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Anglicare Australia response to:

**Fifth National Mental Health Plan
Draft for Consultation**

9 December 2016

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Introduction and general comments

Anglicare Australia

Anglicare Australia thanks the Australian Health Ministers' Advisory Council for the opportunity to respond to the draft Fifth National Mental Health Plan.

The Anglicare Australia network consists of 34 members across every Australian state and territory. With a joint budget of over \$1.05 billion, and a strong workforce of 12,600 staff and 7,800 volunteers, catering to the specific or integrated needs of over 931,000 people and supporting them to identify pathways to participate meaningfully in society.

Anglicare members are independent organisations connected to the Anglican Church. They provide social services in their respective communities and choose to come together as part of the Anglicare network to strengthen their effort in responding to the multiple and complex needs of people and families across Australia, to match local presence to national strength, and ultimately to bring positive change to Australia. Between them they contributed to more than 50 service areas in the community: including social housing, homelessness services , emergency relief, family support, out of home care, home and residential aged care, remote Aboriginal community support, alcohol and other drug management, early childhood education, financial counselling, employment services and disability services. Mental ill health is a result and/or a cause of the circumstances which lead very many people to our services.

In preparing this response to the draft plan we have drawn on the thinking and experience of a number of our experts in the Anglicare network, including: EPIC Assist, Anglicare Western Australia, the Samaritans Foundation, Anglicare South Australia, Anglicare Central Queensland and Anglicare Tasmania.

Ambition

Our response is shaped by shared view that the Australia does not yet have an inclusive, coherent, positive approach to mental health despite years of inquiry, analysis and planning. Nonetheless, we recognise there has been a considerable body of government work, including four previous National Mental Health Plans, a ten-year COAG Roadmap for Mental Health Reform and a Review of Mental Health Programs and Services by the National Mental Health Commission.

That the draft Fifth National Mental Health Plan doesn't link clearly into this 20-year process has led many in the mental health community to question its place in a sustained and systematic process of reform.

Government talking to government

Issues of poor implementation, inadequate funding, and poor government stewardship and accountability are as critical today as they were 13 years ago when they were identified in the review of the Second National Mental Health Plan (Steering Committee for the Evaluation of the Second National Mental Health Plan, Evaluation of the Second National Mental Health Plan, 2003).

In 2013, an expert report, *Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future*, similarly found that "inadequate planning, poor implementation and our complex system of government" have undermined the long term commitment to mental health system reform (Connetica, 2013).

Now, mental health and community service users and providers are still telling governments that the system is broken or in crisis, as we expect the upcoming report on the just-completed round of consultation on this Plan to reflect.

It is our view that the draft Plan provides no concrete assurance that these long standing issues with governance and implementation will be addressed. It doesn't provide clarity on jurisdictional roles and responsibilities, nor what the proposed changes will look like on the ground when they are implemented.

Most concerning to our colleagues in the sector and across the Anglicare network, it doesn't articulate how consumers and carers will be involved in planning their care, or who will be their partners in co-design, despite a commitment to the principle of consumer centred care.

We agree with others who have said this is a plan of "government talking to government", and while we accept that the purpose of the Plan is to address the relationships between governments in regards to mental health strategies, to accept that it will ultimately improve outcomes and experiences for consumers and carers requires too much faith in governments working together effectively, efficiently and inclusively. It also rather misses the point about co-production and working in partnership with consumers and carers.

Targets and timelines

To be effective as a plan rather than a statement of strategic direction; targets, timelines and robust co-design and co-production processes need to be introduced, and the existing Actions

clarified. In many instances in the Plan, it simply isn't clear how the Actions would or could achieve the stated Aims. Setting clear actions and processes as well as targets and timelines for reform would help address the structural challenges in implementation that are seen to have limited progress so far.

We discuss in more detail below our concerns regarding the narrow focus of this plan. At the highest level, however, we urge Ministers and their governments to recommit to and include the whole-of-life targets and indicators that were agreed to by COAG in 2012. Such a commitment would hold governments more accountable for the implementation of meaningful and effective reforms.

Commitment to a long process of systematic reform – as Australian governments have done – also requires ongoing evaluation. Identifying and building off the successes and failures of the previous plans is critical to moving forwards. Without evaluation of the Fourth Plan and an articulation of its ongoing relevance, the role of the Fifth Plan in this long history of reform is not clear.

Another barrier to a better mental health system is profoundly inadequate funding. Funding for mental health does not get close to matching the existing need or burden of disease, but unfortunately the Plan does not make the necessary case to increase and redistribute it. Neither does it acknowledge the significant costs involved in undertaking reforms that span federal and state/territory governments, the health system and community sector. From our experience with the processes of reform in the human services, Anglicare Australia network members are of the opinion that it is not enough to “leverage existing investments”; and a commitment to more funding is urgently required.

Clinical care and community supports

Another way in which the Plan appears to step away from the work of previous plans is in its overwhelming concentration on clinical care. We understand that a key focus in this plan is on providing care and support for people experiencing severe and complex mental illness, and so access to appropriate medical and clinical care is clearly high on the agenda. But it is through access to holistic supports, generally provided by community based and consumer driven services that people can find pathways to a better quality of life, reducing the impact on and need for people to seek clinical services. We are disappointed that the Plan doesn't continue the work of previous plans in developing and promoting holistic outcomes models, or focus on what a recovery model means in these circumstances.

As mentioned in the chapter on Safety and Quality in Mental Health Care, the Fourth Plan produced a national tool (the Living in the Community Questionnaire) to promote a more holistic view of outcomes. This was a response to consumers' calls for outcomes measures to be better aligned with things that were fundamental to their recovery, such as housing, social involvement, work and education. Despite identifying the need for a system that "focuses on the holistic needs of consumers and carers" (pg. 14), the Fifth Plan appears in practise to move away from a holistic approach to support. Responsibility for coordinating care seems to be almost entirely devolved to the clinical health sector through Primary Health Networks (PHNs) and Local Hospital Networks (LHNs), with the community-sector mental health support only mentioned in passing. We are concerned about the ability of PHNs to connect people to the community based services that are said to be fundamental to their care, particularly as the PHN guidelines rule out the commissioning of non-medical services. Indeed, there is no substantial discussion of partnerships with community organisations, only the acknowledgement they may be involved in shared client pathways.

These issues are very much front of mind for the people involved in the roll out of the NDIS, and we draw the Council's attention to the current inquiry in the provision of psycho-social services by the Joint Standing Committee on the National Disability Insurance Scheme

More generally, there is a gap between the Priorities and Actions identified in the Plan and the agreed set of Values on which the Plan is based. And so, while the values statement asserts under *Recovery*, "There should be a focus on recovery and enhancing wellbeing, including by recognising each person's potential to live a fulfilling life and contribute to their own recovery", a recovery-oriented approach is only mentioned four times in the whole document, and appears not to be incorporated at all into the high level Priorities and Actions, even in the discussion of stigma and discrimination.

It will prove hard to ensure that the mental health system maintains a focus on wellbeing and recovery if they are not mentioned in the key documents, and if none of the Actions on the delivery of the Plan are based upon them. We remind the Committee of the whole-of-life targets and indicators agreed to by COAG in 2012, and ask that the measuring and reporting on them be built into the evaluation framework of the Plan, across all priority areas.

Whole of government approach to mental health

We are concerned that the Plan is singularly focused on health services and, in government, the health portfolio. As will be reflected in our responses to the priority areas below, we would like to expand the governmental responsibilities for this Plan across portfolios, including but not limited to, health, education, social and community services, employment and education. A whole-of-government and whole-of-community approach is needed to successfully embed and integrate system reform (see Appendix 2.)

Promotion, prevention and early intervention

Similarly, the Fifth Plan comments that currently there is an “insufficient focus” on promotion, prevention and early intervention and that there is a need to extend integration into prevention and early intervention efforts. Unfortunately, none of the Actions specifically focus on early intervention, nor discuss how it will be integrated into other areas. This Anglicare network response makes a number of comments and proposals in its discussion of each of the Priority areas and their Aims and Actions (below), and we point to many instances where early intervention and prevention need to be more thoughtfully considered. However, it is our view that this topic really needs to be a priority area of its own as it is – and must be – a key element in all the work relating to mental health; ranging from physical health to the continued treatment and support for people experiencing severe and complex mental illness.

Not one size for all

The Anglicare Australia network is also of the view that the Plan does not adequately address tailoring and targeting mental health services to the needs of specific groups. While a consumer directed care approach allows plans to be tailored individually, more groundwork is needed to develop resources that reach and respond to the needs of people who are members of groups such as carers, young people, the LGBTI and CALD communities, care leavers, people with co-morbidity issues, and so on.

Australia has come a long way in recognising the importance of working with and being led by Aboriginal and Torres Strait Islander communities. That same kind of specific and thoughtful and inclusive planning needs to go into the development of strategies to engage with people from other marginalised, at risk and excluded population groups. In the context of this draft plan, however, it is most surprising that the Actions for the particular priority of Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention does not begin with the notion of leadership and control in the hands of Aboriginal and Torres Strait Islander people.

Workforce

Anglicare Australia network members are concerned about the lack of Actions addressing workforce issues. We agree with the discussion in the Plan about the mental health workforce being “under pressure, with shortages, distribution issues, high rates of turnover, and challenges in recruiting appropriately skilled and experienced staff.” We believe that without incorporating explicit action to strengthen the mental health workforce in the Fifth plan, as the economy, our demography and our cultures change and demand continues to grow, we can only expect the problems to compound. Clearly one of the factors is funding, and we reiterate our call for governments to commit to a level of funding that reflects the burden of disease, and the need to ensure that the funding be distributed to adequately support the necessary range of community based and psychosocial services.

We also draw attention to the notion of ongoing sustainability linked to the *Value of Promotion, Prevention and Early Intervention*, and the importance of non-health related services including housing, transport, employment and income support. We make the obvious point that the demand on the mental health system, emergency services and other community support will be much less if basic social protection and connections are adequately resourced and in place.

Finally, while we noted that the proportion of peer workforce was included in the proposed indicators, we could not find any Actions that would drive improvement. We welcome the acknowledgement that the health system itself needs to consider discrimination and stigma when it comes to employing people living with mental ill health, but that is only one side of the equation. Investing in a strong peer workforce acknowledges the strengths that can flow from engaging people with a lived experience of mental illness. In addition to the obvious economic and social benefits for the workers and their families and communities themselves, the health and community services are made stronger and more hopeful through that investment.

More detailed discussion of the Draft Plan’s specific Aims and Actions.

Please find below specific input from Anglicare network members in response to the proposed Aims and Actions of the draft Plan. You will find some comment on all the priority areas as well as the aims and actions proposed for monitoring and reporting on the progress of the reforms.

Importantly, we would like to draw the Council's attention to the case studies provided by Anglicare agencies ([Appendix 1](#)). These case studies highlight the value of community based coordinated treatment, demonstrate how well they can coordinate holistic, tailored supports, and how these services help to improve the mental wellbeing of clients over time.

We conclude this document with some reflections on the links between the details of the Plan, the values we understand it is built upon, and general consumer and community services sector response to date.

Comment and proposals in response to the specific Areas, Aims and Actions

Vision

- ▶ More people will have good mental health and wellbeing.
- ▶ More people living with mental health issues will recover and have a meaningful and contributing life.
- ▶ More people living with mental health issues will have good physical health and live longer.
- ▶ More people will have a positive experience of care and support from a responsive and effective service system.
- ▶ Fewer people will suffer avoidable harm.
- ▶ Fewer people will experience stigma and discrimination.

Comment and proposals

- 1) See proposal for evaluation under “monitoring and reporting of reform progress.”

Priority Area 1: Integrated regional planning and service delivery

Aim	Summary of actions
<p>A service system that works in an integrated way at the regional level to plan and deliver services that are tailored to the needs of consumers and carers, is easier for consumers and carers to navigate, and is delivered in the most effective and efficient way possible.</p>	<ol style="list-style-type: none"> 1. Governments will establish the enablers to support integrated planning and service delivery at the regional level. 2. Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery at the regional level.

Comment and proposals

- 1) The concept of co-design with consumers and carers, and the key involvement of community organisations, advocacy bodies and NFP providers are completely absent at this level.

Governments, LHNs, and PHNs cannot and should not seek to achieve integration by themselves alone. Integration should start with collaborative service mapping that incorporates lead agencies, consumers, carers and stakeholders across the continuum of services including: clinical, psychosocial, housing, education and employment.

The incorporation of these partners into the notion of “establishing the enablers to support integrated planning....” would be a keystone in the development of an inclusive approach to mental health care and support consistent with the values espoused in the Plan.

- 2) The ‘magical realism’ (S Rosenberg, 2016) reflected in the belief that the Primary Health and Local Hospital networks will divine, coordinate and deliver appropriate services at a regional level is a key weakness of the Plan. It seems to be an exercise in shifting the responsibility to organisations that are already under-resourced and overburdened.

The risks of this approach become all too evident when you consider that these networks can neither commission nor fund psychosocial support of any kind; and would be limited to reinforcing a clinical, hospital-centred approach to mental health. Such a strategy makes a mockery of the Plan’s values of *Recovery and Promotion, prevention and early intervention*.

- 3) Community organisations and NGOs often provide a first response to customers in and leading up to crisis and often facilitate programs where customers have maintained wellness due to ongoing and wrap around supports. Customers and community service organisations need to be involved in all aspects of plan priorities for a truly integrated approach, not only through the PHN and LHN frameworks, so as to maximise the integration outcome of Action 1.

Furthermore, a stepped care model may lead to compartmentalising persons needs based on diagnosis; counteracting a co-design model which includes choice and control of level and supports required. Mental wellness often begins and is sustained long term by supporting persons in their own home, through reducing social isolation, by providing opportunities to create friendships, build community networks and develop life skills. Integrated approach Actions need to reflect the importance of sustaining community programs providing this direct support. The value of this support is illustrated in the [case studies](#) provided.

- 4) In terms of regional planning, the guidelines for PHN and LHNs need to be changed to allow them to take a more inclusive (and less medicalised) approach whatever the level of responsibility they are given. Any such plans must take account of, and engage with, local populations groups with specific strengths and needs (including, but not limited to, older rural communities, LGBTI people, youth communities, people from a range of CALD backgrounds, people living with drug and alcohol dependency, and so on.)
- 5) The key issue here, and in the actions of consequent priorities, is there are neither targets nor timelines. If governments are to work effectively with these unevaluated and still evolving health networks to develop regional plans, then an immediate target of co-designing such plans with the community partners identified above, within a year, would seem to be a reasonable first step.

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

Aim	Summary of actions
<p>An integrated and sustainable service system that provides the right amount of tailored clinical and community supports, at the right time, for people with severe and complex mental illness.</p>	<ol style="list-style-type: none"> 3. Governments will support coordinated service delivery for people with severe and complex mental illness through the development of national guidelines. 4. In consultation with key stakeholders, the Mental Health Drug and Alcohol Principal Committee will monitor and report to Health Ministers on emerging health and other related policy issues that may arise from the implementation of mental health reforms and the National Disability Insurance Scheme for people with severe and complex mental illness. 5. Primary Health Networks and Local Hospital Networks will work with health and social service agencies operating in their regions and the community sector to develop region-wide arrangements to ensure coordinated treatment and community support for people with severe and complex mental illness.

Comments and proposals

- 1) Given this is a fairly clinical founded priority focussed on the treatment and care of people living with severe and complex mental illness, one top-line goal should be to reduce the incidence of hospital admissions, with appropriate targets and timelines set by the co-design partners. We note a person in crisis with a mild episodic diagnosis can require the same level of support as a person diagnosed with a complex mental illness. Similarly, a person with a diagnosed complex mental illness may not reach crisis if the right ongoing community supports are provided.
- 2) It seems pertinent here to raise the issue of resourcing. While the aim is to provide the right amount of timely clinical and community supports, working with social service agencies and the community sector to do so will cost money, and there needs to be a way to reference funding commitments in the Plan.

The plan needs to be built on a realistic assessment of need. NDIA modelling has estimated approximately 64,000 people by 2019/2020 will have significant and enduring psychosocial disability requiring support. However, the National Mental Health Commission in its 2014 review found that approximately 690,000 Australians already experience severe mental illness each year. Foresight will be needed to fund the ongoing community services required at ground level in order to reduce and prevent the cost of mental illness to primary health services, legal services and other government and non-government sectors.

An appropriate target would be to fund mental health as a proportion of all health funding to reflect the burden of disease. And, as a secondary target, for 30per cent of all mental health funding to be for community-based mental health services, especially those that community organisations and consumers run.

- 3) It is important that the Committee will monitor and report to Health Ministers on health and policy issues that *may* arise from the implementation of the NDIS (Action item 4). However, given there is evidence of profound issues of exclusion and increased vulnerability relating to the NDIS, it would strengthen the Plan to design Actions to involve the NDIA and address the problems rather than to report on them.

In the context of this priority, the treatment and support for people with severe and complex mental illness, a realistic immediate target might be that none of these people would be worse off consequent to the introduction of the NDIS.

- 4) We make the point that the shift that has come about through the introduction of the NDIS, with its focus on a competitive market designed to deliver care and support at the lowest possible cost, is in some cases leading to the exploitation of highly vulnerable people.

For example, choice for people living with deep and persistent mental illness who require supported accommodation is limited to Supported Residential Facilities (SRFs). SRF management has control of property. The professional boundaries of responsibility for overall client welfare are blurred across federal and state boundaries. Ultimately, SRF management are able to stop services from entering a facility to provide social, emotional and community supports at their discretion, which both reduces choice and control for the customer and increases their vulnerability.

- 5) Transport is another, obvious and crucial need, particularly in rural and remote locations, as well as support for employment and supported social inclusion opportunities. At the very least, the Plan needs to ensure there are links into government departments with these relevant, non-medical, responsibilities.
- 6) Recognition of the value carers play in the lives of those living with complex mental illness and the need for government to provide adequate and timely supports to ensure they are able to sustain their own wellbeing and capability to continue their caring role. Most important is the need for respite and access to social inclusion opportunities.
- 7) While the Aim and the Actions for this priority refer to community supports, the values of *Recovery, Co-production and Promotion, Prevention and Early Intervention* are not mentioned. Nor are the

holistic goals of wellbeing and living in the community. The term 'community support' seems to be a catch-all term in which we are asked to read these investments and outcomes. In the context of a mental health scheme fit for contemporary society, that should be completely unsatisfactory. It suggests a deficit-based approach to mental health.

In practical terms, the failure to identify investment in local support and services simply illustrates the point that prevention and recovery are not a priority in this Priority area. One clear initiative would be to include the words "invest in local psycho-social service and community support services programs" under Action Item 5.

Anglicare Australia network members have provided [case studies](#) that highlight the value of community based coordinated treatment for people with complex mental illnesses.

The case study provided by Anglicare SA highlights the value of community based coordinated treatment for people with complex mental illnesses. It describes how the service's support of a mother with suicidal ideations was able to be extended to a member of the family with paranoid schizophrenia, and improve the situation of the whole family. It emphasises the need for tailored and responsive support, that can be extended to areas such as employment, housing, and community engagement.

Finally, the case study from the Samaritans Foundation illustrates the need for integration across service areas and government portfolios, through a discussion on the need for better responsiveness and coordination between the prison system, the health system and the NDIS.

See [Appendix 1](#)

Priority Area 3: Suicide prevention

Aim	Summary of actions
<p>To reduce the incidence of suicide and ensure that people who have attempted suicide are given effective follow-up support.</p>	<ol style="list-style-type: none"> 6. Governments will work together to renew efforts to develop a nationally agreed approach to suicide prevention that aligns their respective activities, and improves identification of people at risk of suicide and the effectiveness of services and support available to them. 7. Governments will work to develop integrated, whole-of-community approaches to suicide prevention at the regional level. 8. Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services. 9. Governments will work together to strengthen data collections relating to suicide and suicide attempts to strengthen the evidence base and improve quality of care. 10. Governments will develop suitable public health and communication strategies to better inform the community about suicide and suicide prevention.

Comments and proposals

- 1) Suicide and attempted suicide are present in different ways across our society, and require a diverse and nuanced approach relevant to the different communities, and people, affected.

The aim must be to work with communities and the people affected to reduce the incidence of suicide. Similarly, in the actions, Governments need to work *with* communities and people who are affected in order to develop effective approaches to suicide prevention.

- 2) Suicide prevention needs to be seen as a whole-of-community issue and addressed holistically with a focus on wellness and prevention. The documentation developed by government in establishing a national approach to suicide needs to be flexible in the variety of reasons for suicide and include a whole assessment approach. An individual’s connection to others, place, community and a sense of purpose is the best preventative action to avoid suicide. These connections begin at the grassroots level and need to be acknowledged as the primary focus of action.

- 3) There is no mention of suicide bereavement and postvention strategies. This reinforces our sense that the plan adopts an entirely medicalised approach to suicide which is likely to be much less effective in some communities and with some people than with others.

We point to an Anglicare WA run postvention program “Arbor” which works with the families and community members affected by suicide as a culturally appropriate social and community response which has mental health benefits to the people it reaches.

- 4) The Aim should be changed to include survivors, family members and other community members affected by and at risk of suicide and attempted suicide. The Actions need to include the resourcing of co-designed local postvention programs and strategies.
- 5) Again, the Actions in this area need to incorporate well-defined goals, timelines and measurable objectives. This was one of the key points in the WHO’s suicide prevention framework.
- 6) Other relevant Actions for this priority include:
 - a. support and pathways for generalist community and social services, including teachers in schools, the development of localised place-based strategies
 - b. a focus on streamlining services
 - c. funding for accessible services, e.g. Lifeline, mental health and counselling hotlines
 - d. funding to meet specific challenges such as transport in rural and remote locations (equity should be included in action statements)
 - e. culturally specific material, support and engagement strategies for recent arrivals, refugees and asylum seekers, young people, (especially LGBTI young people), carers, care leavers, the aged, Aboriginal people and Torres Strait Islanders, among others, and
 - f. Data collected should be used to measure need for services, and ensure that demand is met.

It could be argued that this is a level of detail that would sit *under* the Aims and Actions above. Anglicare Australia would argue that there is nothing in the Plan that could give confidence that resources would be found to deliver on this level of detail unless it were identified at the higher level.

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

Aim	Summary of actions
<p>Culturally competent care through integrating social and emotional wellbeing services with a range of mental health, drug and alcohol, and suicide prevention services.</p>	<ol style="list-style-type: none"> 11. Governments will work collaboratively to develop a joined approach to social and emotional wellbeing support, mental health, suicide prevention, and alcohol and other drug services, recognising the importance of what an integrated service offers for Aboriginal and Torres Strait Islander people. 12. Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander people at the regional level. 13. Governments will renew efforts to develop a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander people. 14. Governments will work with service providers, including Aboriginal Community Controlled Health Organisations, to improve Aboriginal and Torres Strait Islander access to and experience with mental health and wellbeing services. 15. Governments will work together to strengthen the evidence base needed to inform development of improved mental health services and outcomes for Aboriginal and Torres Strait Islander people.

Comments and proposals

1) There are two key principles here that we expected to see in regard to Aboriginal and Torres Strait Islander Mental Health. They are the need for the actions to be led by Aboriginal and Torres Strait Islander people and organisations, and a holistic approach to their mental health informed by the acknowledgement of past trauma and ongoing discrimination and disadvantage.

None of the Actions under this priority indicate the necessary commitment of resources or handing over of leadership to Aboriginal and Torres Strait Islander people to develop the integrated service which they describe.

2) In this draft Plan, Aboriginal Controlled Health Organisations are seen as a partner to governments at best. Anglicare Australia suggests ACCHOs be given leadership roles and resources in the development of the plan for their people, and that the aim and actions in this priority area be re-written accordingly. In areas where ACCHOs are not present, the government needs to mandate the inclusion of Aboriginal and Torres Strait Islander representatives in PHNs and LHNs.

- 3) We see ACCHOs as exemplars in the search for other culturally specific and responsive health and community development bodies that could, similarly, take a wrap-around approach to improving the social and emotional wellbeing of the people they work with.
- 4) There is a concern that culturally appropriate services are talked about a lot but they are not consistently funded. There is funding in other policy areas for culturally appropriate services (such as CALD in Aged Care). There is also concern that the government does not seem to take responsibility for policy that has impacted on the mental health of Aboriginal people.
- 5) There needs to be funding for Aboriginal people to reconnect to their families and country, and for access to services in remote locations.
- 6) The national approach needs to include targeted support for young people, given 50 per cent of Aboriginal people are aged 25 and under. This should be locally designed.
- 7) Workforce needs to be considered: work needs to be done on the challenges of recruiting Aboriginal mental health workers, and more planning is needed in regards to developing a cultural competency in non-Aboriginal workers.
- 8) Further to the previous point, the system must recognise the important role of Traditional Healers in providing cultural care, comfort, support, for their spiritual and overall healing. The system must recognise the value of the role they undertake at the frontline with Aboriginal people and communities, including resourcing them for the services.

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

Aim	Summary of actions
<p>The physical health care of people living with mental health issues is a national priority, and the life expectancy gap is reduced.</p>	<p>16. Governments will identify suitable guidelines and other resources for use by health services and health professionals to improve the physical health of people living with mental health issues.</p> <p>17. Governments will work with Primary Health Networks and Local Hospital Networks to ensure that the physical health of people living with mental health issues is a priority in the development of regional health plans and service delivery, and that systems are developed for monitoring progress.</p> <p>18. Health Ministers will lead the work of commencing regular national reporting on the physical health of people living with mental health issues.</p>

Comments and proposals

- 1) Anglicare Australia is glad to see the physical health of people living with mental issues identified as a priority. We would, however, expect the social determinants of health to be a focus in this area. Widening the scope of this priority area to include the social determinants of health will help to address many of the causes for poor mental and physical health – such as access to and quality of housing, employment, transport, social support, and material resources. The promotion of physical health should go beyond giving recommendations about diet, smoking prevention and exercise, and seek to address issues related to housing, low incomes, and poor coping strategies (e.g. alcohol). Once again, this work should be led by the needs of consumers, carers and communities.
- 2) In terms of clinical medical care, member agencies have suggested that annual routine physical health screenings be added to Mental Health plans at no extra cost to the consumer. Services supporting the consumer to ensure physical health can be identified on assessment as part of a normalised, holistic approach to care.
- 3) People accessing Anglicare services have reported an increase in poly pharmacy, where GPs are managing the physical side effects of medicines that have been prescribed by psychiatrists by prescribing further medicines. GPs are more inclined to “add on” to existing medication regimes than seek to alter the original medications prescribed, which results in people having to manage a lot of different medications. Health professionals should consider a balance in prescribing medications for mental illnesses which will have a negative impact on the client’s physical health.

- 4) Information relating to the side effects of medicines that have been prescribed to treat mental illness also needs to be made more accessible to consumers.

Priority Area 6: Stigma and discrimination reduction

Aim	Summary of actions
To reduce stigma and discrimination against people living with mental health issues, particularly people with severe mental illness.	<p>19. Governments will broaden their efforts to reduce stigma and discrimination to include a focus on people with severe mental illness. This will be a shared endeavour between governments, consumers and carers, community groups and key organisations.</p> <p>20. Governments will work with key organisations to reduce stigma and discrimination in the health workforce through leadership and training, informed by the views and experience of people who live with mental health issues, and identification and exposure of discriminatory practice where it occurs.</p>

Comments and proposals

- 5) Reducing stigma and discrimination is critical to improving the experiences and circumstances of people with mental illnesses. It is also a complex issue that looks different and is experienced differently by many people.
- 6) It is important to recognise that mental illness is itself often a result of other systematic failures. Anglicare Australia members agree that the actions in this area need to be reworked so as to become more substantial and have tangible and measurable effects. One public campaign does not a reform make! Education needs to be ongoing.
- 7) Anglicare Australia agrees with the comments of a member organisation that provides disability employment services who noted that in many cases “stigma” is, and should be treated as, discrimination. There was some concern that there should be more emphasis on the unlawfulness of discriminatory practices and policies, rather than framing it as “structural stigma”. Anglicare Australia suggests that establishing a mental health legal service would be an effective way of combating discrimination and supporting those who it affects. This also would be a concrete measure to introduce into Action 19, as many people with severe and complex mental illnesses would be protected by the Disability Discrimination Act.
- 8) Employment would be a valuable area to focus efforts to combat discrimination and stigma. Not only are all employers accountable to discrimination laws, but they also by way of this have an

obligation to work on creating inclusive policies and practices. A concrete action that could be taken by government to reduce employer discrimination against people with mental illnesses would be to introduce a quota in the public service for hiring people with mental illnesses. Inclusion in employment will also help to support broader social inclusion of people with mental illnesses.

- 9) Anglicare Australia welcomes the focus on reducing stigma and discrimination in the health workforce. Members have suggested that education and training on stigma and discrimination be extended to the social services workforce to help challenge workers' perceptions of their behaviours and how their support of the customer may be encouraging self-stigma.

Priority Area 7: Safety and quality in mental health care

Aim	Summary of actions
<p>A safe and high quality service system that is tailored to the needs of consumers and carers, is underpinned by continuous monitoring and improvement, and reports on outcomes in a transparent manner.</p>	<ol style="list-style-type: none"> 21. Governments will develop a national mental health safety and quality framework to guide delivery of the full range of health and support services required by people living with mental health issues. 22. Governments will work with the Australian Commission on Safety and Quality in Health Care and the mental health sector to amend the National Standards for Mental Health Services to better reflect their intent in those health services where the National Safety and Quality Health Service Standards also apply. 23. Governments will implement monitoring of consumer and carer experiences of care, including the Your Experience of Service survey tool, across the specialised and primary care mental health service sectors. 24. Governments will agree on a national statement of priorities to guide mental health information developments over the next ten years. 25. Governments will continue to build accountability by ensuring service delivery systems work to monitor the safety and quality of their services and make information about their performance on service quality indicators available to consumers, carers and other stakeholders. 26. Governments will undertake work to improve consistency across jurisdictions in policy underpinning mental health legislation, based on an understanding of their impacts on consumer and carers.

Comments and proposals

- 1) Our network's response to the actions outlined in this priority area express a concern that, in going forward, we should be careful not to create more of the same complexities, inefficiencies and difficulties that are the cause of many current issues in the system.
- 2) Anglicare members have emphasised the need to develop a unified approach to safety and quality, developed from a key set of guiding principles which can be applied generically.
- 3) There needs to be careful and consultative decision making on whether there is a need for another safety and quality framework to guide the delivery of services to people with mental illnesses. If a framework is developed, other intersecting standards frameworks (e.g. Aged Care standards) must be factored into the design. We have also received suggestions that implementing the monitoring of consumer and carers experiences of care (Action 23) be incorporated into the framework, rather than being a responsibility of government.
- 4) In feedback provided, an Anglicare Australia member expressed concern about the safety and quality of supported residential homes. It was suggested that national standards are needed for supported residential facilities (SRFs) and they be included in the framework if it is developed.
- 5) Governments also need to work with key stakeholders, including consumers and carers, in the development of a national statement of priorities to guide mental health information developments over the next ten years. Accessibility and readability should be prioritised in the development of information material.
- 6) We agree there is a need for Governments to work on improving consistency across jurisdictions in policy underpinning mental health legislation, based on an understanding of their impacts on consumers and carers. This is an important first step and needs to include integration with the NDIA and state legislation.

Monitoring and reporting on reform progress

Aim	Summary of actions
<p>Accurate and timely information is available to allow consumers, carers, providers and governments to monitor mental health system reform and the implementation of commitments made in the Fifth Plan.</p> <p>All parts of the mental health service system are supported in using information to improve the experience of, and outcomes for, consumers and carers.</p>	<p>27. Governments will implement a set of national reform and system performance measures to monitor whether we are making a difference in mental health reform.</p> <p>28. Governments will work to develop additional performance measures in response to consumer, carer and community priorities. These will build on investments already made in data collection and performance measurement development.</p> <p>29. Governments will work to ensure that progress and reform are monitored in all parts of the mental health service system.</p> <p>30. Governments will report annually on the progress of mental health reform and implementation of the Fifth Plan.</p>

Comments and proposals

- 1) Auditing, monitoring and evaluation of this plan – when finalised – need to be the responsibility of the National Mental Health Commission, which has *some* statutory independence and can be seen to be outside the short term political pressures and the inter-departmental and jurisdictional tensions that lie beneath the plan’s surface.

The executive of government departments, ranging from health to social services, housing and corrections, need to be accountable for delivery on the plan.

- 2) The goals and achievement of the fifth national plan, when finalised, need to be aligned with earlier plans, for which some of the aims and actions are ongoing. By the same token, the fourth national plan – while in part still a live project – similarly needs evaluation and reporting.
- 3) The Committee needs to revisit indicators of social and emotional wellbeing developed for the fourth plan, as well as other common measures of social and emotional wellbeing. It would make sense to invest in quality of life outcome measures in partnership with the aged care and the disability sectors as they are pursuing the same ends.

- 4) It also makes sense to recap on the vision for this plan and make the point that there is a need to establish baseline figures against which progress can be measured.

The vision

- More people will have good mental health and wellbeing.
- More people living with mental health issues will recover and have a meaningful and contributing life.
- More people living with mental health issues will have good physical health and live longer.
- More people will have a positive experience of care and support from a responsive and effective service system.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination

One primary Action for this priority needs to be the establishment of a baseline against which progress towards this vision can be measured.

Conclusion

In our discussion of the Draft Plan we make several references to the Committee's agreed set of Values. The consultation papers suggest that the Actions are consistent with these Values, but in crucial areas, such as where they relate to Recovery and Co-production, it is often hard to see if they connect at all.

Anglicare Australia is not alone in arguing the draft Fifth National Plan is a significant step back from earlier work. Many of the more stringent criticisms made at the Canberra consultation forum reflected comments made at earlier sessions, which are about the absence of deliberate engagement with consumers, carers, service providers and advocacy groups.

An open letter to the First Ministers of Australia from Mental Health Australia, and co-signed by Anglicare Australia among many others, calls for the Plan to be re-drafted so that it puts consumers at the centre of the planning, funds the necessary community-based resources, isn't limited to the goals of health ministers and health departments, and focusses concretely on prevention and recovery.

We were invited to respond to the plan specifically in terms of the Actions identified under the Priorities. We have attempted to do that, although we do believe there are other key priorities that should be added. We are happy to endorse the Values and briefly review our feedback against them.

Co-production

Despite recognition that "consumers and carers need to be at the centre of the way in which services are planned and delivered" (3), none of the Actions in the Plan ensure governments collaborate with consumers and carers to co-produce services and co-design outcomes.

Promotion, prevention and early intervention

The Plan is all but silent on how governments would improve the support provided to consumers and carers as early as possible. By limiting its Aims and Actions to a clinical, hospital-centred approach to mental health, the Plan undermines any positive partnerships agencies might develop with consumers, carers and community service providers who have long championed community-based care, inclusion and support. We argue that *Promotion, prevention and early intervention* should be a key priority area in itself.

Equity

Equity is not mentioned once apart from in this statement of values. The plan doesn't address social and economic issues that are a large factor in people's mental wellness - such as poverty, unequal access to health services, transport, and housing, and family and community belonging. It is perhaps most evident in the priority relating to Aboriginal and Torres Strait Islander people, who are presumed to be consulted but given no control.

Recovery

A clinical approach to mental illness will not deliver the holistic support needed for recovery. The Plan must be revised to better support the vital services provided by community organisations that establish a foundation from which people can reach and sustain a state of wellbeing.

Accountability

The plan lacks targets, timelines, baselines and measures. Many of the Aims are so broad and unspecific that it would be impossible to accurately say whether they have been achieved. We have suggested some specific targets in our discussion above and suggest all Actions be linked to targets and timelines, and be made the responsibility of agencies and/or departments.

Uphold human rights and dignity

It is noted that the Plan is being developed at "a time where there is opportunity to align national priorities to improve mental health care practices" in Australia with the UN Resolution. Given that many concerns have been raised in regards to human rights in Australia for people with mental illness, this Plan should *commit* governments to aligning policies with relevant human rights frameworks.

Evidence-based and high quality services

There are many Actions in the Plan linked to building an evidence base. We suggest that such an evidence base needs to be designed by consumers and advocates rather than, or in partnership with, governments. The outcomes of many would be dwarfed by the impact of changes to employment, housing and relationship status. Similarly, there are many initiatives which make a difference in people's lives when combined with other support and opportunities. It would be reassuring if the plan talked about

a broader evaluation framework for its vision, and the collective impact of the programs it is supporting, informed by evidence from other non-clinical agencies.

High quality services rely on high quality staff. We note again that the draft Plan shows a minimal interest in workforce issues, and we propose making it a key Priority area.

Innovation

There is considerable scope for innovation, and it would make sense to focus in particular on the possibilities that come from community-controlled organisations and other not-for-profit specialist service providers.

Anglicare Australia would like to extend our thanks to the expert staff from seven network organisations, and the ongoing work that they, and the people they work in partnership with, have done to inform this response. We look forward to seeing the next iteration of the Plan.

Appendix 1. Anglicare network case studies

Anglicare SA

The following case study, provided by Anglicare SA, highlights the value of community based coordinated treatment for people with complex mental illnesses. It demonstrates the importance of community based services that can coordinate tailored emotional and relational supports as well as support for employment, housing, and community engagement:

Jane* lives in the family home with her 64 year old mother Mary* and father Ron*. Mary cares for Jane who has been diagnosed with paranoid schizophrenia, depression and severe anxiety, and for Ron who has a significant physical disability. Mary contacted AnglicareSA in significant personal crisis in 2010, as a final and desperate plea for help. Mary's extended family had turned their backs on her many years ago as they didn't understand her situation and as she had been housebound for over 18 years, Mary had limited involvement in the community other than going to the shopping centre for groceries at night whilst her husband and daughter were sleeping. Mary discussed her feelings of worthlessness and an overwhelming sense of tiredness. Mary contemplated whether her family appreciated her support as she fielded verbal and emotional abuse daily and wondered how long she was able to endure this day in day out. Mary discussed her ongoing suicidal thoughts as she believed the system would take over the care of her family, if she was no longer able.

Jane* is 32 years old . She had not left the home since she returned from high school one day in 1999, after being bullied by classmates and constant feelings people were following her. Jane experienced hearing voices which became louder and more intense once she opened the front door and had refused to go near the door for many years. Jane spent her time watching Netflix and drawing comics. Jane played the Xbox and talked to people online daily. Jane was significantly overweight and found it difficult to get along with her parents as she felt they didn't understand her and asked too many questions.

AnglicareSA through DSS funding of the Mental Health Respite program, was able to implement both immediate and ongoing holistic supports that met both Mary and Jane's needs. A staff member was able to provide immediate counselling assistance over the phone to Mary de-escalating her heightened state of distress and reassuring her that assistance was available. The staff member organised a worker to attend the home the following day to discuss the support needs of Mary and Jane, and to plan initial goals which would pave the way for a brighter future for the family. Respite support began that week with a worker attending the home to build rapport with Jane whilst Mary was able to spend time cleaning or supporting Ron. Over time, Jane began to increasingly trust the worker and agreed to slowly tackle her anxiety relating to leaving the home. At first the worker talked to Jane through a crack in the door, and then as Jane became familiar with this, the worker sat in the patio and talked to Jane whilst she held the door open. 4 months later, Jane held the worker's arm and walked behind her to the letterbox collecting the mail for the first time since high school. Jane and her worker had their first coffee at the local shopping centre 6 and a half months after support began. Jane then began attending the AnglicareSA Mental Health Respite day community engagement groups once a week which gave her mother a day to herself. Almost a year after joining the group, Jane announced that she was enrolling in TAFE and wanted to complete a certificate. Jane is currently working 4 days a week now, has her driver's license and takes her mother to the coffee shop she first went with the worker regularly. Jane lives in her own unit now and comes in to visit AnglicareSA every now and then to give an update on where she is at.

Mary was linked in to counselling immediately and encouraged to contact the program whenever she felt the need for extra support or just an ear to listen. Initially two support workers attended the home to provide support both to Jane and Mary although, as Jane's dependence on her mother decreased Mary was able to engage in the Carer programs also. Mary attended the *I am..Caring* 6 week wellbeing program, the self-defence classes which helped to boost her confidence and several other carer events where she cemented friendships and was able to reduce her social isolation.

Mary and Jane's level of support increased and decreased over several years however, they always knew that they had an ongoing, trusting relationship with the program. They were both able to discuss support needs and choose the intensity of their support. They continue to attend events and educational programs where they have built connections and feel able to discuss their journey with others who are just beginning.

*names have been changed for confidentiality

Samaritans Foundation

This case study highlights the need for better responsiveness and coordination between the prison system, the health system and the NDIS:

Individuals who exit jails, and those who are incarcerated, are vulnerable to poor, untreated mental health. There is a big difference in the skill set and knowledge base of staff who support this cohort. Staff in NDIS are more often used to working with people who have a physical disability, and have little understanding of the impacts of surviving a prison sentence.

There is a high prevalence of intellectual disability, undiagnosed and/or untreated mental health of people in prison system. The health care in prison is very poor. When people are released their access to NDIS plans will be difficult unless there is case co-coordinator working prior to release to establish the goals and support when the person is released. This would need to be done in consultation with a General Practitioner, as well as a plan for accommodation, and transition to life opportunities outside of prison. This would greatly reduce the recidivism rate. The standard 6 x 2 free psychologist sessions are not readily available to this group, as they have no GP to initiate this treatment plan. There is then an impact on the general health care system, when these individuals attend the ED hospital admissions. This is often their only access to physical and mental health support.

NDIS planners find it difficult to understand the complications of post-release individuals being able to organize and attend appointments, as a result of being institutionalized for even a short period of time.