MENTAL ILLNESS FELLOWSHIP of Australia Inc

2018-19 Federal Pre-Budget Submission

Mental Illness Fellowship of Australia (MIFA) is a federation of community-managed mental health providers, established in 1986. Our members deliver specialist services for individuals living with mental illness 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 have substantial experience delivering place-based, community-building programs to those experiencing mental illness, and over 50% of our workforce has a lived experience as a consumer or carer. We thank the Department of Treasury for the opportunity to provide input into the 2018-19 budgetary process.

MIFA remains concerned at the significant under-investment in mental health across Commonwealth and State and Territory governments. Spending on mental health accounts for 7.8% of health expenditure across jurisdictions,[1] while causing 12% of the burden of disease[2]. While what is considered an adequate investment may not precisely correlate with burden, this serves to demonstrates the deficit in funding which has characterised mental health spending in Australia. This lack is evident in the everyday experience of those accessing services - particularly those with severe mental illness: short-term and inadequate clinical supports; major underinvestment in the community supports that complement clinical supports and maintain recovery; and little to no investment in service integration or case coordination on a systemic or individual level. The introduction of the NDIS, while providing significant additional supports to some individuals, has been far from smooth, and resulted in separating out cohorts of people into yet more service frameworks.

The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan)[3] commits all governments to work together to achieve integration in planning and service delivery at a regional level. In particular, Priority Area 3 of the Fifth Plan states that many of the 690,000 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 the 690,000 cohort, over and above the levels already committed under existing funding programs. 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. The 2018-19 Federal Budget should confirm the Commonwealth's

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[1] Australian Institute of Health and Welfare (2016). *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011*. Available at: https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-death-2011/contents/highlights

[2] Australian Institute of Health and Welfare (2017). *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

[3] *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

commitment to fund its share of additional tailored clinical and community supports identified through regional planning initiatives.

MIFA wishes to advocate for serious consideration of investment in the following areas in the 2018-19 Federal Budget.

1. **We need to address the gap.**
   This requires additional federal funding for services that:
   a. Ensure Continuity of Support and address the gap for people with psychosocial disability
   b. Support people in the broader cohort of people with severe mental illness

2. **We need a recovery-oriented, mental health-responsive NDIS, and we need to get the price right.**
   This requires investment in a range of initiatives, including a specialist psychosocial support gateway, that will repair participant confidence in the NDIS.

3. **We need system architecture and service coordination.**
   This requires investment in structures and programs that support integration between services on an individual and systemic level, and situate community-managed mental health as a core element of service provision.

Mind the Gap

MIFA welcomed the 2017-18 budget announced $80m for *Prioritising Mental Health – Psychosocial Support Services.* MIFA notes that the announced "$80m" actually only represents just over $24m per year in federal funding. While this investment is welcome, the rate of roll-out is too slow; the target of the investment remains unclear; and we are further concerned that the amount is too little to meet the gap both for Continuity of Support, for people with psychosocial disability not currently in Commonwealth Programs, and the much broader cohort of people with severe mental illness.

The population estimates for mental health needs in Australia are as follows:

- **3.8 million**[4] people of all ages experience mental illness in Australia each year.
- **690,000**[5,6,7] people have a severe mental health issue.
- Between 280,000[8] to **290,000**[9] people with severe mental illness require some level of psychosocial community support and rehabilitation (or 'disability support') for a primary

[4] Based on National Mental Health Services Planning Framework (unpublished), adjusted to 2015 Australian population, in McGrath, D. (2016). *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

[5] p46, National Mental Health Commission (NMHC) (2014). *Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services.*

[6] p27, *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

[7] NDIA (2017). Additional document to JSC on NDIS Inquiry into NDIS and Psychosocial disability. Available at: http://www.aph.gov.au/DocumentStore.ashx?id=e381f4e0-5784-422a-9397-a2c244da509d

[8] People aged 0-64. Department of Health (2017). Submission 175 to PC Review of NDIS Costs Issues Paper. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0003/216066/sub0175-ndis-costs.pdf

[9] People aged 12-64, McGrath, D. (2016). *Op. cit.*

psychosocial disability each year. It is likely the entire cohort of people with severe mental illness (up to 690,000 people) will require some level of 'disability support' at some point in their lifetime.[10,11]

- There is uncertainty about how many of those people will be eligible for the NDIS. The original Productivity Commission (PC) 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 in with severe mental illness).[12,13] This number has now updated by the NDIA to **64,000**.[14] However, recent modelling by the Department of Health based on the (unpublished) National Mental Health Services Planning Framework (NMHSPF) suggests 91,916 people with "severe and complex disorders"[15] would be eligible.

This suggests that based on current NDIA modelling, over 225,000 people with psychosocial disability, and a further 400,000 people with severe mental illness, are not eligible for the NDIS. These people are already starting to fall through the gaps.

Roll out of the $80m

In Senate estimates, Department of Health representatives advised the funding would be applied as follows[16]:

2017-18	planning and getting infrastructure in place	$7.8m
2018-19	Investment into expanding services	$23.7m
2019-20	Maximum investment deployment at full	$24.1m
2020-21	Scheme transition	$24.4m

This funding is contingent on matched funding from the States and Territories, resulting in a maximum annual investment of $48.8m. MIFA notes that to date the National Psychosocial Support Working Group (NPSWG) had been formed, but terms and conditions of funding are yet to be endorsed.[17]

MIFA notes that current program providers are experiencing high levels of pressure with the current transition schedule, with the staggered cuts to funding in current programs running ahead of the rate of transition of clients. Due to unrealistic in-kind components and unrealistic performance indicators for NDIS applications, providers are focusing resources on supporting clients to apply for the NDIS, and are therefore struggling to properly support those who are ineligible in current programs. They are also

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[10] p46, NHMC (2014). *Contributing lives, thriving communities Report of the National Review of Mental Health Programmes and Services.*
[11] p14, Australian Government Actuary (2012). *NDIS Costings – Review by the Australian Government Actuary.* Available at: https://static.treasury.gov.au/uploads/sites/1/2017/06/doc1.pdf
[12] pM4, Productivity Commission (PC) (2011). Appendix M: The intersection with mental health. *Disability Care and Support: Productivity Commission Inquiry Report*, 54(2), Canberra. Available at: https://www.pc.gov.au/inquiries/completed/disability-support/report/37-disability-support-appendixm.pdf
[13] Detail of Australian Government modelling reported on p14, Australian Government Actuary (AGA) (2012). *NDIS Costings – Review by the Australian Government Actuary. Op cit.*
[14] p26, *NDIA Annual report 2015-16,* Available at: https://www.ndis.gov.au/medias/documents/ha5/h04/8798853726238/NDI7040-AnnualReport2016-vFaccessible.pdf
[15] Department of Health (2017) Submission 175 to PC Costs Issues Paper. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0003/216066/sub0175-ndis-costs.pdf
[16] p20, Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health - Senate Estimates 30 May 2017, Community Affairs Legislation Committee.
[17] Answer to Question on Notice SQ17-001259, 07 Jan 2018 Available at: https://www.aph.gov.au/api/qon/downloadattachment?attachmentId=10c1f0bc-6ef5-420f-9c9f-15edc6375848

unable to meet any new demand for services. The Departments of Health and Social Services have offered some reprieve in transition timelines and are working on re-negotiation of contracts for providers experiencing hardship, however, **people are already falling through the gap**. In the Australian Capital Territory, with transition complete, there is a high level of under-servicing for clients ineligible for the NDIS. **This investment is required now, rather than at full roll-out.**

Who is the target of the $80m?

It remains unclear who the target cohort is for the new funding: current Commonwealth clients who are ineligible for the NDIS (Continuity of Support), and/or the broader cohort of those ineligible for the NDIS. Conflicting information has been provided by the Departments.

The Department of Health factsheet states the funding "*reduces the CMH service gap and provides continuity of support for existing clients of Commonwealth-funded psychosocial services*"[18]. Department of Social Service representatives indicated in Senate Estimates the funding was "particularly for continuity of support for those with a high need outside the NDIS."[19]

However, at the Transition Support Queensland Workshop[20] Department of Health and NDIA representatives stated that the measure is "new money" that is not intended to provide Continuity of Support. They indicated Continuity of Support arrangements are separate obligations and would be finalised soon. This needs to be urgently clarified, to ensure that funding from all governments for psychosocial support programs meets the needs of both Continuity of Support clients and new clients with psychosocial disability.

Underestimation of Continuity of Support

The number of people who are eligible for Continuity of Support remains unclear. **MIFA is concerned there has been an overestimation of the number of current Commonwealth clients eligible for the NDIS**, based on incorrect assumptions about how many clients will transition to the NDIS.

Number of current Commonwealth clients

The Department of Health (DoH) has indicated that the three Commonwealth Community Mental Health programs – Partners In Recovery (PIR), Day 2 Day Living (D2DL), and Personal Helpers and Mentors Service (PHaMs) currently support up to 41,509 people a year[21]. Given they have previously indicated that approximating numbers in PIR is difficult[22], it is unclear how this number was estimated. The Department of Social Services (DSS) indicated that there were 20,409 people in PHaMs in 2015-16[23].

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[18] Department of Health factsheet, http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2017-factsheet28.htm

[19] p12, Ms Felicity Hand, Deputy Secretary, Disability and Carers, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.

[20] 27 October 2017, verbal response to questions, Paula Zylstra, Director, Department of Health, and Deborah Roberts, Director of Mental Health, NDIA.

[21] Department of Health (2017). Submission 175 to PC Review of NDIS Costs Issues Paper. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0003/216066/sub0175-ndis-costs.pdf

[22] p9, Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health - Senate Estimates 30 May 2017, Community Affairs Legislation Committee.

[23] p12-13, Ms Felicity Hand, Deputy Secretary, Disability and Carers, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.

Percentage of Current Commonwealth clients ineligible for NDIS – Continuity of Support clients

DSS has indicated they are expecting 8,700 people in DSS programs will require Continuity of Support[24]. It is unclear how this was modelled.

When responding to questions around transitions, Departmental representatives often quote eligibility rates of 83% of people who have made access requests[25], however, this includes all psychosocial clients (new and existing) applying, and the NDIS has indicated that 56% of applicants are not current State/Territory or Commonwealth clients[26].

This eligibility rate also does not acknowledge the significant number of people who are choosing not to apply. PIR consortia in NSW are reporting a "lost consumer rate" of between 17% and 37% of participants in PIR programs[27], meaning the true eligibility rate for people in Partners in Recovery (PIR) may be closer to 60%.

MIFA members are reporting that up to 40% of PIR clients are not transitioning, around 60% of PHaMs clients, and up to 50% of D2DL clients. Based on these estimates, 12,245 people will require Continuity of Support in PHaMs alone. **It is possible that over $133m in Continuity of Support funding for clients in existing Commonwealth programs may be required.**

	Partners in Recovery	Day to Day Living	PHaMs	Total
Funding in 2016-17[28]	$143.9m[29]	$15.0m[30]	$113.3m[31]	$272.2m
Reported client numbers	*Unavailable*	*Unavailable*	20,409[32]	41,509[33]
Estimated % of non-transitioning clients	40%	50%	60%	~50%
Possible level of Continuity of Support funding required	$57.6	$7.5	$68.0m	$133.0
Possible number of clients requiring Continuity of Support	*Unavailable*	*Unavailable*	12,245	~20,755

Note that 2016-17 funded amounts already represent a reduction on previous years.

These estimates are based on anecdotal evidence from the sector, whereas accurate real-time data is required**.** The NDIA should investigate and publish the current eligibility rates from defined and

[24] p15, *ibid.*
[25] p16 Mr John Riley, Branch Manager, Market Oversight, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.
[26] NDIA (2017). Additional document to JSC on NDIS Inquiry into NDIS and Psychosocial disability. *Op. cit.*
[27] p4, One Door Mental Health (2017). Post- Paper Submission 266 to the PC Review of NDIS Costs Position Paper, Available at: http://www.pc.gov.au/__data/assets/pdf_file/0018/219321/subpp0266-ndis-costs.pdf
[28] p9, Ms Natasha Cole, First Assistant Secretary, Health Services Division, Department of Health, Senate Estimates 30 May 2017, Community Affairs Legislation Committee, and
[29] p9, Ms Natasha Cole, First Assistant Secretary, Health Services Division, Department of Health, Senate Estimates 30 May 2017, Community Affairs Legislation Committee
[30] p9, *ibid.*
[31] p12, Ms Felicity Hand, Deputy Secretary, Disability and Carers, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.
[32] p13, *ibid.*
[33] Department of Health (2017). Submission 175 to PC Review of NDIS Costs Issues Paper. Available at: http://www.pc.gov.au/__data/assets/pdf_file/0003/216066/sub0175-ndis-costs.pdf

transitioning programs, disaggregated by existing program (State/Territory and Commonwealth). Rates of clients who are choosing not to apply to the NDIS should also be monitored, and the reasons these clients are choosing not to apply should be thoroughly investigated[34].

In Senate Estimates, DSS provided some recent data. They reported that in period up to June 2016-17, 231 PHaMs clients had been found ineligible, 158 had withdrawn their request, 162 declined to phase in to the NDIS, and 35 clients did not return their form. It is not clear how many PHaMs participant pathways were followed in the same time period. The Department previously stated that 748 had made an access request as at March 2017, of 800 expected to phase in in 2016-17. At end of March 2017, 281 had received a plan. **This suggests up to 75% of those expected to transition from PHaMs were either found ineligible or choosing not to apply.**

If the $24.4m in the "*Prioritising Mental Health – Psychosocial Support Services"* is to be applied to Continuity of Support services, among the broader cohort of people ineligible for the NDIS, this funding will fall vastly short.

MIFA advocates urgently quarantining and maintaining funding for PIR, D2DL and PHaMs outside the NDIS until true transition rates have been established, to ensure Continuity of Support obligations are met.

Eligibility for Continuity of Support

Department of Health representative comments[35] further suggest participants would need to test their eligibility for the NDIS before their eligibility for Continuity of Support is triggered. It could be argued that funding a parallel block-funded program that serves the same cohort as the NDIS but with less stringent application processes may interfere with the NDIS market – and therefore it is important to ensure that those who are likely to be eligible for the NDIS are encouraged and highly supported to apply. However, **MIFA is concerned that the requirement for all people to test their eligibility will deter people from accessing support through Continuity of Support programs**. There are many clients who are patently ineligible for the NDIS in current programs, particularly PHaMs (up to 60%), which had a much broader entry criteria and actively encouraged people into the program without evidence of lifetime need for support. Requiring that these participants go through the application process, knowing they would not be eligible, is a waste of time for the NDIA, for service providers, and for the participant. It is likely to damage service provider relationships with participants, and damage the reputation of the NDIS. It is also somewhat coercive and contravenes principles of choice and control.

Support for carers

MIFA also advocates maintaining programs for carers of people with a mental illness, independent of a participant's NDIS plan.

Carers need a range of supports, including information, referral, peer support groups, counselling and one-on-one support. This support is required not only once the person they care for has an NDIS plan,

[34] MIFA members report that clients are choosing not to apply in part due to issues with the need for permanency, as well as concerns and reservations about the invasiveness and overwhelming nature of applying.

[35] p10, Mr John Riley, Branch Manager, Market Oversight, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.

but prior to and during the application process. This is important as often carers are the first to reach out, and can be instrumental in encouraging consumers to access services (noting that around 54% of people with mental ill-health do not seek help)[36]. There is also emerging evidence that NDIS planners are failing to properly consider the needs of carers when formulating plans, and participants, planners and support coordinators may not always recognise or value the needs of carers.

The Mental Health Respite – Carer Support (MHR-CS) program is funded at $60.7m[37] and supported 29,141 people in 2015-16[38]. This funding should not be rolled into the NDIS, but rather quarantined to provide for carers.

MIFA advocates investment in a nationally consistent mental health carers support program that is independent of a person's plan, including specialist support for young carers of people with a mental health issue.

Rather than dismantling the infrastructure, workforce capacity and institutional memory in these existing programs, it is arguable these services should remain as is under the MHR-CS program to provide continuity of support to current ineligible clients and support new clients. Alternatively, these services could be provided under dedicated, quarantined, nationally consistent Information, Linkages and Capacity Building (ILC) funding for mental health carer support programs; or as a separate specialist mental health element of the proposed National Integrated Carer Support Service, expanded to include planned carer respite.

Beyond Continuity of Support

Over 225,000 people with psychosocial disability, and a further 400,000 people with severe mental illness, are not eligible for the NDIS. These people require significant investment in clinical supports and community supports that are flexible and recovery-oriented; and service integration and case coordination on a systemic and individual level. States and Territories currently provide over 70% of Community mental health funding[39], and 62.1% of overall mental health funding.[40] Nevertheless, the Commonwealth Government has committed to and is responsible for providing an integrated, culturally competent and sustainable service system under Priority Area 3 of the Fifth Plan.[41]

MIFA urges the Commonwealth to make significant additional investments to provide their appropriate share of services for people with psychosocial disability outside the NDIS, and the broader cohort of people with severe mental illness.

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[36] Whiteford, H., Buckingham W., Harris, M. et al. (2014). 'Estimating treatment rates for mental disorders in Australia.' *Australian Health Review* 38(1): 80-5.

[37] p13, Ms Margaret McKinnon, Group Manager, NDIS Market Reform, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.

[38] p13, Ms Margaret McKinnon, Group Manager, NDIS Market Reform, Department of Social Services, Senate Estimates 31 May 2017, Community Affairs Legislation Committee.

[39] p7, Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation Group, Department of Health, Senate Estimates 30 May 2017, Community Affairs Legislation Committee.

[40] p3, PC (2017) *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

[41] p29, *Fifth National Mental Health Plan*. Available at: http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

While MIFA acknowledges the ongoing federal investment into the NDIS (as funds have transitioned), and other Departmental investments into mental health preventative, suicide responsive, and veteran initiatives, as well as funding through the PHNs, these programs do not directly or adequately address the community-based services needs of people with severe mental illness. The Federal Government has a responsibility under the Fifth Plan to meet at least part of these needs. MIFA has serious reservations about the ability for the recent $24m per annum investment under the *Prioritising Mental Health – Psychosocial Support Services* to meet this responsibility. **The *Prioritising Mental Health – Psychosocial Support Services* funding needs to increase and be used to support all people with psychosocial disability. Furthermore, additional community-managed services are required for the broader cohort of people with severe mental illness beyond psychosocial disability** (see Diagram 1)**.**

There must be a planned and nationally consistent approach to investment in mental health services, to ensure funding is secured over the long-time. 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 NDIS, 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.

Such programs are best provided by services that have visibility, mental health-specific expertise, and pre-existing community connections, and need to have the following characteristics:

- Flexible, low-barrier entry criteria
- Recovery-oriented and preventative
- Flexibility in type, range and length of supports offered
- Timely and crisis-responsive
- Assertive outreach and assertive engagement approaches
- Inclusive of family, carers, and dependents
- Whole of life needs assessment and case management, including ability to navigate and support access to a range of supports across systems, and support for multiagency care co-ordination; and
- Cross-sector collaboration and systemic advocacy

Again, it is arguable that rather than dismantling the infrastructure, workforce capacity and institutional memory in existing programs, current programs PIR, D2DL and PHaMs should remain in place to meet these needs. Alternatively, a PHaMs-PIR hybrid model has been proposed.[42]

[42]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

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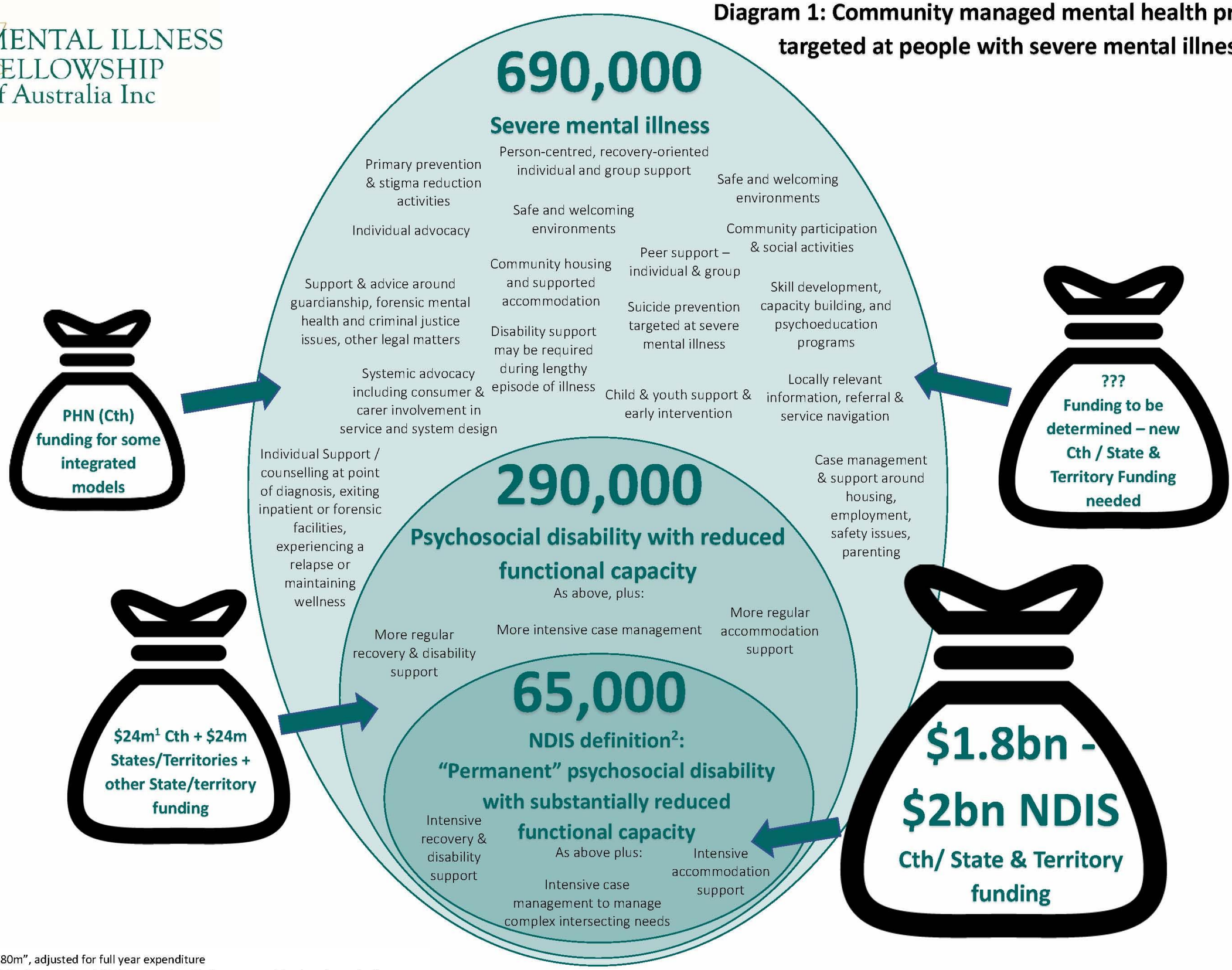
Diagram 1: Community managed mental health programs targeted at people with severe mental illness



[1]Known as "the $80m", adjusted for full year expenditure
[2]Original Productivity Commission definition: people with "severe, persistent and complex" psychiatric needs

Investment in a recovery-oriented NDIS

There have been a number of criticisms levelled at the NDIS in relation to its problematic treatment of people with psychosocial disability. While some people have received excellent and generous support under individual packages, many others have found the NDIA and the NDIS transition to be fraught and unhelpful. The range of psychosocial-specific issues with NDIS processes have been documented elsewhere, including in the Joint Standing Committee on NDIS's Report on Psychosocial Services[43]; and the recently released Mind the Gap report from the University of Sydney and Community Mental Health Australia.[44] NDIA staff and their agents need to be skilled up to reach out to the community of people with mental ill health, and to make decisions about access and planning that are consistent and fair. There is also a need to address the systemic barriers for people with mental illness - such as the requirement that their condition be 'permanent'.

MIFA advocates:

- **Developing a specialist psychosocial access gateway and planning pathway within the NDIA, and properly training staff**
- **Reforming the NDIS legislation to remove the requirement for permanency for people with psychosocial disability**

The transition to market based individualised funding under the NDIS has resulted in significant challenges for psychosocial support providers. The Reasonable Cost Model[45] fails to acknowledge the true cost of providing psychosocial disability support to individuals with serious mental illness. The pricing of the NDIS needs to be reformed, so that it reflects the costs and best-practice models of providing specialist, complex psychosocial support.

The pressures from NDIS pricing, and the shift in models of service provision, has resulted in significant numbers of redundancies, service contraction from certain services (such as information and referral, community spaces and crisis responsiveness); and service contraction from certain areas, particularly rural and remote regions. Some providers have or will be forced to exit the NDIS market altogether.

Investment in the following initiatives are required to prevent market failure:

- **Getting the pricing and type of supports right for psychosocial disability**
- **Improving support for psychosocial support providers, in particular, support for service provider business modelling and back-end development**
- **Developing the psychosocial disability workforce**

[43] Joint Standing Committee on the NDIS (2017). *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*. Available at: https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/National_Disability_Insurance_Scheme/MentalHealth/Report

[44] University of Sydney and CMHA (2018). *Mind the Gap: The National Disability Insurance Scheme and psychosocial Disability. Final Report: Stakeholder identified gaps and solutions*. Available at: http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf

[45] NDIA and NDS (2014), *Final Report of Pricing Joint Working Group*. Available at: https://www.ndis.gov.au/html/sites/default/files/documents/final_report_of_pricing_joint_working_group.pdf

System architecture and service coordination

Mental health is currently extremely siloed and fragmented, with service provision being distributed across up to 12 funding sources in any one jurisdiction[46]. The transition of one sub-cohort of people into yet another service system (the NDIS) has exacerbated this issue.

MIFA strongly supports the integrated approach adopted in the recently endorsed Fifth Plan[47], and advocates strengthening the role of the Primary Health Networks (PHNs) in system planning for mental health, including 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. 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. 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.

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; enable better collection of national datasets; and draw upon national expertise and learnings to support PHN policy initiatives. Such mechanisms could include extending the terms of reference and resources devoted to the newly established Primary Health Network Mental Health Advisory Panel[48].

Because 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. Primary Health Networks need to move away from a clinical focus and commission psychosocial community-managed supports that are fully integrated with the service system.

PHN guidelines[49] should be changed to allow PHNs to commission psychosocial supports.

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[46] Including State Departments of Health, including Local Hospital & Health Services; State Departments of Communities/Social Services; Commonwealth Department of Health; Commonwealth Department of Social Services; Commonwealth Department of Veterans Affairs; Primary Health Networks; National Mental Health Commission (primarily research grants); State Mental Health Commissions (where relevant); Department of Premier or Prime Minister relevant grants; Medicare (Private Practitioner services); Private health insurers (including private inpatient and day patient hospital services); NDIS

[47] p19, *Fifth National Mental Health Plan*. *Op cit.*

[48] 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

[49] p6, Department of Health (2016). *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

Most importantly, 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 is important, but 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; and ensuring adequate and equitable 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.

The NMHSPF (still unpublished) could inform the development of a nationally agreed-to model of long-term investment. Governance structures supporting this work include the Mental Health and Drug and Alcohol Principal Committee; the Fifth Plan Mental Health Expert Reference Panel Aboriginal and Torres Strait Islander Mental Health Subcommittee, and Suicide Prevention Subcommittee; and the National Mental Health Commission.

MIFA thanks the Department of Treasury for the opportunity to provide input into the 2018-19 Budgetary process.

Contact

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Disclaimer

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