Call for Submissions: National Review of Existing Mental Health Programmes and Services

Survey questions for respondents representing the views of an organisation

Important – please note

This document is NOT intended to be filled in – it is provided as an aide to the development of responses which represent the views of organisations. It enables all questions to be read before responses are considered, and also enables organisations to collate responses from multiple stakeholders where appropriate.

Responses must be submitted using the survey form online at:
www.consultations.health.gov.au/national-mental-health-commission/2014_mh_review

INTRODUCTION

The Australian Government has asked the National Mental Health Commission to review how effectively Australia responds to the needs of people living with mental health problems and those who support them. The Review will examine existing mental health services and programmes across the government, private and non-government sectors.

BACKGROUND: SUPPORTING A CONTRIBUTING LIFE

The focus of the Review will be to assess the efficiency and effectiveness of programmes and services in supporting people experiencing mental ill-health and those who support them to lead a *contributing life.*

Living a contributing life means:

- thriving, not just surviving
- having something meaningful to do and something to look forward to
- maintaining connections with family, friends, community and culture
- feeling safe, stable and secure
- receiving effective care, support and treatment
- suicide prevention is a priority

WHY WE NEED YOUR VIEWS

We know that for some people accessing or working in the mental health 'system', it sometimes feels like the money already spent on mental health could be more effectively used. We already know - from previous consultations, inquiries, and reports - that our 'mental health system' is not working as well as it could to support contributing lives.

We also know a lot about 'big picture' principles for improvement - for example, that we need to get better at ensuring services talk to each other, are oriented around peoples' needs, and focus on outcomes. We need to ensure that we all get better value for money and better results for people, their families and supporters.

However, we know a lot less about how to achieve this. Now is the time to get practical and get specific about what needs to change on the ground and in the system, and we need your help.

We want YOU to help us identify exactly what needs to be done differently, by providing us (in the online survey):

1. Specific examples of good practice from your organisation's knowledge and experience;
2. Specific examples from your organisaton's experience of what is not working; and
3. Practical, specific changes that you believe need to happen for practice, behaviour, and outcomes to improve.

When considering your response to the survey, please bear in mind the Terms of Reference for the Review.

Terms of Reference

National Mental Health Commission's Review of Mental Health Services and Programmes

This review will examine existing mental health services and programmes across the government, private and non-government sectors. The focus of the review will be to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community.

Programmes and services may include those that have as a main objective:

- The prevention, early detection and treatment of mental illness;
- The prevention of suicide;
- Mental health research, workforce development and training; and/or
- The reduction of the burden of disease caused by mental illness.

The review will consider:

- The efficacy and cost-effectiveness of programmes, services and treatments;
- Duplication in current services and programmes;
- The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programs except where they have mental health as their principal focus);
- The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services;
- Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments;
- Existing and alternative approaches to supporting and funding mental health care;
- Mental health research, workforce development and training
- Specific challenges for regional, rural and remote Australia;
- Specific challenges for Aboriginal and Torres Strait Islander people; and
- Transparency and accountability for outcomes of investment.

Survey questions for organisational respondents – as they appear online

PAGE ONE OF SURVEY

1. The National Mental Health Commission may want to quote from your responses to this survey in confidential reports to the Australian Government. Please choose the statement below which applies to your organisation.

(Required) Please select only one item

☒ My organisation's name may be associated with any direct quotes taken from this online survey response

☐ Direct quotes taken from this online survey response may only be used after any information that could identify my organisation has been removed.

☐ Direct quotes may not be taken from this online survey response.

PAGE TWO OF SURVEY

ABOUT YOUR ORGANISATION

2.1 What is the name of the organisation submitting this response?

(Required)

Central Australian Aboriginal Congress Aboriginal Corporation

2.2 What is your name?

(Required)

Donna Ah Chee and John Boffa

2.3 What is your role in the organisation?

Chief Executive Officer and Chief Medical Officer Public Health

2.4 What is your email (in case we have any questions about your response)?

(Required)

john.boffa@caac.org.au

2.5 Select the issue(s) with which your organisation is most engaged in relation to mental health.

(Required)

☒ health care (community based)

☐ health care (hospital based)

☐ education

☐ employment

☒ welfare support

☐ online support

☐ peer support

☐ sport/ leisure/ recreation/ arts

☒ carer/ family support

☒ substance use

☐ housing/ homelessness

☐ justice system

☒ cultural issues

☒ other (please specify in box below)

Early Childhood programs and services, *headspace*

2.6 What state(s) and/or territory (ies) does your organisation operate in?

(Required)

☐ Tasmania

☐ New South Wales

☐ Victoria

☐ South Australia

☐ Western Australia

☐ Queensland

☐ Australian Capital Territory

☒ Northern Territory

☐ Other (specify in box below)

2.7 Select the best description for your organisation. *(If more than one applies, please select the one which reflects the greatest proportion of the organisation's activity.)*

(Required)

Please select only one item

☒ Provider of direct support to people experiencing mental health problems and/or their families and supporters *(if you select this item, you must ALSO answer the first 'option based question' following this question).*

☐ Provider of services which are used by people experiencing mental health problems and/ or their families and supporters-health support is not the core purpose of the organisation *(if*

you select this item, you will need to ALSO answer the second 'option based question following this question)

☐ Research organisation

☐ Research council/ funder of research

☐ Commonwealth government agency

☐ State or territory government agency

☐ Local government agency

☐ Other government agency

☐ Private health fund

☐ Political party

☐Professional peak body, society or association

☐ Mental health sector peak body

☐ Union

☐ Consumer or carer representative organisation

☐ Other type of representative organisation

☐ Regulation, accreditation or quality improvement agency

☐ Advocacy organisation

☐ Lobbying or policy influencing organisation, or think-tank

☐ Workforce training or development body

☐ Private business or employer of people living with mental health problems

☐ Other (specify in box below)

PROVIDERS OF DIRECT SUPPORT SERVICES – FIRST OPTION-BASED QUESTION

2.1.a. Please select the description(s) which best fit the type of support your organisation provides. Select all that apply.

(Required only if you have ticked the FIRST box in question 2.7 above)

☐ Public sector provider of specialise mental health support to people living with mental health problems and/or their families/supporters

☐ Private sector provider of specialist mental health support to people living with mental health problems and/or their families/supporters

☒ NGO sector provider of specialist mental health support to people living with mental health problems and/or their families/supporters

☒ Provider of other health services

☒ Housing/accommodation support provider

☒ Education or training support provider

☒ Carer/family support organisation

☐ Employment placement or support provider

☒ Provider of support for substance use difficulties

☒ Provider of other type of direct support to people living with mental health problems, their families or supporters (specify in box below)

Medical care, essential medicines, advocacy

PROVIDERS OF INDIRECT SUPPORT – SECOND OPTION-BASED QUESTION

2.1.b. Please select the description(s) which best define your organisation's core business. Select all that apply

(Required only if you have ticked the SECOND box in question 2.7 above)

☐ General welfare support agency

☐ General education/ trainer provider (e.g. school, university)

☐ Employer of people living with mental health problems

☐ Housing provider

☐ Leisure, sporting, or arts-related service provider

☐ Transport organisation

☐ Justice or corrections sector organisation

☐ Legal Services

☐ Substance misuse organisation

☐ Domestic violence organisation

☐ Provider of other type of service which people living with mental health problems use (specify in box below)

*****PLEASE TURN OVER FOR THE NEXT QUESTION*****

PAGE THREE OF SURVEY

EVIDENCE OF THE MENTAL HEALTH 'SYSTEM' WORKING WELL

3.1 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):

The Australian Nurse Family Partnership program is cost effective and is involved in the primary prevention of mental illness by promoting healthy development in early childhood so there is an increased opportunity for children to have well developed emotional regulation and self-control. There is probably even greater value for money in this regard in the Abecedarian Educational Day Care program and Congress is using this approach in our pre-school readiness program and seeing some children make very large gains very quickly (see attached Congress paper on an Integrated model for Child and Family Service and a centre based approach).

Alcohol supply reduction measures in Alice Springs based on increasing the minimum price of alcohol are incredibly cost effective in the primary and secondary prevention of mental illness. An increase in the price of 25 cents per standard drink, which cost nothing, has reduced population alcohol consumption by 10% and prevented a large number of hospital admissions including admissions for assault. As a result children in their early years are less exposed to the type of violence and trauma which the Californian Adverse Early Childhood study has demonstrated lead to the development of mental illness, especially depression, in later life. In addition, as adults get less drunk less often they are less likely themselves to suffer from alcohol caused mental illnesses and more able to respond to the needs of their own children. Further reduction of alcohol supply is one of the most cost effective initiatives that could be undertaken in the primary and secondary prevention of mental illness. This is also true for the impact that the former system of photo licensing at the point of sale and the Banned Drinkers Register which effectively targeted the heaviest drinkers and led to a major reduction in hospital admissions (see the attached paper from the NDRI on Alcohol Control Measures in Alice Springs for further details).

Congress provides a range of direct therapeutic services based on the model of "3 streams of care" (see the attached paper from the ANZJPH on the evaluation of the Grog Mob program for more detail about this service model). This includes alcohol treatment as well as therapeutic and other interventions for people suffering from depression, anxiety states, OCD etc. It is not possible to assess the cost effectiveness of any of these interventions for the following reasons:

1. The capacity for measuring outcomes from particular structured therapies is very limited and unless this is done in a systematic way then it is not possible to even begin to talk about cost effectiveness. This is partly because therapists themselves seem to not always be clear which particular therapy they are using in a particular session sometimes claiming to be using "multiple" therapies at once which makes it difficult to know what the patient has actually been exposed to. The review needs to focus on the requirement for all mental health service interventions to be able to properly documented and then assessed for outcomes using standardised outcome measurement tools that have been validated.

2. Even when practitioners code that they are using a particular therapy it is not possible to validate whether this therapy has in fact been used and what "dose" the patient has been exposed to. There is an urgent need for greater systematic rigour in the training of therapists such that all psychology registrars are required to undertake the same type of video recording of their clinical therapeutic sessions as GP registrars are for their clinical consultations. Although Congress is aware that this does occur with some registrars at present it has not yet been systematised. There is also a need to ensure that all registrars have an experienced clinical psychologist sitting in with them during their training as well as ensuring that audits are done on whatever therapy they are using to see if in fact they are correctly delivering the particular therapeutic intervention they think they are providing. This will require supervisors to be paid as is the case with GP supervisors and further supported by fully time paid "psychology educators" as equivalent to medical educators. Without these types of arrangements busy supervisors will not always be able to find the time that is needed to ensure adequate rigor in the registrar training program. The Psychology registrars also provide an important "external" way to further reinforce and validate essential training and support. This type of rigour in the training program is required in some countries but not yet in Australia.

Until these types of reforms are implemented so that we can be confident that a particular therapy is being implemented at a sufficient dose to make a difference, based on known evidence and in a way that outcomes can be measured there is no real possibility of assessing cost effectiveness. This is the key challenge for the entire mental health service system. It may also be that for certain patients there is a need to innovate and measure outcomes using therapies that are not yet proven or mainstream but which show significant potential in the most difficult to treat patients such as Active Commitment Therapy. Of course such new therapies should be compared with current best practice and for the most difficult patients with Borderline Personality Disorder the current gold standard is Dialectical Behaviour Therapy. Unfortunately, it seems that the current training system underestimates how long it takes to become really proficient at some of these therapies and the commitment to ongoing training and support needs to be ongoing even for fully registered psychologist and these needs to be supported in a more systematic way. As long as outcomes are being measured then we can assess outcomes in different settings which is vitally important.

3.2 An example of an innovative approach to funding, organising or delivering mental health support:

Congress has pioneered an approach that we have called "3 streams of care" which requires treatment of the whole person and recognition that mental health, physical health and social and cultural health are all interrelated. This means that rather than having separate service responses based on an archaic mind/body dualism there is one comprehensive service that provides:

1 medical care, including pharmacotherapies and preventive health care including health checks to promote, maintain and treat physical health

2. structured psychotherapy using an evidence based therapy such as CBT, mindfulness therapy, relaxation training etc. These therapies are suited to some patients but the real challenge is to see what therapies, if any, work for people who are really disadvantaged and suffering from "personality disorders", violent relationships, poly substance misuse etc . The whole nature of the development of "personality disorders", especially Borderline Personality Disorder, is poorly understood in the context of people who have grown up in very disadvantaged, violent social environments. It could be that "Borderline Personality Disorder" describes what occurs to otherwise normal people who grow up in a very adverse and abnormal environment. This group of people are very difficult to treat and as mentioned earlier, current best practice is DBT and it is vital that therapists working in Aboriginal communities are highly skilled in this type of therapy. It could also be that Active Commitment Therapy is useful in these situations but there needs to be an action research approach to working out what therapeutic approaches work with the most marginalised patients and helping to ascertain in what patient groups proven therapies like CBT and DBT give the best results

3 Social and cultural support. Some patients need basic needs for accommodation met before they are in a position to focus on structured therapeutic interventions. In this regard a very large, well designed recent study has shown that providing housing to homeless people with mental illness is one of the most cost effective "treatments' known: m.theglobeandmail.com/life/health-and-fitness/health/study-shows-housing-the-most-cost-effective-treatment-for-mental-illness/article17864700?service=mobile. **Other patients in a cross cultural context need to be supported to explore issues of cultural identity and reconnect with parts of their culture which may have become less strong. Working in cross cultural contexts also required all mental health professionals to work with local Aboriginal people who can help to ensure that they practise in a culturally safe way. At Congress these workers include Aboriginal Family Support Workers, Aboriginal Community Workers, Aboriginal AOD workers, Aboriginal case workers and others and they play a key role alongside trained mental health professionals. They are able to address social and cultural issues and assist other mental health professionals to understand the patients they are working with.**

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

The Congress Targeted Family Support Service (TFSS) works with many other services in Alice Springs to provide maximum support to high needs families where children are disadvantaged. Some of the parents in these families have significant mental illnesses but again it is not clear how much the Family Support service model helps in these situation compared with more direct therapeutic approaches and other supports. Again there is a need to take an action research approach to the best interventions to assist high needs families where parents have mental illnesses so it becomes clear what works and what does not. It could be that a combination of different approaches gives the best outcomes but this is not clear at present. The TFSS however works with a large number of external agencies and coordinates the care being provided to high needs families including case management as required.

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

When mental health services are fully integrated as part of comprehensive primary health care and are not stand alone, specialist and separate services then it becomes more possible to treat the whole person. This also involves the use of a single Clinical Information System that all professionals use including GPs, psychologists, social workers, Aboriginal Health Workers etc. All members of the multidisciplinary team treating the whole patient need to be able to access each others information so there is a consistent approach to treating the patient. It is not possible to buck pass in such a service model as it is with "Dual Diagnosis" which is a creation of a non-integrated service system. Within a comprehensive primary health care service the 3 streams of care service model is possible and the whole person is treated recognising the root causes of poor physical health and poor mental health are the same and so many patients have both. This also assists to ensure that the physical health needs of mentally ill patients are not neglected as severely mentally ill people mainly die prematurely of untreated physical health problems such as CHD and diabetes *and not from their mental illness.*

The benefits of locating a mental health specific service within a comprehensive primary health care service have also been realised with the Congress *headspace* service where young people are able to access STI treatment, contraception advice, health checks etc and not only mental health and substance misuse diagnosis, treatment and support. In fact it is the bulk billing medical service which is the first point of contact for most disadvantaged young people and then other mental health issues can be assessed. If the service was not integrated in this way many young people would not present in the first place.

3.5 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 people, 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 premise of this question is somewhat problematic in that there is an implicit assumption that the mental health needs of people in these categories will be met differently to those of people living in cities or non-Aboriginal people in general. By and large there is very little, if any evidence that people are so different that they require a different approach to meet their service needs. By and large it is probable that services that have been shown to be effective amongst many different peoples of different cultures in different parts of the world are likely to be effective with Aboriginal people and other people living in rural and remote areas. To assume otherwise just becomes an excuse for not implementing what is already known to work – it becomes a mantra to justify the failure to invest adequately for services for these groups of people. *The way* the services are delivered may be different but not the services themselves. It is especially important that mainstream evidence is used

to inform the development of services and program for Aboriginal people unless there is clear evidence that a specific or special approach is more effective. Where there is no specific evidence then mainstream evidence is a better starting point than building services on no evidence at all. The latter approach leads to a wide variation in what is considered to be best practice and as in all attempts to improve the quality of health systems unexplained variation is not a good thing. Although at times there is a need to adapt mainstream approaches to suit local needs this needs to be done very carefully and in a way that ensures outcomes are being achieved. Variation on normal best practice without proper justification is a concern.

For example, in the key area of early childhood mainstream evidence supports the Nurse Family Partnership Program and the Abecedarian Educational Day Care program – there is no basis to suggest any other alternatives for either Aboriginal people or other disadvantaged people living in rural and remote areas. The key is to implement and evaluate based on what is already known. The abject lack of access that Aboriginal people have had to clinical psychologists and psychologists has been because this has been justified by the assumption that it is not "culturally appropriate" to treat Aboriginal people with such mainstream professionals. Thankfully this is starting to change and Congress now employs eight psychologists including clinical psychologists . This is in spite of the fact that people have the same types of mental illnesses that other people have and are therefore likely to respond to some of the same interventions. While there may be a need for special approaches at times this should never be used to justify the lack of access to mainstream service models delivered within Aboriginal community controlled health services. Aboriginal people with depression, generalised anxiety disorders, Panic Disorder etc etc need access to the normal services that we know are effective in these situations. One of the tragedies of contemporary Australia is that some of the most "stressed" people in Australia do not have access to self-help and other tools to assist them to learn effective stress management such as muscle relaxation techniques, breath awareness and mindfulness techniques and other therapies that are known to be of benefit. Where these techniques are used they seem to work and are very well received by many Aboriginal people. There is little access to self-help CDs, phone applications and other tools that will also be of benefit to a growing number of Aboriginal people. It is far more important to ensure good access to all of these types of therapeutic options than it is to not do so under the mistaken view that this is not appropriate. In the experience of Congress, Aboriginal people get better with CBT, they get cured from Panic Disorder through the normal therapeutic approached based on gradual exposure techniques etc etc. Too few people have access to these therapies however.

3.6 An example of effective and efficient use of reporting:

In the area of mental health specific services there are no examples of effective and efficient reporting that Congress is aware of – the reporting that we currently do is neither effective or efficient. However, in terms of the primary clinical services and programs that Congress provides there is a very effective and efficient mechanism for reporting using OCHREStreams and the nKPIs and the AHNTKPIs. There needs to be a similar set of core indicators developed for mental health services that are not only process indicators but include reporting on agreed outcomes measures – we need to know if people with depression are getting better just as we need to know if people

with hypertension have their BP treated well. We need to know if people who have been through an alcohol treatment program have reduced their alcohol consumption at 12 months just as we need to know whether a diabetic has good glucose control 12 months after diagnosis. A common set of core mental health service indicators, collected using modern clinical information systems is urgently needed and these need to be a requirement of funding. It is not acceptable for government to continue to fund services and programs in mental health without any prospect of knowing whether such services are working. Psychologists and other therapists will need to code the type of therapy they are using with a particular patient and not attempt to use some eclectic mix of therapies that cannot be evaluated. Of course many psychologists do this already and the psychology profession has been leading the development of better outcome tools in recent years but Congress has had significant experience in recent years employing psychologists and other therapists and it is very clear that there is a large, unexplained variation in practice. This puts far too much pressure on service providers to try to get a more systematic, coherent approach to best practice treatment of common conditions. There will also need to be regular audits of therapy so that we can be confident that a particular therapy has been delivered and coded appropriately and that an appropriate outcome measure has been used. There needs to be much more rigour applied in this area.

3.7 An example of a service, programme, policy or initiative which is not subject to unnecessary red tape (e.g. approvals processes, reporting etc.):

The problem is not "red tape" per se the problem is that the tape needs to be blue and not red. This means that it is entirely appropriate to have to spend some time reporting on the right indicators and outcome measures but not to report on meaningless things that do not help anyone assess whether a service or program is really working or not. This type of reporting creates great frustration and the term "red tape" is then appropriate. In the experience of Congress the requirements for reporting on mental health, family support and other services are not so much onerous as irrelevant to whether the programs are really working or not. This is the key problem not reporting per se.

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

We have attached the recent presentation given to the Lowitja CQI conference on the way in which data monitoring was used to drive service improvement in the Congress Safe and Sober Support Service –an alcohol treatment service based on the Grog Mob, 3 streams of care approach.

3.9 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):

The historical publication "All that Rama Rama Mob" was a good example of the meaningful involvement of people with mental illness in service planning but it is now dated. It is time that a similar planning study was done with this target group.

3.10 An example of clear public accountability for the outcomes of investment:

The evaluation of the Safe and Sober Support Service (attached) and the publication of the evaluation of the Grog Mob service (attached). In addition to this Congress makes many conference presentations on service models and outcomes.

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

We have attached the independent evaluation of the Safe and Sober Support Service as well as the Grog Mob paper as above. Congress is also undertaking an independent economic evaluation of the Family Partnership Program and the Intensive Family Support Service with UniSA using an NH&MRC 5 year research grant. Unfortunately, although the Centre for Remote Health has employed an academic psychologist who is a word expert on quality improvement, auditing of therapies and some of the very things that are needed in our service we have not been able to engage his services at least partly due to the opposition of some mental health professionals to these types of practises. Again there is wide variation with some supporting these types of developments and others opposing – they are yet to be systematised and normalised. Although, doctors have now become used to file audits throughout their professional lives and observed consultations this is not the case for all psychologists and social workers at this stage and this will need to change.

3.12 An example of effective workforce planning, development or training:

Congress has been training our Aboriginal AOD workers in a certificate 4 course but this has been quite a struggle. Congress has been supporting some staff to undertake tertiary training in social work. The main area where Congress has been successful is in providing registrar training for psychologists and this has been a major strategy in the recruitment and retention of psychologists who become fully qualified. However, there is an urgent need for much greater support for registrar training as mentioned earlier and this includes the need for more observed consultation with funded supervisors and educators as well as greater capacity to regularly use video recordings to assess therapeutic sessions both in training and to maintain full registration. This requires the same type of infrastructure to be developed as with GP training and continuing professional development requirements set by the RACGP. This could probably best be done through the GP Training organisations such as NTGPE which has developed a lot of expertise in the vocational training of registered health professionals.

3.13 An example of the use of technology to improve the experience or effectiveness of services:

Congress has effectively used the Communicare clinical information system for the recording of all clinical information for our mental health services. This means that psychologist enter their information on Communicare just as doctors, Aboriginal Health Practitioners and other health professionals do. Progress notes can be hidden for selected consults but not the key diagnostic and treatment data for the consultation. This system also enables the capacity to code the type of therapy being

provided, for the number of session and to assess outcomes using tools such as AUDIT C, K5 and K10 and SOFAS.

3.14 An example of a service, programme, policy or initiative which has proven to be efficient and effective and has resulted in good outcomes for people experiencing mental health problems and/or their families:

As mentioned earlier it is not possible to assess the efficiency and effectiveness yet of most of our services and programs in many of these areas although with the assistance of good research Congress hopes to be in a position to do this in coming years.

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EVIDENCE OF THE MENTAL HEALTH 'SYSTEM' NOT WORKING WELL

4.1 Please provide an example of services, programmes, policies or initiatives (from your own experience or that of your organisation) which demonstrate or encourage inefficiency in organisation or delivery of services:

Buck passing of patients with both mental health, AOD and physical health issues between different mainstream service providers. This allows service providers to effectively choose which patients they will treat and ensure that the most difficult patients get transferred somewhere else – it is a recipe for arbitrary decision making.

4.2 An example of an inappropriate balance or prioritisation of funding:

Far too little funding is going into the primary prevention of mental illness through early childhood programs compared with trying to "rehabilitate people" with established serious mental illnesses and "personality disorders". This is in spite of the fact that best evidence for cost effectiveness and return on investment comes from early childhood programs. The recent study highlighted earlier undermines the importance of addressing the social determinants of mental illness including the reality that providing housing to homeless people with mental illness is possibly the most cost effective form of "treatment". The World Health Organisation has made it clear that mental illness is now one of the most important global health issues that needs to be addressed and the relationship between mental illness and being poorly educated, unemployed and living in poverty is now well established. There will therefore be an disproportionate level of mental illness amongst marginalised peoples across the world including Aboriginal people here in Australia

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

Multiple funding streams have led to multiple service providers in many Aboriginal communities that do not integrate the care they provide with other elements of the health system. This has led to fragmented care and patients not being treated as whole patients. An example in Alice Springs has been the PHAMS program which was given to Mission Australia without consideration of integrating this service within the Congress Social and Emotional Well Being Service.

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

Patients who were thought to have a mental illness were found to have cognitive impairment thanks to improved access to services due to a PHAMS case manager. However the catch 22 is that under the PHAMS program such patients were not able to continue to have a case manager when their cognitive impairment was proved as this is not a "mental illness". There is no similar capacity to provide case management in the same way in the disability sector and so the patients care declined.

Patients with Schizophrenia being picked up and taken to community mental health by an ALO to ensure they get their injection but not to the clinic to ensure they have their diabetes managed as this is not the job of the mental health ALO and the mental health service takes no responsibility for physical health issues.

4.5 An example of practices which result in people living with mental health problems and/or their supporters having a poor experience:

Patients who need to access structured therapy being diverted into non directive counselling where they were not provided with any of the appropriate interventions to manage anxiety such as muscle relaxation training, breath awareness, mindfulness therapy etc – this is a common occurrence. There needs to be greater delineation of the particular roles that health professionals play in the treatment of mental illness. For example the key role that GPs and other primary clinical care workers play is in screening for mental illness and providing brief interventions and referrals coupled with crisis counselling when needed. Once patients are referred into specialised mental health services it needs to be much more transparent to the referring GPs when to expect clinical treatment or structured therapy compared with non-directive counselling. If a patient is referred for clinical treatment or structured therapy for a problem such as Depression or Generalised anxiety then they deserve to be seen and assessed by a therapist who has the capacity to provide treatments like CBT and mindfulness therapy. At times and for some conditions referral to a "counsellor" who can then provide non directive counselling is appropriate but this is porly defined. In the current system there is far too much confusion between these two very different interventions and the skill level of "counsellors" and this often means that patients have a poor experience of "counselling" and believe that it does not work when in fact what they really needed was structured therapy which they did not even get offered. The introduction of access to Medicare for structured therapy has provided an opportunity to address this but it seems that the bar has been set too low as in the experience of Congress social workers can get accredited by the ASSW as "therapists" by spending a few hours completing some paper work. There is no protection for consumers in this system and there needs to be better ways to assess the competencies of any given therapist prior to being granted access to the Medicare rebates. If psychology registrars have better training support in the ways outlined earlier then the community could be more confident that once a psychologist becomes registered they are competent in core evidence based therapies. Social workers and others should also be able to be assessed for competencies as a

therapist but the assessment process must include observation of therapy and video recording and cannot simply be based on completing some paper work

4.6 Up to 2 examples of services programmes, policies or initiatives where the specific needs of particular communities are not effectively recognised or met:
For example, Aboriginal and Torres Strait Islander people, 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.

Fly in Fly out service model do not work for any people in this sensitive area let alone Aboriginal people. Relationship is key to the success of therapy and this will not be achieved without a long term relationship between a provider and a community. Therapists need to be employed within Aboriginal community controlled health services wherever possible as this helps to ensure their cultural safety and assist them to build an appropriate therapeutic relationship with their patients.

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

Again, the problem is the wrong type of reporting not reporting per se

4.8 An example of failure to use outcomes monitoring as a quality improvement tool:

It has been a struggle to get providers delivering alcohol treatment services to acknowledge the need to assess alcohol consumption level using tools such as the AUDIT C in order to be able to assess the effectiveness of treatment. There has been a lot of resistance from professionals of all types to this type of approach. Congress has also found it very difficult to get our team of therapists to reach agreement on some consistent and effective tools to measure outcomes that can be uploaded into Communicare. There will be a need to change the culture in these professions to one where assessment of outcomes is the norm and not an optional, added burden.

4.9 An example of failure to meaningfully involve people who use services in their design or delivery (e.g. by incorporating their feedback):

There is not an effective consumer group of Aboriginal people with mental illnesses to provide such feedback

4.10 An example of unclear or opaque accountability for outcomes:

Nil

4.11 An example of a locality/area where there is duplicated provision of services or programmes:

Santa Teresa

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

There are enormous gaps in the provision of mental health services and early childhood services throughout the NT.

4.13 An example of where research activity is poorly prioritised, funded or organised:

There has been little attempt to genuinely assess outcomes in the mental health service area. In many ways everything that is done in this area including the therapies being used and the way outcomes are measured should be treated as an action research project so we can learn what works best and for whom.

4.14 An example or poor use of planning or workforce/human resources:

The lack of access to competency based, on the job training for CBT and other therapies has been a major impediment in ensuring that mental health professionals have these skills in rural and remote areas. As mentioned earlier the bar has been set too low for access to Medicare benefits and this needs to change. While Congress is aware that there is a suggestion that only clinical psychologists should be able to access Medicare benefits this would be too restrictive and if the training reforms for psychology registrars that we have described are implemented then the community could be more confident that psychologists have the necessary skills before they get fully registered. Access to Medicare would then come with full registration. There are some social workers and other professionals who have probably become competent therapists with some therapies and this also needs to be able to be assessed through a local competency based assessment process. This could perhaps be a role for University Departments of Rural Health as they have a key role in workforce development in rural and remote areas.

4.15 An example of a service programme, policy or initiative which has proven to be inefficient or ineffective and has not resulted in good outcomes for people experiencing mental health problems:

The program funded in the NT through MHACA to provide intensive support to people with severe psychiatric illnesses to prevent them from having frequent admissions into the psychiatric ward. The funds for this program were never offered to Congress even though most of the people in this category are Aboriginal people.

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ACTIONS NEEDED FOR CHANGE

5.1 One practical step to improve things in the mental health system would be:

To ensure that mental health services (including AOD services) are fully integrated into primary health care services and that there is a common approach to mental illness based on the 3 streams of care service model which applies for Addictions of all types as well as Depression, Anxiety Disorders etc. This will require multidisciplinary teams using a single clinical information system working within a single employer, preferably a community controlled health service wherever possible.

This will also require a new funding model that moves away from competitive tendering of distinct, vertical programs and towards pooled funding of integrated programs that are then allocated according to need through population health planning processes. This will further require a typology of core mental health services to be developed and delivered by a core mental health workforce, with core indicators and population staffing ratios for the different disciplines that are required. Such an approach could ensure the equitable allocation of resources and corresponding availability of workforce and programs across all regions according to need.

5.2 A second practical step to improve things in the mental health system would be:

To fund key evidence based early childhood programs because these are the key to the primary prevention of both mental and physical illness and will save the community a lot of funding in the future in terms of jail, supported accommodation, employment etc.

5.3 A third practical step to improve things in the mental health system would be:

To ensure that a core set of performance indicators is developed that measure both processes and outcomes that enable an assessment to be made of services that are working to improve outcomes for patients with mental illnesses. Coupled with this is the need to ensure access to the necessary training and quality improvement processes that would enable greater confidence that evidence based therapies are being implemented to the right patients at sufficient dose to make a difference

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MENTAL HEALTH PROGRAMMES FUNDED BY THE AUSTRALIAN GOVERNMENT

6.1 Do you/your organisation have an interest in commenting on Commonwealth-funded mental health programmes?

Please select only one item

☒ Yes (please continue below)

☐ No (please go to the next page)

6.2 IF YES: Please indicate the programme/s you wish to comment on.

☒ Better Access to Psychiatrists, Psychologists and GPs under the Medicare Benefits Schedule

☒ Access to Allied Psychological Services (ATAPS)

☒ headspace

☒ Partners in Recovery

☒ Mental Health Nurse Incentive Programme

☒ Mental Health Services in Rural and Remote Australia

☒ Personal Helpers and Mentors (PHaMs)

☒ National Suicide Prevention Programme

☐ Other (specify in box below)

6.3 Please briefly explain your involvement with the programme/s (e.g. as a provider, stakeholder, consumer, family member, carer, professional, administrator etc.)

As an Aboriginal Community Controlled Primary Health Care Service in a remote centre all of these programs are relevant. One key concern that exists through all of these "vertical", single issue programs is that this type of funding model militates against integrated, comprehensive, whole person health care. The very nature of the funding model suggests that mental health is separate to physical and social health and that a "specialist", stand-alone service sector is required. When competitive tendering is added to the mix you have a recipe for a fragmented, uncoordinated health system that is not so much based on the need for services but on the capacity to tender.

The Aboriginal health improvement that has occurred in the NT, where we have seen more than a 30% decline in all-cause mortality, has been built around the opposite type of funding model based on collaborative needs based planning according to need using needs based funding formula and ensuring that all funding is integrated into primary health care. It would be much better to pool all of the funds under these separate funding streams and develop a core mental health services model and then fund all localities according to their need for these core services. This will also require the development of corresponding core indicators. This would ensure that the mental health workforce of psychologists, social workers, AOD workers, case managers, family support workers, Aboriginal community workers and liaison officers etc etc could be resourced in all areas according to need. It could also ensure integration of other funding streams that have a big impact on mental health including early childhood such that key programs such as the Nurse Family Partnership Program could be funded in more sites. There is a lot of funding coming into the NT under all of these programs and it could be much better spent if it was pooled and allocated in this manner utilising planning structures such as the Northern Territory Aboriginal Health Planning forum and the Medicare Locals. These should be a key role for the Medicare Locals – needs based resource allocation but not direct service provision. The funding silos must be broken down if an integrated, whole person service model is to be realised.

Where some of these programs have been delivered through Aboriginal community controlled primary health care services the outcomes are likely to be much improved compared with where they have not. A good example is the Alice Springs *headspace* service. The existing infrastructure that Congress had, enabled this *headspace* service to constantly be able to maintain a bulk billing GP workforce as well as the mental health professionals working as an integrated team. In this way young people present to the service for all of their needs and are not labelled as "being no good in the head" just because they present to *headspace.* This significantly reduces the stigma and enables an integrated, holistic service model. This contrasts starkly with the Alice Springs PHAMS which was awarded to Mission Australia without even a tender process that Congress was aware of. There was no consideration of where the

needs were and how to integrate this important new service with the existing Social and Emotional Well Being Programs that Congress already has. There could have been much greater efficiencies created by an approach which recognised that an Aboriginal community controlled health service is the appropriate provider for such a service where the majority of the clients in need are Aboriginal people.

Finally, since the NTML has become established there has been a greater willingness to support Aboriginal health service to be able to tender for services and programs and this has led to more Aboriginal health services being funded than previously including in the Partners in Recovery Program. However, it is still fundamentally a tender driven process and many of the smallest services, in the highest need areas to not get a tender in and they then miss out on the funding.

There has also been an improvement in the latest round of the ATAPS program with the NTML making a very conscious effort to try to allocate these resources according to need and get some of the funds out of Darwin and into the bush. These efforts have been commendable and would not have occurred if it was not for the unique structure of the NTML which is one third owned by AMSANT and is constitutionally required to allocate its resources according to need. The NTML has now joined the NTAHF and the big challenge now will be to see whether it is able to completely move away from competitive tendering and join with the needs based, resource allocation process of the NTAHF. This will require the DoH to change its funding guidelines and contracts with the NTML so that it is not contractually required to tender. This is a vitally important policy change for mental health services and for continued Aboriginal health improvement here in the NT.

The national suicide prevention program has not had much of an impact in the experience of Congress and had only limited funds available. Partly there is a lack of understanding of the precursors to suicide and this led to an overemphasis on education and promotion programs aimed at looking for "early warning signs". The reality is that most suicides amongst young people do not occur in people who have clinical depression or even overt warning signs. The risk of suicide needs to be understood more at a population level in relation to the reality that children who grow up in a disadvantaged early childhood situation where they do not experience sufficient parental care that responds to their needs and also are exposed to violence and fear are much more likely to lack emotional regulation and self-control. It is this that becomes the key "risk factor" for suicide along with many other physical and mental health problems. It is also clear that this is a key risk factor for the development of addictions including alcohol abuse. In any population where there is both a high prevalence of impulsivity and alcohol abuse there is a major population risk of suicide. This requires a response that is centred on early childhood and community awareness raising about the way in which lack of responsive care for young children predisposes them to many risks including suicide. This needs to be explained in a very sensitive way but it is important that the community begins to appreciate these issues and the reality that there are some very effective early childhood programs that can help to prevent this from occurring. It is also the case that once young people have been identified as having multiple problems, including possible suicide risk, there are only a few evidence based interventions that are known to make a difference and none of them are cheap. For example, multisystemic

therapy is an important intervention that needs to be available but by and large it is not available and young people at risk get referred into youth programs and services for which there is very little evidence of effect. It is possible to prevent many suicides but early childhood is the key and the national suicide prevention program paid little attention to this. It is also possible to work effectively with young people who have dropped out of school, involved with polysubtance misuse, in trouble with the police etc but this required a sustained intervention with them and their families if suicide is to be prevented. MST is expensive but it works!

6.4 Please indicate in which state(s)/territory(ies)/towns(s)/area(s) your involvement is or has been (or if national, state 'national').

NT and National

6.5 Please describe what, in your/ your organisation's experience, has worked well with this/these programme/s. *Please include brief concrete example/s of good practice. You may wish to comment on issues such as programme design, funding, local implementation, accountability, reporting, outcomes, monitoring, evaluation, red tape (over-regulation), gaps in provision, or communication between services or programmes.*

The implementation of the headspace program has worked very well but only after a very large struggle to ensure that the funds were provided to Congress and not to the local Division.

6.6 Please describe what, in your/ your organisation's experience, has NOT worked well with this programme/ these programmes. *Please include brief concrete examples. You may wish to comment on issues such as programme design, funding, local implementation, accountability, reporting, duplication, red tape (over-regulation), gaps in provision, or communication between services or programmes.*

The PHAMS program (as above), Better Access to psychologists and Mental Health Services in Rural and Remote Australia has led to isolated psychologists and other mental health workers employed by a myriad of organisations not integrated into primary health care and duplicating existing effort while requiring the expertise of local Aboriginal health services to try to access clients. The Mental Health Nurse Program could have worked but from the moment Congress was able to employ a Mental Health Nurse the funding for this program was capped and we have been unable to access it. As noted above all of these funds should be pooled into a single *mental health program* and funds should then be allocated according to need as detailed above.

6.7 Please describe what specific actions, in your/ your organisation's view, would improve the design, delivery, or operation of this programme/ these programmes in future.

See the recommendations for a single funding stream, collaborative needs based planning not competitive tendering to provide core services, with core indicators, agreed workforce population ratios and the integration of these services into primary health care across all regions of Australia. Without a fundamental change to the funding model there will not be a fundamental change to the outcome and fragmentation of services will continue.

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YOUR VIEWS ON SPECIAL ISSUES

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

(Please select all that apply)

☒ Mental health in Aboriginal and Torres Strait Islander communities (please answer question 7.2 below)

☒ Mental health in rural and remote Australia (please answer question 7.3 below)

☒ Mental health research (please answer question 7.4 below)

☒ Mental health workforce development and training (please answer question 7.5 below)

☐ None of the above (go to the next page)

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

It is inadequate not because of a lack of potential funds but due to the way the funds are appropriated and allocated and the failure to properly support the development of these services within Aboriginal community controlled health services through a planned, needs based approach

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

A new way to appropriate and pool mental health service funds that can then be added to a primary health care pool and allocated according to need. In Aboriginal Health this requires utilisation of the Aboriginal Health Planning Fora. In the meantime, while such a change is being planned, tender specifications can be required to award funds to Aboriginal community controlled health service in preference to other providers and to ensure that new funds are integrated into existing primary health care service providers and not used to fund non primary health care service providers including Mission Australia, Save the Children, New Beginnings, Life without Barriers, World Vision etc etc. if these organisations are needed it should only be in partnership arrangements with Aboriginal community controlled health services in accordance with the APONT guidelines on the role of non-Aboriginal NGOs in Aboriginal communities.

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

Inadequate for the same reasons as listed above – the funding model must change

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

As above

7.4 What is your/ your organisation's view about the current funding, organisation and prioritisation of mental health research?

There needs to be a much greater focus on applied research within services so that we treat most mental health service provision as an action research program until it is much clearer what works best. This is particularly the case with the most marginalised patients who often have multiple issues including so called "personality disorders", especially Borderline Personality Disorders, Addictions, Depression, Anxiety and physical health issues all at once. It is also important to be clear about when to use which type of therapy and for how long etc. As mentioned earlier, there also needs to be greater clarity about which patients should receive non directive counselling and which patients need therapy and the distinction between them. There is a need to define much better outcome measures that can be incorporated into routine IT systems. There is a need to develop and test effective on line, I Phone apps, self-help CDs etc for a range of common illnesses especially anxiety. All of these are major goals for research

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

The new approach of requiring research institutions to partner with service delivery organisations through Partnership Centres is the right way to go. It is only when research institutions are in formal and structural partnerships with primary health care services including Aboriginal community controlled health services that such applied research will become a priority. The greatest challenge is to research the way we implement what we already know works in ways that enable us to properly evaluate whether what has been implemented is in fact what we thought it was. So much of what is provided in terms of mental health service has little to do with what we know works and when it does not work it undermines public confidence in the very concept of mental health services to make a difference. In the future funds for mental health research in Aboriginal communities should only be given to institutions that have formed structured partnerships with Aboriginal community controlled health services.

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

It is need of major reform and some of the key issues have already been outlines above

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

The most important strategy is to build on the registrar training year for psychologists so that they get the support of paid supervisors located within services as well as funded Psychology Educators similar to medical educators in the GP training program. While Congress acknowledges the steps made by the Psychology profession down this pathway if it is to become systematised in the way that is needed it will require substantial government investment. In fact the vocational training of psychologists who have completed their undergraduate years should be modelled on the training for GPs and the existing infrastructure of the GP training providers such as NTGPE could be used for this as they have developed great expertise in the delivery of such vocational training. This includes the greater use of video recordings of consultations so that psychology registrars get to see the way they implement known evidence therapeutic approaches such as CBT. Such training could then help to ensure that such skills are properly developed under paid supervision so that we can be more confident that someone who becomes fully registered is competent in a range of evidence based therapies. If supervisors continue to be unpaid then work commitments will continue to override training commitments as used to occur in the GP training system before supervisors were remunerated properly and trained properly. A similar "on the job" training program should be required for anyone who wants to aspire to Medicare eligibility to provide structure therapies including social workers and other professionals. There also needs to be quality improvement programs that focus on regular auditing of therapy and assessment of ongoing skills

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YOUR VIEWS ON SPECIAL ISSUES

8.1 If you have any further comments, please briefly state them in the box below, or use the link to upload further documentation relevant to the Review *(note - this will only show up in the online version of the survey).* **Please note that although we will attempt to include this documentation in our analysis, we will place most importance on the responses you have provided in this online survey.**

Further comments

Please upload documents in Word, Excel, or PDF format.

****END OF SURVEY****