# Submission to the National Mental Health Services Review Second Submission

## June 2014

WAAMH

Western Australian Association for Mental Health

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

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## Background

The Western Australian Association for Mental Health was incorporated in 1966 and is the peak body representing the community-managed mental health sector in WA. With more than 100 organisational and individual members, our vision is to lead the way in supporting and promoting the human rights of people with mental illness and their families and carers, through the provision of inclusive, well-governed community-based services focused on recovery. WAAMH advocates for effective public policy on mental health issues, delivers workforce training and development and promotes positive attitudes to mental health and recovery. Further information on WAAMH can be found at http://www.waamh.org.au

## First Submission

WAAMH completed a response to the National Mental Health Services Review (the Review) survey online (Attachment 1). The submission advocated for:

- The retention of programs including Personal Helpers and Mentors and Partners in Recovery, rather than partial or full roll-in to the NDIS, and the development of Tier 2 supports for both people who identify with having a psychosocial disability as well as those who do not and wish to access mental health services and supports outside the NDIS system.
- The roll out of the Individual Placement and Support (IPS) employment program across Australia, including the funding and establishment of IPS development, training and support units to establish partnerships and ensure fidelity to the program
- The need for an increased proportion of mental health funding to be directed to the community sector for the development and implementation of innovative recovery and early intervention services
- More services that target people with complex needs including Aboriginal people, people experiencing homelessness, and community based supports for those interacting with the criminal justice system.
- More services in rural and remote areas
- Evidence based funding and design of community mental health services
- The need to move to an outcomes framework for community mental health service delivery
- A more integrated approach to workforce development.

The submission highlighted the following as promising or effective initiatives:

- Looking Forward Aboriginal Mental Health Project
- IPS
- The involvement of consumers and carers as peer workers.

The submission also identified:

- The need for improved communication and partnership between private and community mental health services
- Organisations with both state and federal funding experience administrative complexity in reporting requirements and program management.

Many of the issues raised in WAAMH'S first submission are also reflected in the issues raised by WAAMH members who informed this second submission, albeit with more of a local needs focus.

# Issues raised in this second submission

To inform this submission WAAMH developed a brief survey, distributed to our members, which include community managed mental health organisations and individuals. Ten responses were received. Two were providers of Commonwealth services and seven were providers of other mental health services. Of the ten, some respondents were both mental health professionals and people with lived experience - three were consumers and three were carers.

The content of this submission reflects the issues raised by WAAMH members in response to the survey. WAAMH designed the survey to capture a quick snapshot of the main 'front of mind' priorities for the community managed mental health sector in Western Australia, and focused primarily on three main areas: top priorities for reform, service gaps and the experience of the community managed mental health sector in delivering services. The survey was not intended to explore the issues in depth; WAAMH will consult more deeply with the sector to inform a third submission in the coming months.

## Top Five Issues for Reform

WAAMH's member survey asked respondents to rate their top five issues for reform as they relate to the Review's terms of reference. WAAMH also asked about 'consumer and carer participation' as this is a key reform direction, which did not appear to be explicitly included in the Review's terms of reference.

The results, in descending order of priority, were:

1. Service gaps
2. The role of factors such as employment, accommodation and social connectedness relevant to people's experience of living a contributing life
3. Funding arrangements for mental health services
4. Workforce development and training, particularly in the area of peer support
5. Consumer and carer participation AND challenges for regional, rural and remote Australia (equal fifth)
6. Challenges for Aboriginal people
7. Reporting requirements.

We know that service gaps, and challenges, in both rural and remote areas and for Aboriginal people are significant priority areas for WA[1]. The survey results are likely to be reflective of the experiences of WAAMH members; a significant majority of which are metropolitan based.

The broader structural issues of gender inequality, high levels of violence against women and poverty are significant factors negatively affecting women's mental health. Two respondents advocated strongly for the need to recognise and take a

[1] 'Mapping Report Community Mental Health Sector in WA',2012, Barbara Gatter and Associates and Colin Penter Consulting

gendered approach to research, policy, planning, service development and implementation, noting there is a lack of focus on women's mental health as a specific area both in WA and nationally.

## Experience of providers of Commonwealth funded MHS

Two respondents to the WAAMH survey were providers of Commonwealth services. Issues raised were:

- Service descriptions can be too restrictive, particularly for those programs that target hard to engage groups, who may need a broader range of supports than those funded by the program
- Although there is some flexibility allowed by the Commonwealth in tailoring services to local needs, more flexibility is required
- Some programs dictate the type of mental health professional that can be employed under the program, which severely curbs hiring options and can have a negative impact on the services provided
- One respondent identified a need for the provision of IT infrastructure and software when Commonwealth programs are rolled out. This would enable organisations to meet reporting requirements without drawing on other sources of funding, or using time-consuming paper and pen methods; both of which reduce resources available for direct service provision.

## Effective Approaches

The strongest themes about effective services, programs and approaches were:

- Individualised approaches which allow holistic service provision
- Gender, violence and trauma informed support
- Tailoring services to local needs
- Integration with other services and supports; including to primary and tertiary care, and to community and informal supports depending on individual needs
- Community mental health programs and services, which were described as being more effective at providing continuity of care, more accessible to people with a broad range of mental health issues and illness and more fully understanding the person in their community and cultural context
- Lived experience input into program development.

Other elements that work well were described as:

- Reducing barriers to accessing supports including cost, child care and transport
- Joint peer and professional programs
- Intensive programs for high risk issues such as suicide.

Specific programs that were named as working well were:

- Body Esteem Programs - 20 week programs
- Parent Education Support Program (eating disorders)
- Overeaters Anonymous.

## Service gaps

Survey respondents rated service gaps as the top priority issue for reform. Specific service gaps identified are set out in the tables that follow.

| Service type | Service focus | Target group | Region | Comments |
|---|---|---|---|---|
| Personal recovery programs | Support to live a good life, in accord with their own goals and outcomes including self-directed supports. | All mental health consumers | State-wide | |
| Preventative family therapy / counselling support | Eating disorders | Young women and their families | State-wide | There is only one service funded in Perth; this is for north metro only. |
| Eating disorder support | | Young people aged 16-18 | State-wide | Significant gaps in this area as there are no public mental health services or funded community services for this age group. |
| Perinatal mental health | Supporting families in the first six months of babies life | Mums and babies, including single mothers and fly in fly out families. | State-wide | One organisation has an established program in Perth north metro, with significant demand, which requires ongoing funding. |
| Counselling | Grief and loss | | | Particularly suicide bereavement. |
| Counselling | | People who are not suitable for public community MH services, but whose needs are too complex for short term programs e.g. Better Access, ATAPS. | | |

| Service type | Service focus | Target group | Region | Comments |
|---|---|---|---|---|
| Counselling and group work | | Consumers with difficult to manage and complex issues including Borderline Personality Disorder. | | People with complex needs can fall through service gaps; few organisations provide services to people experiencing this issue. |
| Early intervention and prevention | Skills development and promotion of resilience. | Children and young people. | | |
| Community development and capacity building approaches | Long term focus. | Whole population, targeted communities and identified at risk groups. | State-wide and in targeted communities. | Too often these approaches are short term and require communities to work alone with little or no funding. Long term (decades) approaches are required. The WA government's last suicide intervention plan did not work well. |
| Accommodation services | | People who are unable to live independently but do not require hospitalisation. | | The supports as well as homes are needed. |
| Ongoing support | Long-term preventative and therapeutic support. | | State-wide | |
| Social inclusion, life skills supports. | Social skills, community access and integration and daily living skills support. | | Perth | Not available in public services, community services are under-resourced and not available in some areas. |
| Employment supports | | | | Extremely limited. General disability employment supports described as often not responsive to the needs of people with mental illness. |
| Emergency supports | | All | National service to coordinate emergency responses. | Rural, regional and remote populations have major challenges to timely and responsive emergency supports. |

General comments about service gaps included:

- General lack of accessible services for people in rural areas - people often have to come to Perth for services
- The challenges in working through mental health issues which are affected by aspects of the person's life which are difficult to resolve, such as homelessness
- Despite the focus on involving carers and other family members in both service development and delivery, this needs to be more fully developed and consistently implemented
- There is too much focus on crisis responses and vast under-resourcing of longer-term prevention, early intervention and recovery oriented supports.

Two respondents argued eloquently for the need to develop and provide gender informed and trauma responsive mental health services. One respondent recommended that Federal, state and territory governments invest in the development of more co-located psychological and psychiatric services within women's health services.

Most organisations reported to WAAMH that they could not meet demand for services. A range of methods to target services at those most in need were reported, including using waiting lists, tightening eligibility criteria, triaging/prioritising and referring to other services. One organisation reported running out of money to provide the service before the end of the financial year in some years.

Carer and consumer survey respondents spoke to the inadequate levels of public community mental health provision and identified specific gaps and problems. These included a crisis focus rather than preventive or therapeutic, under-resourcing with no ability to bring appointments forward and the lack of functional support in areas such as daily living skills, social skills and community access. One parent of three sons with mental health issues described the emergency response to those who are harming or at risk of harming as 'outrageously under-resourced' and 'sometimes unavailable'. These respondents were all supportive of growing the community managed mental health sector.

## Evidence of effectiveness

Some organisations reported that internal evaluation or feedback from consumers provided strong evidence for positive outcomes, and that consumer feedback and demand were key drivers of continuous improvement and program development. Organisational survey respondents reported many years of service delivery experience and constant refinement and continuous improvement of programs. However, most survey respondents stated that external evaluations were not available, usually due to funding constraints. One maintained that there is little or no funding available for rigorous, formal external evaluations.

One organisation noted that although organisations report data to funding bodies, analysis of this is not publicly available and argued that this would be beneficial to the community mental health sector.

## Research, Reviews and Policy

One respondent, a community women's health service providing both general health and mental health services stated that current research into women's mental health

and mental disorders is patchy and poorly funded. One recommendation was for the Federal Government to commission a report into the impact of violence against women and girls and the development of mental illness. The organisation also recommended a number of policy changes to include a gender focus, and gender, domestic violence and trauma specific strategies to better meet the needs of women consumers. These included linking National Mental Health Plans with the National Women's Health Policy and the National Plan to Reduce Violence Against Women and their Children, and the provision of leadership and advice to mental health services on gendering action across the social determinants of health through the Ten Year Roadmap for National Mental Health Reform. One other respondent raised gender issues.

Although the number of respondents raising gender issues are few this should not be taken as a low area of need; rather it is reflective of the paucity of focus on this issue in Australia.

A consumer representative organisation recommended a strategic review of co-production at a national systemic level as a key component of the national Review, and consideration of the suite of co-production activities in Australia as part of the Review. This was in recognition of the need for national leadership on co-production. This organisation further recommended adequate funding and support of consumer and carer representative organisations and support services, and consumer operated organisations.

Other areas identified for research were research into the efficacy of long term drug therapy, people who have recovered and are doing well, and alternative therapy methods specifically deep brain stimulation and Avatar therapy (carer). One organisation advocated for an increase in consumer led research, to support consumers moving beyond anecdotal and narrative accounts of why and how some programs are more effective than others are. A final area recommended for research was the systemic analysis of barriers to accessibility and relative investment across access barriers, relative to prevalence of barriers.

## Conclusion

The issues raised by respondents reflect the views of the service providers and the individual experiences of those who responded to the survey.

Gaps in services are the top priority of reform identified by those WAAMH members that responded to the survey. This was the case for both organisational respondents and people with lived experience. The types of services and programs that were considered to be particularly lacking included those focused on specific conditions (eating disorders, Borderline Personality Disorder) and those relevant to all people affected by mental health issues - early intervention, recovery oriented and individualised services and supports that can address people's life goals and the range of issues that are affecting them. The need for gender and trauma informed responses was also identified as a critical gap in WA as well as being broadly reflective of national policy.

Many of the service gap themes were echoed in the issues raised by the providers of Commonwealth services - the need to be able to tailor services to local needs and design flexible, individualised supports focused on the whole person.

WAAMH submits that the views of respondents about the specific service gaps in WA are reflective of a deeper need for the Review to take a long-term recovery oriented view. It is clear that service provision is patchy, and that those services that are available do not always reflect the types of supports people need to recover and live

a meaningful and contributing life. It is also clear that policy, system reform, service funding, and service design needs to be more evidence based to ensure that investment delivers on outcomes.

Going forward, mental health reform needs to avoid the piecemeal approach to funding and provision of services to date. The Review should consider people's equitable access to a fuller range of prevention, recovery and crisis supports, with a focus on achievement of good whole of life and whole person outcomes. This must include how the mental health system interacts with other important services and systems that affect individuals' lives and their mental health and recovery.

WAAMH wishes again to emphasise that the Review should equally value the views of people with expertise through lived experience to those of professional experts. To achieve improved outcomes their concerns and experiences must be central to the recommendations of the Review going forward.

# ATTACHMENT 1 – PREVIOUS SUBMISSION TO NMHSR ONLINE SURVEY

## 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.[2]

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 services[3].

**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:

[2] Australian Government, Department of Education, Employment and Workplace Relations, Evaluation of Disability Employment Services Interim Report Re-issue March 2012.
[3] 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 Unit4.

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. 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.

**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.

[4] 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

# 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 Sector[5] in WA noted an 'almost nonexistent interface' between CMMH services and the

private mental health 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.

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

**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 regions[6]. 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 funding[7].

**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.

[6] Health Implementation Taskforce (2007) cited in WAAMH (2012) Report: A project to map the Community Mental Health Sector in Western Australia
[7] 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

**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?**

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.