mental health
community coalition ACT

ACT
Mental Health
Consumer Network

Submission to

# Senate Community Affairs Committees

# Inquiry into Commonwealth Funding and Administration of Mental Health Services

July 2011

Room 1.06, Level 1, Griffin Centre, 20 Genge Street, Canberra City, ACT 2601
T (02) 6249 7756, F (02) 6249 7801, email: admin@mhccact.org.au
website: www.mhccact.org.au

## Introduction

The Mental Health Community Coalition ACT (MHCC ACT) and the ACT Mental Health Consumer Network (ACT MHCN) welcome the opportunity to comment on the Commonwealth funding and administration of mental health services. We also welcome the increased investment into mental health in the recent 2011-12 Commonwealth Budget.

In particular, MHCC ACT and ACT MHCN congratulate the Government on the increase of funding to community mental health services including the Personal Helpers and Mentors Program (PHaMs) and Day to Day Living services, the establishment of a Mental Health Commission and the investment into coordination of services for people with severe and persistent mental illness.

We also welcome the establishment of the new national mental health peak consumer organisation. We believe that the development and implementation of all mental health services should be informed by people with mental illness – the consumers of those services.

We strongly recommend that the delivery of all Budget measures include effective collaboration with consumers and commitment to capacity building within the mental health consumer sector.

MHCC ACT and ACT MHCN emphasise the importance of ensuring all services developed and supported by the Commonwealth are both evidence based and recovery focused. The *ACT Community Mental Health Sector Review*[1] describes recovery oriented care as a consumer driven process that incorporates attention to personal factors and resources, social factors, such as housing, social connectedness and work as well as physical and mental health issues. It is a holistic model of care that addresses all aspects of a person in the context of hope and trust.

These principles need to remain at the centre of all service planning and delivery.

MHCC ACT and ACT MHCN will provide brief comments on selected aspects of the Committee terms of reference.

[1] Health Directorate, ACT Government, *Review of the ACT Community Sector of Mental Health Services,* May 2011 available at http://health.act.gov.au/health-services/mental-health-act/review-of-the-act-community-sector-of-mental-health-services

## National Engagement

We support the development of a National Partnership Agreement on Mental Health and the funding available for States and Territories to identify and address gaps in their service systems. Housing, including supported accommodation and independent living services and supports following hospital discharge are key gaps in many systems, and are continually identified by consumers and carers as priorities for investment. We hope this process will encourage and reward innovative service delivery where it will make the greatest difference. These services also need to be accompanied by increases in access to and funding for advocacy services (individual, peer and systemic).

MHCC ACT and ACT MHCN strongly advocate for the involvement of States and Territories in the development of a 10 Year Roadmap to Mental Health Reform. Although we recognise timeframes around the Roadmap's development are short, we feel it will be far more effective if it has been developed in partnership with State and Territory Governments, as well as consumers, carers and the community sector.

## National Mental Health Commission

We welcome the establishment of a National Mental Health Commission and the Government's assurances that it will include consumer representation. It is important that consumer involvement be at the heart of the Commission's work. If the Commission is to operate effectively, we consider that its membership should include more than one consumer, and that the Commission must include substantial involvement by consumers in all of its processes.

As for the 10 Year Roadmap, MHCC ACT and ACTMHCN hope the National Mental Health Commission's scope will extend to the States and Territories. We are concerned that if the Commission's scope only includes federally funded services, it will be less effective in contributing to an integrated and consistent mental health system.

## Care Coordination

MHCC ACT and ACT MHCN recognise that coordination and continuity of care across the mental health sector is a challenge faced by many consumers, their

carers and families. For this reason, the focus on increasing care coordination is positive.

To ensure the delivery of seamless support, through an integrated system of mental health care, there is a need for Medicare Locals, community mental health organisations and the wider mental health sector to work closely together in the planning, delivery and evaluation of services.

We note that the funding allocated for care coordination and flexible care packages will be put out to tender to Medicare Locals and large NGOs. We understand the successful organisations would then be responsible for providing a single point of contact to coordinate both clinical and non-clinical care. While we support the closer linkages and collaboration between Medicare Locals and community mental health organisations, we would not like to see the care coordination funding directed towards clinical care only, to the exclusion of psychosocial supports. The psychosocial supports provided by the community sector are an essential part of many people's recovery journey, but have historically been undervalued by the clinical and medical sectors. There is likely to be a need for culture change in both the primary health care and clinical sectors to ensure the contribution of the community sector is valued in the new model.

At the very least there is a need for ongoing evaluation and monitoring of this new program to ensure it is meeting its goals. It is also important to ensure the assessment tool is adding value and not placing unnecessary burdens on organisations, thereby impacting on the amount or effectiveness of services provided to consumers.

## Changes to Better Access Initiative

MHCC ACT and ACT MHCN support the rationalisation of GP mental health services, as we believe the funding saved from this rationalisation can be used to target specific population groups and improve outcomes among those people experiencing the greatest disadvantage. Recent evaluations of the Better Access Initiative showed that while it increased access to treatment by some population groups, many key population groups, including disadvantaged groups, do not have better access to services through this program.

Without doubt, the best scenario would always be all people able to access the right service for them, at little or no cost and without restriction on how many sessions they can attend. But given the reality of a tight budgetary environment and limited resources, we support targeting funding at harder to reach and vulnerable groups, including people on low incomes, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) people and people experiencing geographical disadvantage.

Evaluations of the Access to Allied Psychological Services (ATAPS) program has shown that it has been more successful at engaging disadvantaged groups and people with severe and persistent mental illness. For this reason we support the increase of funding to the ATAPS program. However, we are not sure how the system will work to ensure priority is given to those most in need. It is important that service providers are required to engage with communities and the broader system (including community organisations that already work with many harder to reach groups including young people and people from CALD backgrounds) rather than waiting for people to come to them.

## Funding for Disadvantaged Groups

### *CALD Communities*

The *ACT Multicultural Strategy* states 22% of people living in Canberra were born overseas, coming from more than 200 different countries.[2] According to the 2006 Census, 42% of the ACT population have at least one parent born overseas and close to 20% of people speak a language other than English at home all or some of the time. The *ACT Multicultural Strategy* also estimates 2% of the ACT population does not speak English well or at all. There is a need for services targeted at the large group of Canberrans from culturally and linguistically diverse backgrounds.

Despite this, with the exception of a health service for survivors of torture and trauma and newly arrived refugees, there are very few programs or organisations in the ACT specifically funded to support the mental health needs of CALD people.

[2] Community Services Directorate, ACT Government, *ACT Multicultural Strategy 2010-2013,* available at http://www.dhcs.act.gov.au/__data/assets/pdf_file/0010/104689/Final_ACT_Multicultural_Strategy_2010_-2013_25_Nov.pdf

Funding for services to better meet the need of Canberra's culturally diverse population is regularly among the recommendations made by the ACT community mental health sector. For example, the 2011 report, *Review of the ACT Community Mental Health Sector* strongly emphasised the gaps in services to meet the needs of multicultural communities. The review recommended the design and delivery of more extensive locally based services.

During consultations around an MHCC ACT project aimed at reducing stigma around mental illness in CALD communities, multicultural communities also expressed their distress at continually seeing pilot programs being rolled out for only one or two years then ending.

We strongly recommend additional ongoing funding for CALD specific service delivery, and resources to build the capacity of mainstream mental health services to provide culturally appropriate services.

***Indigenous Communities***

Aboriginal and Torres Strait Islander people in the ACT experience significant social disadvantage in comparison to the non-Aboriginal and Torres Strait Islander population. The Aboriginal and Torres Strait Islander population has higher rates of family breakdown, lower employment participation rates, lower standards of literacy and lower levels of health than the non-Aboriginal and Torres Strait Islander population.[3] Many of these are indicators of poor social wellbeing and risk factors for mental health issues.

Due to the small Aboriginal and Torres Strait Islander population in the ACT, we have only one Aboriginal Community Controlled Health Service providing support to the local population. This service is stretched, and not always able to meet the needs of all individuals in the local community. MHCC ACT and ACT MHCN would like to see funding dedicated to building capacity of mainstream services to support people from Aboriginal and Torres Strait Islander backgrounds.

***Dual Disability***

People with co-occurring mental health and disability are among the most marginalised in our community. They often find it more difficult to access

[3] Australian Bureau of Statistics, *Social and Cultural Profile of Aboriginal and Torres Strait Islander people in Canberra,* 2006.

services and can be pushed between service systems. Often the services they do access lack the necessary capacity and staff training to appropriately meet their needs.

The NSW Council of Intellectual Disability has estimated only 10% of adults with an intellectual disability and a mental illness receives mental health interventions in a given year.[4]

As well as funding for specific areas, we support the call for cross disciplinary training in intellectual disability and mental health to build capacity of staff to respond to the needs of people with comorbidities. Joint planning and service collaboration is also essential to ensure coordinated care that does not allow people to 'slip through the cracks'.

***Welfare recipients***

Consumers regularly raise concerns about the lack of support provided by and through Centrelink to assist welfare recipients with mental illness, whether diagnosed or not. It is critical that staff involved in developing and implementing processes including work capacity assessments undertake training in mental health and related issues of psychosocial disability.

For this reason, MHCC ACT and ACT MHCN welcome the additional investment in employment participation, particularly around building capacity of employment service providers to support people with mental illness.

## Workforce

Perhaps even more so than other jurisdictions, one of the biggest issues facing the mental health sector in the ACT is workforce. The competition between the community and public systems to recruit and retain staff is equally, if not more, acute in the ACT, as organisations must compete with both the ACT and the Commonwealth public sectors for a limited pool of workers. With the highest average income in the country, community organisations are often unable to offer competitive salaries, conditions and career pathways.

The *National Mental Health NGO Workforce Project* was a welcome initiative aimed at improving the understanding of the existing community mental health

[4] National and NSW Councils for Intellectual Disability, *The Place of People with Intellectual Disability in Mental Health Reform,* March 2011, available at http://www.nswcid.org.au/images/pdfs/ID_MH_rfm_511_4.pdf

workforce. As stated in the preface to that document, until it was completed, there was no national picture of the sector and its workforce.[5] It is now important that we use the data collected as a tool to inform future workforce planning.

Currently there is little overall workforce planning and workforce development initiatives are inconsistent. Organisations funded through different levels of Government and Departments have access to different training and professional development opportunities. For example, MHCC ACT receives funding from the ACT Government to undertake workforce development activities and offer training to workers in the community mental health sector. Although we have advocated that the funding be used to support all community mental health workers, not just those working for programs funded by the Territory Government, our contracts require us to preference those organisations funded by the ACT.

MHCC ACT and ACT MHCN recommend that Commonwealth, State and Territory governments should liaise more closely to develop and fund a more consistent approach to workforce development across the community mental health sector, including a strategy to up skill workers and improve the ability of community organisations to recruit and retain staff.

If people with mental illness are to benefit from a better informed and educated workforce, the training and development of that workforce, including clinicians and allied health professionals, must include the use of consumer educators.

An important aspect of the workforce is consumer-led and directed services. The effectiveness of this approach is supported by strong national and international evidence. For example; research shows that consumer-led services are capable of achieving outcomes in areas where traditional services often fall behind, such as increasing employment levels and improving living arrangements for people living with mental illness. Studies also demonstrate that consumer-oriented mental health services generally reduce the number of hospitalisations and thus the overall cost of mental health services.[6]

[5] National Health Workforce Planning and Research Collaboration, *Mental Health Non-Government Organisation Workforce Project,* June 2011.

[6] See, for example, Doughty, C. and Tse, S. (2010). Can Consumer-Led Mental Health Services be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries. Community Mental Health Journal Online from http://www.springerlink.com/content/dr40755811535247/about/

An important strategy for bringing about consumer-led mental health services is the use of peer support workers. Peer support workers are people who have expertise gained through lived experienced and recovery from mental illness, and who have the capacity to build empathic relationships with mental health consumers as a result.[7] Evidence suggests that the services offered by peer support workers are likely to be at least as effective as traditional services in supporting recovery from mental illness, and likely to produce even more positive outcomes when complemented with traditional services.[8]

The role of a peer support worker in this context would be to:

- design and implement group and individual daily activities, including psychosocial rehabilitation programs;
- support each client to develop and implement their own recovery plan;
- assist clients to navigate the mental health system and access psychosocial support services available in the community;
- be part of discharge plans, including at the point of admission and the review process; and
- provide reintegration support to individuals following their discharge.

Research shows that the success of peer support programs is heavily influenced by the availability of support for the peer support workers themselves.[9] Support that should be available for peer support workers includes:

- individual, group and clinical supervision; and

[7] Fox, L. and Hilton, D.(1994). Response to "Consumers as service providers: The promise and the challenge." *Community Mental Health Journal*, 30(6), 625-627.

[8] Paulsen, R., Hendrickx, H., Demmler,J., Clarke, G., Cutter,D. and Birecree, E. (1999). Comparing practice patterns of consumer and non-consumer mental health service providers. *Community Mental Health Journal*, 35(3), 251-269; Solomon, P. and Draine, J. (1995). *One-year outcomes of a randomised trial of consumer case management. Evaluation and Program Planning*, 18, 117-127; Klein, A., Cnaan, R. and Whitecraft, J. (1998). Significance of peer social support for dually-diagnosed clients: Findings from a pilot study. *Research on Social Work Practice*, 8, 529-551.

[9] Orwin, D. (2008). *Thematic Review of Peer Supports: Literature review and leadership interviews*. Mental Health Commission, New Zealand, http://www.mindandbody.co.nz/wp-content/uploads/2009/04/peer_supports_thematic1.pdf; McLean, J., Biggs, H., Whitehead, I., Pratt, R., and Maxwell, M. (2009). Evaluation of the delivering for mental health peer support worker pilot scheme. Scottish Government Social Research: Edinburgh, http://www.scotland.gov.uk/Resource/Doc/291864/0089933.pdf; Daniels, A., Grant, E., Filson, B., Powell, I., Fricks, L., Goodale, L.(Ed). (2010). *Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services*. www.pillarsofpeersupport.org

- technical assistance in relation to the specific recovery needs of the consumers they assist, for example social enterprise development possibilities or information technology supports.

Peer support services can significantly improve outcomes for people in or leaving acute, sub-acute, or community-based services. Consumers widely express the view that the assistance of experienced peers in navigating the service system and supporting their goals to live in and contribute to the community in a sustainable way would greatly improve their recovery. We recommend that any mental health workforce strategy include appropriate recognition and funding of peer support services.

## Online Services

MHCC ACT and ACT MHCN strongly support the development of online services as an option for people with mental illness and note the growing body of evidence for the efficacy of online intervention programs.[10] We think that online services are likely to be an effective tool in reaching some groups, including young people and people living in rural and remote areas. Existing and emerging evidence-based online tools should be rolled out consistently across the country.

However it is important that online services are seen as one of a suite of tools to ensure people are able to access mental health services. Online tools are unlikely to be the most appropriate option for everyone. In particular, it is our experience that people from culturally and linguistically diverse backgrounds and older people are less comfortable with online tools and people from economically disadvantaged groups may not have easy access to online services in a private setting. With potentially lower overheads and staffing costs, there may be a temptation for more services to be delivered online, rather than face to face.

Instead MHCC ACT and ACT MHCN advocate for a wide range of services, including online services, across the spectrum of interventions.

[10] Griffiths KM, Farrer L, Christensen H: "The efficacy of internet interventions for depression and anxiety disorders: a review of randomised controlled trials", *Medical Journal of Australia* 2010 Jun 7;192(11 Suppl):S4-11