
Submission to the National Mental Health Services Review



WAAMH

**Western Australian Association
for Mental Health**

Peak body representing the community-managed mental
health sector in Western Australia

Western Association for Mental Health
Lotteries House, 2 Delhi Street, West Perth WA 6005

ABN: 15 165 640 637

T: (618) 9420 7277 F: (618) 9420 7280 E: reception@waamh.org.au W: www.waamh.org.au

Evidence of the mental health 'system' working well

Please provide an example from your own experience (or that of your organisation) of a service, programme, policy or initiative demonstrating value for money (cost-effectiveness)

In 2013/14 the MHC provided Western Australian Association for Mental Health (WAAMH) with project funding of \$150,000 to provide development and technical assistance to establish at least four Individual Placement and Support (IPS) competitive employment partnerships in metropolitan and rural WA. WAAMH's approach is based on the State Trainer model developed at Dartmouth Medical School in the USA and implemented by the National Health Service in the UK.

Through these partnerships mental health services receive direct access for their clients to specialist employment services, have an employment specialist co-located within their service, and receive expert development support and technical assistance from an independent specialist IPS development unit.

IPS has been evaluated in 19 randomised controlled trials in North America, Europe, Asia and Australia. 60% or more of IPS clients obtain competitive jobs, compared to about 24.3% of those achieved the DES service in Australia in 2012.¹

Substantial improvements in mental health are achieved by assisting clients to gain some form of competitive employment, and large savings for the community can be achieved through reducing reliance on welfare payments and reduced use of acute mental health services².

An example of good integration, joint working, or collaboration with other services, programmes or initiatives

The full integration of disability employment services into mental health treatment is central to the Individual Placement and Support (IPS) model and its greatest strength. The IPS Developmental Unit acts a 'bridge' resourcing the effort associated with drawing agencies from different sectors into formal integrated arrangements. It establishes systems and processes to deliver integrated services critical to achieving employment outcome success:

¹ Australian Government, Department of Education, Employment and Workplace Relations, Evaluation of Disability Employment Services Interim Report Re-issue March 2012.

² Burns T., and Catty J., 'IPS in Europe: The EQOLISE Trial, Psychiatric Rehabilitation Journal 2008, Vol. 31, No. 4, 313-317. and Bush P., Drake R., Haiyi X., Mc Hugo G., Haslett W., 'The Long-Term Impact of Employment on Mental Health Service Use and Costs for Persons With Severe Mental Illness, Psychiatric Services' August 2009.

Table 1: Models of Mental Health and Employment Support (Adapted from; Collaborative Care Framework, Alcohol and Other Drug and Mental Health Services)

Serial / Consecutive	Parallel	Integrated
Mental health problems and employment needs are addressed consecutively with little communication between services.	Mental health services establish a liaison with supported employment services to provide treatment and support concurrently.	Concurrent provision of specialist mental health and supported employment services within the same team (designated service).

Both the MHS and the DES contribute to the partnership from their existing resources, with the Development Unit overseeing progress, providing necessary support, training and evaluation. The Development Unit ensures partnerships achieve high levels of fidelity, essential to IPS’s success, and avoid ‘program drift’ which causes reduced effectiveness over time.

An example of a service or initiative which supports the needs of the whole person (e.g. physical health, housing, education and training)

The Individual Placement and Support (IPS) Programme has eight core practice principles, one which is “client preferences” – this is to ensure all job search activities are focused on the choice and interests of the individual. Time unlimited support is another principle which creates the opportunity for tailored support services once successfully placed in a job to assist longevity and sustainability. IPS combines mental health and wellbeing with employment support to ensure a whole person approach. Individuals that have social support needs can work in partnership with the employment specialist whilst simultaneously undertaking employment support.

Up to 2 examples of services, programmes, policies or initiatives which effectively target and meet the mental health needs of specific communities: For example, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse peoples, people living in rural and remote Australia, people who identify as lesbian, gay, bisexual, transgender or intersex, people who experience substance use difficulties, people living with intellectual disability

The Looking Forward Aboriginal mental health project aims to design, develop and pilot a culturally safe mental health service framework that will benefit the community and provide a benchmark for organisations to provide more effective mental health services to Aboriginal people.

The project is a partnership between public and non-government service providers particular mental health services; general practitioners and other health professions; Aboriginal Medical Service Derbarl Yerrigan, and lead project agencies Ruah Community Services and the Telethon Institute for Child Health Research.

The project will run over four years using a participatory action research process with community engagement and consultations in the South-East Corridor, Western Australia.

An example of effective monitoring of outcomes and experiences to drive service improvement

The Individual Placement and Support (IPS) Programme comes with quality assurance measuring tool. The demonstrated international model for effectively implementing IPS is by providing expert developmental support and ongoing technical assistance (i.e. training and fidelity reviews) to IPS sites through a Development Unit³.

The fidelity scale measures the effectiveness of services delivered, the organisation, and staffing. There are 25 anchors each rating 1-5. The higher the fidelity rating, the better the employment outcomes. The tool enables IPS services to reflect on their partnership, systems, philosophy and practice at regular intervals. Additional to the fidelity scale are the monthly snap shot reports completed by the employment specialist, monthly outcomes report that is discussed each month by the steering committee and the evaluation database which gathers information about all participants accepted onto the IPS Program. With the variables on the evaluation database staff are able to assess the effectiveness of outcomes over a certain period of time. These monitoring and evaluation tools have been developed by the Queensland Centre for Mental Health Research.

An example of meaningful involvement of people living with mental health problems and/or their families/supporters (for example, in the planning of services, decision-making, or feeding back views)

WAAMH is currently facilitating the Peer Work Strategic Framework project as part of the Mental Health reform agenda to embed peer work into the delivery of Public and Community Managed Mental Health and Alcohol and other Drug services. In successfully embedding peer work, it is hoped the framework will assist in creating a sustainable workforce that understands and meets the diverse needs of people with mental health and/or alcohol and other drug problems, their families, carers and communities.

The framework will outline concepts and definitions of peer work within the Mental Health and Alcohol and Drug Sector and provide an outline for what is required of organisations wishing to engage, or improve their existing engagement of peer workers.

³ Waghorn G., and Child S. (2012), 'Enhancing Community Mental Health Services Through Formal Partnerships With Supported Employment Providers, American Journal of Psychiatric Rehabilitation, 15: 157-180

An example of regular and effective use of evaluation or research to inform evidence-based practice

The Individual Placement and Support (IPS) Programme. All IPS sites are provided with a list of recommended readings linked to IPS, an evidence based model of supported employment. They are also encouraged to monitor and evaluate services so they may publish and share findings with the sector and add to the growing evidence around IPS. Dartmouth College in the USA and the Centre for Mental Health in UK all research IPS and a number of publications are released annually to add to the knowledge base of the model.

Evidence of the mental health 'system' NOT working well

An example of an inappropriate balance or prioritisation of funding

It is well established that many people in mental health hospitals could return to the community should sufficient supports be available. The WA Mental Health Commission's 'Mental Health 2020' report identified balancing investment across the full range of supports and services as one of three key reform directions. The National Mental Health Planning Framework has identified the shortfall in community alternatives to hospital beds as a critical investment need,

During consultation for the Stokes Review managers and clinicians reported that there are more acute mental health beds per head of population in WA than in other states, and it was suggested to the review that the mental health system in WA is skewed towards an inpatient focus. Graylands remains as a stand-alone psychiatric hospital.

WAAMH argues that the proportion of WA Government mental health funding going to the community managed mental health sector should increase to 25-30%, which is similar to the rate in New Zealand. Increasing the spend in the community sector would allow the development of innovative recovery and early intervention services where there are few or none available.

An example of where different services, programmes, policies or initiatives are not well integrated or don't communicate with each other

The WAAMH Mapping Report of the Community Mental Health Sector⁴ in WA noted an 'almost nonexistent interface' between CMMH services and the private mental health

⁴ WAAMH (2012) Report: A project to map the Community Mental Health Sector in Western Australia

sector. The report found that only 3% of organisations that responded to the survey noted the private mental health sector as one of their three most frequent sources of referral.

An example of the needs of the whole person not being effectively addressed or met (e.g. physical health, housing, education and training)

The WAAMH Mapping Report of the Community Mental Health Sector in WA identified a number of organisations who provide mental health services but whose core business is in the area of homelessness, drug and alcohol, or supports for Aboriginal people.

Homelessness service providers said that the lack of services that recognised the special needs of people with mental illness, whose life skills were geared to survival on the streets, was the single major contributor to the homelessness of many people in their services. Another area where there is overrepresentation of people with mental illness but limited links between the sectors is the criminal justice system.

Up to 2 examples of services, programmes, policies or initiatives where the specific needs of particular communities are not effectively recognised or met: Examples of particular communities are Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse peoples, people living in rural and remote Australia, people who identify as lesbian, gay, bisexual, transgender or intersex, people who experience substance use difficulties, people living with intellectual disability

Evidence based models for people with complex or multiple needs are required, particularly for those with severe and persistent mental illness who may experience homelessness or interface with the criminal justice system. For these groups, while there is a strong policy commitment to recovery, some WA organisations have noted recovery would continue to be “off the radar” for many of these individuals until there is a more cohesive and a collaborative evidence based approach to helping them find and retain safe, secure, person centred accommodation.

There is a need to develop community based alternatives to imprisonment for people with mental health issues in the criminal justice system. This includes people who are found unfit to plead or not guilty for reasons of mental illness, and sentenced prisoners; both groups often spend longer in prison than people without mental health issues. For these groups the most significant barrier for return to the community is often the lack of appropriate accommodation, community and community justice supports and services.

An example of excessive red tape (e.g. unnecessary and burdensome reporting requirements taking resources away from service delivery)

The WAAMH Mapping Report of the Community Mental Health Sector in WA identified that for many organisations there is a high level of administrative complexity in reporting and managing programs with similar target groups, sometimes in the same locations, from both state and federal funding sources. This arises as a result of the lack of a coordinated state and federal funding framework.

An example of an area, state or territory where there are gaps in services or programmes

In WA there is an uneven geographical coverage of community mental health services, with rural and remote areas, particularly Aboriginal communities lacking in critical services. The Midwest, Gascoyne/Murchison and the Pilbara have high levels of unmet need, relatively low levels of state funding CMMH services and no federally funded core CMMH services. There is also uneven coverage of services targeting specific cultural or other needs groups, including people with diverse or complex needs.

The Sector Mapping Report identified the complexity and diversity of State and Commonwealth mental health funding arrangements to community sector organisations. The report noted, on analysis of the data, that it was not possible to discern any logic that might underpin the reasons why each level of government has chosen to locate services where they have in relation to the services provided by the other level of government. It further noted no discernable logic regarding who is targeted, what high level outcomes are sought and what service models are supported and why.

Actions Needed for Change

3 practical steps to improve things in the mental health system would be

1. Improve use of outcomes, monitoring and evaluation to ensure programs meet needs, and to enable funding of evidence based programs into the future
2. A more strategic, coordinated and collaborative approach from the State and Federal Governments to the evidenced based funding and design of community mental health services, including an articulation of the roles of each Government in supporting community mental health service development and delivery.
3. Develop a cohesive strategic framework that guides current mental health accommodation and accommodation support arrangements, and strengthens the capacity of the homeless and supported accommodation/social housing sectors to respond to the mental health needs of their consumers.

Do you (or your organisation) have an interest in commenting on any of the following issues?

What is your/your organisation's view about the current provision of support for Aboriginal and Torres Strait Islander people's mental health?

Aboriginal Community Controlled Health Services are the major health provider for about 30% of Aboriginal people in WA, and are the usual source of care for 76% of Aboriginal people living in very remote regions⁵. Whilst the Aboriginal community controlled health sector has historically played a major role in responding to people displaying high levels of social and emotional distress and high levels of disturbance and self-destructive behaviour, it has lacked the resources and trained staff to adequately deal with these complex issues.

The Australian Indigenous Psychologist Association argues that the recognition of the importance of these services in providing mental health and social and emotional wellbeing services to Aboriginal people has not translated into appropriate funding⁶.

What is your/your organisation's view about the current provision of mental health support in remote and rural Australia?

As previously noted geographical coverage is very patchy, including access to appropriately funded and available supports for Aboriginal people in remote communities.

What specific action or strategy has the potential to improve this?

Development of a coordinated state and federal funding framework for mental health services.

What is your/your organisation's view about the current funding, organisation and prioritisation of mental health research? What specific action or strategy has the potential to improve this?

Research into effective engagement and provision of Tier 2 type services inclusive of PIR, PhaMS.

What is your/your organisation's view about the current way mental health workforce development and training is carried out in Australia?

⁵ Health Implementation Taskforce (2007) cited in WAAMH (2012) Report: A project to map the Community Mental Health Sector in Western Australia

⁶ Australian Indigenous Psychologist Association (2009) *Submission to the Expert Reference Group on the "Towards as National Primary Health Care Strategy"* Discussion paper February 2009), cited in in WAAMH (2012) Report: A project to map the Community Mental Health Sector in Western Australia

Contributors to the WAAMH Mapping Report of the Community Mental Health Sector in WA expressed a view that a more systematic and emphatic approach to workforce training and development is required.

What specific action or strategy do you think has the potential to improve this?

The Sector Mapping Report identified that introduction of contemporary curriculum in relation to recovery and treatment models that are more holistic and less embedded in traditional medical models is a critical factor in successful community mental health service delivery. Curriculum developments that would assist include:

- Defined and mandatory standards of curriculum development and training delivery
- A new and more contemporary approach to training and development, for example embedding recovery across the curriculum and incorporating peer support roles
- Accredited courses and curriculum development that addresses skills requirement across all work roles
- Developing updated curriculum in training for professions that engage with people with mental illness e.g. GPs, psychiatry, social work, psychology, nursing and occupational therapy.

A further beneficial initiative would be adding 'community mental health worker' to the Australian and New Zealand Standard Classification of Occupation list. Acknowledging community mental health workers as a discrete profession would have a range of implications for workforce training and development, funding streams, and skilled migration.

Further comments

The National Disability Insurance Scheme is a critical issue with significant ramifications for the funding and delivery of community managed mental health services. WAAMH supports the introduction of the scheme and the inclusion of people with psychosocial disability, however is deeply concerned about the potential for loss of funding to services that support people outside Tier 2 and 3 of the NDIS.

WAAMH advocates for an NDIS that:

- Increases access to Tier 3 supports for people with psychosocial disability
- Increases access to Tier 2 supports for people with psychosocial disability and their carers
- Is inclusive of a recovery oriented approach.

WAAMH also argues strongly for the protection and development of community managed mental health services into the future that are broader than, but interact with, the NDIS - rather than rolling up funds from programs such as PHaMS and PiR into the NDIS.

This argument stems from a pragmatic approach, allowing for the likelihood that the eligibility issues around permanency, severity of impairment and complexity of needs will remain. The parameters for eligibility for NDIS, even for Tier 2 services, require permanent and significant functional impairment. This is problematic not only because people can and do recover, but also for those consumers wishing to access CMMH services whose mental illness does not result in disability, whose mental illness is not considered sufficiently severe, or who do not have sufficient functional impairment to be considered NDIS eligible. These are by far the majority of people with mental health issues or illness. It is also essential that services, which are not part of the NDIS, be available to carers.

Supporting and funding non-NDIS community managed mental health services will allow the continuation and further development of best practice recovery oriented services that fill the gap between NDIS psychosocial supports and the acute and crisis care provided by the hospital and public community health service system.