

5 April 2019

**Mental Health inquiry**  
Productivity Commission  
GPO Box 1428  
Canberra City ACT 2601

Via email: [mental.health@pc.gov.au](mailto:mental.health@pc.gov.au)

Dear Sir/Madam,

**Productivity Commission Inquiry into Mental Health**  
**Submission by: Professor Allan Fels AO**

*Note: the views expressed in this submission are personal and not those of any organisation I am involved with.*

This submission is in two parts.

In the first part I set out some views on matters specific to the inquiry. In the second part I provide three speeches I have made to the National Press Club in my then role as Chair of the National Mental Health Commission.

**PART ONE**

**Benefits of Inquiry**

There are several potential benefits from this inquiry:

- Recognition of the economic benefits of an improved mental health system. This will mean that political leaders, central agencies and economic departments, the community and media will give higher priority to investing in and improving the mental health system. At present, mental health policy is a low priority of governments.
- A whole of person, whole of life, whole of government perspective on mental health. Most policy making on mental health has been driven by a health-centric approach. A health-centric approach insufficiently considers non-health factors which can contribute substantially to better mental health.
- The application of economics to mental health policy.

**APPLICATION OF ECONOMICS TO MENTAL HEALTH**

The inquiry provides an opportunity to ask standard economic questions about mental health. Economists are especially concerned with such matters as proper, efficient resource allocation, the role of incentives, the role of markets, choice and competition, and the link between inputs, outputs, outcomes and productivity. These factors tend to

be underexplored and overlooked in many analyses of mental health policy.

Some economic questions concern:

- Resource misallocation. One of many examples is that there is insufficient allocation of resources to prevention and to early intervention compared to treatment.
- There is insufficient allocation of resources to the 'missing middle'. Considerable resources are devoted to the primary system of mental health e.g. spending on GPs and psychologist and on medicine. At the tertiary end there is high spending on acute illness and on hospitals. There tends to be a serious gap in the middle. This is undesirable in itself, but also there are major cost savings if the middle keeps people out of hospitals and treats them at a lower cost and with the benefits (including therapeutic benefits) of being in the community.
- Inappropriate incentives. There is for example geographic maldistribution of the mental health workforce. This stems from the nature of the Medicare payment system. GPs, psychiatrists, psychologists and others receive a provider number and can choose to locate their practice wherever they like. They tend to congregate heavily in better off urban areas. There are major inadequacies in the mental health workforce supply in poorer areas of big cities and in rural and remote Australia.
- The underlying fee for service model seems to be very unsuitable for many aspects of mental illness especially regarding prevention and early intervention.
- Access to private psychiatry and possibly private psychology is limited in various respects. My understanding is that most private psychiatry does not bulk bill but adds a significant "top up" which denies access to potential low or medium income clients who are trapped in the middle.
- Questions of the role of incentives in mental health are complex. For example, there has been much talk of having Activity Based Funding (ABF) applicable to mental health hospital models. Whilst there is a good case for activity based funding for many medical procedures with predictable average costs, the unpredictability and variability of mental health costs make an ABF system highly problematic for mental illness.
- Economic analysis takes a system wide approach. It is likely to pick up sharply on the numerous inequities in the mental health system whether horizontal (people with the same needs receive different levels of treatment); vertical (people who are better off receive more treatment than people who are less well off); and geographic (different treatment for people in different areas).
- There is probably also some age maldistribution inequity – support for mental health at various stages of life can be highly variable.

## Hazards of an economic based inquiry

Whilst I applaud the decision to hold an economics based inquiry, it is important that some of the hazards are recognized: an undue emphasis on economic costs and benefits especially in the narrowest monetary sense when there are major social “costs” and benefits that need to be considered and that are an important part of the public value equation applicable to mental health.

Likewise, there can be an undue emphasis on achieving ‘easy gains’ by focusing on the end of the spectrum where the problems are fewest. In this regard it is worth noting that in a number of areas of social policy e.g. the provision of employment services – reforms have been established which have had the effect of diverting incentives, markets and efforts to dealing with problems that are less substantial and easy to fix at the expense of dealing with deeper, long-term underlying problems. Whilst the emphasis on participation benefits from improved mental health in this inquiry is welcome, and deserves the attention they are receiving. These are not the only economic benefits available from better mental health. They are very considerable economic benefits available from a better handling of the serious complex needs end of the spectrum as it is in this area that expenses per head are the highest, and as reform could reduce those expenses heavily.

Moreover, any emphasis on short-term productivity can distract attention from such fundamental investments such as in prison reform or better accommodation that could yield economic and social benefit but that don’t translate quickly into a surge in workforce participation or productivity.

Finally on this point, the core objectives of health policy differ from the objectives that are often pursued by government intervention in markets characterized by market failure. In areas e.g. competition law, the government intervenes because of failures to achieve the optimal outcomes that would occur if there was competition in an informed and flexible market. In other words, the aim is to get as close as possible to the results that would be achieved in ideal market conditions. In health policy, however, this is not the aim. The aim includes the provision of equal opportunity – or something approaching that – for all citizens in their health treatment. This typically heavily modifies any approach based on seeking to achieve an outcome that as far as possible aims to replicate a market outcome. This point is clear with a paper done by myself and Dr Darryl Biggar of the ACCC for the OECD. This paper is attached to this submission.

## Productivity Commission priorities

I have some doubts about the choice of priorities on Page 5 of the discussion paper. It looks strange to hold an inquiry into mental health and not to make some priority of the area where the problems are greatest and the impact on quality of life is so severe. In addition, an important distinctive feature of the PC inquiry is, as mentioned above, that it can address whole of life problems and whole of government problems that go beyond those normally dealt with by health sector inquiries. These challenges are greatest in the area of dealing with severe and complex needs.

Moreover, the Productivity Commission over the years has strongly emphasized the importance of dealing with disadvantaged groups. Persons with severe and persistent

mental illness make up a significant element of the disadvantaged community and for this reason require close attention. Whilst the Commission has done good work on persistent disadvantage, it would be useful if it could look as deeply as possible into severe mental illness as part of this.

### **Accommodation is needed for persons with mental illness**

Persons with serious persistent mental illness need suitable stable accommodation. I believe every person, but especially every person with a mental illness, has a right to stable accommodation.

Without stable accommodation, medical treatment of persons with mental illness will not work. A person who leaves hospital and cannot find suitable accommodation is virtually certain to have a relapse.

Typically without satisfactory accommodation, persons with serious mental illness are especially vulnerable – to social, physical, financial, sexual and other forms of abuse. Self-harm is another form of vulnerability.

Suitable accommodation in the community also makes more space available in hospitals. Commissioner King in a speech mentioned the case of a patient whom the Productivity Commission had met – the person was well enough to leave hospital but suitable accommodation could not be found for that person and she had to be kept in the hospital, depriving others of a bed.

There is a very important need for accommodation that meets the needs of people coming out of hospital. Those needs may include a need for accommodation, care and support.

This kind of accommodation saves money because it helps to avert relapse.

It also means that other people who would be heading to hospital can have their needs met in a less expensive environment in the community.

Also, good accommodation keeps people out of prisons. Prisons have become a source of accommodation for a certain part of the population.

### **Homelessness**

The target population for housing policy is not just the 'homeless'. Discussion is often related to the plight of persons who are 'homeless' or 'roofless'. The needs here are important but the problems of accommodation for persons with mental illness cover a wider population. Many people with serious mental illness live in unstable, unsuitable, uncomfortable, crowded accommodation. They can be subjected to bullying and other unpleasantness and may have limited opportunities for truly independent living. Living on the edge in this manner is not conducive to recovery. The prison population also needs to be looked at.

## **Policy neglect**

Despite the importance of accommodation, the issue of housing policy for persons with mental illness has been the subject of much neglect and low priority in practice. There are a number of reasons for this including:

- Commonwealth/State disagreement over who is responsible for housing and over who will fund it.
- The high cost of providing housing.
- The ‘medical treatment’ model which deemphasizes housing.
- Mental Health policy has been mainly made in mental health departments and housing may not be such a high priority in the minds of health decision makers. Moreover those decision makers have little influence on other departments responsible for housing.

It is notable that the National Disability Insurance Scheme makes no provision whatsoever for funding accommodation needs for persons with serious mental illness. This is an unacceptable discrimination and policy needs to change.

## **Housing First**

The ‘Housing First’ model which originated in New York City provides a valuable service. It has been especially important in emphasising that there are limitations on a ‘medical’ method of treating mental illness. As indicated above, if a person is well treated by medicine, for example in a hospital, but on leaving hospital has nowhere suitable to go, the treatment will not work.

The Housing First philosophy has placed great importance on the role of accommodation. In some cases it seems to believe that providing accommodation is a sufficient approach to meeting needs. In fact, the provision of housing must be accompanied by the provision of appropriate care and support. Whilst Housing First approach may sometimes provide a pathway to eventually getting necessary support, from a policy perspective, however, the provision of housing needs to be linked with the provision of care and support. This is one of the many lessons from the Canadian National Mental Health Commission Study of Housing First models.

## **Housing models**

The housing needs of persons with severe, persistent mental illness vary from one case to another.

The accommodation of each individual (or sometimes a couple or family) can vary. For example, I know of a case where a person with severe mental illness needs special accommodation because she is prone to very loud shouting at different times of the day or night and amongst her needs is a sound proof bedroom.

Notwithstanding such variations, the provision of a basic apartment meets the needs of

numerous persons.

Although I have not studied the subject closely, it is my impression that Housing Commissions around Australia have adopted a somewhat inappropriate model for the provision of housing to persons with serious mental illness.

First, an apartment is often provided. The person is left on their own. There is no accompanying model of care and support. There is a significant risk of self-harm. Residents can also be very vulnerable to exploitation of the kinds referred to above.

Another model is to establish small communal homes of say five or six people who share a small house. Each has a room but there is shared cooking, cleaning, and bathroom facilities. This is also often an unsuitable environment for people with serious mental health problems.

I see much merit, as part of the mix, in the development of a model which provides accommodation, care and support for small groups of persons (say fifteen) with serious, persistent mental illness.

The residents can combine independent living with community interaction. That is each resident (whose rights are governed by the Residential Tenancies Act) would have a self-contained apartment. They are responsible for their own cooking, cleaning etc. even if they need tutoring, guidance and help. At the same time there is an opportunity to take part in communal activities. There is a professional mental health service provider.

The model ideally provides 24/7 staff attendance. An overnight presence may be needed as problems with mental illness strike at any time of day or night.

A typical funding model would be:

- Land. Funded by the NGO.
- Building. Funded by Commonwealth or State Government.
- Staff and other operating costs NDIS.
- Living costs of residents. Disability Support Pension.
- Costs of maintenance and upkeep of property. Twenty five percent of DSP.

## PART TWO

### National Mental Health Commission

When I was Chair of the National Mental Health Commission, I gave three speeches to the National Press Club which set out my views and those of the NMHC at that time.

They relate specifically to:

- The concept of a contributing life – which points to the need for a person-centred approach to mental health.
- An overview of mental health programs and services.
- Physical and mental health

I attach them as part of my submission