



# Submission

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## Fifth National Mental Health Plan Draft for Consultation

Suite 5 Mayfair Plaza  
236 Sandy Bay Road  
Sandy Bay TAS 7005

Phone: (03) 6224 9222

Email: [cdigolis@mhct.org](mailto:cdigolis@mhct.org)

Contact: **Connie Digolis**  
Chief Executive Officer

Prepared by: **Elida Meadows**  
Policy and Sector Development Manager

**Elinor Heard**  
Sector Liaison Officer

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## **Preface**

The Mental Health Council of Tasmania (MHCT) is a member based peak body. We represent and promote the interests of community managed mental health services and have a strong commitment to enabling better mental health and wellbeing outcomes for every Tasmanian.

MHCT welcomes the opportunity to respond to the Australian Department of Health's *Fifth National Mental Health Plan: Draft for Consultation*. Our response is based on consultation with the Tasmanian Mental Health Leaders Forum and our member organisations, listed below.

<b>Advocacy Tasmania</b>	<b>Salvation Army Bridge Program</b>
<b>Anglicare Tasmania</b>	<b>Tasmania Recovery from Eating Disorders</b>
<b>Australian Red Cross</b>	<b>Teen Challenge Tasmania</b>
<b>Baptcare</b>	<b>The Hobart Clinic</b>
<b>Bethlehem House</b>	<b>Wellways</b>
<b>Carers Tasmania</b>	<b>White Cloud Foundation</b>
<b>Caroline House</b>	<b>Wise Employment</b>
<b>CatholicCare Tasmania</b>	<b>Working it Out</b>
<b>Causicare Inc</b>	<b>Youth, Family and Community Connections</b>
<b>Choose Life Services</b>	
<b>Club Haven</b>	
<b>Colony 47</b>	
<b>CORES Australia</b>	
<b>Cornerstone Youth Services</b>	
<b>Epilepsy Tasmania</b>	
<b>Flourish</b>	
<b>GROW</b>	
<b>Headspace Hobart</b>	
<b>Langford Support Services</b>	
<b>Lifeline Tasmania</b>	
<b>Life Without Barriers</b>	
<b>Mental Health Carers Tasmania</b>	
<b>Migrant Resource Centre</b>	
<b>Mission Australia</b>	
<b>OzHelp Foundation</b>	
<b>Rainbow Communities Tasmania</b>	
<b>Relationships Australia Tasmania</b>	
<b>RESPECT Occupational Therapy</b>	
<b>Richmond Fellowship Tasmania</b>	
<b>Rural Alive &amp; Well</b>	

## General comments

In its significant reliance on government collaboration as the primary vehicle of reform the Fifth National Mental Health Plan makes no great departure from preceding plans. Key priorities have shifted, however, and some reference to the factors underlying these shifts – for example, away from promotion, prevention and early intervention (PPEI) – would have been useful within this latest Plan.

MHCT endorses the principles of collaboration and integration but sees key players missing from the landscape of mental health care as it is described within the Plan, including the community mental health sector itself. And while the Plan names many roles – PHNs, LHNs, advisory groups, professional bodies, service providers and local communities – there is little definition and delineation of each one and precisely how they intersect. Collective effort is named up but there is no indication of who will oversee this and ensure that it works.

True integration and collaboration would also mean recognising the broader determinants of mental health and the critical importance of domains such as housing, education and employment to long-term recovery and wellbeing. The opportunity here to contribute to the breaking down of silos and establish a whole of life, whole of person approach to mental health service delivery is missed. The responsibility for mental health as it is defined within the Plan remains firmly in the province of the Department of Health and Health Ministers.

The Federal Government has stated its commitment to an innovation agenda including in the area of mental health reform.<sup>1</sup> However, the Plan assumes that mental health care provision over the next 20 years will be provided in much the same way it has been provided over the last 20 years. There is virtually no reference to the new digital gateway which was a critical part of the Government's response to the National Mental Health Commission's review and its own pre-election mental health commitments. E-mental health services should form a critical element of the next wave of mental health reforms but do not feature in this Plan.

Finally, it is of great concern that the Plan offers neither a clear description of jurisdictional responsibilities – including explicit financial responsibility – across states, territories and the Commonwealth, nor a plan or timeline for implementation. There is a general lack of detail with regard to funding, communication, benchmarking, targets, measures and timeframes within the Plan and it is to be wondered how real change will be achieved without explicit mechanisms to guarantee effective implementation and accountability.

## Recommendations

1. The Plan should involve the broader mental health and health sectors, acknowledging the vital role of allied health professionals and community managed mental health services.

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<sup>1</sup> Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services (2015), Canberra, Department of Health, p. 10.

2. The Plan should contribute to the breaking down of silos to encompass areas outside health including employment, training, housing and education.
3. The Plan should more fully commit to promotion, prevention and early intervention (PPEI).
4. The Plan should clearly articulate jurisdictional responsibilities including explicit financial responsibility across states, territories and the Commonwealth.
5. The Plan should provide a timeline for implementation including the sequence in which priorities must be addressed to be effective.
6. The Plan should demonstrate the Commonwealth Government's stated commitment to an innovation agenda, utilising new modes of service delivery such as e-health to improve service access in regional and remote communities.
7. The Plan should specify its commitment to a whole of life, whole of person approach as the basis for all actions.

## Priority Areas

### Priority Area I: Integrated regional planning and service delivery

This is a commendable priority however the Plan fails to stipulate the jurisdictional roles, responsibilities and intersections that will deliver an integrated system. There is no explanation of the process by which the national agenda will translate to jurisdictional, then regional, then local and individual actions, beyond suggesting that the Plan will complement existing state and territory plans.

Again the role of the community managed mental health sector is missing here, as are key linkages with housing, disability, training, employment, child and family services, alcohol and other drugs, aged care and justice. This is a retrograde step from the Fourth National Mental Health Plan, which named up the importance of cross-sectoral collaboration across these domains<sup>2</sup>.

The Plan gives virtually no detail about how integration will be implemented, nor does it provide any performance indicators that directly relate to the measurement and evaluation of this priority. The Plan would be far stronger if it articulated specific goals, targets and enablers of integration. We also need to understand how the Commonwealth Government intends to support integrated planning in the context of jurisdictional differences, noting that there will be different starting points and some regions are further advanced along reform routes than others.

## Recommendations

8. The Plan must provide greater clarity around jurisdictional responsibilities and intersections, including an explanation of how state and national mental health plans will be integrated.
9. The Plan should acknowledge the vital role of the community managed mental health sector and articulate which community managed services and programs are the responsibility of state and federal governments.
10. The Plan must support greater integration between mental health services and other services such as disability, housing, education and employment.
11. The Plan needs detailed actions, targets and measures that directly relate to integration.

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<sup>2</sup> Fourth national mental health plan: an agenda for collaborative government action in mental health 2009–2014 (2009), Canberra, Commonwealth of Australia, p. 32.

## Priority Area 2: Coordinated treatment and supports for people with severe and complex mental illness

The Plan gives a cursory nod to community services in this priority targeting individuals with severe and complex mental illness, and yet in describing “the necessary regional architecture” for coordinated care pathways it names PHNs and LHNs only<sup>3</sup>. The role of community based mental health services in the provision of supports to people with complex mental health conditions is marginalised and the concept of avoiding hospital admissions is not mentioned at all.

The Plan outlines the development of national guidelines as the mechanism to ensure coordinated service delivery but gives neither a method nor timeframe for the provision of this framework beyond urging an “open and collaborative process”<sup>4</sup>. Likewise, the Plan describes oversight of this reform priority area by the Mental Health Drug and Alcohol Principal Committee (MHDAPC) in relation to the ongoing roll out of the National Disability Insurance Scheme (NDIS) but stops short of describing the lines of reporting, accountability and response when service gaps or other issues are identified.

Given that successive National Mental Health Plans have grappled with the issue of how to provide effective care pathways and continuity of supports for consumers without clear success it is essential that this Plan offers more than good intentions with regard to the “region-wide arrangements”<sup>5</sup> that will ensure coordinated care for individuals with severe and complex mental illness. Consumers and carers must play a central role in the design of these arrangements which in turn must be embedded in a real-world framework of actions, targets, measures and evaluation.

### Recommendations

12. The Plan should acknowledge the vital role of community managed mental health services in the provision of both clinical and psychosocial supports within the community.
13. The Plan must show how coordinated supports will deliver easily navigable care pathways and how the mechanisms for coordination will be measured and evaluated.
14. The Plan should provide a process and timeframe for the development of national guidelines informing coordinated service delivery.
15. The Plan must describe its functional relationship to the NDIS, including in relation to jurisdictional differences, monitoring of service gaps and lines of reporting and accountability.
16. In addition to monitoring emerging silos and gaps the Plan should guarantee oversight of existing silos and gaps against which channels of reform are already in train.

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<sup>3</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 27.

<sup>4</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 28.

<sup>5</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 29.

## Priority Area 3: Suicide prevention

The actions in this area align well with Tasmania's Rethink Mental Health Plan strategies and Suicide Prevention Plans. However, it would help to have some detail on how suicide data will be reported and collected and a timeframe for the establishment of the intergovernmental advisory group.

Focusing on the acute end may reduce suicide but it is a false economy given there are no preventative measures to reduce individuals moving into the acute/late intervention arena. As recommended by the World Health Organization, a public health approach to suicide prevention integrates crisis intervention and enhanced support for people at risk of suicide with broader community awareness and stigma reduction, postvention support and mental health and wellbeing initiatives<sup>6</sup>. In this regard the Plan only supports the 1 in 20 consumers at the acute end, not the 19 in 20 consumers moving towards the acute end.

The plan does not address the specific accountabilities of 'health administrations' for their role in suicide prevention which will surely lead to continuing confusion and lack of accountability.

## Recommendations

17. The Plan should provide detail about how suicide data will be collected.
18. The Plan should give a timeframe for the development of community public health and communication strategies about suicide and suicide prevention.
19. The Plan should recognise the need for more effective and quantifiable early approaches to suicide prevention and intervention rather than relying on acute/late stage interventions.
20. The plan must nominate the specific accountabilities of health administrations for their role in suicide prevention so as to avoid the 'not our responsibility' mantra.

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<sup>6</sup> Preventing suicide: A global imperative (2014), World Health Organization, Luxembourg, p. 56.



## Priority Area 4: Aboriginal and Torres Strait Islander mental health and suicide prevention

We support the actions outlined in this priority area and suggest an action specifically focusing on physical health might be warranted as people in the Aboriginal and Torres Strait Islander population have high levels of mental illness and co-occurring chronic diseases. A study which looked at the health of Aboriginal and Torres Strait Islanders in custody found that they “suffer from complex health problems, with a high prevalence of co-occurring disorders that may include chronic health conditions, mental health disorders, substance use disorders and intellectual disability.”<sup>7</sup>

The Aboriginal Indigenous Infonet informs us that, “for 2006-2010, there were 312 Aboriginal and Torres Strait Islander deaths from ‘mental and behavioural disorders’. Compared with the non-Indigenous population, Aboriginal and Torres Strait Islander people were one-and-a-half times more likely to die from these disorders. Deaths from ‘mental and behavioural disorders’ do not include deaths from ‘intentional self-harm’ (suicide).”<sup>8</sup> This suggests that the lifespan gap already noted in the mainstream community for those with severe mental illness who die earlier from the poor physical health outcomes related to their mental illness is even wider in Aboriginal and Torres Strait Islander communities.

### Recommendations

21. Priority Area 4 might also include an action specifically focusing on physical health for people from Aboriginal and Torres Strait Islander communities because an effective approach to co-occurring disorders for these groups may differ from the actions outlined in the specific priority, ‘Physical health of people living with mental health issues’.

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<sup>7</sup> Ed Heffernan, Kimina Andersen, Elizabeth McEntyre and Stuart Kinner (2014), Mental disorder and cognitive disability in the criminal justice system, *Working Together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* pp. 165-178, p. 172.

<sup>8</sup> Summary of Aboriginal and Torres Strait Islander health, Aboriginal Indigenous Infonet, <http://www.healthinfonet.ecu.edu.au/health-facts/summary>

## **Priority Area 5: Physical health of people living with mental health issues**

Rather than needing the same level of physical health care as the general population it is arguable that people living with mental health issues need a higher level of physical health care and support. The notion that, “better screening, early intervention, person-centred treatment and care” will lead to “improved health outcomes, including better management of co-existing mental and physical health conditions, reduced risk factors, and improved life expectancy” by simply “working together”<sup>9</sup> is naïve. More is needed in terms of policy and accountability and it will require broad systemic change to ensure a concerted and coordinated push towards screening and risk management.

Programs targeting physical health issues need to be prominently promoted and widely accessible. There also needs to be a consideration of systemic barriers and how they can be addressed before any real, lasting change in the approach to the health of people with mental illness is achieved. One question raised by our members is – why only physical health? Physical health is only one component of wellbeing and a more integrated and holistic approach acknowledging this would be valuable.

### **Recommendations**

22. A timeframe should be given for the identification of suitable guidelines and other resources for use by health services and health professionals to improve the physical health of people living with mental health issues.
23. Include as an action making physical health education available to consumers, carers and families to provide them with the knowledge they need to identify and manage risk.
24. Community managed mental health services which interface every day with consumers and carers need to be included in Priority Area 5.

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<sup>9</sup> Fifth National Mental Health Plan: Consultation draft (2016), Canberra, Department of Health, p. 48.

## Priority Area 6: Stigma and discrimination reduction

The Plan is to be commended for acknowledging that severe mental illness requires a focus on stigma reduction. But what will this look like, how will responsibility be shared and who will lead the work? The Plan refers to the importance of continuing “to build and examine the evidence base on appropriate and effective approaches to reduce stigma and discrimination and reflect on lessons learned.”<sup>10</sup> However, there is no suggestion within the Plan of a mechanism to achieve this. We feel that there is already a strong evidence base, particularly from jurisdictions in comparable countries, like New Zealand. There is more than sufficient evidence now to lead to meaningful action in this area.

### Recommendations

25. The Plan should articulate the need for a much broader stigma reduction program that includes increasing knowledge and providing skills to promote good mental health.
26. The Plan needs to demonstrate how “a better understanding of mental illness and improved attitudes towards people who live with mental health issues”<sup>11</sup> will be measured and evaluated.
27. The Plan should provide measures, timeframes and clarity over roles and responsibilities in stigma reduction.
28. The Plan needs to describe the mechanism “to continue to build and examine the evidence base on appropriate and effective approaches to reduce stigma and discrimination and reflect on lessons learned.”<sup>12</sup>

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<sup>10</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 54.

<sup>11</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 54.

<sup>12</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 54.

## **Priority Area 7: Safety and quality in mental health care**

An implementation plan with timeframes and milestones is essential. If this work does not happen it will hold up all the other work related to the Plan. In relation to service quality, the Plan calls for amendment to the national standards, and to mandate their use. However, the failure to establish genuine accountability has been one of the major and enduring characteristics of successive national mental health plans. Without major accompanying commitments, this will not change. The Plan is almost completely devoid of specific measurable and achievable goals and defined targets oriented to real reform. There is also a significant lack of evidence-based and recovery-focused practices and service delivery systems. Once again, the community managed mental health sector is absent and MHCT is concerned by the lack of detail regarding the provision of transparent monitoring and accountability.

### **Recommendations**

29. The Plan must refer to specific measurable and achievable goals and defined targets oriented to real reform.
30. The Plan must demonstrate how the Commonwealth will be satisfied that standards are met and service provision is accountable and how it will work to improve consistency across jurisdictions.
31. There is a need for availability and access to timely data and long-term data collection analysis.
32. The Plan should include a commitment to fund new and independent ways to collect and report data, particularly on the issues of most import to consumers and carers, such as employment, education and quality of life.
33. The Plan must incorporate a transparent monitoring and accountability system, ideally via an independent authority or commission representing all stakeholder interests, to ensure that all policies and plans are reform-focused, and that practical targets are achieved.

## Monitoring and reporting on reform progress

It is difficult to see how some of the proposed indicators will be measured, and what the specific purpose might be in posing these indicators, for example:

- Rate of social/community/family participation in people with mental illness
- Proportion of people with mental illness in employment
- Proportion of carers of people with mental illness in employment

Number 2 looks at the rate of long term health conditions of people with mental illness where, we believe, it might be more useful to look at rates of screening for long term health conditions in this population.

Number 9 refers to population access to mental health care but given the lack of reference to and acknowledgement of the community managed mental health sector we might assume these services will not be captured by this indicator?

MHCT welcomes the addition of new national indicators of mental health system performance and reform<sup>13</sup> and believes they would be effective in providing the kind of data that relates to mental health improvements in the community.

## Recommendations

34. Include indicators relating to the identification of children at risk of developing mental illness and to population-wide access to interventions and screening.

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<sup>13</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 68.

## Summary of recommendations

1. The Plan should involve the broader mental health and health sectors, acknowledging the vital role of allied health professionals and community managed mental health services.
2. The Plan should contribute to the breaking down of silos to encompass areas outside health including employment, training, housing and education.
3. The Plan should more fully commit to promotion, prevention and early intervention (PPEI).
4. The Plan should clearly articulate jurisdictional responsibilities including explicit financial responsibility across states, territories and the Commonwealth.
5. The Plan should provide a timeline for implementation including the sequence in which priorities must be addressed to be effective.
6. The Plan should demonstrate the Commonwealth Government's stated commitment to an innovation agenda, utilising new modes of service delivery such as e-health to improve service access in regional and remote communities.
7. The Plan should specify its commitment to a whole of life, whole of person approach as the basis for all actions.
8. The Plan must provide greater clarity around jurisdictional responsibilities and intersections, including an explanation of how state and national mental health plans will be integrated.
9. The Plan should acknowledge the vital role of the community managed mental health sector and articulate which community managed services and programs are the responsibility of state and federal governments.
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11. The Plan needs detailed actions, targets and measures that directly relate to integration.
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15. The Plan must describe its functional relationship to the NDIS, including in relation to jurisdictional differences, monitoring of service gaps and lines of reporting and accountability.
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19. The Plan should recognise the need for more effective and quantifiable early approaches to suicide prevention and intervention rather than relying on acute/late stage interventions.
20. The plan must nominate the specific accountabilities of health administrations for their role in suicide prevention so as to avoid the 'not our responsibility' mantra.
21. Priority Area 4 might also include an action specifically focusing on physical health for people from Aboriginal and Torres Strait Islander communities because an effective approach to co-occurring disorders for these groups may differ from the actions outlined in the specific priority, 'Physical health of people living with mental health issues'.
22. A timeframe should be given for the identification of suitable guidelines and other resources for use by health services and health professionals to improve the physical health of people living with mental health issues.
23. Include as an action making physical health education available to consumers, carers and families to provide them with the knowledge they need to identify and manage risk.
24. Community managed mental health services which interface every day with consumers and carers need to be included in Priority Area 5.
25. The Plan should articulate the need for a much broader stigma reduction program that includes increasing knowledge and providing skills to promote good mental health.
26. The Plan needs to demonstrate how "a better understanding of mental illness and improved attitudes towards people who live with mental health issues"<sup>14</sup> will be measured and evaluated.
27. The Plan should provide measures, timeframes and clarity over roles and responsibilities in stigma reduction.

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<sup>14</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 54.

28. The Plan needs to describe the mechanism “to continue to build and examine the evidence base on appropriate and effective approaches to reduce stigma and discrimination and reflect on lessons learned.”<sup>15</sup>
29. The Plan must refer to specific measurable and achievable goals and defined targets oriented to real reform.
30. The Plan must demonstrate how the Commonwealth will be satisfied that standards are met and service provision is accountable and how it will work to improve consistency across jurisdictions.
31. There is a need for availability and access to timely data and long-term data collection analysis.
32. The Plan should include a commitment to fund new and independent ways to collect and report data, particularly on the issues of most import to consumers and carers, such as employment, education and quality of life.
33. The Plan must incorporate a transparent monitoring and accountability system, ideally via an independent authority or commission representing all stakeholder interests, to ensure that all policies and plans are reform-focused, and that practical targets are achieved.
34. Include indicators relating to the identification of children at risk of developing mental illness and to population-wide access to interventions and screening.

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<sup>15</sup> Fifth National Mental Health Plan: Draft for Consultation (2016), Canberra, Department of Health, p. 54.