

**Submission in response to the Productivity
Commission Inquiry into mental health**

APRIL 2019

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Executive summary

Many inquiries have been conducted into mental health with minimal impact on either the mental health of Australians or the fragmented suite of services sometimes referred to as “the mental health system”. Yet Mental Health Australia welcomes this Productivity Commission Inquiry into mental health with hope. This Inquiry is unique because of its focus on the impact of mental health on our economy, our productivity, and our economic and social participation.

If the existing mix of mental health governance, finance, services and programs were working effectively, Australians would not be experiencing the levels of social exclusion, distress, illness, lost productivity and premature death that are so prevalent today.

If this Inquiry is successful, it will only be because it establishes a new mix of mental health governance, finance, services and programs.

If this Inquiry is successful, in ten years Australians will be able to celebrate how it fundamentally changed Australia’s mental health.

If this Inquiry is successful, it will recommend radical systemic reform but it will also be mindful of institutional stability.

If this Inquiry is successful, it will articulate both a vision for improved mental health and a change management process to ensure that vision is realised.

To demonstrate the success of this Inquiry, Australia will be able to measure a significant increase in mental health, in social and economic participation, in the nation’s productivity, and in increased access to mental health services.

This transformation will be achieved by:

- increasing the overall suite of mental health and related support services with embedded consumer and carer co-design to address anticipated need for all Australians, no matter where they live
- improving the social determinants of mental health, especially for the most vulnerable groups in our community
- rebalancing the mental health system to improve team based, community mental health service delivery
- establishing governance, funding and administrative structures that support an integrated, accessible, and sustainable mental health system
- making all governments and services accountable by ensuring key targets are developed and implemented as part of transparent sector reporting.



This submission provides recommendations to the Productivity Commission about how to target its investigations throughout the Inquiry.

Australia's mental health system has been shaped by our legacy health financing arrangements and as a result investment has focussed primarily on a narrow biomedical model. Most people seeking assistance for mental health issues visit their general practitioner for help and/or present to emergency departments. There is very limited access to community based mental health services. A world class mental health system would balance clinical and social care and support.¹

Demand for mental health services and programs currently outstrips supply at almost every level of care. Australia must expand all mental health services to match need and must shift the balance of the mental health service system toward team based, community based mental health support.

It is equally important this Inquiry recommends strategies to improve the living conditions of people across the life stages in order to increase population mental health, and to reduce risk of those mental health issues associated with social inequalities.² To achieve this the Productivity Commission will need to consider both the type and mix of services needed and also the intergovernmental governance and finance arrangements required to support the optimal mix of services and programs.

To support reform, the Productivity Commission should also detail the priority and sequencing and funding of its recommendations, and the manner in which they should be implemented. Failure to address transitional arrangements and change management has been a failing of previous inquiries.

For more than a decade, mental health services have been subject to unprecedented uncertainty. Mental Health Australia urges the Productivity Commission to make recommendations that acknowledge and build on the strengths of existing services and system structures, while also recommending a planned and orderly transition to new arrangements.

Most importantly, the Productivity Commission will need to listen to the voices of mental health consumers and carers. Through lived experience expertise the Productivity Commission will be able to better understand the current barriers to realising mental health and begin to envisage solutions that will make a real impact. Mental Health Australia has already assisted the Commission to engage with our consumer and carer networks and other members, and will continue to do so.

In addition to this submission, and in collaboration with KPMG, Mental Health Australia has provided the Productivity Commission with a technical briefing about Mental Health Australia and KPMG's *Investing to Save* Report (cited in the Productivity Commission's Issues Paper) and will provide a targeted global evidence review of innovative and best practice service delivery models, and recommendations for improved governance and finance

¹ United Nations Human Rights Council (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standards of physical and mental health*. p6

² World Health Organization and Calouste Gulbenkian Foundation (2014) *Social determinants of mental health*. Geneva, World Health Organization



arrangements. Through this work with KPMG Mental Health Australia looks forward to assisting the Productivity Commission throughout this Inquiry into mental health.

Recommendations

Mental Health Services Planning

Recommendation 1: Using the National Mental Health Service Planning Framework, Mental Health Atlases and Primary Health Networks needs assessments, the Productivity Commission should fully model and cost Australia's preferred mental health system, and identify where current support programs and services fall short of meeting anticipated need.

Preventing people from becoming unwell

Recommendation 2: The Productivity Commission should recommend the development and implementation of initiatives to improve the social determinants of mental health, with a particular focus on Aboriginal and Torres Strait Islander people.

Recommendation 3: The Productivity Commission should make recommendations to ensure the mental health system is safe and accessible and meets the needs of vulnerable and high risk populations including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, people with co-morbidities and dual disabilities and LGBTIQ+ populations.

Recommendation 4: The Productivity Commission should recommend implementation of an 'any door' system, to remove the barriers to accessing treatment and support for people with co-morbidities and dual disabilities.

Recommendation 5: The Productivity Commission should recommend new investment in evidence based promotion, prevention and early intervention initiatives, and the expansion of initiatives that are working.

Recommendation 6: The Productivity Commission should make recommendations to ensure successful digital technology and interventions are scaled up within an integrated framework to supplement and (where appropriate) replace traditional face to face services.

Recommendation 7: The Productivity Commission should recommend appropriate mechanisms to ensure trauma, and particularly childhood trauma, is adequately addressed through all mental health services.

Recommendation 8: The benefits of expanding investment in family based interventions are well documented and should be identified as part of the Productivity Commission's recommendations.

Supporting the mental health of people with mild and moderate mental illness

Recommendation 9: Through consultation and co-design, the Productivity Commission should identify urgent reforms to address system access barriers, reduce assessment and treatment waiting times and costs for consumers and their carers and families.

Recommendation 10: The Productivity Commission should identify a suite of service offerings to match the needs of people with a moderate mental illness and their carers and families through consultation and co-design with consumers, carers, community mental health organisations, mental health professional organisations and clinical experts.

Recommendation 11: The Productivity Commission should draw upon the expertise of the Mentally Healthy Workplace Alliance to identify the levers governments can use to fully capitalise on the wave of interest from business and industry in mental health in the workplace



and optimise the potential return on investment.

Treatment and support for people experiencing severe mental illness

Recommendation 12: The Productivity Commission should make recommendations about investment in team based community based service options that provide integrated support to avoid the hospitalisation of people with serious mental illness.

Recommendation 13: The Productivity Commission should make recommendations about the implementation of programs to prevent people with serious mental illness becoming involved with the justice system.

Recommendation 14: The Productivity Commission should make recommendations which ensure the provision of appropriate mental health services to those who are incarcerated.

Recommendation 15: The Productivity Commission should identify the level of need for integrated psychosocial support services and recommend their urgent expansion.

Recommendation 16: The Productivity Commission should recommend expanding investment in assertive outreach for suicide prevention.

Recommendation 17: The Productivity Commission should recommend expanding individual supports for people with severe mental illness to gain and maintain employment.

Embedded consumer and carer co-design and engagement

Recommendation 18: The experience and expertise of mental health consumers and carers should be harnessed by the Productivity Commission to inform the development of appropriate mechanisms to permanently embed arrangements for ongoing and active co-design in all areas of policy and oversight, development of models of care, service and program reform, and evaluation.

Recommendation 19: The Productivity Commission should recommend appropriate mechanisms to permanently embed arrangements for ongoing and active co-design with consumers and carers in all areas of policy and oversight, development of models of care, service and program reform, and evaluation.

Unpaid care – supporting a fragile system

Recommendation 20: The Productivity Commission should recommend appropriate levels of support for the Integrated Carer Support Service Model to meet the needs of mental health carers both in assisting with the sustainability of the caring role and in re-entering the workforce where this is possible.

Intergovernmental arrangements

Recommendation 21: The Productivity Commission should recommend improved intergovernmental arrangements to best facilitate the cross-portfolio, cross-jurisdictional input to and accountability for a unified mental health and social care system.

Data and reporting

Recommendation 22: The Productivity Commission should develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity



and economic growth.

Recommendation 23: The Productivity Commission should recommend processes and structures are established to ensure that the Primary Mental Health Care Minimum Data Set and the Multi-Agency Data Integration Project can enable the measurement of mental health outcomes across the social determinants of health.

Recommendation 24: The Productivity Commission should consult consumers and carers on whether the Your Experience of Service survey and its reach is meeting their expectations about data collection in relation to consumer and carer experiences.

Research and evaluation

Recommendation 25: The Productivity Commission should make recommendations to ensure:

- a) there is strong engagement of mental health consumers and carers in mental health research and support for research undertaken by mental health consumers and carers
- b) mental health research priorities are set by mental health consumers, carers, providers and other relevant stakeholders
- c) mental health research is governed by appropriate oversight and coordination mechanisms
- d) there are clear pathways to translate mental health research into policy, program design and practice and to take successful and promising programs to scale nationally
- e) there is appropriate resourcing for independent evaluation of community mental health initiatives including but not limited to the effectiveness of mental health consumer and carer peer work.

Workforce

Recommendation 26: The Productivity Commission should investigate the impact of the National Disability Insurance Scheme and Primary Health Network reforms on the mental health workforce, including casualization, de-skilling and loss of recovery focussed support, making recommendations to support existing workforce and develop future workforce, including mental health consumer and carer peer workers.

Recommendation 27: Once the Productivity Commission has articulated a vision for the mental health system (for example through a process similar to that outlined in Recommendation 1) the Productivity Commission should articulate an accompanying mental health workforce strategy to achieve that vision.

Individual and systemic advocacy

Recommendation 28: The Productivity Commission should recommend support for appropriate individual and systemic independent advocacy as key components of a thriving mental health system.



Introduction

This Productivity Commission Inquiry is a once in a generation opportunity. There is a clear economic and social case for incremental mental health reform, and a very large majority of the Australian population supports mental health reform. The case for integrating social and mental health policies and services into a unified system that supports mental health and wellbeing is not only morally and socially compelling, it is economically fundamental.³

The impact of mental illness on economic and social participation, productivity and the economy is well documented and costed, with much of this work being done by the National Mental Health Commission in its 2014 *National Review of Mental Health Programmes and Services* ('the National Mental Health Commission Review').⁴ The Organisation for Economic Cooperation and Development (OECD) estimated the direct medical and nonmedical costs of poor mental health in Australia to be \$28.6 billion per year, which doubles if the indirect costs of productivity loss or sickness absence is added.⁵ In addition, people with mental health issues bear a higher burden of physical health conditions, many with serious consequences.

*"Persons who accessed mental health-related treatments accounted for 49.4 per cent (75,858 deaths) of all deaths in the period [10 August 2011 to 27 September 2012]. The standardised death rate for persons who accessed mental health-related treatments in 2011 was almost twice (1.9 times) that of the standardised death rate for the total Australian population (11.4 deaths per 1,000 population compared with 6.1 deaths per 1,000 population respectively)."*⁶

As recognised by the Productivity Commission's Issues Paper, Mental Health Australia and KPMG have already gone some way to identifying evidence based interventions across the social determinants, with proven and significant economic and social gains for individuals and governments in the *Investing to Save* report.⁷

This submission provides preliminary advice to the Productivity Commission about how to target its Inquiry both in relation to the suite and mix of mental health services needed, and the structures which underpin those services and enable integration across the social

³ Jennifer Westacott (2013) *Grace Groom Oration*, National Press Club

⁴ National Mental Health Commission (2014) *National Review of Mental Health Programmes and Services: Volume 1*

⁵ Organisation for Economic Cooperation and Development (2015) *Mental Health and Work: Australia*

⁶ Australian Bureau of Statistics (2017) 4329.0.00.006 - *Mortality of People Using Mental Health Services and Prescription Medications, Analysis of 2011 data*

⁷ Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*, p10



determinants of mental health. This submission does not aim to provide a comprehensive set of issues related to components of the mental health service system as many member organisations will submit their own perspectives and advice on a range of potential strategies to improve mental health service delivery.

In addition, Mental Health Australia will also:

- progressively inform the Productivity Commission's work with additional detailed papers, member consultations and access to experts during the course of its Inquiry
- outline expectations of the Productivity Commission's final report alongside how Mental Health Australia can assist the Productivity Commission toward this goal.

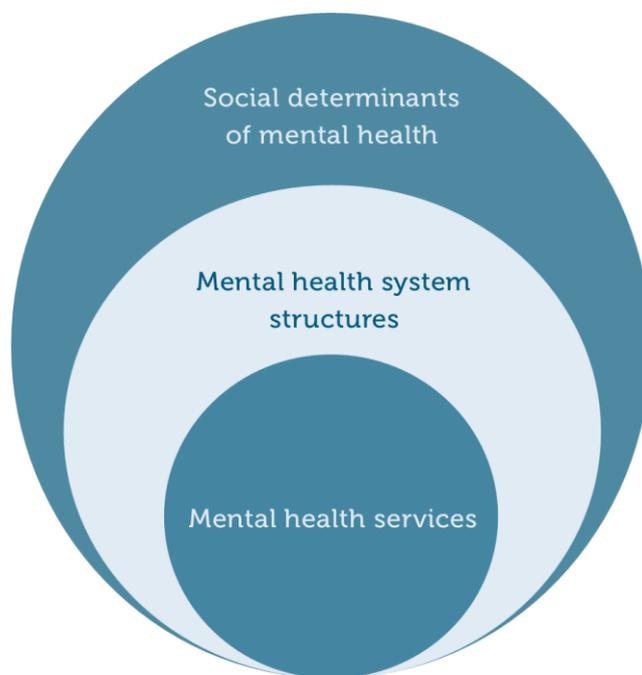


The Productivity Commission's final report

If this Inquiry is successful, in ten years Australians should be able to celebrate how it incrementally but fundamentally changed the landscape of mental health in Australia. It should outline radical systemic reform but also be mindful of institutional stability. Australia should be able to measure a significant increase in mental health, in social and economic participation, in the nation's productivity and in increased access to mental health services.

The terms of reference for this Inquiry recognise responses to mental illness go well beyond individual health to address issues across the social determinants of health. Mental Health Australia anticipates the Productivity Commission's final report should therefore include recommendations to address:

- the suite of mental health services and programs required to address anticipated need
- administrative structures to underpin the above-mentioned suite of services
- an approach to addressing the social determinants of mental health.



Mental Health Australia anticipates the Productivity Commission will identify proven interventions that demonstrate strong returns on investment (across portfolios and jurisdictions) to be scaled up to meet anticipated need, and to optimise return on investment. More challenging for the Productivity Commission, but essential, are recommendations about intergovernmental arrangements that ensure the different parts of all governments work towards a common goal, with clear roles and responsibilities, and budgetary processes that recognise and account for cross-portfolio and cross-jurisdictional responsibilities.

The Productivity Commission should recommend action to increase the social and political appetite for the significant cultural and system change that will be required to scale up investment in the social determinants of mental health for long term benefit. The mental health system has been the subject of many government initiated reviews, some of which have been implemented albeit in ad hoc and piecemeal ways. In formulating its recommendations, the Productivity Commission will need to consider what the catalysts might be to achieve system change toward a vision.

Almost equally as important as instigating this catalyst for change, will be the manner in which the Productivity Commission recommends it is implemented. Mental health services have historically been subject to significant uncertainty, short term investment, and ad hoc decision making. Major reforms such as the implementation of the National Disability Insurance Scheme (NDIS) and the regionalisation of Commonwealth community mental health spending through Primary Health Networks (PHNs) have dramatically destabilised and undermined an already fragile sector.

Mental Health Australia therefore urges the Productivity Commission to make recommendations that acknowledge and build on services and system structures that are working.

This submission makes a range of recommendations about how the Productivity Commission should target its Inquiry activities. Our contribution to the Productivity Commission Inquiry is outlined in the next section of this submission.



Mental Health Australia's contribution to the Productivity Commission Inquiry

Mental Health Australia will facilitate access by the Productivity Commission to Mental Health Australia's:

- Members⁸ and stakeholders, including national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.
- Mental health consumer and carer networks.

Mental Health Australia has already provided a background briefing to the Productivity Commission about Mental Health Australia and KPMG's *Investing to Save* Report, referenced in the Inquiry Issues Paper. In addition Mental Health Australia is working with KPMG to:

- Provide the Productivity Commission with a targeted global evidence review of innovative and best practice service delivery models. This work will draw on both KPMG's global networks and the diverse expertise present across Mental Health Australia's membership.
- Convene experts in intergovernmental relations to consider the governance and financing arrangements that would best facilitate the cross-portfolio, cross-jurisdictional input to, and accountability for, a unified mental health and social care system.

Where others are best placed to provide input to the Inquiry, Mental Health Australia is actively encouraging them to do so. For example, Mental Health Australia has already written to a vast array of peak organisations representing issues across the social determinants of mental health encouraging them to contribute to the Productivity Commission Inquiry.

⁸ See a full list of Mental Health Australia members at Appendix A.



Mental Health Australia members are best placed to provide advice to the Productivity Commission about the efficacy of specific mental health interventions, treatment and supports and have been encouraged to do so through regular communications and Members Policy Forums.



Part one: mental health services

An integral component to the Productivity Commission's final report will be recommendations about the suite of mental health services required to address anticipated need. This section of the submission provides advice to the Productivity Commission about what to consider in making recommendations about mental health services. First it discusses issues that cut across all levels of need, then it considers issues faced by mental health consumers and their families across the levels of severity of illness.

Issues that cut across all levels of need

A world class mental health system would balance the scales between clinical and social care and support.⁹ Promising clinical interventions can fail if a person's psychosocial support needs are not met. Similarly, services delivered outside of health care can be less effective without the right clinical treatment.

Australia's mental health system has been shaped by our legacy health governance and financing arrangements and, as a result, investment has focussed primarily on a biomedical model. Most people seeking support for mental health issues visit their general practitioner for help and/or present to emergency departments. There is very limited access to community based mental health services. Consequently, general practice is experiencing unprecedented presentations for mental health issues. Psychological conditions represent 60 per cent of the reason for patient visits to general practitioners, and are considered as the health issue causing most concern for the future.¹⁰

In 2016-17:

- 3,762,418 people filled a mental health-related prescription written by a general practitioner, compared to 338,739 people filling prescriptions written by psychiatrists¹¹

⁹ United Nations Human Rights Council (2017) *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standards of physical and mental health*, p6

¹⁰ The Royal Australian College of General Practitioners (2017) *Health of the Nation*

¹¹ Australian Institute of Health and Welfare (2018) *Table PBS.3: People receiving Medicare-subsidised mental health-specific services, by provider type, item group of service, states and territories, 2016-17*



- 1,971,131 people received Medicare subsidised mental health-specific services with their general practitioner.¹²

In 2016-17, 276,954 people presented at public hospital emergency departments seeking care for a mental health related condition. Only 39 per cent of those people were admitted to hospital or referred to another hospital for admission,¹³ suggesting the needs of around 60 per cent of people presenting to public hospital emergency departments need to be addressed by other types of services.

The current mental health service system offers general practitioners and emergency departments few options for referring patients to complementary community based mental health services to support the care of people with mental illness.

There is a clear need for Australia to both grow all mental health services to match demand and to rebalance the mental health service system toward community based mental health support in particular.

Mental health services planning

The National Mental Health Service Planning Framework (NMHSPF)¹⁴ was a seminal tool for the mental health system. Developed through a comprehensive process of consultation with the mental health sector, it was once highly regarded. Having invested significantly in its early development, the broader mental health sector has not been involved in its completion or subsequent use. To our knowledge, neither has the framework been subjected to peer review. This creates a dilemma.

With the appointment of Professor Harvey Whiteford as an Associate Commissioner to the Inquiry, the Productivity Commission is well placed to assess the NMHSPF and its potential contribution to planning the mental health system.

Using the NMHSPF, the Productivity Commission may be able to estimate the cost of a mental health system built around historic service models, and identify where current support programs and services fall short of meeting need.

It is equally important to compare this estimate against what is happening on the ground. The Centre for Mental Health Research at the Australian National University is developing a comprehensive set of Mental Health Atlases that identify factors related to variations in care provision, including disparities in service access, care, and gaps.

PHNs have also undertaken regional needs assessments and led local service commissioning of services that can inform the Inquiry in this task.

Recommendation 1: Using the National Mental Health Service Planning Framework, Mental Health Atlases and Primary Health Networks needs assessments, the Productivity Commission should fully model and cost Australia's preferred mental health system, and identify where current support programs and services fall short of meeting anticipated need.

¹² Australian Institute of Health and Welfare (2018) *Table MBS.1: Patients dispensed with PBS/RPBS mental health-related prescriptions, by type of medication prescribed and prescribing medical practitioner, 2005-06 to 2016-17*

¹³ Australian Institute of Health and Welfare (2018) *Table ED.10: Mental health-related emergency department presentations in public hospitals, by episode end status, states and territories, 2016-17*

¹⁴ The National Mental Health Service Planning Framework provides national average benchmarks for optimal mental health service delivery across Australia.



Preventing people from becoming unwell

Social determinants of mental health

The mental health of people is affected by the social, economic, and physical environments in which they live. Many risk factors for mental illness are associated with social inequalities. The Productivity Commission should identify strategies to address the social determinants of mental health. Doing so will improve the living conditions of people across the life stages, and reduce risks of the mental health issues associated with social inequalities.¹⁵

Aboriginal and Torres Strait Islander mental health

These above-mentioned social inequalities have had a profound impact upon the health and mental health of Aboriginal and Torres Strait Islander people.¹⁶ The disproportionate number of Indigenous children who have taken their own lives is a national tragedy. Considerable work has been undertaken to summarise the evidence base for what works in Indigenous community-led suicide prevention, including responses to the social determinants of health that are ‘upstream’ risk factors for suicide.¹⁷ The Productivity Commission should consider these as part of its Inquiry.

LGBTIQ+ mental health

LGBTIQ+ populations are more likely to experience a mental health disorder, attempt suicide and complete suicide than the rest of the population. The National LGBTI Health Alliance states these outcomes are “directly related to experiences of stigma, prejudice, discrimination and abuse...”.¹⁸ There is a clear need to ensure any mental health system recommended by the Productivity Commission is safe and accessible and meets the needs of LGBTIQ+ populations.

Mental health of people from culturally and linguistically diverse backgrounds

The Australian Institute of Health and Welfare (AIHW) reports that immigration can be a source of trauma and refugees have high rates of mental health problems.¹⁹ Recent research found refugees in Melbourne were 3.1 times more likely to have a mental disorder and twice as likely to have post-traumatic stress disorder compared with Australian-born individuals.²⁰

¹⁵ World Health Organization and Calouste Gulbenkian Foundation (2014) *Social determinants of mental health*

¹⁶ Dudgeon P, Milroy H, Walker R, Telethon Institute for Child Health Research/Kulunga Research Network, in collaboration with the University of Western Australia (2014) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*

¹⁷ Dudgeon P, Milroy H, Calma T, Luxford Y, Ring I, Walker R, Cox A, Georgatos G, & Holland C (2016) *Solutions That Work: What The Evidence And Our People Tell Us: Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*

¹⁸ LGBTI National Health Alliance (ND) *the Statistics at a Glance: the Mental Health of Lesbian, Gay, Bisexual, Transgender and Intersex People in Australia*, retrieved from: <https://lgbtihealth.org.au/statistics/>

¹⁹ Australian Institute of Health and Welfare (2018) *Australia's Health 2018*

²⁰ Shawyer F, Enticott J, Block A, Cheng I & Meadows G (2017) *The mental health status of refugees and asylum seekers attending a refugee health clinic including comparisons with a matched sample of Australian-born residents*. BMC Psychiatry



Mental Health Australia, the Federation of Ethnic Communities' Councils of Australia, and the National Ethnic Disability Alliance are preparing a separate joint submission focussing specifically on the needs of Culturally and Linguistically Diverse individuals that will contain recommendations for best practice.

Mental health of people with intellectual disability

The AIHW reports that 57 per cent of people aged under 65 years with intellectual disability also had a psychiatric disability.²¹ Yet the two needs are usually treated in isolation of each other, if at all. The National Mental Health Commission Review reported the mental health needs of a person with intellectual disability can go unrecognised due the limited number of professionals with expertise in this area and a dearth of specialist intellectual disability services and professionals across Australia.

There is potential for the provision of cross-sectoral training and for PHNs and Local Hospital Networks (LHNs) to work to identify local clinicians to increase access to multi-disciplinary team approaches for people with coexisting intellectual disability and mental health needs.

Mental health of people with drug and alcohol comorbidity

The National Institute on Drug Abuse (NIDA) reports that about half of the people who experience a mental illness will also experience a substance use disorder at some point in their lives and vice versa.²² The National Mental Health Commission Review reported that 20 per cent of people with a mental illness use alcohol excessively or have a drug addiction. They also reported that there is a strong service silo approach in response to the needs of people who experience both substance misuse and mental illness.

Barriers to accessing services can arise when entry requirements to services precludes either condition. A mental health service may exclude someone who they believe has an alcohol or drug substance issue and an alcohol and drug service may exclude someone who is deemed to have a mental illness. It can be difficult to separate the two issues. Poor access to drug and alcohol rehabilitation services only exacerbates this problem.

NIDA recommends that treatment for comorbid illnesses should focus on both mental illness and substance use disorders together, rather than one or the other. Yet anecdotal reports indicate that service integration in Australia remains an aspiration rather than a reality with consumers needing to seek support across both service systems.

Mental health promotion, prevention and early intervention

Mental health promotion, prevention and early intervention programs offer the opportunity to prevent mental illness, increase mental health, and reduce the severity of mental illness over a lifetime and therefore reduce personal impacts and significant related costs.

Evidence based investment in promotion, prevention and early intervention activities was recommended by the National Mental Health Commission Review. Mental Health Australia commissioned a report 'Invest now, save later: The economics of

²¹ Australian Institute of Health and Welfare (2008) *Disability in Australia: intellectual disability*. Bulletin no. 67. Cat. no. AUS 110

²² National Institute on Drug Abuse (2018) *Comorbidity: Substance Use Disorders and Other Mental Illnesses*. Retrieved from <https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses>



promotion, prevention and early intervention in mental health' that outlines the economic argument and framework for increased investment in mental health promotion, prevention and early intervention.²³

Cognitive Behavioural Therapy for children

There is good quality evidence for interventions involving Cognitive Behavioural Therapy for children and young people whose parents have a depressive disorder. KPMG estimated the direct healthcare savings from reduced mental illness can cover the cost of the intervention.²⁴

Childhood adversity and trauma

Improving the safety of children and enhancing family safety and relationships can be a key contributor to positive mental health outcomes. In 2015, the Blue Knot Foundation estimated 3.7 million Australians were facing negative life outcomes (including significant mental health impacts) because of child abuse and neglect.²⁵ In addition, an American study estimated childhood adversities were present in 44.6 per cent of all childhood-onset disorders up to 32 per cent of later-onset disorders.²⁶ The costs to governments as a result of the impact of un-addressed or inappropriately addressed childhood adversities and trauma are substantial.²⁷

Research indicates the impact of childhood trauma can be resolved through appropriate treatment, services and support.²⁸ However, the current mental health system does not adequately address complex trauma. Complex trauma often goes unrecognised, misdiagnosed or unaddressed and consumers are required to tell their story multiple times to an array of uncoordinated services. This compounds their experience of trauma.

The Productivity Commission should examine childhood trauma closely, given what we know about the interrelationship between trauma and mental illness, the cost implications and that effective treatment is possible. In its recommendations the Productivity Commission should outline how trauma can adequately be addressed through all mental health services, in line with established guidelines.²⁹

Supporting families to protect child and adolescent mental health

Poor mental health of one family member can affect other family members and family relationship-related issues can impact on all family members' mental health. However, mental health funding arrangements (for example through the services connected to a GP Mental Health Treatment Plan or the NDIS) encourage service providers to focus intervention on the needs of the consumer, not necessarily the family unit. The risks of this approach are profound including:

²³ Urbis (2015) *Invest now, save later The economics of promotion, prevention and early intervention in mental health*

²⁴ Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*

²⁵ Kezelman C, Hossack N, Stavropoulos P (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*

²⁶ Green J, McLaughlin K, Berglund P, Gruber M, Sampson N, Zaslavsky A, Kessler R (2010) *Childhood adversities and adult psychopathology in the National Comorbidity Survey Replication (NCS-R) I: Associations with first onset of DSM-IV disorders*

²⁷ Kezelman C, Hossack N, Stavropoulos P (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*

²⁸ Kezelman C, Hossack N, Stavropoulos P (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*

²⁹ Kezelman C, Stavropoulos P (2012) *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*



- a lack of support for family members who may be supporting a person with mental illness (see section ‘unpaid care – supporting a fragile system’ below)
- a missed opportunity of early intervention to support families before childhood adversity and trauma occurs
- a missed opportunity to build on the significant resources and resilience families have in relation to a family member with mental illness.

The Productivity Commission will need to consider the emerging evidence in relation to family-focussed interventions.³⁰

The role of early learning services and schools

Early learning centres and schools play an important role in the development of a child’s mental health. There are mental health promotion and prevention initiatives targeting schools³¹ however their uptake and implementation is based on subjective decision making by individual schools. The collection and access to reliable data on the effectiveness of these initiatives needs to be made available to school decision makers.

E-mental health

There is strong evidence for e-mental health interventions that deliver components of psychological therapies through teleconference/telephone, video conference and/or internet-based apps without a one-to-one relationship with a clinician. The use of digital technology and interventions within an integrated framework can supplement traditional face to face services adding considerable flexibility and capacity to the mental health sector at a more affordable cost than building the workforce can achieve alone.³² KPMG estimated a return on investment of \$1.60 for every \$1.00 invested in effective e-mental health interventions. However, there is also a recognised need for more oversight and coordination to ensure safety and quality of e-mental health content.³³

Early intervention for psychosis

There is also good evidence to support early intervention in relation to psychosis in the form of community based assertive outreach. KPMG estimated a \$25 million investment in early Cognitive Behavioural Therapy interventions that reached 50,000 children would cover its costs in the short term and deliver long-term benefits of \$230 million.³⁴

Recommendation 2: The Productivity Commission should recommend the development and implementation of initiatives to improve the social determinants of mental health, with a particular focus on Aboriginal and Torres Strait Islander people.

Recommendation 3: The Productivity Commission should make recommendations to ensure the mental health system is safe and accessible and meets the needs of vulnerable and high risk

³⁰ Carr A (2018) *The Effectiveness Of Family Therapy And Systematic Interventions For Child-Focussed Problems*, the Journal of Family Therapy

³¹ Be you, Beyondblue (ND) *Evidence Summary*, retrieved from <https://beyou.edu.au/about-be-you/evidence-base>

³² REACH OUT.com, Ernst &Young (2014) *Crossroads: Rethinking The Australian Mental Health System*

³³ Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*, p68

³⁴ Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*



populations including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, people with co-morbidities and dual disabilities and LGBTIQ+ populations.

Recommendation 4: The Productivity Commission should recommend implementation of an ‘any door’ system, to remove the barriers to accessing treatment and support for people with co-morbidities and dual disabilities.

Recommendation 5: The Productivity Commission should recommend new investment in evidence based promotion, prevention and early intervention initiatives, and the expansion of initiatives that are working.

Recommendation 6: The Productivity Commission should make recommendations to ensure successful digital technology and interventions are scaled up within an integrated framework to supplement and (where appropriate) replace traditional face to face services.

Recommendation 7: The Productivity Commission should recommend appropriate mechanisms to ensure trauma, and particularly childhood trauma, is adequately addressed through all mental health services.

Recommendation 8: The benefits of expanding investment in family based interventions are well documented and should be identified as part of the Productivity Commission’s recommendations.

Supporting the mental health of people experiencing mild and moderate mental illness

Access to primary mental health care services

The National Mental Health Commission Review found there was evidence of low levels of access in the Australian population to timely, appropriate, evidence-based clinical services for mental health problems. The Department of Health found that:

- an estimated fewer than half of people experiencing a common mental health problem access treatment for that problem³⁵
- there is inequitable opportunity to access appropriate support in rural areas and in Indigenous communities. Help-seeking is low among certain populations, including those who are homeless, and young men
- the private sector, funded by either insurance funds, personal funds or through MBS-subsidised items such as psychiatrist and psychologist consultations, plays a significant role in Australia’s mental health provision. Eight out of ten people who received mental health-specific health services received these from the private sector.³⁶

Accessing mental health services is confusing for consumers and can be difficult even for mental health workers to navigate. The emergency department is a prominent access point, however, the majority of people who present to emergency departments will be turned away

³⁵ Department of Health and Ageing (2013) *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011*

³⁶ Department of Health and Ageing (2013) *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011*



as they have limited places, little or no articulation to community based supports, and only deal with the most unwell and usually in an acute phase of mental illness.³⁷

People struggling with a serious mental health problem late at night, and the families who are trying to help them, will find little support when it is needed the most.

Assessments of mental illness are wide-ranging and variable, with consumers having to undergo these at multiple points to access services through different programs or through different service providers. This is a particular issue for accessing mental health assessments for children, as these can require multidisciplinary approaches that increase waiting times and costs for parents and carers. Timely access to these assessments is critical to ensuring appropriate interventions and support at the earliest stages of onset.

General practitioners are the most common access point, with mental health issues being one of the highest reported presentations.³⁸ However the National Mental Health Commission Review raised concerns about the efficacy of general practitioner mental health care plans and, with the introduction of the stepped care model and low intensity services, there is a lack of clarity as to who is best placed to make sometimes complex assessments, and who general practitioners should be referring to and when.

At present, there are no outcome measurements undertaken by primary mental health care providers. While mental health interventions may have a strong research evidence-base there is no similar evidence-base on how individual providers deliver them and the impact they have on a person presenting with a mental illness. There is also good evidence that shows the use of outcome measurement during treatment improves treatment outcomes.³⁹

Recommendation 9: Through consultation and co-design, the Productivity Commission should identify urgent reforms to address system access barriers, reduce assessment and treatment waiting times and costs for consumers, their carers and families.

The missing middle

There is no government subsidised service available for people with a moderate mental illness that require more support than what is subsidised through Medicare GP Mental Health Treatment Plans, but who are not experiencing symptoms severe enough to warrant hospital admission. This leaves those who are unable to afford, or who have been refused private health insurance because they have a mental illness, without a service that potentially could lead to a costly hospital admission.

Investing in a suite of services to match the need of people with moderate mental illness could elicit significant savings through reduction in costly hospital admissions and reductions in absenteeism or presenteeism in the workplace.

Recommendation 10: The Productivity Commission should identify a suite of service offerings to match the needs of people with a moderate mental illness and their carers and families

³⁷ Australian Institute of Health and Welfare (2019) *Table ED.10: Mental health-related emergency department presentations in public hospitals, by episode end status, states and territories, 2016–17*

³⁸ The Royal Australian College of General Practitioners (2017) *Health of the Nation*

³⁹ Lancet Psychiatry (2001) *Feedback informed treatment versus usual psychological treatment for depression and anxiety: a multisite, open label, cluster randomised controlled trial*



through consultation and co-design with consumers, carers, community mental health organisations, mental health professional organisations and clinical experts.

Mentally healthy workplaces

Mental health issues in the workplace cost the economy \$12.8 billion each year. There are a range of initiatives workplaces can undertake in order to improve mental health in the workplace and which offer significant return on investment.⁴⁰

The Mentally Healthy Workplace Alliance⁴¹ is an established national leadership group on mental health in the workplace. The Alliance is a collaboration of business, the mental health sector, unions, regulators and peaks and continues to engage with and support Australian businesses. It has seen considerable growth in action, including by ASX100 companies, in the past couple of years. The Commonwealth Government also supports the Heads Up initiative, which promotes the benefits of mentally healthy workplaces, engages with business and industry, and provides advice, tools and resources for all employers across all sectors.

Recommendation 11: The Productivity Commission should draw upon the expertise of the Mentally Healthy Workplace Alliance, to identify the levers governments can use to fully capitalise on the wave of interest from business and industry in mental health in the workplace and optimise the potential return on investment.

Treatment and support for people experiencing severe mental illness

Access to services

The National Mental Health Commission Review identified there are an estimated 9,000 premature deaths each year among people with a severe mental illness. The gap in life expectancy for people with psychosis compared to the general population is estimated to be between 14 and 23 years.

People living with a severe and chronic mental illness and their carers face significant social, emotional, physical and financial barriers in accessing treatment and support services. They require access to timely treatment services, physical health care and community support services including psychosocial interventions, the latter of which is discussed more fully below.

When these supports are unavailable or break down they can exacerbate or even become the precursor to a period of illness that requires an emergency response that is expensive, can be distressing for consumers and their families, and may contribute to further disengagement with the system.

For some people these break downs or lack of support can result in them becoming involved in the justice system. The AIHW reports almost half of prison entrants (49 per cent)

⁴⁰ Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*, p24

⁴¹ Information about the Mentally Healthy Workplace Alliance and the Heads Up Campaign can be found on the National Mental Health Commission website: <http://www.mentalhealthcommission.gov.au/our-work/mentally-healthy-workplace-alliance.aspx>



reported being affected by a mental health issue and prescription rates of antipsychotic medicines are nine times higher than in the general community, indicating the prevalence of people with serious mental illness is much higher in Australian prisons than the general community.⁴²

There is emerging evidence co-located models embedding mental health professionals with the police, and additional training, can reduce unnecessary incarceration and the workload of police in preventing people with mental illness being caught up in the justice system.⁴³ Such innovative programs should be considered as part of the Productivity Commission's recommendations.

For many people with severe mental illness emergency departments have become the revolving door of access during periods of illness. This is an area that is already struggling with service demand, with significant numbers of people with mental illness presenting for service being turned away.⁴⁴ Increasing access to alternative community based options that have integrated services to keep people well in the community should be a high priority for the Productivity Commission.

The National Mental Health Commission Review identified *“for people with complex needs, such as a person with severe bipolar disorder, optimal care (based upon greater GP contact, increased support from community mental health teams and continued access to care coordination and psychosocial supports) can yield savings over nine years of \$323,000, with about half of that saving being directly to the states through reduced acute care costs (admissions) and about one-third to the Commonwealth”*.

Recommendation 12: The Productivity Commission should make recommendations about investment in team based community based service options that provide integrated support to avoid the hospitalisation of people with serious mental illness.

Recommendation 13: The Productivity Commission should make recommendations about the implementation of programs to prevent people with serious mental illness becoming involved with the justice system.

Recommendation 14: The Productivity Commission should make recommendations which ensure the provision of appropriate mental health services to those who are incarcerated.

Psychosocial support services

It is estimated that 3.1% of Australians have a severe mental disorder,⁴⁵ equating to 778,000 people.⁴⁶ Around one third of this population have a need for some form of individualised psychosocial support, *“ranging from low intensity or group-based activities delivered through mainstream social services to extensive and individualised disability*

⁴² Australian Institute of Health and Welfare (2015) *The health of Australia's prisoners 2015*. Cat. no. PHE 207. Canberra: AIHW.

⁴³ Henry P, Rajakaruna N, Sellinger Centre for Research in Law, Justice and Social Change (2018) *WA Police Force Mental Health Co-Response Evaluation Report*

⁴⁴ Australian Institute of Health and Welfare (2019) *Table ED.10: Mental health-related emergency department presentations in public hospitals, by episode end status, states and territories, 2016–17*

⁴⁵ Australian Government Department of Health (2015) *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*

⁴⁶ The Australian Bureau of Statistics (*Table 3101.0 – Australian Demographic Statistics, Sep 2018*) reports the Australian population to be 25,101,900. 3.1% of 25,101,900 is 778,000 rounded.



support.⁴⁷ The psychosocial support needs of only some of these people are being met through:

- the NDIS – which is projected to meet the needs of 64,000⁴⁸ people
- for people not eligible for the NDIS, temporarily through:
 - » \$160 million through PHNs (\$80m) and LHNs (\$80m) until June 2021⁴⁹
 - » \$121 million under a 12 month continuation of programs transitioning to NDIS⁵⁰
 - » \$92 million for people currently receiving support under programs that are transitioning to the NDIS, but who are found to be ineligible for NDIS, until June 2022.⁵¹

The architecture of Australia's mental health service system requires a permanent structure to provide psychosocial support services to people with psychosocial disability, as well as a proportion of people with moderate illness who are at risk of developing a disability and who also require some form of social support.

Recommendation 15: The Productivity Commission should identify the level of need for integrated psychosocial support services and recommend their urgent expansion.

Assertive outreach for suicide prevention

Suicide costs the Australian economy more than \$1.7 billion in 2016, with 2,866 lives lost.⁵²

A previous suicide attempt is the most reliable predictor of a subsequent death by suicide. Between 15 to 25 per cent of people who attempt suicide will re-attempt, with the risk being highest during the first three months following discharge from hospital after an attempt. Of these, 5 to 10 per cent will die by suicide. Half of the people discharged from hospital after a suicide attempt do not attend follow-up treatment. Two thirds of people who do attend follow up treatment cease treatment after three months.⁵³

There is a clear need to expand community based assertive outreach services to people who have attempted suicide. These initiatives require substantial new investment, but are also likely to have a dramatic positive short term impact.

KPMG found an investment of \$0.5 billion nationally for such an initiative would quickly achieve savings of \$1 billion.⁵⁴

Recommendation 16: The Productivity Commission should recommend expanding investment in assertive outreach for suicide prevention.

⁴⁷ Australian Government Department of Health (2015) *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services*, p17

⁴⁸ Productivity Commission (2017) *NDIS Costs Study Report*. p31

⁴⁹ Federal Budget 2017-18. Budget Paper No. 2

⁵⁰ Paul Fletcher MP (2019) *Joint Media Release: Morrison Government continues funding to support people with a mental illness to transition to the NDIS*

⁵¹ Federal Budget 2018-19. Budget Paper No. 2

⁵² Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*

⁵³ Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*

⁵⁴ Mental Health Australia and KPMG (2018) *Investing to Save: the Economic Benefits for Australia of Investment in Mental Health Reform*



Employment support

Mental Health Australia and KPMG found high quality evidence for positive outcomes from interventions to assist people with severe mental illness to gain and maintain employment using the Individual Placement Support (IPS) model. This model centres on participant preferences and tailors individual responses based on a person's goals and interests. KPMG estimates "an incremental investment of \$52 million could potentially provide IPS to 10,000 people with severe mental health issues, and return over \$90 million in the first year and \$120 million over two years".⁵⁵

Recommendation 17: The Productivity Commission should recommend expanding individual supports for people with severe mental illness to gain and maintain employment.

⁵⁵ KPMG and Mental Health Australia (2018). *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, p40



Part two: mental health service system enablers

As described in the National Mental Health Commission Review, the system is compromised by “poor planning, coordination and operation between the Commonwealth and states and territories, resulting in duplication, overlaps and gaps in services.”⁵⁶

None of the many previous reports, inquiries, reviews and evaluations of the mental health system have resulted in comprehensive lasting reform. Reforms that have been analysed at length by experts, subjected to public consultation, and recommended by people with significant standing in the community and with governments, have not been implemented.

This lack of reform suggests the intergovernmental governance and finance arrangements are not robust enough to overcome a lack of will, action, nor accountability to the Australian people, by all levels of government. To improve mental health outcomes in the long term, all levels of government need to agree on, and commit to, how they are going to work towards a unified goal. This includes the many structural features and system enablers which underpin a sustainable mental health sector, the key parts of which are outlined below.

Embedded consumer and carer co-design and engagement

Mental health consumers and carers have the right to participate in, actively contribute to, and influence the development of government policies and programs that affect their lives.⁵⁷ Genuine engagement results in greater consumer and carer empowerment and ownership of mental health programs.^{58,59}

In both the *Fifth National Mental Health and Suicide Prevention Plan: Implementation Plan*, endorsed by the Australian Government, and the NDIS, consumer and carer co-design is identified as a key commitment, and as a critical success factor, however negligible funding has been allocated to achieve it. Properly resourced arrangements for consumer and carer co-design are a key enabler to improving mental health outcomes and ultimately productivity of all Australians.

Previous work by Mental Health Australia and the Consumer Reference Group to establish a national mental health consumer peak was extensive and engaged a diverse range of people with lived experience and other sector stakeholders. The project developed governance and operational documents to support the establishment of a future

⁵⁶ National Mental Health Commission (2014) *National Review of Mental Health Programmes and Services: Volume 1*, p40

⁵⁷ Adapted from National Consumer and Carer Forum (2004) *Consumer and Carer Participation Policy: a framework for the mental health sector*

⁵⁸ Slay J, Stephens, L, (2013) *Co-production in mental health: A literature review*

⁵⁹ World Health Organization (2010) *User empowerment in mental health – a statement by the WHO Regional Office for Europe*



independent and sustainable mental health consumer peak organisation.⁶⁰ This work stands ready for implementation and would be a useful resource for the Productivity Commission when considering appropriate mechanisms to support consumer and carer engagement and co-design.

Recommendation 18: The experience and expertise of mental health consumers and carers should be harnessed by the Productivity Commission to inform the development of appropriate mechanisms to permanently embed arrangements for ongoing and active co-design in all areas of policy and oversight, development of models of care, service and program reform, and evaluation.

Recommendation 19: The Productivity Commission should recommend appropriate mechanisms to permanently embed arrangements for ongoing and active co-design with consumers and carers in all areas of policy and oversight, development of models of care, service and program reform, and evaluation.

Unpaid care – supporting a fragile system

The Productivity Commission's original report into Disability Care and Support (which instigated the NDIS) recommended greater assistance for unpaid carers.⁶¹ The report mounts a compelling economic argument as to the benefits of support which enables carers to participate in paid work.

Mind Australia estimated the cost of replacing informal mental health carers with a paid support workforce is \$13.2 billion per annum, indicating the considerable contribution mental health carers already make in supporting the mental health system.⁶² Mental Health Australia holds grave concerns for the future of a fragile mental health system propped up by an informal caring workforce which is ageing and for which appropriate supports have been severely disrupted and/or removed through implementation of the NDIS. In the absence of appropriate support services many families become the system of last resort, which can place enormous social, emotional and financial pressures on those least able to bear it.

Recommendation 20: The Productivity Commission should recommend appropriate levels of support for the Integrated Carer Support Service Model to meet the needs of mental health carers both in assisting with the sustainability of the caring role and in re-entering the workforce where this is possible.

⁶⁰ Resources developed through the National Mental Health Consumer Organisation Establishment Project are available at: <https://mhaustralia.org/https%3A//mhaustralia.org/national-mental-health-consumer-organisation-nmhco-establishment-project-completed-may-2015/project-resources>

⁶¹ Productivity Commission (2011) *Disability Care and Support*, p331.

⁶² Diminic S, Hielscher E, Lee Y, Harris M, Schess J, Kealton J, & Whiteford H, (2016) *The economic value of informal mental health caring in Australia: technical report*, pxiii.



Intergovernmental arrangements

Governance

The Organisation for Economic Cooperation and Development has identified Australia's governance arrangements are hindering efforts to overcome the economic and social impacts of mental health.

“The fragmented nature of policy initiatives and the lack of continuity in government funding hinder the country's ability to improve labour market and social outcomes among workers who suffer from mental ill-health. A more structured approach is required to: make employment issues a concern of the health care services; help young people succeed in their future working lives; make the workplace a safe, supportive psychosocial environment; and better design and target employment services for jobseekers with mental ill-health.”⁶³

Here are two examples to demonstrate the shortcomings of the current intergovernmental arrangements and a bias for inaction by governments.

First, despite the *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) setting out the various governments' roles and responsibilities, and the mechanisms for governments working together, the Council of Australian Governments (COAG) Health Council communique dated 8 March 2019 illustrates the apparent difficulty governments have addressing particular problems with any specificity:

“Mental Health Services

States and territories expressed concerns about access to necessary primary care mental health services. States, territories and the Commonwealth will work constructively so that access to primary mental health services is improved particularly for consumers outside the NDIS.”

What is interesting about this communique is the Fifth Plan actually bestows responsibility for implementing integrated planning and service delivery on PHNs and LHNs,⁶⁴ something that successive governments have failed to achieve. The example warrants examination by the Productivity Commission to uncover why the COAG intergovernmental arrangements, supported by the Fifth Plan have failed to secure access to an appropriate level of primary mental health care services (assuming governments know what the appropriate level of service is they had hoped to achieve).

The second example illustrates a failure of governments to follow through on an agreed course of action. In December 2012, COAG asked the National Mental Health Commission to chair an Expert Reference Group (ERG) to assist the COAG Working Group on National Mental Health Reform to develop targets and indicators for mental health by providing advice on a set of ambitious and achievable national, whole-of-life, outcome-based

⁶³ Organisation for Economic Cooperation and Development (2016) *Mental Health and Work. Australia*, p13

⁶⁴ Council of Australian Governments Health Council (2017) *The Fifth National Mental Health and Suicide Prevention Plan*, p21



indicators and targets for mental health that will drive systemic change. After extensive consultation the ERG provided its advice to COAG on 25 September 2013.

Subsequently, the National Mental Health Commission Review recommended eight mental health and suicide prevention targets as the key priorities to pursue over the next decade, and for the Commonwealth to lead a process to develop and/or confirm appropriate indicators and measures to support the eight targets. There was substantial overlap between the ERG's advice to COAG and the National Mental Health Commission's subsequent recommendations.

Targets and indicators for Australia's mental health system have long been a very high priority for the broader mental health sector and stakeholders. In 2013 and 2016, dozens of organisations wrote jointly to First Ministers reminding them of their 2012 commitments. While the Fifth Plan contains the indicators recommended by the National Mental Health Commission, the absence of targets demonstrates that COAG has reneged on the commitment made in 2012.

Intergovernmental arrangements must compel a bias for action on mental health, otherwise Australia's mental health system will continue to flounder. The Productivity Commission must find a way to overcome the fact that responsibility for mental health and psychosocial disability is split across governments and across portfolios. The Productivity Commission must also find a way for accounting for cross-portfolio and cross-jurisdictional savings that will occur by integrating mental health and social care services.

The Productivity Commission will no doubt draw on its recent review of the National Disability Agreement. It may wish to explore the merits of a national mental health agreement that is modelled on the National Indigenous Reform Agreement (which focusses on people and operates across service areas, such as health, education, skills and housing).

Financial arrangements

Mental health services are funded through multiple funding streams:

- primary mental health care is delivered by general practitioners and funded by consumers who receive Medicare rebates for a percentage of the cost and must pay the rest of the fee themselves
- community based mental health care is provided by medical and allied health professionals and funded by:
 - » consumers who receive Medicare rebates for a percentage of the cost
 - » private health insurers' contributions.
- hospital based mental health services are funded through:
 - » activity and block grants from federal and state governments
 - » private health insurers' contributions
 - » consumer contributions.
- community based psychosocial support is most often provided by community mental health organisations and funded through:



- » individualised fee-for-service funding provided through NDIS.
- » short-term grants provided by PHNs, LHNs and some Commonwealth programs (noting all Commonwealth and some state programs will expire as a result of transition to NDIS)
- » philanthropic donations.

These funding arrangements encourage a predominantly biomedical approach to mental health service delivery. People with mental health issues can visit their general practitioner for help, access capped psychological assistance from allied health professionals and turn to public hospital emergency departments in times of acute crisis. But these same people tend only to access support from community mental health organisations once a severe psychosocial disability has developed.

The funding arrangements place community mental health organisations in a uniquely difficult position through requiring organisations to organise their business to accommodate multiple funding models (e.g. both block funding and individualised fee-for-service). In addition, organisational sustainability is undermined through unpredictable and short term contracting, sometimes from multiple sources, increasing unnecessary administrative burden.

Community mental health organisations' funding has been continually subjected to political decision making by successive governments without a long-term vision to stabilise and grow these essential services. In order to remove the politics from community mental health spending the Productivity Commission should investigate permanent funding structures delivered through a clear delineation of payment sources. Decisions about what is funded should be delegated to experts (including consumers and carers) as is the case for other forms of health funding.

As a first step, the Productivity Commission could propose an appropriate mechanism for services delivered by the community mental health sector to be described and costed, by community mental health experts, consumers and carers. This would result in a common list of services and corresponding costs, which governments could agree and draw on in funding community services regardless of the funding mechanism.

Enabling cross-portfolio savings through budget processes

The Productivity Commission's Issues Paper rightly highlights the potential benefits for mental health of investments across the social determinants of health. In many contexts, less expensive, and potentially better fit-for-purpose, non-clinical supports should be preferentially favoured over expensive clinical supports. The mental health system would be well served by reconfiguring current budget processes to better recognise the longer-term and cross-portfolio impacts on mental health as a result of investment in other portfolios, and by other jurisdictions.

For example, prioritising housing for young people with mental health issues delivers substantial cross-portfolio and cross-jurisdictional savings. In 2016-17 there were 42,000



young Australians aged between 15 and 24 who were homeless.⁶⁵ KPMG found that prioritising housing for half of the young people with a mental illness experiencing or at risk of homelessness provides a return of \$9.30 for every \$1.00 invested. For an investment of \$0.5 billion, the course of a young peoples lives can be changed with a saving of \$4.8 billion in the long term.

While the investment in housing is largely made by state and territory governments, and is not administered at the Commonwealth level, the greatest savings are realised by the Commonwealth. Decisions around housing must therefore be considered in the context of broad agreed national targets, with systems that are cohesive and unified. The Productivity Commission therefore should recommend the establishment of Commonwealth and State Budget processes to identify and account for cross-portfolio and cross-jurisdictional return on investment.

Recommendation 21: The Productivity Commission should recommend improved intergovernmental arrangements to best facilitate the cross-portfolio, cross-jurisdictional input to and accountability for a unified mental health and social care system.

Data and reporting

National mental health targets

Significant investment and effort has already been made to develop a set of ambitious and achievable national, whole-of-life, outcome based indicators and targets for mental health that drive systemic change. The National Mental Health Commission convened an Expert Reference Group on Mental Health Reform, chaired by Professor Allan Fels AO. This group presented its final report, National Targets and Indicators for Mental Health Reform, to the Council of Australian Governments Working Group on Mental Health Reform in September 2013. The framework of targets and indicators was informed by extensive consultations with people with lived experience of mental health issues, their families and other supporters, clinicians, researchers, non-government organisations, peak bodies, Ministerial Councils and other key stakeholders. More information about the process to develop targets and subsequent inaction is provided as an example under the above 'Governance' section.

Recommendation 22: The Productivity Commission should develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth.

Data Integration

The National Mental Health Commission, the Productivity Commission and the Grattan Institute have all identified the Australian primary mental health system is not currently able to measure primary mental health outcomes. As such, the Commonwealth is not able to effectively measure the extent to which its investment in primary care reduces hospital costs, or the best allocation of its investment in primary care, let alone the impact of investment across the social determinants of health.

⁶⁵ KPMG and Mental Health Australia (2018) *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, p45



The Australian Government has made two positive steps towards resolving this issue.

- The Primary Mental Health Care Minimum Data Set provides the basis for PHNs and the Commonwealth Department of Health to monitor and report on the quantity and quality of mental health services commissioned by the 31 PHNs.
- The Australian Government's Multi-Agency Data Integration Project is a project among Australian Government departments integrating information on healthcare, education, government payments, personal income tax, and the Census. It is possible this project will enable measurement of cross-portfolio impacts for particular investments, for example the impact of investment in primary care on emergency presentations.

Recommendation 23: The Productivity Commission should recommend processes and structures are established to ensure that the Primary Mental Health Care Minimum Data Set and the Multi-Agency Data Integration Project can enable the measurement of mental health outcomes across the social determinants of health.

Consumer and carer experience data

The Your Experience of Service (YES) survey is designed to gather information from consumers about their experiences of care in public mental health services and variations of the tool are being developed for use by community mental health organisations and PHNs. Two state governments have published early results from their first YES surveys with other jurisdictions planning its implementation. As each jurisdiction rolls out the YES surveys in various forms and begins to publish their results, governments should support all services that interact regularly with people with mental illness regardless of funder type (to undertake and report on the survey).

Recommendation 24: The Productivity Commission should consult consumers and carers on whether the Your Experience of Service survey and its reach is meeting their expectations about data collection in relation to consumer and carer experiences.

Research and evaluation

In its 2015 review, the National Mental Health Commission observed a number of significant problems in relation to mental health research including a lack of clear pathways to translate research into practice, no national prioritisation, oversight or coordination and a lack of systematic involvement of people with lived experience in research.⁶⁶ The National Mental Health Commission stated:

“Our use of evidence is impeded by research priorities predominantly driven by investigators instead of the needs of people with mental illness, service providers and policy-makers. Findings are not consolidated or communicated, meaning examples of success often are not scaled-up or translated into practice.”⁶⁷

⁶⁶ National Mental Health Commission (2014) *The National Review of Mental Health Programmes and Services*

⁶⁷ National Mental Health Commission (2014) *The National Review of Mental Health Programmes and Services*, p15



The *Fifth National Mental Health and Suicide Prevention Plan* recognised these problems, committing governments to “request the National Mental Health Commission to work in collaboration with the National Health and Medical Research Council, consumers and carers, states and territories, research funding bodies and prominent researchers to develop a research strategy to drive better treatment outcomes across the mental health sector.”⁶⁸

However there is little public transparency about the progress of this initiative with the National Mental Health Commission’s progress report on the Fifth Plan simply reporting this action as “on track”.⁶⁹

In addition to the commitment outlined in the Fifth Plan, the Commonwealth Government has also established the Million Minds Mental Health Research Mission, with \$125 million in funding provided over ten years from the Medical Research Future Fund.⁷⁰

Despite these positive steps by government, the issues outlined by the National Mental Health Commission’s review have not yet been resolved. There is a need to improve the structures which underpin and set priorities in mental health research. Mental Health Australia members advise this is particularly relevant for community mental health organisations struggling to afford independent evaluations to prove the effectiveness of their important work.

Recommendation 25: The Productivity Commission should make recommendations to ensure:

- a) there is strong engagement of mental health consumers and carers in mental health research and support for research undertaken by mental health consumers and carers
- b) mental health research priorities are set by mental health consumers, carers, providers and other relevant stakeholders
- c) mental health research is governed by appropriate oversight and coordination mechanisms
- d) there are clear pathways to translate mental health research into policy, program design and practice and to take successful and promising programs to scale nationally
- e) there is appropriate resourcing for independent evaluation of community mental health initiatives including but not limited to the effectiveness of mental health consumer and carer peer work.

Workforce

The Australian mental health workforce is facing rapid change with increasing demand for service provision. Major reforms in the last five years have seen the workforce diminished by greater casualisation, lower qualifications, shorter term contracts and unprecedented uncertainty. The Productivity Commission will need to be mindful that without a careful implementation and transition plan, its own recommendations could further exacerbate this uncertainty, and cause even poorer access to services for the people who most need them.

⁶⁸ Council of Australian Governments Health Council (2017) *The Fifth National Mental Health and Suicide Prevention Plan*, p47

⁶⁹ National Mental Health Commission (2018) *Monitoring Mental Health and Suicide Prevention reform: Fifth National Mental Health and Suicide Prevention Plan*, p38

⁷⁰ Australian Government Department of Health (2018) Million Minds Mental Health Research Mission, retrieved from <https://beta.health.gov.au/initiatives-and-programs/million-minds-mental-health-research-mission>



It is difficult to understand how a systematic approach to workforce development could be undertaken without there being national agreement about what an ideal mental health system might look like, and the scale and nature of the workforce that will be required to service it.

Recent changes include the impact of major new initiatives such as the NDIS, the need for upskilling to provide effective treatments to address the growth in eating disorders, improving suicide prevention responses, support for older Australians in residential aged care, and adaption to new technologies that may assist in increasing access to treatment particularly for people living in rural and remote areas.

At the same time there are new opportunities with the growth in low intensity service provision and in the development of the consumer and carer peer workforce to build the mental health workforce capability.

The mental health workforce has been characterised by the National Mental Health Commission's review of mental health services as being fragmented, with many clinicians working in isolation of each other, and who do not operate at the top of their scope of practice.⁷¹

The introduction of access to psychological interventions via Medicare Benefits Schedule (MBS) funding arrangements has seen a major shift in the growth of mental health clinicians working in private practice where there are limited mechanisms for multidisciplinary and team-based care. While this can be a very effective way of managing mild to moderate mental illness, it can be problematic when a person needs to have more than one clinician involved in their support.

It could be argued the mental health workforce has undertaken massive change via the privatisation of mental health services over the past 10 years where the majority of growth in the number of mental health beds has occurred in the private hospital sector and through expanded access to mental health interventions in primary mental health care via the MBS.^{72,73} At the same time, state-based community mental health services have been downscaled, with consumers increasingly being redirected to NDIS and MBS-funded providers where they incur additional out of pocket costs.⁷⁴ These changes have seen a major shift in the mental health workforce moving out of state-based services and into private practice. As a consequence, there has been a loss of alternate service provision for consumers and of state-based professional training opportunities including exposure to team-based care and multidisciplinary practice for mental health professionals.

In addition, state-based service providers have increasingly employed mental health professionals into generalist roles preventing them from working to their scope of practice and using their specialist skills, as highlighted by the National Mental Health Commission Review.

⁷¹ National Mental Health Commission (2014) *The National Review of Mental Health Programmes and Services*

⁷² Australian Institute of Health and Welfare (2018) *Mental Health Services in Australia*, Table CMHC.2: Community mental health care service contacts, patients and treatment days, states and territories, 2005–06 to 2016–17

⁷³ Australian Institute of Health and Welfare (2018) *Mental Health Services in Australia*, Table FAC.12: Public sector specialised mental health hospital beds, by hospital type and program type, states and territories, 1992–93 to 2015–16

⁷⁴ Australian Institute of Health and Welfare (2018) *Mental Health Services in Australia*, Table MBS.5: People receiving Medicare-subsidised mental health-specific services, by provider type^(a), remoteness area^(b), 2007–08 to 2016–17



There has not been a national mental health workforce planning strategy undertaken since 2012.⁷⁵ This strategy was well received at the time and has many areas that remain relevant although since that time there are now new emerging mental health workforces in development and new technologies that were not part of its considerations.

The NDIS is having a significant impact on the psychosocial workforce which is integral to improving mental health outcomes for people with chronic and complex mental health issues and is the subject of a report⁷⁶ that is worthy of consideration during the Inquiry process.

As part of its Inquiry, the Productivity Commission should consider reinvestment by state and territory governments in community based mental health services and the development of a mental health workforce strategy underpinned by the needs of consumers that better meets their current and future needs are major priorities. This would ideally be over a 10 year period, informed by costings determined by using the National Mental Health Service Planning Framework and compared to what is happening on the ground at present.

Recommendation 26: The Productivity Commission should investigate the impact of the NDIS and Primary Health Network reforms on the mental health workforce, including casualisation and de-skilling and loss of recovery focussed support, making recommendations to support existing workforce and develop future workforce, including mental health consumer and carer peer workers.

Recommendation 27: Once the Productivity Commission has articulated a vision for the mental health system (for example through a process similar to that outlined in Recommendation 1) the Productivity Commission should articulate an accompanying mental health workforce strategy to achieve that vision.

Individual and systemic advocacy

Individual and systemic advocacy are integral enablers for an ideal mental health system. Firstly, personal advocacy has allowed independent and knowledgeable third parties to negotiate better outcomes for individuals seeking to access the service system. These third parties develop expert knowledge of eligibility and service options and assist individuals to make more informed approaches to service agencies. These third parties also frequently play an important role in mediating disputes and in some cases, testing eligibility and access decisions through various forms of appeal.

Secondly, across a wide range of social, disability and community services, governments have deemed it desirable to fund systemic advocacy as reflected in the National Disability Strategy 2010-2020 (the NDS):

“Systemic advocacy seeks to introduce and influence longer term changes to ensure the rights of people with disability are attained and upheld to positively affect the quality of their lives. Systemic advocates can influence positive changes to legislation, policy and

⁷⁵ Miller M, Siggins I, Ferguson M, Fowler G (2011) *National mental health workforce literature review*

⁷⁶ Community Mental Health Australia (2015) *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*



service practices and work towards raising and promoting community awareness and education of disability issues.”⁷⁷

Systemic advocates take the experience of other players in the system (consumers and carers, service providers, researchers and others) and turn this into policy advice aimed at constantly improving the overall service system. This advocacy is often a source of early warning about system failures, and offers governments a very cheap and reliable source of ongoing advice about system performance.

Sometimes this is with advice direct to service agencies, sometimes with advice to consumers directly, and sometimes with advice directly to governments. This advice can target legislative improvement, regulations and agency practice, service provider capacity, and consumer and carer capacity.

Peak bodies, which carry out systemic advocacy, are subject to funding uncertainty created by unpredictable and short term contracts that do not provide enough funding to ensure organisational sustainability. This has resulted in inadequate support for robust systemic advocacy in a period of significant change and upheaval, precisely when such activities are needed most.

It appears that both individual and systemic advocacy are largely missing from the ecosystem imagined by governments. An ideal mental health system includes independent voices that hold governments to account for their commitments and encourages continuous improvement, through systemic advocacy.

Recommendation 28: The Productivity Commission should recommend support for appropriate individual and systemic independent advocacy as key components of a thriving mental health system.

⁷⁷ Council of Australian Governments (2011) *National Disability Strategy*, p17



Conclusion

This submission has highlighted the historic opportunity presented by the Productivity Commission's Inquiry into mental health. The Productivity Commission will need to consider appropriate catalysts to ensure its recommendations for change do not go unheeded, like so many preceding reviews.

Mental Health Australia looks forward to reading the Productivity Commission's final report outlining its recommendations for:

- increasing the overall suite of mental health and related support services with embedded consumer and carer co-design to address anticipated need for all Australians no matter where they live
- improving the social determinants of mental health, especially for the most vulnerable groups in our community
- rebalancing the mental health system to improve team based, community mental health service delivery
- establishing governance, funding and administrative structures that support an integrated, accessible, and sustainable mental health system
- making all governments and services accountable by ensuring key targets are developed and implemented as part of transparent sector reporting.

It is clear chronic underfunding has left mental health services in a position where overall expenditure must grow and the balance between clinical, psychosocial and community mental health must be restored. Significant intergovernmental structural arrangements must be established in order to elicit the catalyst for change required to instil in governments a bias for action, not inaction, across the social determinants of health; and mental health consumer and carer engagement must be tangibly and practically embedded throughout the system.

These are formidable challenges for the Productivity Commission to address but they are not insurmountable. Mental Health Australia is committed to assisting the Productivity Commission throughout the course of this important Inquiry to grasp this opportunity for much needed mental health reform.



Appendix A

2019 Mental Health Australia – Voting Members



2019 Mental Health Australia – Non-Voting Members



Mental Health Australia



Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

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