



Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Senator Seiwert,

For more than 25 years, MIFA and its member organisations have played a leading role in defining and delivering recovery-based services in Australia. We know recovery of a better quality of life is possible. With carers and consumers as our 'grassroots', we advocate strongly and inform policy by highlighting relevant issues and recommending changes to current practices at local, state and national levels with governments, clinical services and individuals.

Within the terms of reference of the Inquiry MIFA would wish to draw the attention of the Standing Committee to several items.

Better Access Initiative

While supporting the changes to the Better Access initiative in general, MIFA and its member organisations are concerned that changes to this program which reduce the number of visits available per annum to an individual with severe and persistent mental illness may impact on the efficacy of longer term treatments such as cognitive behaviour therapy or counselling. We recognise that the great majority of people using Better Access do not fall into this category, but for those that do, which is most of the participants that we assist, short term support is frequently not sufficient.

MIFA members:

- Mental Illness Fellowship of Nth Queensland Inc**
- Mental Illness Fellowship Victoria**
- Mental Illness Fellowship South Australia Inc**
- Mental Illness Fellowship of Western Australia Inc**
- Mental Illness Fellowship of Queensland Inc**
- Schizophrenia Fellowship of New South Wales Inc**
- Mental Health Carers (ARAFMI) NT**
- Association of Relatives and Friends of the Mentally Ill (Tas)**

Access to Allied Psychological Services

Once again we have concerns that some of the changes to this low or no cost program to the individual will impact on those people with the most limited resources.

We propose that the program eligibility criteria should be tightened to ensure that people with severe and persistent mental illness, especially in hard to reach populations such as people from culturally diverse backgrounds, people in rural and remote regions, and people requiring more than a few appointments, are adequately serviced.

MIFA would like the committee to consider that these services could be made more accessible to people with severe mental illness by encouraging contracts with non-government agencies with specialist expertise. Such providers are able to ensure a continuity of care from allied health to community support. They also have ready access to some of the most isolated and vulnerable Australians through other mental health service program delivery, therefore reducing the number and type of organisations required to support a person with severe mental illness.

Services available for people with severe mental illness and the coordination of those services

MIFA fully supports improved coordination of services for people affected by severe and persistent mental illness. We believe that there are several principles to consider.

- Where NGOs are already doing an effective job of entry point assessment and coordination—ie, delivering ‘no wrong door’—they should be resourced to do more. Information services on-line, on the phone and at our front desks, linked to programs like PHaMS, are delivering the coordination of community support and clinical services that the Government correctly understands consumers and carers are asking for.
- ‘Clinical outreach’ has not proven effective in coordinating overall services for people affected by severe and persistent mental illness. In general, specialist mental health NGOs are proving to best placed as the locus of care coordination for consumers and carers, ‘reaching in’ as required to link to clinical services
- Primary medical care, government clinical services and recovery sector NGOs must work together more closely, opening up referral pathways, sharing resources and building mutual trust. Building those linkages at the system level is a major task in itself, which needs to be mandated and resourced, not as an alternative to effective case-by-case coordination, but to support it.

- Until the clinical services—in-patient units, psychiatrists, psychologists, allied health and community mental health clinical teams—are actually operating as a ‘system’, no amount of case-by-case coordination will reliably deliver continuity of clinical care. Clinical care-treatment and management of the mental illness *per se* --may only constitute about 20% of the necessary ingredients in a recovery journey, but it is the vital starting point upon which our work is built. From our perspective, this is the key challenge in mental health for the new Medicare Locals and Local Hospital Networks.

For these reasons, MIFA and its members believe that coordination of mental health services for people affected by severe and persistent mental illness should generally be delivered by community (primarily NGO) service providers with a specific mental health focus. Crucially, they have a workforce that includes many peers, both consumers and carers, and a wide range of services to support a ‘whole of family’ approach. In summary, they are better connected to the health and non-health supports that people affected by mental illness require.

Mental health workforce issues

MIFA would like to take this opportunity to draw the attention of the committee to the exciting developments in the NGO sector based on peer work principles.

Community support programs such as FaHCSIA’s Peer Helpers and Mentors (PHaMS) program, DoHA’s Day to Day Living Program and other programs such as carer education and programs at a state level, rely on a core of peer support workers, where people experiencing recovery or with experience in caring for a person affected by mental illness offer their experience as well as their skill to support others.

Many NGOs have succeeding in recruit new workers with valuable skill sets to support people affected by mental illness, in the process avoiding some of the employment “bottle-necks” experienced in the health profession-based workforce. Peer work is a well recognised and evidence-based service response to the day to day needs of people affected by mental illness.

Disadvantaged Groups

MIFA is most concerned that groups experiencing disadvantage in accessing appropriate mental health services, including the community sector, experience a range of issues not limited to language or location. Successful new initiatives such as cultural brokerage (PHaMS), encompassing specialist one-on-one skills for humanitarian entrants

and other people with significant cultural and language barriers assist individuals and families to find long term solutions as well as providing immediate support. Mental Illness Fellowship SA, a MIFA founding member, has successfully recruited employees from more than 5 countries, speaking more than 8 languages to work with additional cultural brokers from even more diverse backgrounds to ensure services and supports are tailored to individual circumstances.

Like other Australians, MIFA remains concerned about the health and well-being of indigenous Australians. MIFA seeks to be involved in services and supports to indigenous Australians in remote, regional, suburban and urban settings when possible, both in specific indigenous programs, as well as in inclusive local programs and supports. MIFA supports any improvements planned and delivered in conjunction with indigenous Australians in a location and a manner of their choosing.

Physical health of people with mental illness

People affected by severe and persistent mental illness are some of the most disadvantaged Australians by virtue of their mental illness, without the complicating factors of their cultural, language or indigenous status. We would also like to draw the attention of the committee to the poor physical health of people with severe mental illness. For example:

- 31% of people with schizophrenia and coronary heart disease (CHD) are diagnosed under the age of 55, compared with 18% of others with CHD. After five years, and adjusting for age, 22% of people with CHD who have schizophrenia have died, compared with 8% of people with no serious mental health problems.
- 41% of people with schizophrenia and diabetes are diagnosed under the age of 55, compared with 30% of others with diabetes. After five years, 19% of people with diabetes who have schizophrenia have died, compared with 9% of people with no serious mental health problems.
- 21% of people with schizophrenia who have a stroke are under 55, compared with 11% of others who have a stroke. After five years, 28% of people who have had a stroke and who also have schizophrenia have died, compared with 12% of people with no serious mental health problems.
- 23% of people with schizophrenia and respiratory disease are diagnosed before the age of 55, compared with 17% of others with respiratory disease. After five years, 28% of people with respiratory disease or chronic obstructive pulmonary disorder who also have schizophrenia have died, compared with 15% of people with no serious mental health problems.

In 2011, MIFA commissioned a literature review about the physical health of people affected by severe mental illness. The review, attached as an appendix, identifies the shortened life span of people with mental illness, the range of health issues that are responsible for this reduction in life span, and the associated disabilities.

MIFA believes that in the determination of 'disadvantaged' or high risk groups for interventions for many chronic conditions, severe mental illness should automatically be recognised as a likely marker of high risk.

We suggest that the development of specific initiatives that address the physical health of people with mental illness could improve quality of life, open pathways to social inclusion, offer hope to enter education and employment, and extend the healthy lifespan for more people.

An example of this approach is the Tobacco and Mental Illness program funded by Department of Health and Ageing and conducted in five locations across Australia by MIFA member organisations. The foresight of the Tobacco Control Branch to recognise that although smoking rates had decreased considerably across Australia, a significant number of people who continue to smoke were people with a mental illness, led them to adopt a proposal from MIFA for this specifically targeted program. The program, developed in South Australia, and run for several years as a state based initiative, is based on the principles of peer support and education. The key outcomes for this program have been evaluated and the research published widely. Based on the results achieved in SA, the 10-week programs would expect approximately:

- 30% of participants will manage to stop smoking for over 30 days
- 20% of participants will not be smoking at 12 months after completing the program

Of those who continue to smoke, 70% will remain motivated and continue to tackle tobacco and most will have managed to reduce the number of cigarettes smoked each day. Given that most participants will be living with significant disability associated with their mental illness, and that they are smoking on average more than 30 cigarettes per day, these results are highly significant.

Another example of an initiative is the 'New Moves' program developed and piloted by the Schizophrenia Fellowship of NSW, another founding MIFA member. The program is designed in 16 weekly sessions that include physical activity, education and meal preparation and sharing. Each participant in the program participates in a fitness evaluation, health screening, cardiac risk factor identification screening as well as quality of life measures which are repeated at the commencement and completion of the program.

The program evaluation identified its key characteristics and successes, but was not able to find funding to run beyond the pilot phase. Significant, evidence based programs such as this are an essential ingredient to community based, long term support for people affected by severe and persistent mental illness to improve their chances of a long and healthy life like other Australians. MIFA is currently developing a proposal for funding to train peer workers and to extend this valuable, evidence based program to as many locations for as many people as possible.

Conclusion

MIFA seeks to ensure that mental health funding and reform meets the challenge of supporting people experiencing severe and persistent mental illness as well as their families, friends and supporters. Our objective with all our participants and their families is recovery of the best possible quality of life, assisted by well-evaluated programs, developed in consultation with consumers and carers.

Our observations on the Better Access and ATAPs programs, on coordination within clinical services and between clinical and recovery services, on workforce issues and on physical health are all designed to assist the Committee in its review of the recent mental health budget initiatives, so that the best outcome is achieved for the people we work with and for.

David Meldrum
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