discuss their preferences for treatment options with their families, their doctors and other relevant people. They should be informed of their right to appoint someone to make decisions about their health care should they become unable to make their own decisions.

Recommendations:

- Assurance of action for emerging gaps following the implementation of the NDIS.
- Include mental health advanced care directives in multi-agency care plans
- Encourage the use of a single recovery plan

Priority area 3: suicide prevention

Commitment to a national suicide prevention target

A key outcome measure of a successful mental health strategy is a percentage reduction in the suicide rate. (The World Health Organisation (WHO). Preventing suicide: a global imperative. WHO, Luxembourg, 2014). The first step needed in Priority Area 3 of the Fifth National Mental Health Plan is leadership and commitment to a measurable suicide prevention target. A national strategic target indicates the Government's clear commitment to dealing with the issue of

suicide and a vital component of allocating resources for achieving both short-to-medium and long-term objectives.

Deliberate, continuous, coordinated and effective intervention following hospital admission

MIFA believes a more strategic approach to suicide prevention following discharge from a psychiatric in-patient unit is required to reduce suicide rates. There is a significantly high risk of suicide following mental health inpatient care, particularly during the first day and week following discharge (IM Hunt, N Kapur, R Webb, J Robinson, J Burns, J Shaw, L Appleby (2009). Suicide in recently discharged psychiatric patients: a case-control study (UK). Psychological Medicine 39, 443–449). In WA, 8% of all suicides in 2010 were in the first weeks immediately following discharge from a hospital-based psychiatric facility, 15% of suicides occurred on the day of discharge, and a further 15% the following day. (Review of the admission or referral to and discharge and transfer practises of public mental health facilities/ services in Western Australia. https://www.health.wa.gov.au/publications/review/chapters/mental_health_3.2.pdf).

Most of those people who suicided after discharge had discharge plans, however, not all received the hospital aftercare that was planned or the aftercare was ineffective. Many people are discharged into a life-situation that is not conducive to recovery.

Reports such as the Tracking Tragedy report have shown that the availability and capacity of mental health care services may have contributed to up to one third of deaths by suicide (NSW Mental Health Sentinel Events Review Committee. (2007). Tracking Tragedy: A systemic look at homicide by mental health patients and suicide death of patients in community mental health settings. (Third Report of the Committee). New South Wales Government: Department of Health. Accessed 6 December, 2016 at http://www.health.nsw.gov.au/pubs/2007/pdf/tracking_tragedy_07.pdf). The report highlights the critical importance of continuity of care, beyond clinical services alone, in the transition to community living from in-patient services. Investment in programs that aim to maintain continuity of care following discharge from a psychiatric in-patient unit is crucial to reduce post-discharge suicide. Programs such as the Hospital to Home Program (H2H), which was trialled by SF NSW in 2015, have been externally evaluated and demonstrated to be entirely successful at reducing suicide post-discharge to zero. (The University of Sydney and SF NSW (2016). Evaluation of the SF NSW Hospital to Home Program. Manuscript in preparation).

H2H focuses on helping consumers to self-manage their recovery, connect with their social networks and minimise feelings of isolation. This is achieved by a support worker making regular contact with the person while in hospital and participation in the discharge planning process.

Through the H2H program, SF NSW has successfully transitioned 63 people from inpatient facilities into community living with no readmissions or suicide attempts over the program period[7]. Participants in the program reported significant improvements in social, intellectual and psychological outcomes[7].
This provides clear evidence that a national approach that provides deliberate, coordinated, continuous and effective intervention, by the community mental health sector, during and post-discharge from a mental health inpatient facility will reduce the suicide rate.

The Fifth National Mental Health Plan should provide a national commitment towards zero suicides in the first 6 months following discharge from hospital- it can, and should be, achieved.

Target suicide prevention campaigns to people living with a mental illness, their carers and health professionals

Extensive public health and communication strategies to date have done well to reduce the stigma of engaging in discussion about suicide. However, these campaigns do not target those at high risk of suicide, namely those with a mental illness, and those important supports in their lives including families, carers and health professionals.

Mental illness is one of the most common and significant risk factors for suicide. While not all people that complete suicide have a mental illness, it is generally acknowledged that over 90% of those who complete suicide had a diagnosable mental disorder. (Bertolote JM, Fleischmann A (2002). Suicide and psychiatric diagnosis: a worldwide perspective. World Psychiatry 2002 Oct; 1(3): 181–185).

In considering recommendation 10 in the Draft Fifth National Mental Health Plan, a combination of population strategies and a more targeted approach is needed. This strategy would be one whereby suicide prevention public health campaigns aim to reach those with a mental illness, their carers and health professionals.

Recommendations:

- Commitment to a national suicide prevention target is needed.
- A commitment towards zero suicides in the first 6 months following discharge from hospital.
- Include direct recognition of the role of the community mental health sector as an effective provider of follow-up care for those who have attempted or are at risk of suicide.
- Ensure a combination of population strategies and an approach targeting those with mental illness, their families, carers and health professionals is included in suicide prevention public health campaigns.

Priority area 4: Aboriginal and Torres Strait Islander mental health and suicide prevention

Co-design of services with communities is crucial

The summary of recommendations in priority area 4 should be broadened to include not only governments working collaboratively, with PHNs and LHNs, service providers, Aboriginal Community Controlled Health Organisations, but also Aboriginal communities or Aboriginal and Torres Strait Islander consumers and carers to co-design policy in this area. Working with Aboriginal and Torres Strait Islander communities in co-design as outlined in Action 12, however is a crucial element and should be included as a stand-alone action.

Recommendations:

- Working with Aboriginal and Torres Strait Islander communities in co-design should be included as a stand-alone action.
- Regions in desperate need of aboriginal workforce training
- Commitment to providing training support to non-indigenous mental health professionals- however, this should be broadened to include supporting training for clinical staff and community workers.

Priority area 5: physical health of people living with mental health issues

Clearly define outcomes for physical health improvements

The 5th National Mental Health Plan refers to poorer physical health outcomes for those living with a mental illness including increased cardiovascular disease, respiratory disease, metabolic syndrome, diabetes, osteoporosis, cancer, tobacco use, and dental health issues. (National Consensus Statement on Physical Health and Mental Illness, 2016). In fact, cardiovascular disease in those living with a mental illness contributes to double the number of excess deaths than excess deaths by suicide. (Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001). Duty to Care: Physical Illness in people Living with Mental Illness. Perth: The University of Western Australia).

Although physical health outcomes have always benefited from relative ease of measurement of outcomes in comparison to psychological outcomes, the 5th National Mental Health Plan fails to identify target areas of physical health for improvement and associated outcome measures. It is MIFA's view that these should be clearly defined and should also include dental health and nutrition.

Outline data collection sources

MIFA supports the use of existing and new data collection mechanisms to report on the physical health of those living with a mental illness. As stated in the draft plan, a large amount of data is collected regarding physical health of Australians- which is one of the advantages of policy making in the realms of physical health, which is poorly performed in the area of mental health.

However, it is not clear how the government plans to collect data, what data will be collected and from where, in what timeframe the data will be collected and how links physical and mental health issues will be made. Informative data will be that which highlights any changes in treating a "primary" issue in isolation or ignorance of a secondary concern.

Investment in this area is needed

As stated in the draft of the 5th National Mental Health Plan, physical health outcomes for those living with a mental illness are poorer than for those that are not. The development of resources, support of PHNs and LHNs and the collection of data may go some way to achieving improvements in this area, however, investment in a national program of service delivery, a commitment for formal training for health professionals and awareness campaigns are also needed.

Recommendations:

- Clearly define targets and outcome measures for improvements in health outcomes for those living with a mental illness
- Clarify what data will be collected and from where, in what timeframe the data will be collected and how links physical and mental health issues will be made.
- Investment in national physical health programs, formal training mechanisms for health professionals and awareness campaigns.
- Adopt a whole of person approach which targets not only cardiovascular and diabetes and includes dentistry.

Priority area 6: stigma and discrimination reduction

MIFA welcomes action on stigma reduction and discrimination in the health workforce. SF NSW urges that the Fifth National Mental Health Plan should include more detail as to how priorities and systemic stigma will be identified, for example, will this be through funded independent research?

Furthermore, there is little direction on how stigma will be reduced and plans for evaluation of the effectiveness of such campaigns. (Corrigan P, Shapiro JR. (2010). Measuring the Impact of Programs that Challenge the Public Stigma of Mental Illness. Clin Psychol Rev; 30(8): 907–922). The draft plan states education and training of health workforce, the identification of champions and leadership are necessary, yet there is no detail on the where and to whom training and education will be implemented, which has been demonstrated to be a critical element for success in the area of stigma reduction. (Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D, Koschorke M, Shidhaye R, O'Reilly C, Henderson C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. Lancet; 12;387(10023):1123-32).

Increase the use of peer workforce

MIFA believes that there should be a commitment to improving practices around the use of peer workforce in the health sector.

Peer worker initiatives could partially address the high levels of unemployment experienced by people living with a mental illness, while also tackling the shortage of skilled staff in mental health services. Consumer-operated programs have also reduced expenses, generated income, increased efficiency, and increased service demand by implementing quality improvement practices that incorporate evaluation findings. (Campbell and Leaver, 2003)
Disability Employment Services (DES) provides existing infrastructure that could be used towards achieving employment outcome targets for those living with a mental illness, provided that the DES has sufficient in-house capacity to understand the mental health specific needs surrounding employment.
Leadership in this area is essential. Benchmarks for training and employing peer workers at all levels of government and in the health workforce would be a clear example of leadership in this area.

Recommendations:

- Include detail on how priority areas for targeted stigma reduction campaigns will be identified.
- Develop a strategy for implementation of stigma reduction.
- Set benchmarks for peer worker numbers across the health system and all areas of government service, including justice and housing.
- Adopt direct consumer presentations, the “real person” approach, in anti-stigma campaigns.