



Public Health Association
AUSTRALIA

Supplementary Submission to the Commission's Inquiry into the Role of Improving Mental Health to Support Economic Participation and Enhancing Productivity and Economic Growth

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, commercial, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.



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Introduction

The PHAA made a Submission in April 2019 to the Productivity Commission's inquiry into the role of improving mental health to support economic participation and enhance productivity and economic growth. After reviewing the Commission's Draft Report (October 2019) and consulting with Commission staff, we now offer some supplementary contributions which we hope are useful to the Commission.

Our Key Messages

- The social determinants of mental health should remain a guiding principle in the development of the final Report's recommendations.
- The role and associations of climate change, sleep, and other comorbidities in mental health is an require further attention.
- The final Report should specifically take into account the impact of climate change, and its consequences, on mental health in society, especially in regard to children and young people.

Once in a generation opportunity

A national approach to tackling mental health in Australia is belated, but now very welcome, call-to-arms. The efforts of the Productivity Commission, its stakeholders and the contributors to shape and produce the latest Draft Report is to be commended.

However, as a once in a generation opportunity, we must get it right, and we must hope that the outcome of this inquiry will be influential. The DraftReport covers many subjects, but perhaps one overall comment is that the Final Report should prominently present an overall vision tying the numerous aspects of mental wellbeing together.

Mental health is explicitly connected to the social determinants of health which, with varying complexities, impact individuals in different ways. This framing should become a guiding principle that underpins the Commission's recommendations for this inquiry and others into the future.

The Commission should work to identify and address the effects of poverty, homelessness, encounters with the justice systems, weak senses of community and identity, issues arising from diversity, and employment, working from a holistic approach with the mental wellbeing of individuals at the forefront of thinking.

Additionally, there is a pressing need for measurable, obtainable targets that seek to improve the trajectory and severity of those impacted by mental health, not only as consumers but simply as people. We found this to be a weakness in the Draft Report, particularly in areas of early and timely interventions. Without these, the objectives of the final Report, to promote and protect good mental health for everyone, will fall short of its potential.

One overlooked topic which must be highlighted is the impact of climate change on both the physiological health and the psychological wellbeing of people. As Australia continues to choke under the smoke that blankets our cities and communities, we look to see evidence-based strategies in the final Report that acknowledge the environment as a determinant of mental health and overall wellbeing.

With these issues in mind, we have provided further comments that pertain to our previous submission for consideration below.

Comments on current content of the Draft Report

1 The Draft Report's coverage of the issue of mental wellbeing and the workplace

1.1 LGBTIQ people: a snapshot of mental health and the workplace

Stigma surrounding LGBTIQ and the experience of mental ill-health is discussed at page 815. However, the Draft Report does not cover in any detail issues for LGBTIQ people specifically pertaining to their role in the workplace.

We agree with the proposed recommendations of placing an emphasis on anti-stigmatisation programmes and initiatives and workplace education for promoting mentally healthy workplaces. However, more attention needs to be given to the voice of LGBTIQ people in the workplace. LGBTIQ people make up a growing number of workers. Despite many social advances in recent decades, LGBTIQ people continue to face stigma and discrimination that can ultimately impact their mental health and their abilities to economically participate and contribute to their communities. Recommendations within the final Report should acknowledge this and seek to reorient and strengthen LGBTIQ initiatives and programmes within workplace and employment-seeker settings. We urge the Commission to pay close regard to input from LGBTIQ people about their experiences in the workplace.

1.2 Impact of suicide

The Draft Report identifies the indirect costs of suicide as a measure of lost productivity (e.g. wages) in Chapter 3, and Chapter 21 (p. 847), Box 21.1 (p. 848) and Table 21.1 (p. 849). Key suicide risk factors (including employment and occupation), vulnerable groups and interventions are outlined in Figure 21.7 (p. 852).

However, the Draft Report does not identify specific linkages between workplace initiatives regarding prevention or post-care of suicide.

Regarding suicide prevention and intervention, we believe more information and attention should be placed on initiatives and programmes that are supported within workplaces.

Much of the emphasis in the Draft Report was placed on medical and community approaches, but it is our recommendation that future efforts should aim to create supportive workplace environments that not only reduce workplace stressors and bullying, but provide early intervention networks and return-to-work policies. Similarly, further information should be elucidated on occupations with higher rates of suicides (for example, veterinarians, dentists, and young graduates in new and challenging roles to name only a few) as this may direct core recommendations (such as preventing burnout) and advocacy areas. Specific recommendations and targets that address these is strongly encouraged.

2 The Draft Report's coverage of the issue of access to employment and support within employment for people with low-prevalence mental disorders

2.1 Flexible working conditions and workplace accommodations

The Draft Report encourages employers to provide flexible working arrangements as part of the set of proposed organisational priorities (Box 19.2, p. 743). The issue is also noted as a community level barrier to employment in Figure C.6 (p. 1109), and is discussed in more detail in Section C.3 (p. 1113-4). However, the

Draft Report contains no clear or specific information covering low-prevalence mental disorders on how to manage and approach flexible employment options.

Though we agree with the Draft Report's proposed recommendations, considerable attention is warranted in the final Report to both understand and acknowledge the unique experiences of those with low-prevalence mental disorders, such as schizophrenia, bipolar affective disorders, and psychoses and how this may impact their ability to seek, access and sustain employment.

This is especially pertinent as their experiences may differ significantly to individuals with higher-prevalent mental disorders. For example, flexible working conditions and schedules can be challenging if little is done to appreciate the often episodic nature of these low-prevalence mental disorders.

The right for self-advocacy and self-determination to protect the individuals from being overlooked during job-seeking and maintaining employment should not be ignored. Workplaces and the stakeholders involved should be educated on how to accommodate this, and it is encouraged that further emphasis is placed on recommendations tailored to assisting these individuals.

2.2 Informal carers and their employment

The Draft Report provides a paragraph on informal carers (p. 1138), but does not directly link this to low-prevalence mental disorders. However, the Draft Report does acknowledge that informal carers typically provide care on an unpaid basis (p. 459), and are often caring full-time (p. 463).

An estimated annual replacement cost by the Government (approximately \$15 billion in 2018) does not include the emotional cost or adverse physical impacts on the carer of their caregiving (p. 1138). This is discussed in more detail in Chapter 13.

The Draft Report does not present information on the option for flexible working arrangements of informal carers.

PHAA recognises and supports the proposed recommendations for ensuring the health and wellbeing of informal carers, however, more information on the employment opportunities and options for flexible working conditions for those caring for individuals with low-prevalence mental disorders is encouraged. Informal carers who care for individuals with low-prevalence mental disorders are placed at considerable risk of burnout, fatigue and ill-health and thus often experience their own plight with mental illness. As such, the mental wellbeing and health of informal carers should remain a priority in the final Report, especially as they are often heavily relied upon and overlooked members of the community and existing policy reforms. Input from informal carers who care for these people is strongly recommended.

3 The Draft Report's coverage of the right to employment for people with low-prevalence mental disorders

3.1 Overcoming stigma in the workplace

The Draft Report broadly discusses efforts in anti-stigma interventions, with a mention of destigmatising schizophrenia and other low-prevalence disorders (p. 801), and provides a draft recommendation for a National Stigma Reduction Strategy (short-term [in the next 2 years]) particularly for those with schizophrenia and borderline personality disorders (p. 807). However the Draft Report does not specifically mention the role of the workforce, or workforce access efforts.

We agree with the proposed recommendations, however, further advocacy on the rights, accessibility and support for people with low-prevalence mental disorders under the NDIS should remain an incumbent

priority. As people with low-prevalence mental disorders often struggle to navigate the already complex system, PHAA is keen to see if these proposed changes alleviate the existing burden placed on its users – and, most importantly, get it right. It is hoped that these changes are wholly representative of these people, speak for and on behalf of the people that access it, and provides coordination to successfully achieve their right for employment. Specific targets and recommendations that focus on early intervention efforts, address existing accessibility and coordination concerns, and ensure regular evaluation of effectiveness under the NDIS is strongly recommended.

3.2 Early intervention in health services

The Draft Report proposes a recommendation in the short-term (in the next 2 years) to cease directing PHNs to fund headspace centres including the Youth Early Psychosis Program (Draft Recommendation 24.2 – Regional autonomy over service provider funding, pg. 979), which is counter to the recommendations outlined in our submission. We therefore disagree with this recommendation.

At this point in time, the outcomes of a proposed centralised funding process by the Federal Government is uncertain. Despite the variability, the recent PHN Advisory Panel Review (2018) did provide some positive evidence of the capacity of PHNs to accomplish and implement change within their communities.

An alternative question is whether the Government would be better equipped to strengthen and support service provider funding by PHNs in order to maintain their regional autonomy. Funds allocated to youth headspace centres should therefore be maintained for their intended purposes, particularly adolescent early intervention and mental health programmes.

Suggested additional content for the final Report

4 The role of sleep health in relation to mental wellbeing

We urge the Commission to pay more regard to the role of sleep in mental wellbeing.

Sleep health is a growing domain of health knowledge in Australia, and it has direct implications for mental wellbeing.

Sleep insufficiency/insomnia are strongly linked to productivity/absenteeism, as well as safety in the workplace. Sleep disturbances doubles the risk for the development of mental disorders and that treatment of insomnia in people with various mental disorders reduces the severity of symptoms such as depression, anxiety, PTSD and bipolar affective disorders to name only a few.

At a population level, no wide scale interventions have yet been developed for sleep health. Instead, sleep is routinely left out of so-called ‘lifestyle’ interventions despite being a third of life, thus, there is an overwhelming need for research and policy development in this important area. Delayed school start time to ensure the high-risk group of adolescents have sufficient sleep has been implemented overseas and demonstrated improvements to mental wellbeing, reduced MVA risk, and enriched academic performance. However, Australia generally has later school start times than other countries, and therefore the applicability of such reform may not be as pertinent. Similarly, flexible working hours and conditions for adults are thought to facilitate sleep health, and thereby mental wellbeing.

The key current issues in this field are the lack of national data on sleep and the need for public health departments to monitor sleep indicators as part of prevention efforts.

Acknowledgement of international guidelines around sleep duration may be helpful.

The main limitations around delivering more behavioural sleep interventions relate to the workforce capacity of psychologists/sleep physicians. There are efforts to develop and trial brief sleep interventions that can be delivered by GPs and pharmacists.

5 The role of complementary medicine in relation to mental health and wellbeing

An important omission in the report is reference to the role of complementary medicine (CM) in mental health and wellbeing.

How and why people use CM for their mental health is an important consideration as there are potential risks associated with its use. There are also potential benefits for mental health consumers that are not currently considered in mental health care. Here we define CM as treatments (e.g., herbal medicines, vitamin and mineral supplements) and practices (e.g., yoga and meditation) not considered part of mainstream health care. Similarly, most CM practitioners (e.g., naturopaths, Western herbalists, massage therapists) are not regulated professions and generally not considered part of the health care system.

Despite this, there is high use of CM within the Australian population, including for the treatment of mental health and management of mental wellbeing. Many Australian adults self-prescribe CMs for their mental health and wellbeing¹. This is a concern as there are direct and indirect risks associated with CM use (J. J. L. Wardle & Adams, 2014) such as herb-drug interactions, delayed or incorrect diagnosis of mental health symptoms and disorders, and potentially ineffective treatment². People using CMs frequently consult non-professional information sources such as the Internet and family and friends¹; consequently, they may not be receiving accurate information about the efficacy, dose, or safety of the CMs they are using. In addition, mental health consumers may be adding an additional unnecessary expense to their mental health care.

People report using CM for their mental health as they are dissatisfied with the medical encounter¹. This can result from barriers to engaging in shared decision-making with health practitioners due to a perceived lack of support, or fear of judgment related to a person's choice to use CM. This is a serious concern as it may further alienate people from conventional mental health care, putting them at risk of not receiving the most appropriate treatment³.

Most CM practitioners providing mental health care are unregulated. Traditional Chinese medicine practitioners, osteopaths and chiropractors are the only CM practitioners regulated by federal law in Australia and registered with the Australian Health Practitioner Regulation Agency (AHPRA). The remaining CM professions are self-regulated, generally operating outside conventional health care.⁴ This situation continues despite continued lobbying from the Western herbal medicine and naturopathy professions, supported by recommendations from key stakeholders outside these professions, for regulation to ensure minimum education standards, and to protect the public⁴⁻⁶. Given that naturopaths and Western herbalists are playing an active role in mental health care, it is important that these professions are regulated and preferably integrated into the health care system.

There is a lack of evidence for CM treatments for mental health. While a number of CM treatments are supported by high-level evidence for the treatment of various mental health disorders (e.g. St. John's Wort and yoga for mild to moderate depression^{7,8}; herbal medicines and yoga for some anxiety disorders^{9,10}, and herbal medicines for attention deficit disorder¹¹), the majority of treatments do not have a robust evidence-base. There is research continuing in this area; however, more efficacy and effectiveness studies are urgently needed.

Australian population studies are needed to determine the prevalence of CM use for mental health and wellbeing specifically, and to understand consumer decision-making.

6 The impacts of climate change on mental wellbeing

The events of the current summer highlight the importance of government policy taking into account the impacts of climate change.

Perhaps the major recent study of this topic has been the work of the MJA-Lancet Countdown project. Their most recent study (2019) noted that:

“The Countdown on health and climate change was established in 2017 and produced its first Australian national assessment in 2018. It examined 41 indicators across five broad domains: climate change impacts, exposures and vulnerability; adaptation, planning and resilience for health; mitigation actions and health co-benefits; economics and finance; and public and political engagement. It found that, overall, Australia is vulnerable to the impacts of climate change on health, and that policy inaction in this regard threatens Australian lives.”¹²

Drought, bushfire emergencies, and related air quality events have all added massively to the anxieties experienced by Australians, and related acute mental health trauma. The scale of these climate-related events is far beyond what might be regarded as a ‘normal’ extent of situational harms to mental wellbeing. The funding, resources and workforce needed to assist people suffering during these times are far more than are ‘normally’ available. Identifying community-level resources to assist in responding to mental harm and illness will require fresh thinking.

Extreme weather events mean that the demand for mental health service will outweigh ability to deliver. Services need to be equipped to deal with escalation in the frequency and severity of weather events.

7 The specific impact of climate change and environmental crises on children

The recent/current bushfires have had a devastating impact on the physical and mental wellbeing of millions of people in communities across Australia. Environmental destruction on a massive forms part of this impact. We are especially concerned about the impact on children.

Children and young people may respond to the bushfires in different ways; however, it is important to consider their heightened vulnerability. Children can feel particularly disempowered because they are rarely involved or consulted during important decision-making processes and they don’t have the same level of agency or opportunity as other members in the community. Being the passive recipients of these decisions limits their sense of agency, often resulting in feelings of helplessness and fear.¹³

In light of the bushfires we would like to emphasise the importance of empowering children to develop the skills in which they can advocate for themselves and their peers. This can ensure that they feel their voice is heard and their actions are valued. Children and young people need opportunities to be involved in political debate so they feel engaged and have a positive role in shaping society’s future (see the Mission Australia Youth Survey Report 2019, CEO note at page 2).¹⁴

The impact of climate change on children’s mental health and wellbeing is also addressed in a 2011 ARACY report and literature review.¹⁵

The Draft Report’s section on children and schools could also look at supporting children in their psychological adaptation to climate change. Although there is a lack of evidence about effective interventions, the New Zealand government has in recent weeks announced that they would provide teachers with educational resources to teach children about climate change and what they can do about it.

Conclusions

The PHAA appreciates the opportunity to make this submission and the opportunity to participate in this important inquiry. We re-affirm our intention to work constructively with the Commission during the further stages of this inquiry.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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