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MHACA

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Submission: Productivity Commission Draft Report on Mental Health

Thank you for the opportunity to provide comment on the Draft Report of the Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health.

MHACA is a community managed organisation that provides individual and group based psychosocial support services, NDIS support coordination, tenancy support and homelessness assistance, education and training, suicide prevention and mental health promotion programs in Central Australia. We are the only specialist mental health NGO in the NT outside of Darwin. From July 2020 we will be the only community mental health psychosocial support provider in Alice Springs and the surrounding area.

We are a member of the Northern Territory Mental Health Coalition and NT Shelter, and have contributed to and endorsed their responses to the draft report. However, we would like to draw your attention to some specific areas that are relevant to our experience in a Central Australian context

Psychosocial Support

We share the view of the NT Mental Health Coalition that the draft report does not consider in depth the very key role of the community managed mental health support sector in assisting people with mental health difficulties over the long-term in their process of recovery, engagement in community and skill development. As documented in the report this sector receives at best 7% of the mental health dollar despite supporting the long-term recovery of a significant proportion of people who experience mental illness. There is potential for the sector to contribute further in the stepped care model bridging the gap between clinical and non-clinical services, and along the whole continuum of care.

Psychosocial support services offer a skilled and holistic approach to supporting people to achieve their life goals and live meaningful lives in the community. There is clear evidence that assisting people to build and sustain a sense of purpose, connection and belonging in the community is a key to recovery from mental health difficulties.[1] In turn this has potential to reduce demand on in-patient services.

Whilst the NDIS may be considered to now be responsible for this role for people with severe and persistent mental illness, we do not believe the pricing structures adequately recognise the skills and infrastructure costs associated with this skilled work. Funding models need to recognise that a coordinated care approach will need to accommodate the time spent in case planning and networking activities which support the capacity to offer a holistic and coordinated approach.

We share the concern raised in the report about the lack of services available in the community for those not eligible for the NDIS. We are now in a challenging situation as a service provider because we have people who have declined to apply for the NDIS still requiring supports but who don't have any funding which would allow us to provide the service. We also have a significant proportion of participants who are highly mobile and it is often difficult to determine if they have an NDIS plan, or if they do, to get support arrangements in place quickly enough for us to be paid for the supports we provide. It creates a strong ethical dilemma. Do we exclude people in dire circumstances

[1] https://www.ncbi.nlm.nih.gov/pubmed/28803484; http://www.copmi.net.au/images/pdf/Research/social-inclusion-fact-sheet.pdf

from receiving a service because they do not have funding attached to them? We don't feel we can exclude them but it creates a strain on our resources which may not be sustainable over time.

Many of our clients present with quite complex needs and it is not the role of NDIS funded support coordination to provide the cross-sector care coordination previously delivered through the Partners in Recovery Program.

Under the National Psychosocial Support Measure which is intended to respond to the needs of new, emerging and people who refused to test eligibility, we receive funding of $16,500 per year, enough to fund a qualified support worker for about one day week. We use the funds to deliver an intake and referral function, but it is not possible to actually provide direct recovery focused support to individual clients, as we receive approximately 4 referrals a week. This is clearly inadequate to meet the emerging mental health needs of Alice Springs and the surrounding community, or to assist those potentially eligible for the NDIS to prepare their access requests.

We estimate at least 5 – 8 days of work is associated with the preparation of access requests, due to the difficulties in pulling together the materials needed to support people with a psychosocial disability to gather their evidence, and to have a clear understanding of what the scheme could offer them.

Over 50% of MHACA's clients are Aboriginal, a number of whom regularly visit Alice Springs from remote communities. Many are exiles in Alice Springs, not welcome in their home communities due to their illness or behaviours and feeling stuck in their recovery due to being homesick for country and having nowhere to call home.

Aboriginal people with severe and complex mental health challenges are some of the most marginalised people in Australia. The living conditions of some of these people are truly appalling and it limits their capacity to recover from mental illness. The recognition of the intersection between mental health, the justice system and homelessness in the draft report is particularly welcome and we support the recommended directions.

Aboriginal people in remote and very remote communities in the NT have been very severely disadvantaged in their mental health care and have never received adequate supports. They are supported through FIFO clinical services and local clinics, which often have limited mental health expertise and high staff turnover. There are virtually no psychosocial supports and limited capacity to respond to emerging mental health needs, particularly for children and young people.

Whilst greater access to telepsychiatry and psychological services are welcome, it is important to recognise cultural differences and that these models of response to mental health needs may not be as effective in the context of remote communities.

We welcome a heightened emphasis on the development of an Aboriginal Mental Health Workforce to support a culturally appropriate response on community. We would like to emphasise that the service response needs to accommodate recognition of the disability associated with mental illness and include a psychosocial rehabilitation component.

Suicide Prevention

MHACA has a long history of working in the area of suicide prevention and response. We welcome the attention to this issue in the draft Report. We believe the key issues have been identified and support the general directions proposed. In particular we support the universal implementation of evidence-based aftercare support for people who have attempted suicide. We want to take this further to ensure these approaches are implemented in remote and very remote communities. We encourage the implementation of evidence-based approaches beyond Emergency Department settings to community clinics.

MHACA has worked closely with the Aboriginal community in Central Australia to develop Suicide Story, a two-way learning and capacity building program, delivered by Aboriginal people to Aboriginal communities. The program aims to develop local skills and awareness in risk identification, encourage help-seeking and to identify strategies to mitigate risk of suicide at a local level. We support the emphasis on delivery of suicide prevention by Aboriginal and Torres Strait Islander organisations and encourage a strategy to build the capacity of those organisations to develop place-based strategies. This should be supported by a National Framework for Suicide Prevention, culturally appropriate assessment tools and drawing on the resources identified through the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project.

We encourage the commitment to ensure the lessons learnt at trial sites, particularly those in remote locations, can be promoted and implemented quickly.

We also support a greater level of clarity about the respective role of the Commonwealth and States/Territories in the area of suicide prevention, and funding approaches that are responsive to the actual needs and identified risks of the communities.

Peer Workforce

There has been no government investment at all in development of the peer workforce in the NT, at either a policy or workforce development level. The Certificate 4 in Peer Work is not available in the NT and there are no funded positions. We have only one Consumer consultant and one Carer Consultant position for the whole of the Territory, and no policy commitment to support consumer and carer participation. The NDIS is also a threat to the employment of peer workers due to the high productivity levels required of the workforce which may be difficult to achieve for people entering or re-entering the workforce fir those living with mental illness.

Despite this, MHACA has been very active in promoting opportunities for people with a lived experience to build their skills and capacity to participate in the mental health workforce, either in peer support roles or other positions. We currently have six people employed in either part-time or casual roles – one in a project role, two as day program hosts and three assisting in quality data collection. We have also employed two people with lived experience in full-time roles, one in our admin team and the other in the drop-in program.

We believe that an emphasis on peer work is important and support the recommendations in the draft Report however we encourage a broader reflection of the many and varied ways in which people with mental health difficulties can bring their lived experience to mental health services.

The NDIS will also narrow our capacity to maintain financial viability as an organisation, which in turn will mitigate against being able to continue to fund the training and professional development required of this fledgling workforce.

Funding and commissioning of services

MHACA welcomes the discussion of the approach to commissioning and greater clarity of responsibilities. The current approaches are confusing, difficult to navigate, require multiple different data collection and accountability frameworks, all which mitigate against efficiency. The NDIS has only added to the administrative burden of the NGO sector with its own quality framework and the complexity of being able to claim funds for services provided through the scheme.

Recent National Psychosocial Measure funding through the PHN has a ridiculous level of accountability required for tiny sums of money – monthly activity report, monthly TRIS report, a quarterly activity report and a quarterly

financial report, as well as significant additional client data collection which is not fit for purpose and is highly intrusive. Some agencies have chosen not to accept the funding due to these demands which has meant that people in those communities are unable to access support, as the funds were only available to those who had previous received Commonwealth mental health funding.

We believe that the approach to commissioning requires extensive discussion due to the potential for unintended consequences associated with any change. The basis for funding also requires careful consideration as Australia is not a level playing field when it comes to the delivery of mental health services, and there is potential for the NT with its small and significantly under-resourced mental health sector, and the limited capacity for Territory investment due to our dire economic circumstances, to experience further disadvantage. We think it is an important discussion and that it may take time to work out whether to "renovate or rebuild".

In conclusion, we believe the Draft Report has provided a comprehensive summary of the challenges facing the efficient and effective delivery of mental health services. However we draw attention to the value of the community managed mental health support sector, the distinct approach required when considering mental health in Aboriginal communities, the importance of development of the peer workforce and the impact of the NDIS on regional organisations like MHACA.

We would be most happy to speak to this submission should the opportunity arise and look forward to the implementation of the final recommendations of the Inquiry

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