Mental Health
Community Coalition ACT

# 2024-25 ACT Pre-budget Submission

JANUARY 2024

# Acknowledgements

## Acknowledgement of country

Mental Health Community Coalition ACT is located on Ngunnawal Country. We acknowledge the Traditional Custodians of the land. We pay our respects to their Elders, past and present. We further acknowledge all Aboriginal and Torres Strait Islander Traditional Custodians and Country and recognise their continuing connection to land, sea, culture, and community.

## Acknowledgement of mental health lived experience

We also acknowledge the individual and collective expertise of those with a living or lived experience of mental health. We recognise their vital contribution at all levels and value the courage of those who share this unique perspective for the purpose of learning and growing together to achieve better outcomes for all.

# Introduction

Mental Health Community Coalition ACT is our Territory's peak body for community-based mental health.

Our 52 members make up two-thirds of Canberra's mental health system and include Canberra's soup kitchens, childcare centres, domestic violence shelters, and health services for marginalised groups.

We advocate for a mental health system that offers people support and belonging as part of our community.

**Our vision is of an inclusive ACT that prioritises community-building and wellbeing.**

This vision is consistent with the principles underpinning the very first national mental health plan in 1992, which committed all state and territory governments to expand community mental health services, to help people with mental illness live well and with dignity in the community.

Our sector supports people with mental health conditions to do this and meet everyday challenges when and where they need it most. The community-managed sector is a vibrant, creative place which adapts to the unique needs of individuals, families, and communities.

These needs might range from crisis to ongoing recovery support, capacity building and skills development, housing, employment, and social connection.

Meeting these needs is best done in the community, where our members can provide services which connect service users with each other while building skills and relieving stressors with practical resources like food and shelter. Through community supports, service users find a sense of purpose and meaning in their day-to-day lives.

The community-managed mental health system prides itself on universal access to support services. We offer support to people who may distrust public services due to previous experiences of trauma, or people who are not eligible for other services due to strict eligibility criteria, cost barriers, or visa limitations. We provide supports delivered by and alongside people who understand where you are coming from, who speak your language.

Our sector delivers care at a much larger scale than the public system. For example, inpatient public psychiatric units treat up to 120 people at a time, costing over $1030 per person, per day. Meanwhile, all Canberrans are potential community mental health services users, which are currently delivered at the per capita cost of $18 per year.

Our sector saves money and achieves scale because we deliver mental health care *before* people face acute crisis, and we help people *maintain* their mental health after crisis points to prevent them from future hospitalisations.

Prevention, early intervention, rehabilitation, healing, and recovery are integral to building wellbeing and resiliency. They also save money and can relieve increasingly unsustainable systemic pressures.

Since the introduction of the NDIS, however, the community-managed mental health system has faced severe funding gaps that have resulted in our members reporting unprecedented turn away rates. Demand for services has doubled over the past 10 years while at the same time, there is less funding to meet this demand.

Funding has not only failed to keep pace with demand, but has also failed to keep pace with inflation, population growth, and the fact that ACT services serve people beyond ACT residents.

In real terms, we have fewer resources to stem the significant stress faced in our region. This has severe implications for the ACT's struggling public health system, significant downstream economic costs, and costs to human flourishing, with consequences for individuals, families, and our community more broadly.

The Australian Government's NDIS Review had several observations and recommendations about the inadequacy of funding for mainstream services outside the NDIS, including mental health supports.

**Pressure on the ACT's community mental health sector**

The ACT's community mental health sector faces the same challenges as the broader ACT health sector: increased demand on services due to a growing population, underfunding of the health system because of undercounting of the ACT's population, inflationary pressures, and the ability to attract and retain appropriately qualified staff.

A combination of low bulk-billing rates in the ACT and high out-of-pocket costs for Medicare health services means the community sector provides a crucial role in providing mental health and psychosocial services in the ACT, but without the funding required to adequately service existing and growing demand.

Private health providers have no incentive to take on complex mental health cases, which again creates additional pressure on services provided by the community mental health sector and the ACT Government.

Our Budget Submission offers cost-effective solutions that protect mental health and prevents over-reliance on hospital-based psychiatric care – which, according to the Australian Institute of Health and Welfare, cost the ACT Health budget over $63 million during 2020-21 alone.

More broadly, the Productivity Commission estimates that mental ill-health and suicide are costing Australia $220 billion per year, or around $600 million per day.

The reforms recommended in the landmark Productivity Commission Report into mental health – of which investment in community mental health is a key part – is expected to lead to national cost savings of up to $1.7 billion and increases in aggregate income of up to $1.3 billion per year.

Our funding requests represent significant value for money for the ACT, as it will reduce reliance on services provided by the ACT Government while also improving community and productivity outcomes.

This submission outlines an exciting opportunity for the ACT to invest in mental health reform to reap its share of these economic and social rewards.

We propose a series of actions that will deliver better mental health and wellbeing outcomes for the ACT. We ask that these points be considered as Ministers make decisions on the 2024-25 Territory budget.

We would be pleased to discuss our proposals in more detail and would be excited to work with the ACT Government on their implementation.

# 1. Increase funding for the community-managed mental health sector from 13% to 20% of total mental health funding

The community-managed mental health sector delivers two-thirds of the ACT's mental health services and yet only gets 13% of the total mental health service funding.

It is a paradox that since the NDIS was introduced in the ACT in 2016, per capita funding for community-managed mental health services outside of the NDIS has halved, leading to a dramatic loss of services for the vast majority of Canberrans living with mental illness.

While delivering more funding, in fact the NDIS has been used as an excuse to divert funding away from community services, the logic being that the appropriate funding for individuals who need long-term supports will come through the NDIS. But the NDIS was never intended to meet the diverse support needs that exist in our community.

ABS data shows that almost half of Australians aged 16-85 have experienced a mental health condition at some point in their life, and over one in five experience mental ill-health each year. Only a small number of people who need mental health support will be eligible for NDIS funding. In many cases, the episodic nature of many mental health conditions will make it difficult to make the case for permanent disability required for the NDIS. For example, perinatal mental ill-health affects 1 in 5 new mothers and 1 in 10 new fathers, and cost the Australian economy $877 million in 2019 in the first years of the lives of babies' lives. Perinatal mental health challenges will always sit outside of the NDIS as they are connected to life stage.

In addition, individualised care plans provided through the NDIS are not suitable for all people – many would benefit from, and would prefer, care delivered through communal settings. It is also likely that a considerable proportion of existing NDIS funding is being directed towards private providers (such as psychologists) rather than through community mental health organisations providing psychosocial services.

The Australian Government's NDIS Review and the Productivity Commission's 2020 Mental Health inquiry both identified gaps in psychosocial supports outside the NDIS, with the NDIS Review identifying "major gaps in psychosocial supports outside the NDIS". The NDIS Review recommended this be jointly funded by National Cabinet, but this would not preclude the ACT from making its own investment in mental health supports.

The intensity and severity of mental health conditions vary widely. According to Orygen, and backed up by the NDIS Review, around half of people with mental health conditions fall in the "missing middle" – "too severe" for straightforward treatment managed by a GP and through ten Medicare subsidised psychology sessions, and "not severe enough" for crisis care or ongoing, intensive supports through the NDIS. The NDIS Review also noted that there are "too few clinicians and significant waitlists in some areas, and a shortage of community mental health services for people who need more intensive support than general practice services, but less than specialised state and territory mental health services," and recommended more investment in accessible mainstream services.

The community-managed mental health sector is well-placed to address this gap, it just needs a boost in its capacity.

Despite the funding deficit we face, community-managed mental health has good evidence of general returns on investment (ROIs) across the board. Mental Health Victoria calculates an ROI of $3 for every

dollar invested in community-managed mental health. Some programs, such as early psychosis intervention, have even higher ROIs of $8.60 per dollar invested.

These returns can be made in the short-term because our interventions reduce pressure on emergency departments, police, and ambulance services. In the long-term, there are additional savings (not counted in these ROI figures) as participants are more likely to enter training and employment.

Further, additional spending on early intervention within the mental health system and greater mainstream mental health investment will see reduced pressure on the NDIS and specialist acute services.

More funding to our sector over time – starting with a modest increase from 13% to 20% of total mental health spending – will lead to financial savings for the ACT. Moreover, we find in New Zealand – where 25% of overall mental health funding goes to the community sector – there is a much greater range of service alternatives and less reliance on hospital-based care.

This funding increase would support many of the priorities identified by the ACT Disabled Peoples Organisations' budget submission (endorsed by MHCC) in that it would enable the sector to improve mainstream services as per recommendations from the NDIS review; increase capacity for coordinated care management; provide a longer and more diverse chain of post hospital supports and options for people as per the ACT Disability Health Strategy; and expand access to crisis services as part of an intersectional approach to violence prevention.

## 2. Provide funding for the community-managed mental health sector to meet the demands of outcomes measurement

The community-managed mental health sector welcomes the opportunity to better measure its outcomes and report its impact through the commissioning process. There will be a transition from reporting outputs (such as number of people seen, number of interventions undertaken) to reporting on the overall impact of programming (such as number of hospitalisations avoided, service user satisfaction, and reductions in symptoms).

This change will come at a cost if the sector is to avoid taking valuable time and resources away from service delivery. We need funding dedicated to building our outcomes measurement capacity, allowing the sector to offer training on how to measure outcomes, provide expertise on data analysis, and to build proper data analysis ICT systems.

Without additional funding, the ACT government is essentially asking an already under-funded, over-worked sector to do more with the same amount of money, which is impossible.

We would welcome similar consideration being given to this kind of outcomes measurement and reporting right across the ACT's mental health system, not just in the community sector. Funding for emergency departments and psychiatric units, for example, is not contingent on their outcomes reporting.

Turn away rates; rates of re-admission; rates of dehumanising, restrictive practices such as seclusion and restraint; and patient satisfaction rates within the public sector do not result in a revocation of funding (though concerns regarding accreditation have been raised in the past).

The interest in efficient and humane use of mental health funding should be system wide. Services with the capacity to clearly demonstrate such care should be rewarded.

# 3. Develop the ACT's peer workforce

Peer workers play an increasingly vital role in the mental health system across Australia but their adoption in the ACT has lagged. According to the Productivity Commission in 2020-21, there were 4.4 paid consumer workers (FTE) per 1000 paid direct care staff and 2.0 paid carer workers, while the national average was 10.5 and 3.3 respectively.

Peer workers are people with lived and living experience of mental ill-health who have undertaken training and personal development to harness their experience for others' therapeutic benefit. Peer workers offer deep empathy and understanding towards those experiencing distress as well as a commitment to mutuality – they work *with* mental health consumers towards common goals. They also offer hope as they show that recovery is possible.

The move towards peer work marks an important shift in the way the welfare system operates as we see greater emphasis put on the relationships between workers and service users. Building rapport has been shown by the work of UK social welfare reformer, Hilary Cottam, to also build confidence, skillsets, and hope, whereby people are encouraged to pursue goals they never thought they would be capable of.

Over time, recipients of these services become less likely to rely on them, and more likely to enter transformative opportunities such as further education, training, employment, volunteering, and other modes of flourishing.

The benefits of peer workers have been well-documented, including in the ACT's own Mental Health Workforce Strategy as well as the federal government's recent Lived Experience Workforce Guidelines. These latter Guidelines identify investment needs in strengthening the peer workforce. Recommendations that could begin to be actioned through the 2024-25 Budget would be:

- Funding to institute a peer workforce peak body.
- Funding for MHCC ACT to offer training to our members regarding peer worker integration into the mental health system.

# 4. Fund the Certificate IV in Mental Health Peer Work and related skill sets

We have been encouraged to see that the ACT government is supportive of a mental health peer workforce, as evidenced by its annual Mental Health Peer Work Scholarship Program of $5000 offered to 6 people studying a Certificate IV in Mental Health Peer Work.

Unfortunately, no education provider in the ACT currently offers this qualification. Successful scholarship applicants (and any other Canberran who wants to study peer work) must undertake their studies in another jurisdiction, such as NSW, or online, which may not be a preferred learning method.

The lack of options for undertaking this qualification compounds the existing challenge of a disproportionately small peer workforce in the ACT. It is also an unnecessary situation, as CIT has previously offered this qualification and, we recommend that they should do so again. Alternatively,

we could find a different RTO capable of providing this qualification in the ACT, especially if the ACT Education Directorate identifies peer work as an area of skill shortage through the ACT Skills Needs List and provides funding for this life-saving, transformative training.

Through our participation in the Mental Health and Alcohol and Other Drugs Alliance, we have identified an additional area of training need which concerns people with mental health conditions co-morbid with alcohol and other drug use (AOD use).

Over half of people experiencing AOD use have a mental health condition and 60% of people with a mental health disorder are also experiencing AOD dependence, and yet, services across public, private, and community sectors are under-resourced to offer people help for both issues.

We find people reporting "bouncing" between service referral: an AOD service will say they cannot provide treatment because of an underlying mental health issue, and then a mental health service will also turn the same person away because of an evident AOD dependence.

We urgently need workers (and thus services) that are confident and capable of seeing people as they are. Our recommendation is to incorporate both mental health and AOD skill sets onto the ACT Skills Needs to ensure appropriately funded and supported training.

# 5. Redress disparities between pay and conditions of mental health workers in the public and non-profit sectors

As we have explored in our ACT community-managed mental health workforce profile, the public sector is having an effect of crowding out capacity building among non-profits, an understandable unintended consequence of efforts to improve the pay and conditions of ACT Health workers. Our profile of 2000 workers across 55 ACT organisations revealed:

- Mental health services are struggling to recruit, train and retain staff with the necessary skills and experience, and workforce growth is not keeping up with the demands on services.
- The community-based, not-for-profit mental health sector is not funded by government to provide competitive wages and conditions, nor is current funding sufficient to employ the number of skilled workers we need to meet growing community demand for mental health care.
- Employment insecurity in our sector is driven by the short length of service contracts.
- We are seeing elevated levels of burnout and staff attrition alongside low morale.

Historically, the rate of increase provided to MHCC member contracts has not kept pace with wages, and our workforce has seen an erosion of pay and conditions. MHCC is concerned that adding additional unfunded administrative requirements through the commissioning framework will compound our existing workforce pressures, which will create additional demand in other parts of the broader ACT health system.

The pressures of increasing demand, complexity in people's mental health needs, and chronic under-resourcing and understaffing are unsustainable. Unless these issues are addressed, workforce shortages will only increase, and this will affect our capacity to meet the community's growing demand for mental health support into the future. As a starting point, provision of service funding should allow organisations to pay workers comparably with public sector workers who are similarly qualified and take on similar levels of responsibility.

# 6. Reinstate the ACT Recovery College

Recovery Colleges provide an education-based mental health support service where people with lived experience of mental ill-health teach others with lived experience general life and psychological skills. Recovery Colleges have strong, international evidence of efficacy, and have been recommended in the NDIS Review as a priority area of investment and a much-needed resource in community settings.

Indeed, an evaluation of the ACT's Recovery College revealed that for an operational cost of around $400,000 per year, students reported feeling safe, supported to achieve their goals, and that the College provided opportunities for learning, thriving, and growth.

Further funding beyond the ACT Recovery College trial (which ended in December 2020) was not provided for arbitrary reasons: the tender for continuation was not open before the trial ended. This is a lost opportunity and a poor reason to miss the growth of a community-led, well-evidenced, cost-effective resource. We suggest that a Recovery College be reinstated, offered through one of our member organisations.

# 7. Fund policies to reduce rates of loneliness in the ACT

Following from our submission to the inquiry into loneliness and social isolation, we make the following suggestions for expenditure that would improve the wellbeing of individuals in the ACT, and overall community connectedness:

1. Pilot a process to screen and monitor individual levels of isolation and loneliness in primary care settings.
2. Fund a campaign to increase awareness of loneliness as a public health issue, with a view to encouraging community connectivity. This campaign would occur during Loneliness Awareness Week (held in August) and could be run similarly to Mental Health Month.
3. Fund programming delivered by mental health organisations present in schools to tell stories to destigmatise loneliness.
4. Scope and fund a loneliness-specific, evidence-based, community-managed therapeutic group program targeting loneliness.
5. Scope, pilot, and fund grassroots projects to tackle loneliness such as befriending initiatives, community cafes, and innovative ideas that come from Canberrans themselves.
6. Increase funding across the community-managed mental health sector to increase its peer support and advocacy functions.
7. Pilot a voluntary social prescribing program, allowing people partake in activities in the community inexpensively or for free to measure its impact on loneliness.
8. Undertake the 4-day work week trial in the ACT public service and extending the opportunity to the community sector, measuring its impact on loneliness, social isolation, and social participation.
9. Work with communities to build tailored third spaces for existing neighbourhoods to flourish.
10. Improve walkability in all ACT suburbs, particularly with a view to increasing tree canopy, footpaths, and lighting, ensuring that neighbourhoods are physically accessible to people with prams and people with disabilities.
11. Develop the ACT's bus network and services to increase the accessibility of public transport for people who don't live in population centres.

12. Fund afterschool community programs and subsidise recreational activities to enable social connections beyond social media.
13. Provide education on healthy technology use that fosters safe connections.

Our submission to the inquiry into loneliness and social isolation has further recommendations and context and will be forwarded upon finalisation.

# 8. Fund policies to ensure an equitable, wellbeing-focused response to climate change in the ACT

Following from our submission to the inquiry into climate change and a just transition, we make the following suggestions for expenditure that would improve the ACT's climate mitigation and adaptation strategies:

1. Strengthen our right to a healthy environment.
    a. Penalise breaches of the recognised right to a healthy environment in the ACT.
    b. Pursue healthier environments in urban planning efforts, for example, minimise heat island effects.
2. Enact equitable climate change mitigation strategies.
    a. Consider less regressive policy strategies than electric vehicle and solar panel subsidies, such as improvements to public and social housing, and supports to renters and low-income households.
    b. Investigate the prevalence of insurance stress in the ACT, working on structural ways of reducing insurance premiums.
    c. Increase services and coverage of bus services in the ACT.
3. Centre mental health, vulnerable people, and connected communities in climate change strategies.
    a. Measure the mental health impacts of disasters.
    b. Ensure mental health and community connection is included in future climate change strategies.
    c. Plan inclusive disaster responses.
    d. Undertake efforts to increase community connection.
4. Invest in the capacity of the community mental health sector to survive disaster events and provide necessary supports to the community pertaining to climate.
    a. Ensure that community organisations can survive disaster events.
    b. Build the capacity of the community sector to mobilise and provide much-needed help before/during/after disaster events.
5. Clarify the compensatory rights of volunteer and non-traditional first responders.
    a. Follow the lead of other Australian jurisdictions by providing presumptive compensation in respect of PTSD for volunteer first responders.
    b. Plan for the potential psychological needs of non-traditional first responders in disaster situations.
6. Invest in innovations to strengthen connections to nature.
    a. Scope, pilot, and fund programs that allow people to connect with their local environment.

b. Provide means for funding for mental health programs through Environment and Climate portfolios.

Our submission to the inquiry into climate change and a just transition is attached as an appendix, for reference.

# 9. Scope and develop an innovative peer-led acute alternative mental health service

A considerable gap that exists in the ACT (and Australia more broadly) is innovation in the way acute care is delivered. Acute care follows the model of 'business as usual'. Business-as-usual mental health care is expensive, as discussed above. And it may get more expensive: according to Health Policy Analysis, demand for mental health inpatient services in the ACT is expected to double in the next 20 years if we continue our current approach.

We can take inspiration from models across the world to find new paths forward. One such model is Tupu Ake, from New Zealand. Tupu Ake is a ten-bed acute care program that has been operational for 16 years.

Care is delivered in a house, and provides a welcoming space that encourages recovery and hope. Tupu Ake also offers an additional day program. An evaluation found that Tupu Ake was valued by guests, staff, and the wider mental health sector.

The service measurably reduced guests' distress levels with a 28-day readmission rate of 7% (much lower than the ACT's public psychiatric hospital readmission rate of 18% in 2022-23). Positive outcomes can be delivered in a brief period (the average length of admission is 7 days) because of the skill of peer workers in meaningfully sharing their experiences and using plans and tools that contribute to long-term wellness.

This humanistic alternative to acute hospital care reduces risk of traumatisation, early discharge, and stigma as people are cared for by those who understand what they are going through in a comfortable environment.

We believe that the ACT needs programming with similar vision.

**Mental Health**
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