SCHIZOPHRENIA FELLOWSHIP

"Succeeding Together"

Schizophrenia Fellowship of NSW

Submission in response to the draft of the *Fifth National Mental Health Plan*

December 2016

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About the Schizophrenia Fellowship of NSW

SF NSW is a specialist mental health recovery organisation, with a 31 year history, committed to improving access to services and the circumstances of people living with severe and complex mental illness.

SF NSW delivers trauma-informed recovery-oriented psychosocial support programs and services for carers and consumers. This includes care coordination, housing, employment, social inclusion, clinical and peer supported services. Each year, 10 000 people, across 33 sites in NSW and ACT, access our services.

The Fellowship:

- Has successfully transitioned 63 patients out of in-patient psychiatric units with no suicides or suicide attempts in the recently trialled the Hospital to Home Program.
- 74% of our employees have lived experience as a carer or consumer of mental illness.
- Runs the New Moves consumer program, addressing the physical health needs of consumers with a mental illness and/or psychiatric disability.
- Provides crucial carer and respite services, including for young carers.
- Is the largest, or one of the largest provider of Day to Day Living Program, Personal Helpers and Mentors Program (PHaMs) and Partners in Recovery in the country.
- Provides Medicare rebatable clinical services through Sunflower Health Services.
- Delivers specialist mental health Disability Employment Services (DES) in 14 locations in NSW.

As such, Community Mental Health Organisations (CMOs) such as SF NSW, are well placed to comment on and anticipate real impacts of changes in mental health policy. SF NSW delivers services and coordinates care for people across silos of sectors, funding and policy through the building of relationships and trust with other providers, funding bodies and most importantly, individuals and the communities they operate in.

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Executive summary

SF NSW appreciates the opportunity to provide comment towards the draft of the Fifth National Mental Health Plan.

Mental health is one of the only areas of health where Australian's continue to see poorer outcomes over time. Australia is experiencing extraordinary increases in the suicide rate at a time when the rates in other countries are decreasing.

The Fifth National Mental Health Plan represents a critical framework with the potential to bring stability and leadership to the mental health sector, which is currently in an unprecedented state of uncertainty as the National Disability Insurance Scheme rolls-out across Australia. A key issue for SF NSW is how Health will respond to impacts of the NDIS, to assist people with psycho-social disability to gain high quality support to reduce impacts of their illness.

It is important that any changes in policy and funding in Health are not considered mutually exclusive from those changes in Social Services- both are of fundamental importance to the ability of our organisation and others to support people in their recovery journey. SF NSW considers that the 5th National mental health plan should be a whole of Government responsibility.

Prevention, early intervention and management of mental illness, particularly severe mental illness, in Australia are grossly under-invested in and have been for many years. Spending has grown, but this still does not match the need. Further investment is needed in order to move from the traumatic experience of a fragmented and resistant system that many consumers and carers currently encounter, to timely, agile and mobile services that provide psychological continuity for consumers and carers at all levels of need.

Meaningful growth in investment is needed to reach parity of improvement in outcomes for mental health that we have seen with investment in other major threats to human health, such as cancer.

SF NSW supports the recognition of the needs of under-serviced groups, such as those living with a severe mental illness and Aboriginal and Torres Strait Islander people living with a mental illness. These people are among the most marginalised, stigmatised and vulnerable people in Australia and an understanding of how these communities can be reached and supported requires careful consideration.

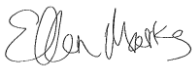
SF NSW supports further attention to the following in the Fifth National Mental Health Plan:

- defined targets
- clearly defined outcomes measures

- accountabilities
- timelines
- resource allocation
- a shift from focus on “clinical” services towards a whole of person approach to improving wellbeing
- a framework for provision of appropriate services for underserviced groups and areas such as CALD and LGBTI communities, older people, perinatal care and forensic consumers.
- the development of a National Mental Health Workforce Strategy

SF NSW would welcome the opportunity to participate in further discussions towards the development of the Fifth National Mental Health Plan.

Regards,



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Summary of SF NSW Recommendations

SF NSW recommends further consideration of:

- defined targets
- clearly defined outcomes measures
- accountabilities
- timelines
- resource allocation
- a shift from focus on "clinical" services
- a framework for provision of appropriate services for underserviced groups and areas such as CALD and LGBTI communities, older people, perinatal care and forensic consumers.
- development of a National Mental Health Workforce Strategy

Priority area 1: integrated regional planning and service delivery

- Investment in capacity building for community mental health programs.
- Further block funding of key successful community mental health programs commenced under the Howard Government COAG reforms.
- Commitment to a specific reduction target in waiting times for crucial psychiatric and psychosocial services.
- Recognition of the clinical value of community mental health programs.
- Increase the length of funding contracts to a 5 x 5 year model.

Priority area 2: coordinated treatment and supports for people with severe and complex mental illness

- Assurance of action for emerging gaps following the implementation of the NDIS.
- Include mental health advanced care directives in multi-agency care plans
- Encourage the use of a single recovery plan

Priority area 3: suicide prevention

- Commitment to a national suicide prevention target is needed.
- A commitment towards zero suicides in the first 6 months following discharge from hospital.
- Include direct recognition of the role of the community mental health sector as an effective provider of follow-up care for those who have attempted or are at risk of suicide.
- Ensure a combination of population strategies and an approach targeting those with mental illness, their families, carers and health professionals is included in suicide prevention public health campaigns.
- Implement workforce strategies that take advantage of the success of peer worker interventions

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

- Working with Aboriginal and Torres Strait Islander communities in co-design should be included as a stand-alone action.
- Regions in desperate need of aboriginal workforce training
- Commitment to providing training support to non-indigenous mental health professionals- however, this should be broadened to include supporting training for clinical staff and community workers.

Priority area 5: physical health of people living with mental health issues

- Clearly define targets and outcome measures for improvements in health outcomes for those living with a mental illness
- Clarify what data will be collected and from where, in what timeframe the data will be collected and how links physical and mental health issues will be made.
- Investment in national physical health programs, formal training mechanisms for health professionals and awareness campaigns.
- Adopt a whole of person approach which targets not only cardiovascular and diabetes and includes dentistry.

Priority area 6: stigma and discrimination reduction

- Include detail on how priority areas for targeted stigma reduction campaigns will be identified.
- Develop a strategy for implementation of stigma reduction.
- Set benchmarks for peer worker numbers across the health system and all areas of government service, including justice and housing.
- Adopt direct consumer presentations, the "real person" approach, in anti-stigma campaigns.

Specific comments on, and recommendations for, identified priority areas

Priority area 1: integrated regional planning and service delivery

Investment in capacity building of "non-clinical" specialised community mental health support programs

The introduction of the NDIS has seen a drastic removal of funding for community mental health programs ahead of approval of NDIS packages for individuals using the services and the implementation of funds through Information, Capacity and Linkages building (ILC) programs.

SF NSW anticipates that there will be a net reduction in investment in community psychosocial supports which has the potential to result in the closure of programs and services. Capacity building through meaningful block funding investment in "non-clinical" specialised community mental health support programs is needed to sustain current levels of support and continue to delivery integrated services.

Currently several community mental health programs are unable to take more participants resulting already in the development of large waiting lists. Timely access to mental health services is critical to successful treatment of people with a severe mental illness, and is necessary to reduce psychiatric hospitalisations and the risk of suicide.

Capacity building of community mental health supports can also reduce waiting lists for in-patient care, specialist psychiatric and psychosocial interventions. Timeliness is a key quality indicator in calls for improvement to the mental health care system- the 5th National Mental Health Plan should commit to a specific target of reduction in waiting times for critical services and programs.

Recognition of the clinical value of community mental health programs

Mental health reform should aim to improve a person's quality of life. This requires that policy frameworks move away from a focus on what are considered "clinical" services. Classification of services into clinical versus non-clinical devalues non-clinical services.

Many services currently classified as "non-clinical" specialised community mental health support programs, result in statistically significant improvements in clinical outcomes. For example, SF NSW delivers programs that have seen significant ($p<0.01$) improvements in functional, personal, clinical and social domains as measured by Recovery Assessment Scale- Domains and Stages (RAS-DS)[1].

Longer funding contract lengths

[1] Hancock, N., Scanlan, J.N., Bundy, A.C., & Honey, A. (2016). Recovery Assessment Scale – Domains & Stages (RAS-DS) Manual- Version 2. Sydney; University of Sydney

Stability in the mental health sector could also be achieved by increasing the length of funding contracts. In our experience, and as identified by the Productivity Commissions Review of Human Services[2], short contract lengths and tendering processes creates competition in a sector that has typically relied on collaboration. This breakdown in partnerships could be somewhat alleviated by increasing contract length and thereby reducing the number of "competitive events".

Contracts covering 5 years with clearly defined KPIs should be established. For those services able to satisfactorily meet the KPIs, funding should be automatically renewed. A value-add of this proposal is increased workforce stability, which the NFP sector often struggles with due to the inability to attract and maintain quality staff given constant funding instability.

Recommendations:

- Investment in capacity building for community mental health programs.
- Further block funding of key successful community mental health programs commenced under the Howard Government COAG reforms.
- Commitment to a specific reduction target in waiting times for crucial psychiatric and psychosocial services.
- Recognition of the clinical value of community mental health programs.
- Increase the length of funding contracts to a 5 x 5 year model.

Priority area 2: coordinated treatment and supports for people with severe and complex mental illness

Assurance of action for emerging gaps following the implementation of the NDIS

Community mental health service provision is a key foundation for promotion, prevention, early intervention and support towards recovery for those living with a mental illness. Not-for-profit (NFP) organisations such as SF NSW are driven by their vision to see the most vulnerable people included and participating in meaningful life.

Changes in policy and funding in Health and Social Services are not mutually exclusive and integration between the two is of fundamental importance to the ability of our organisation and other CMOs to support people in their recovery journey. However, the interface with the NDIS and the 5th national mental health plan is not clear.

[2] Productivity Commission 2016, Introducing Competition and Informed User Choice into Human Services: Identifying Sectors for Reform, Study Report, Canberra.

With the transition of funding for many mental health programs such as PHaMs, D2DL and PIR to the NDIS, a real gap is emerging. Without restoration of a portion of block funding, it is likely that these programs will be unable to be delivered to those who do not receive and NDIS package.

These programs keep people well and participating in the community. They reduce hospitalisations, reduce emergency department visits, reduce chronic disease burden, improve employment outcomes and improve the wellbeing of entire families.

SF NSW supports monitoring and reporting on emerging policy issues and gaps relating to the implementation of the NDIS by the Mental Health Drug and Alcohol Principle Committee. However, assurances are needed that once gaps are identified, Health Ministers will intervene to address these gaps. This will create a sense of security in a sector that is currently experiencing a great deal of instability.

Include mental health advanced care directives in multi-agency care plans

It is SF NSW's view that advanced care directives should be included, as a matter of priority, in multi-agency care plans. Through an advanced care plan, a person is able to give guidance to healthcare professionals on their preferences and view of treatment should they lose capacity.

This is particularly useful for severe episodic mental illness, when often a person has previous experience of what treatment was or was not successful in their recovery.

People with a severe episodic mental illness should be encouraged, while able, to discuss their preferences for treatment options with their families, their doctors and other relevant people. They should be informed of their right to appoint someone to make decisions about their health care should they become unable to make their own decisions.

Recommendations:

- Assurance of action for emerging gaps following the implementation of the NDIS.
- Include mental health advanced care directives in multi-agency care plans
- Encourage the use of a single recovery plan

Priority area 3: suicide prevention

Commitment to a national suicide prevention target

A key outcome measure of a successful mental health strategy is a percentage reduction in the suicide rate[3]. The first step needed in Priority Area 3 of the Fifth National mental Health Plan is leadership and commitment to a measurable suicide prevention target. A national strategic target indicates the Government's clear commitment to dealing with the issue of suicide and a vital component of allocating resources for achieving both short-to-medium and long-term objectives.

Deliberate, continuous, coordinated and effective intervention following hospital admission

SF NSW believes a more strategic approach to suicide prevention following discharge from a psychiatric in-patient unit is required to reduce suicide rates.

There is a significantly high risk of suicide following mental health inpatient care, particularly during the first day and week following discharge[4]. In WA, 8% of all suicides in 2010 were in the first weeks immediately following discharge from a hospital-based psychiatric facility, 15% of suicides occurred on the day of discharge, and a further 15% the following day[5]. Most of those people who suicided after discharge had discharge plans, however, not all received the hospital aftercare that was planned or the aftercare was ineffective. Many people are discharged into a life-situation that is not conducive to recovery.

Reports such as the Tracking Tragedy report have shown that the availability and capacity of mental health care services may have contributed to up to one third of deaths by suicide[6]. The report highlights the critical importance of continuity of care, beyond clinical services alone, in the transition to community living from in-patient services.

Investment in programs that aim to maintain continuity of care following discharge from a psychiatric in-patient unit is crucial to reduce post-discharge suicide. Programs such as the Hospital to Home Program (H2H), which was trialled by SF NSW in 2015, have been externally evaluated and demonstrated to be entirely successful at reducing suicide post-discharge to zero[7].

H2H focuses on helping consumers to self-manage their recovery, connect with their social networks and minimise feelings of isolation. This is achieved by a support worker making regular contact with the person while in hospital and participation in the discharge planning process.

[3] The World Health Organisation (WHO). Preventing suicide: a global imperative. WHO, Luxembourg, 2014.
[4] IM Hunt, N Kapur, R Webb, J Robinson, J Burns, J Shaw, L Appleby (2009). Suicide in recently discharged psychiatric patients: a case-control study (UK). Psychological Medicine 39, 443–449.
[5] Review of the admission or referral to and discharge and transfer practises of public mental health facilities/ services in Western Australia. Accessed 24 November, 2016 at https://www.health.wa.gov.au/publications/review/chapters/mental_health_3.2.pdf
[6] NSW Mental Health Sentinel Events Review Committee. (2007). Tracking Tragedy: A systemic look at homicide by mental health patients and suicide death of patients in community mental health settings. (Third Report of the Committee). New South Wales Government: Department of Health. Accessed 6 December, 2016 at http://www.health.nsw.gov.au/pubs/2007/pdf/tracking_tragedy_07.pdf
[7] The University of Sydney and SF NSW (2016). Evaluation of the SF NSW Hospital to Home Program. Manuscript in preparation.

Through the H2H program, SF NSW has successfully transitioned 63 people from inpatient facilities into community living with no readmissions or suicide attempts over the program period[7]. Participants in the program reported significant improvements in social, intellectual and psychological outcomes[7].

This provides clear evidence that a national approach that provides deliberate, coordinated, continuous and effective intervention, by the community mental health sector, during and post-discharge from a mental health inpatient facility will reduce the suicide rate.

The Fifth National Mental Health Plan should provide a national commitment towards zero suicides in the first 6 months following discharge from hospital- it can, and should be, achieved.

Target suicide prevention campaigns to people living with a mental illness, their carers and health professionals

Extensive public health and communication strategies to date have done well to reduce the stigma of engaging in discussion about suicide. However, these campaigns do not target those at high risk of suicide, namely those with a mental illness, and those important supports in their lives including families, carers and health professionals.

Mental illness is one of the most common and significant risk factors for suicide. While not all people that complete suicide have a mental illness, it is generally acknowledged that over 90% of those who complete suicide had a diagnosable mental disorder[8].

In considering recommendation 10 in the Draft Fifth National Mental Health Plan, a combination of population strategies and a more targeted approach is needed. This strategy would be one whereby suicide prevention public health campaigns aim to reach those with a mental illness, their carers and health professionals.

Recommendations:

- Commitment to a national suicide prevention target is needed.
- A commitment towards zero suicides in the first 6 months following discharge from hospital.
- Include direct recognition of the role of the community mental health sector as an effective provider of follow-up care for those who have attempted or are at risk of suicide.
- Ensure a combination of population strategies and an approach targeting those with mental illness, their families, carers and health professionals is included in suicide prevention public health campaigns.

[8] Bertolote JM, Fleischmann A (2002). Suicide and psychiatric diagnosis: a worldwide perspective. World Psychiatry 2002 Oct; 1(3): 181–185.

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

Co-design of services with communities is crucial

The summary of recommendations in priority area 4 should be broadened to include not only governments working collaboratively, with PHNs and LHNs, service providers, Aboriginal Community Controlled Health Organisations, but also Aboriginal communities or Aboriginal and Torres Strait Islander consumers and carers to co-design policy in this area. Working with Aboriginal and Torres Strait Islander communities in co-design as outlined in Action 12, however is a crucial element and should be included as a stand-alone action.

Recommendations:

- Working with Aboriginal and Torres Strait Islander communities in co-design should be included as a stand-alone action.
- Regions in desperate need of aboriginal workforce training
- Commitment to providing training support to non-indigenous mental health professionals- however, this should be broadened to include supporting training for clinical staff and community workers.

Priority area 5: physical health of people living with mental health issues

Clearly define outcomes for physical health improvements

The 5th National Mental Health Plan refers to poorer physical health outcomes for those living with a mental illness including increased cardiovascular disease, respiratory disease, metabolic syndrome, diabetes, osteoporosis, cancer, tobacco use, and dental health issues[9]. In fact, cardiovascular disease in those living with a mental illness contributes to double the number of excess deaths than excess deaths by suicide[10].

Although physical health outcomes have always benefited from relative ease of measurement of outcomes in comparison to psychological outcomes, the 5th National Mental Health Plan fails to identify target areas of physical health for improvement and associated outcome measures. It is SF NSW's view that these should be clearly defined and should also include dental health and nutrition.

Outline data collection sources

SF NSW supports the use of existing and new data collection mechanisms to report on the physical health of those living with a mental illness. As stated in the draft plan, a large amount of data is collected regarding

[9] National Consensus Statement on Physical Health and Mental Illness, 2016
[10] Coghlan R, Lawrence D, Holman CDJ, Jablensky AV (2001). Duty to Care: Physical Illness in people Living with Mental Illness. Perth: The University of Western Australia.

physical health of Australians- which is one of the advantages of policy making in the realms of physical health, which is poorly performed in the area of mental health.

However, it is not clear how the government plans to collect data, what data will be collected and from where, in what timeframe the data will be collected and how links physical and mental health issues will be made. Informative data will be that which highlights any changes in treating a "primary" issue in isolation or ignorance of a secondary concern.

Investment in this area is needed

As stated in the draft of the 5th National Mental Health Plan, physical health outcomes for those living with a mental illness are poorer than for those that are not. The development of resources, support of PHNs and LHNs and the collection of data may go some way to achieving improvements in this area, however, investment in a national program of service delivery, a commitment for formal training for health professionals and awareness campaigns are also needed.

Recommendations:

- Clearly define targets and outcome measures for improvements in health outcomes for those living with a mental illness
- Clarify what data will be collected and from where, in what timeframe the data will be collected and how links physical and mental health issues will be made.
- Investment in national physical health programs, formal training mechanisms for health professionals and awareness campaigns.
- Adopt a whole of person approach which targets not only cardiovascular and diabetes and includes dentistry.

Priority area 6: stigma and discrimination reduction

SF NSW welcomes action on stigma reduction and discrimination in the health workforce. SF NSW urges that the Fifth national Mental Health Plan should include more detail as to how priorities and systemic stigma will be identified, for example, will this be through funded independent research?

Furthermore, there is little direction on how stigma will be reduced and plans for evaluation of the effectiveness of such campaigns[11]. The draft plan states education and training of health workforce, the identification of champions and leadership are necessary, yet there is no detail on the where and to whom

[11] Corrigan P, Shapiro JR. (2010). Measuring the Impact of Programs that Challenge the Public Stigma of Mental Illness. Clin Psychol Rev; 30(8): 907–922.

training and education will be implemented, which has been demonstrated to be a critical element for success in the area of stigma reduction[12].

Increase the use of peer workforce

SF NSW believes that there should be a commitment to improving practices around the use of peer workforce in the health sector.

Peer worker initiatives could partially address the high levels of unemployment experienced by people living with a mental illness, while also tackling the shortage of skilled staff in mental health services. Consumer-operated programs have also reduced expenses, generated income, increased efficiency, and increased service demand by implementing quality improvement practices that incorporate evaluation findings.[13]

Disability Employment Services (DES) provides existing infrastructure that could be used towards achieving employment outcome targets for those living with a mental illness, provided that the DES has sufficient in-house capacity to understand the mental health specific needs surrounding employment.

Leadership in this area is essential. Benchmarks for training and employing peer workers at all levels of government and in the health workforce would be a clear example of leadership in this area.

Recommendations:

- Include detail on how priority areas for targeted stigma reduction campaigns will be identified.
- Develop a strategy for implementation of stigma reduction.
- Set benchmarks for peer worker numbers across the health system and all areas of government service, including justice and housing.
- Adopt direct consumer presentations, the "real person" approach, in anti-stigma campaigns.

[12] Thornicroft G, Mehta N, Clement S, Evans-Lacko S, Doherty M, Rose D, Koschorke M, Shidhaye R, O'Reilly C, Henderson C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. Lancet; 12;387(10023):1123-32.
[13] (Campbell and Leaver, 2003).