



Productivity Commission Inquiry into Mental Health Draft Report Submission

January 2020



Mentally healthy people,
Mentally healthy communities

Contents

Executive summary	1
Introduction	6
Principle 1: strike a new national agreement for mental health	7
Principle 2: build a mental health system that is truly person-led	11
Principle 3: address the root causes of mental health issues	14
Principle 4: invest in early intervention and prevention	20
Principle 5: fund Indigenous mental health, wellbeing and suicide prevention according to need	23
Principle 6: provide integrated, comprehensive support services and programs	28
Principle 7: expand community based mental health care	34
Principle 8: support workforce development	39
Principle 9: build an evidence based, accountable and responsive system	44
Conclusion	47
About	48



Executive summary

Mental Health Australia welcomes the Productivity Commission's Inquiry into Mental Health Draft Report ('the Draft Report'). For months, Mental Health Australia has been promoting this Inquiry as a once in a generation opportunity for significant mental health reform. The Draft Report offers a strong foundation to build upon by focussing on fixing what is in place now; however it is not enough to do what we are doing now but better. If it is to seize this opportunity, the Productivity Commission's Inquiry into Mental Health Final Report ('the Final Report') must build on the Draft Report to set out an ambitious vision and agenda for mental health reform, with supporting governance structures to enable effective implementation.

This ambitious vision and agenda must outline a world class mental health system, which balances clinical and social care and support and is led by mental health consumers and carers. In doing so, the Final Report must recommend tangible structures to ensure consumer and carer led design, significant growth of community mental health, and address the social determinants of mental health. It must be strategically aligned with the mental health sector's *Charter 2020: Time to Fix Mental Health* ('*Charter 2020*') and the National Mental Health Commission's *Vision 2030* ('*Vision 2030*').

Using the *Charter 2020* Key Principles as a guide, this submission provides advice to assist the Productivity Commission to build on the strong foundation of its Draft Report to work towards outlining an ambitious agenda for mental health reform. The Productivity Commission has consulted widely, actively listened, and articulated issues well in its Draft Report. Gaps emerge however in the articulation of action to address these issues in the form of concrete recommendations.

In terms of structural reform, the Draft Report rightly calls out the need to clarify governments' roles and responsibilities through the development of a National Mental Health and Suicide Prevention Agreement. However, the processes identified to develop the Agreement do not go far enough to ensure whole-of-government action or genuine consultation and engagement with the mental health sector and an enduring focus on people with lived experience and their carers. Similarly, the Draft Report's acknowledgment of the need for much stronger accountability is also both clear and welcome. Commissioner Dr Stephen King has commented that under a true consumer and carer driven mental health system, the value of a service is determined by consumer and carer experience. In fact, the Draft Report passionately articulates the importance of engaging people with lived experience in service and system design and delivery, but falls short of offering suggestions for tangible infrastructure to meet this goal.

The Draft Report rightly acknowledges that structural reform is also needed to better connect and integrate services and programs, as well as address governance, accountability and funding issues. The Productivity Commission has engaged with this issue through proposing two alternate models ('renovate' or 'rebuild') for structural reform. However, Mental Health Australia believes that limiting the discussion to debating between these two proposed models would be pre-emptive. More importantly, we need to articulate and agree on the end goal of an integrated



system which provides holistic, person-centred care. Reform towards this end goal will require flexibility, as different jurisdictions progress to this from differing current positions.

Clearly, whatever new structural model is chosen to incentivise system integration, it should draw significantly on lessons learnt from recent reforms leading to Primary Health Networks' (PHNs) regional commissioning of mental health services. The Draft Report is currently silent on the opportunities and necessity in the longer term to better integrate mental health reform with work underway in current Royal Commissions into both aged care and the violence, abuse, neglect and exploitation of people with disability. While it is not possible to pre-empt outcomes of either of these Royal Commissions, the Final Report needs to acknowledge comorbidity issues and ensure that any governance structures are able to improve integration between these funding and delivery systems to improve person centred care and broader sustainability.

The Draft Report is admirable in its breadth and acknowledgement on the impact of the social determinants on people with lived experience and their carers. However, it fails to articulate a broader plan to improve social determinants in order to prevent mental illness. Equally, the Draft Report has a keen and critical focus on early intervention and prevention, but this is limited to the early years of life, with little acknowledgement of early intervention and prevention across the life-span.

Mental Health Australia welcomes the Draft Report's emphasis on ensuring Aboriginal and Torres Strait Islander people are at the forefront of making decisions about their own social and emotional wellbeing. There is scope for the Productivity Commission to further bolster its recommendations in its Final Report to better reflect the needs of Aboriginal and Torres Strait Islander people through work with Gayaa Dhuwi (Proud Spirit) Australia to both ensure the principles in the *Gayaa Dhuwi (Proud Spirit) Declaration* are infused into all elements of the mental health system and work towards expanding access to culturally safe, effective mainstream services.

The Final Report should also be stronger in acknowledging the role of societal exclusion and stigma in the disproportionate experience of mental illness amongst LGBTIQ+ communities, people with disability, culturally and linguistically diverse (CALD) communities and other marginalised groups. The Productivity Commission should provide recommendations to ensure: systemic and individual advocacy for under-served groups in the health system; increase the inclusiveness and cultural responsiveness of mental health services; and improve data collection to improve service access for these groups.

The Draft Report acknowledges the major gap in mental health services between primary and acute care, and the impact of this on personal wellbeing and over-reliance on crisis services. However, it falls short from offering implementable recommendations to grow community mental health in order to realise a world class national mental health system that keeps Australians out of hospitals. A discussion about community mental health is also absent in the Draft Report's analysis of the mental health workforce, with the exception of discussion about the peer workforce. The omission of community mental health must be addressed in the Productivity Commission's Final Report.

The recent bushfires have highlighted further the vulnerability of regional and rural communities which will compound the impacts people living in these communities already faced through years of drought. These communities already have poorer access to mental health services. This is a prolonged issue that the Draft Report touches on but now, when these communities are faced with massive multiple environmental disasters, it highlights the ineffectiveness of current mental health workforce planning and the need for contingency strategies to meet future disasters.



In its Final Report, the Productivity Commission should make recommendations which set out an ambitious agenda for mental health reform, which balances clinical and social care and support and is led by mental health consumers and carers. In order to do this the Final Report should include recommendations which:

- 1. strike a new National Agreement for Mental Health and Suicide Prevention**
 - a. identify a process that enables true whole-of-government collaboration on development of the National Mental Health and Suicide Prevention Agreement
 - b. identify a process that enables genuine consultation and engagement with the mental health and suicide prevention sectors and privileges the voices of people with lived experience to inform development of the National Mental Health and Suicide Prevention Agreement
 - c. suggest content and processes that would enable true whole-of-government collaboration on implementation of the National Mental Health and Suicide Prevention Agreement
- 2. build a mental health system that is truly person-led**
 - a. improve infrastructure to support consumer and carer participation and control at the systemic and individual levels, including through use of electronic care management and service feedback platforms
- 3. address the root causes of mental health issues**
 - a. expand recommendations in relation to employment services to encompass other successful models such as the Customised Employment and Discovery Model and Social Enterprise Model
 - b. engage with consumers and carers to improve the process for identifying experience of mental illness in engaging with employment services
 - c. review Disability Employment Services policies and frameworks to support individualised support for people with psychosocial disability
 - d. ensure income support payment rates are set independently and revised regularly to meet reasonable costs of living
 - e. broaden the scope of housing related recommendations to include people who are at risk of developing mental illness
 - f. emphasise a preventative approach in the justice system and increase availability of community mental health services for people in contact with the justice system
 - g. build on the work of the Mentally Healthy Workplace Alliance to increase early intervention and prevention of mental health issues in the workplace
 - h. enhance the impact of the Productivity Commission's proposed stigma-reduction strategy with actions to increase help-seeking amongst culturally and linguistically diverse communities
 - i. address discrimination and exclusion of marginalised populations through equitable funding for representative bodies and actions to increase inclusiveness of mental health services



- j. incorporate holistic responses to trauma across the recommended mental health system
 - k. address disparities in access to physical health care for people living with mental illness
 - l. expand effective initiatives to reduce social isolation
- 4. invest in early intervention and prevention**
- a. increase the links between the education and mental health systems
 - b. meet the need for mental health services for children under 12 years of age
 - c. recognise the context of people experiencing mental illness and the potential role of families in early intervention
 - d. enable early intervention in the experience of mental illness across the life-span, including through expansion of community mental health services
- 5. fund Indigenous mental health, wellbeing and suicide prevention according to need**
- a. ensure Aboriginal and Torres Strait Islander people and their representative leaders in mental health lead all future reform efforts in relevant areas of the mental health system
 - b. develop and implement initiatives to improve the social determinants of mental health, with a particular focus on Aboriginal and Torres Strait Islander people
 - c. provide needs-based funding to Aboriginal and Torres Strait Islander mental health services
 - d. fund expedited implementation of existing frameworks and strategies so as to bolster services and initiatives which are culturally safe and support self-determination of Aboriginal and Torres Strait Islander people
 - e. fund opportunities for Aboriginal and Torres Strait Islander people to engage in the mental health workforce, along with ongoing capability training throughout their career
- 6. provide integrated, comprehensive support services and programs**
- a. recommend structural reform to incentivise integration, that builds on lessons learnt through recent reforms to regional commissioning of mental health services
 - b. better articulate what the ideal future state of integrated and comprehensive mainstream services looks like, identify gaps between this and the current state, and develop a tangible path for reform
 - c. ensure the needs and experiences of consumers and carers, including under-served population groups, drive reform towards an integrated and comprehensive system
- 7. expand community based mental health care**
- a. outline a clear plan for governments to significantly expand successful services across the community mental health sector
 - b. map and expand community based mental health care



8. support workforce development

- a. develop a new definition of community mental health services to include non-specialised service provision
- b. include community mental health workforce as part of the *National Mental Health Workforce Strategy*
- c. revise the *National Mental Health Services Planning Framework* to include community mental health sectors workers
- d. include actions to increase the diversity and cultural responsiveness of the mental health workforce in the *National Mental Health Workforce Strategy*
- e. develop an agreed framework to support interdisciplinary team care, including cross-disciplinary training for the mental health workforce
- f. consider establishing a centre of mental health workforce development to develop and coordinate education, training and service delivery improvement for the mental health workforce including development of contingency plans to ensure workforce capacity to respond to future disasters
- g. ensure incentives to improve mental health workforce geographical spread, to address the maldistribution of mental health professionals

9. build an evidence based, accountable and responsive system

- a. introduce readily accessible consumer and carer driven service feedback and outcomes measurement with the use of digital devices
- b. increase accountability for responding to priority populations including LGBTIQ+ people, through improving data collection
- c. develop a strategic respond plan to increase the capability of the mental health system to support communities responding to disaster and large-scale traumatic events

Only once the above-mentioned issues are addressed will the Productivity Commission have realised this once in a generation opportunity for substantive mental health reform. Mental Health Australia looks forward to continuing to assist the Productivity Commission in this work.



Introduction

The Productivity Commission's Inquiry into Mental Health offers a once in a generation opportunity for mental health reform leading to a world class mental health system. Mental Health Australia welcomes this opportunity to provide a submission on the Productivity Commission's Inquiry into Mental Health Draft Report ('the Draft Report'). This submission provides advice to assist the Productivity Commission to build on the strong foundation of its Draft Report in order to outline an ambitious agenda for mental health reform in the Productivity Commission's Inquiry into Mental Health Final Report ('the Final Report').

In a deep display of unity and support for the Inquiry, in 2019 the mental health sector joined together to create *Charter 2020: Time to Fix Mental Health* ('Charter 2020').

Charter 2020 outlines nine key principles agreed to by more than 120 organisations across the mental health and suicide prevention sectors, which outline what is required for Australia to move towards a world class mental health system. These principles are:

1. strike a new National Agreement for Mental Health
2. build a mental health system that is truly person-led
3. address the root causes of mental health issues
4. invest in early intervention and prevention
5. fund Indigenous mental health, wellbeing and suicide prevention according to need
6. provide integrated, comprehensive support services and programs
7. expand community based mental health care
8. support workforce development
9. build an evidence based, accountable and responsive system

This submission is shaped around these nine key principles as a lens through which to analyse the Draft Report. It is through this same lens that we offer advice to the Productivity Commission about the contents of an optimal Final Report.



Principle 1: strike a new national agreement for mental health

Charter 2020 key messages

An agreement that delivers integration and coordination of mental health services, including agreed objectives, indicators, monitoring arrangements and funding between all levels of government.

Critical to this agreement is:

- improved accountability, coordination and transparency through clarity of governance and funding responsibilities across federal, state and territory governments
- improved data collection to support accountability, effective funding arrangements, and monitoring of outcomes, and
- targeted actions for the most vulnerable populations disproportionately affected by mental health issues.

Overview of the Draft Report

The Productivity Commission's Draft Report has recommended the Council of Australian Governments (COAG) Health Council develop a National Mental Health and Suicide Prevention Agreement ('the Agreement') as a key component to any systemic or structural reform in mental health (Rec 22.1).

This aligns with the first principle of *Charter 2020* and Mental Health Australia's previous recommendations to the Productivity Commission throughout its Inquiry. The Draft Report also rightly recognises the importance of consumer and carer engagement as a critical success factor in developing the Agreement.

The Draft Report proposes the Agreement would exist separately from the National Health Reform Agreement, clarify roles and responsibilities between the Australian Government and states and territories, facilitate the transfer of funds from the Australian Government, and reinforce obligations around monitoring, reporting and evaluation.

It is critical the Agreement recognises the importance of safeguarding the mental health sector from becoming siloed and instead works towards integration and collaboration. Markers of success in outcome reporting should include better integration and collaboration across systems responsible for mental health, physical health and social determinants of health.

The Draft Report also proposed a distinction of responsibilities between the Australian Government and state and territory governments; states and territories would maintain responsibility for hospital and community health services and the Australian Government would maintain responsibility for Medicare Benefits Scheme (MBS) funded services. The Draft Report proposes National Disability Insurance Scheme (NDIS) psychosocial supports remain with the



Australian Government but non-NDIS supports be the sole responsibility of the states and territories.

In addition, the Draft Report has proposed the COAG Health Council develop a new whole-of-government National Mental Health Strategy, which would integrate services and supports delivered in health and non-health sectors and improve population mental health over a generational time frame (Rec 22.2). The COAG Health Council would be encouraged to collaborate with other COAG councils on issues that cut across the social determinants of health, and other COAG councils are encouraged to ensure their agreements and strategies (as relevant to mental health) outline how they contribute to the aims of the new National Mental Health Strategy. Involving the breadth of COAG councils will be critical to the success of the National Mental Health and Suicide Prevention Agreement, due to its likely broader intersection with the education, justice, employment, and income support systems.

Key considerations for the Final Report

Mental Health Australia welcomes the Draft Report's recommendations to develop a Mental Health and Suicide Prevention Agreement alongside a new whole-of-government National Mental Health Strategy. The Productivity Commission has clearly articulated the need stating:

“none of these [the *Fifth National Mental Health and Suicide Prevention Plan*, the *National Health Reform Agreement* and the *National Healthcare Agreement*] provides sufficient clarity or detail to promote system performance, nor to assuage concerns about the ability of governments, jointly or severally, to be held accountable for mental health outcomes” (Vol 2, p890).

In addition, Australian governments have articulated their own commitment agreeing at the COAG August 2019 meeting to make “mental health and suicide prevention a national priority and to work together on this priority drawing on the best experience and learnings across all Australian jurisdictions”.¹ In addition, the COAG Health Council announced in early November 2019:

“Health Ministers have agreed to establish partnerships between the Commonwealth and states and territories to clarify roles, strengthen shared responsibilities and improve the integration of mental health services and other services such as the National Disability Insurance Scheme and drug and alcohol services with physical health services”.²

Minister for Health, the Hon. Greg Hunt MP, categorised these agreements as a “national partnership for an integrated mental health system”.³ It appears the mental health sector, the Productivity Commission, and all Australian governments are committed to the idea of a National Agreement for Mental Health and Suicide Prevention. There are therefore two issues for the Productivity Commission to grapple with in its Final Report:

- What should the proposed National Agreement cover in order to best deliver improved mental health outcomes (and therefore productivity) across Australia?
- What process to develop a National Agreement would most likely arrive at the ideal agreement?

¹ Council of Australian Governments (2019) *Communique* 9 August 2019, p2.

² COAG Health Council (2019) *Communique* 31 October – 1 November 2019, p4.

³ The Hon. Greg Hunt MP (2019) *Transcript - Interview with Chris Kenny (Sky News Australia)* 31 October 2019, p3.



Identify a process that enables true whole-of-government collaboration on development of the National Mental Health and Suicide Prevention Agreement

The Draft Report considers how to ensure a whole-of-government Agreement is developed in practice. Further analysis is required to consider whether the Productivity Commission's proposed means of developing the Agreement would foster whole-of-government collaboration.

The process for developing the National Agreement will in part determine its ability to truly reflect the cross portfolio nature of mental health and its policy levers. The Draft Report proposes the National Agreement be developed by the COAG Health Council; as rightly acknowledged by the Productivity Commission, a key risk of this approach is the development of a health-centric approach to addressing mental health nationally. Such an approach could undermine governments' and therefore providers' ability to invest in addressing the root causes of mental health, which span well beyond the health portfolio (see Principle 3 below).

The process will also need to provide avenues for longer term alignment with outcomes of highly relevant national inquiries including the current Royal Commissions into aged care and violence, abuse, neglect and exploitation of people with disability.

Mental Health Australia suggests that if the COAG Health Council is tasked with developing the Agreement, a whole-of-government, time-limited, cross-jurisdictional taskforce should be established at government official level to support development of the Agreement. In establishing the taskforce, governments must balance health and social care representation, as well as expertise across the wide-ranging social determinants of mental health.

When considering the number of members of the taskforce, careful consideration should be given to balancing the need for broad expertise and ensuring the membership number is not overly cumbersome so as to stifle progress. Given COAG's recent commitment to make mental health and suicide prevention a national priority, it is not unreasonable to expect high level oversight of the development of such an Agreement by first ministers.

Identify a process that enables genuine consultation and engagement with the mental health sector and privileges the voices of people with lived experience to inform development of the National Mental Health and Suicide Prevention Agreement

Mental Health Australia welcomes the Draft Report's focus on consumer and carer engagement as a critical success factor in developing the Agreement. It is imperative the Final Report outlines the Productivity Commission's view on the structural and funding processes required to enable genuine co-design and engagement with consumers and carers (see Principle 2 for more information).

In addition, other key stakeholders in the mental health sector (such as community mental health service providers and health professionals) hold critical information and functional knowledge about the practical implementation of national agreements, including actions which enable or prevent service integration on the ground. The Productivity Commission's Final Report should outline a strategy for engaging with other key stakeholders in the mental health sector (and beyond, where appropriate) to inform development of the Agreement. For example, peak bodies can be crucial partners in designing and implementing national and genuine engagement processes with key sector stakeholders.



Suggest content and processes that would enable true whole-of-government collaboration on implementation of the National Mental Health and Suicide Prevent Agreement

The Final Report should propose content and processes that would enable true whole-of-government collaboration and genuine sector engagement on implementation of the Agreement. Mental Health Australia's third submission to the Productivity Commission Inquiry proposed a National Agreement on Mental Health should be holistic and focussed on the needs of population groups, rather than focussed on a particular service stream. This is also in line with recommendations made by the Productivity Commission in relation to its recent review of the *National Disability Agreement*.⁴ An example of encouraging whole-of-government collaboration through the Agreement could be the inclusion of outcome measures across the social determinants of mental health. This would encourage governments to invest across the social determinants of health and in cross sector collaboration and integration.

The Productivity Commission's Draft Report is decidedly cautious in its description of how the content of the Agreement could encourage whole-of-government collaboration. The Draft Report includes high-level statements about the need for the Agreement to recognise "the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports" (Vol 1, p99). The Final Report should strengthen this statement and be more explicit as to how to support greater cross sector collaboration.

Mental Health Australia also welcomes the Productivity Commission's recognition of the need to formally clarify through the Agreement the roles and responsibilities across governments. However, there may be some unintended consequences to consider in relation to the Draft Report's specific suggestion that in order to clarify roles and responsibilities, sole responsibility for non-NDIS psychosocial services rests with state and territory governments. The Productivity Commission should seek input from key stakeholders and further consider this in addition to providing a rationale.

It is imperative the Agreement achieves better alignment between mental health and other significant health and human services funding streams at the national level, including but not limited to, aged care and disability. Mental health should not be siloed from other mainstream services. The Agreement should incentivise identification of administrative mechanisms and policies that create perverse incentives for programs to operate separately rather than integrate, and identify the impacts of current settings. At a practical level, it should encourage integration of programs to minimise duplicative and complex eligibility assessments and requirements, which are narrow in focus and fail to take a holistic approach.

⁴ Productivity Commission (2019) *Review of the National Disability Agreement, Productivity Commission Study Report*, p170.



Principle 2: build a mental health system that is truly person-led

Charter 2020 key messages

Deliver a system centred on what people with lived experience of mental health issues and their carers say they need, including the structures and processes required to ensure co-design of services and programs.

A mental health system that meets the needs of our diverse communities is one that is co-designed by our communities. Consumer and carer involvement in policy, service design, delivery and governance is essential.

Overview of the Draft Report

The Draft Report clearly intends to place consumers and carers at the centre of any changes to the mental health system, both at the individual level and the structural level. There is strong general alignment between the key messages of *Charter 2020* and solutions proposed in the Draft Report. However, more consideration is required to develop a robust and tangible structure for effectively supporting consumer and carer engagement, particularly in systemic advocacy.

At the structural level, the Draft Report recommends consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives (Rec 22.3). The Draft Report does not examine whether the existing consumer and carer infrastructure is sufficiently robust or if it has the breadth of participation to be reflective of the broader mental health sector in order to effectively inform future changes.

At the individual level, the Draft Report calls for the establishment of new, electronic 'single care plans' for consumers with moderate to severe mental illness (Vol 1, p346) alongside improvements to care coordination (Rec 10.3, 10.4). The intention is to better coordinate care across providers with the consumer at the centre. However, given the single care plans would be managed by the 'primary treating clinician', with GPs often playing this role, careful consideration is required as to how consumers will be leaders in their own care with these reforms.

Key considerations for the Final Report

The Draft Report received some criticism for lacking a clear narrative for reform. This was addressed by Presiding Commissioner Dr Stephen King at the Mental Health Australia Grace Groom Memorial Oration in November 2019. In that speech, Dr King clearly outlined a number of significant shifts the Inquiry offers to the mental health sector. Chief amongst these is Dr King's statement that *unless mental health services are valued by consumers and carers, they have no value*. Mental Health Australia strongly supports this stance.



It is well recognised mental health consumers and carers have the right to participate in, actively contribute to, and influence the development of government policies, programs and services that affect their lives. Genuine engagement results in greater consumer and carer empowerment and ownership of mental health programs.^{5,6}

Improve infrastructure to support consumer and carer participation and control

Properly resourced arrangements for consumer and carer participation, engagement and co-design are key enablers to improving mental health outcomes for all Australians.

At the structural (systemic) level, this means robust infrastructure and mechanisms to support active and diverse consumer and carer participation. The Final Report should make recommendations that will ensure mental health consumers and carers:

- are supported to be actively involved in policy and service design, delivery and governance processes required to ensure co-design of programs at a local, state and national level⁷
- have representatives from diverse communities (e.g. culturally responsive mental health support services and service systems need to be developed in collaboration with Aboriginal and Torres Strait Islander representatives and CALD communities. Services intended to meet the needs of specific communities, such as LGBTIQ+ people, should be designed in consultation with the respective community. In addition, mainstream services and service systems must also ensure there is diverse representation amongst those who are consulted on their design), and
- are supported by executive leadership and sponsorship, mentoring, co-design, paid participation, and mandated requirements reflected in governance bodies and operational standards.

At the individual level, consumers and carers need choice and control of service delivery. This is a significant shift, as the mental health sector has historically been predicated on a culture of compliance and enforcement. This shift will require significant reforms that need to be reflected in the Final Report. Transition to a truly person-centred model could incorporate tools such as supported decision making where this is wanted and needed in shifting power to consumers.⁸

How can government deliver on major person-led reforms when there are no systems in place to measure what consumers and carers value? There is no transparency when it comes to finding public information on the performance of individual or organisational providers of mental health services to inform consumer and carer choice.

⁵ Slay J, Stephens L (2013) *Co-production in mental health: A literature review*.

⁶ World Health Organization (2010) *User empowerment in mental health – a statement by the WHO Regional Office for Europe*.

⁷ Thinking and work related to consumer and carer-led/peak organisations has occurred in other places already, for example see:

European Patients Forum (2017) *The Added Value of Patient Organisations*, https://www.eu-patient.eu/globalassets/library/publications/epf_added_value_report_final.pdf and resources developed through the National Mental Health Consumer Organisation Establishment Project <https://mhaustralia.org/https%3A//mhaustralia.org/national-mental-health-consumer-organisation-nmhco-establishment-project-completed-may-2015/project-resources>.

⁸ Mental Health Australia and ACT Disability, Aged and Carer Advocacy Service DACAS (2019) *Fact Sheet: Supported decision making for potential National Disability Insurance Scheme (NDIS) participants with psychosocial disability*, <https://mhaustralia.org/fact-sheet-supported-decision-making-psychosocial-disability-and-ndis>.



Mental health consumers and carers should have:

- improved choice and control of service provision, including access to packages of care that better support people in the community and upon discharge from hospital if required
- equitable access to services including face to face interventions — this requires significant reduction of out of pocket costs particularly for the most vulnerable
- access to inclusive, culturally responsive mental health services which acknowledge the specific and individual needs of people who belong to marginal communities
- person-centred (not bureaucracy-centred) needs assessments in transitioning between intensities of service supports
- opportunity to use readily accessible electronic platforms to inform outcome measurement, demonstrate value of effectiveness at a service provider level and provide data transparency, and
- control over care plans using electronic platforms (such as the cdmNET Coordinated Care Platform⁹) that provides tools that consumers and carers can utilise.

⁹ Precedence Health Care (2020), *cdmNet Coordinated Care Platform*, <http://cdmnetplatform.com/>.



Principle 3: address the root causes of mental health issues

Charter 2020 key messages

Eliminate stigma and discrimination and address the social and environmental determinants of poor mental health including housing, employment, trauma, physical health and financial security. There is evidence that particular experiences and social circumstances can trigger and/or perpetuate mental health issues, including housing instability and homelessness, trauma, relationship stress, stigma and discrimination (among others).

Holistic, tailored mental health care that tackles the root causes of mental health issues is critical for the mental wellbeing of Australians. The root causes of mental health issues transcend the health sector, and Australia's mental health is the responsibility of all sectors and all levels of government.

Overview of the Draft Report

The Productivity Commission is to be commended for offering draft recommendations across multiple social determinants of mental health including employment services, financial security, housing, justice, experience of stigma, and workplace health and safety.

In the area of employment, the Productivity Commission has focused on improving government-funded employment services to better identify and flexibly support people living with mental health issues. Mental Health Australia supports the recommendations in the Draft Report regarding tailoring of online employment services (Rec 14.2), increasing systematic assessment of whether people are receiving personalised Job Plans (Rec 14.4), and greater flexibility in application of the Targeted Compliance Framework for people living with mental illness (Rec 14.4).

Mental Health Australia also supports the Productivity Commission's draft recommendations to improve access to legal aid services for people appearing before mental health tribunals and ensure non-legal advocacy services are available for all people subject to involuntary treatment under mental health legislation (Rec 16.3, 16.4).

In relation to the justice system, the Productivity Commission recommends a systematic approach should be implemented across all state and territory governments to enable police, health and ambulance services to collectively respond to mental health crisis situations (Rec 16.1). Mental Health Australia strongly supports a collaborative response to mental health crisis situations and notes such models are being trialled and established across multiple jurisdictions in Australia.

Mental Health Australia also supports the Draft Report's recommendation that the National Mental Health Commission should develop and drive a national stigma reduction strategy relying on the leadership and direction of people with lived experience of mental illness (Rec 20.1).



The Draft Report has gaps in relation to fundamental social determinants such as addressing discrimination, trauma and physical health. In addition, the Report focusses on improving the way non-health systems respond to people already experiencing severe psychological distress or mental illness, rather than taking a preventative approach. The Final Report should go beyond this limitation and recommend real investment in prevention of psychological distress through addressing social determinants of mental ill health.

Key considerations for the Final Report

Social determinants of mental health covered by the Draft Report

Employment: expand recommendations in relation to employment services to encompass other successful models

The Draft Report recommends a staged rollout of the Individual Placement and Support model of employment support through trials in conjunction with state and territory community mental health services (Rec 14.3). Mental Health Australia supports the Individual Placement and Support model, with our *Investing to Save Report* noting an incremental investment of \$52 million could potentially return over \$90 million in the first year.¹⁰

In the Productivity Commission's Final Report it will be important that a number of different models of employment support are recommended to be available because, as with any social service, one size does not fit all. Community Mental Health Australia has already pointed out other successful models that the Productivity Commission may wish to consider such as the Customised Employment and Discovery Model and the Social Enterprise Model.¹¹

Employment: consult with consumers and carers to improve employment services assessment tools

The Draft Report recommends the Australian Government review assessment tools for jobactive and Disability Employment Services to be more relevant to people with mental illness (Rec 14.1). The Draft Report states that many people experiencing mental illness do not disclose this during the Job Seeker Classification Index (JSCI) screening so are not appropriately streamed to receive more intensive supports. The Draft Report recommends providing further information to people undertaking the JSCI and including a short diagnostic tool.

Mental Health Australia recommends a review of these assessment tools centre on thorough engagement with consumers and carers to identify the reasons why people experiencing mental illness often do not self-identify during the JSCI process, and to develop appropriate solutions to address this. Mental Health Australia also supports increasing flexibility in enforcement of the Targeted Compliance Framework, particularly for people with complex needs such as mental illness.

¹⁰ Mental Health Australia and KPMG (2018) *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, p40.

¹¹ Community Mental Health Australia (2019) *Submission from Community Mental Health Australia on the Productivity Commission Review of the Economic Benefits of Improving Mental Health*, p12.



Employment: review Disability Employment Services framework to support individualised support for people with psychosocial disability

The Productivity Commission outlines the effectiveness of personalised support in employment services and models, however does not consider enough the impact of the current policy framework in supporting or inhibiting this. The current funding and performance framework arrangements for Disability Employment Services (DES) are not conducive to the individualised support often necessary to successfully support people with psychosocial disability to transition into sustained employment. The shift to outcome-based funding and performance frameworks has reduced providers' ability to provide pre-vocational and ongoing support to jobseekers, particularly necessary for people with psychosocial disability and other complex needs.¹² The Productivity Commission should recommend the DES performance and funding frameworks be reviewed in engagement with mental health consumers and carers.

Income support: recommend that income support payment rates are independently set

Income support is particularly significant in reducing the impacts of mental illness, as there is a strong association between financial insecurity and mental ill health. People who have recently experienced financial hardship are 22% more likely to experience decreased mental health in the next year, and people experiencing severe psychological distress are 89% more likely to experience financial hardship in the next year.¹³ Australians receiving Newstart and other income support payments are more likely to be living with a mental health condition than other Australians.¹⁴ The Productivity Commission's Final Report should recommend an immediate stop-gap increase to the rate of Newstart, and the development of mechanisms to ensure income support payments are set independently and regularly reviewed to meet reasonable costs of living.¹⁵

Housing: broaden the scope of housing related recommendations to include people who are at risk of developing mental illness

The Productivity Commission recommends governments commit to no discharge from institutional or correctional care into homelessness; that governments work towards meeting the need for long-term housing, supported housing and homelessness services for people with mental illness, and consider Housing First policies. Mental Health Australia strongly supports these recommendations. While critical, these recommendations are focused only on people experiencing severe mental illness, which could have the unintended consequence of further excluding people experiencing mild to moderate mental illness. Given the strong association between housing insecurity and mental illness, Mental Health Australia would expect the Final Report to broaden the scope of housing related recommendations to include recommendations for people at risk of developing mental illness.

¹² Community Mental Health Australia (2019) *Submission to the NDIS Participant Employment Taskforce*;

Rebecca Cotton, Worklink (2019) *How People with a Mental Illness in Disability Employment Services are Predisposed to Failure*.

¹³ Trajectories Project, Australian Housing and Urban Research Institute and Mind Australia (2010) *Conference presentation*, AHURI Conference 2019.

¹⁴ Butterworth P, Burgess PM, Whiteford (2011) 'Examining welfare receipt and mental disorders after a decade of reform and prosperity: analysis of the 2007 National Survey of Mental Health and Wellbeing,' *Australia and New Zealand Journal of Psychiatry* 45(1):54-62.

¹⁵ Mental Health Australia (2019) *Submission to the Senate inquiry into the adequacy of Newstart*.



The Productivity Commission has previously found Australia's social housing system is broken, and under extreme pressure due to the lack of secure and affordable private rental accommodation.¹⁶ In light of Australia's current housing crisis, the Productivity Commission should broaden its recommendations to increase access to secure housing to support social and economic participation. From a whole-of-system view, it is critical to increase the supply of medium term housing with associated mental health supports.

Justice: emphasise preventative approaches in the justice system and increase availability of community mental health services

The Productivity Commission makes recommendations to improve access to and the quality of mental health services in correctional facilities and upon release (Rec 16.2, 16.3). Mental Health Australia suggests the Final Report should also recommend increasing access to mental health services for people in correctional facilities alongside investment in community mental health services more broadly (see Principle 7). Preventative and diversionary approaches such as justice reinvestment models and Koori Court¹⁷ should also be considered.

Workplace health and safety: build on the work of the Mentally Healthy Workplace Alliance

The Productivity Commission makes a number of targeted recommendations to elevate psychological health and safety in workplace health and safety legislation, and to increase the coverage of workers compensation for responding to and motivating prevention of psychological injury. However, the Draft Report has too strong a focus on compliance and needs a stronger emphasis on early intervention and prevention in workplace mental health. Mental Health Australia's *Investing to Save* report (in collaboration with KPMG) identified that investment in workplace mental health interventions could save \$4.5bn a year.¹⁸

The Final Report should seek to build on the work of the Mentally Healthy Workplace Alliance (the Alliance), which comprises leading workplace and mental health sector organisations. The Alliance is working with the National Mental Health Commission to deliver a three year funded project to provide guidance and develop resources to support mentally healthy workplaces that have a prevention and early intervention focus.

Reduce stigma: enhance impact of stigma-reduction strategy through actions to increase help-seeking amongst diverse communities

To reduce stigma, the Productivity Commission recommends that the National Mental Health Commission should develop and drive a national stigma reduction strategy focusing on poorly understood mental illnesses, and include programs to reduce stigma perpetuated by health professionals (Rec 20.1). This strategy would rely on the leadership and direction of people with lived experience of mental illness. Mental Health Australia supports this approach to stigma

¹⁶ Productivity Commission (2017) *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*.

¹⁷ For example, Magistrates' Court of Victoria, *Koori Court*, www.mcv.vic.gov.au/about/koori-court; Aboriginal Legal Service NSW/ACT, *What is Youth Koori Court*, www.alsnswact.org.au/koori_court

¹⁸ Mental Health Australia and KPMG (2018) *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*.



reduction targeting these key issues including stigma from health professionals¹⁹, directed by people with lived experience.

In addition to stigma reducing strategies which target whole-of-population, the Productivity Commission should recommend stigma reduction strategies for targeted population-groups, such as CALD communities, LGBTIQ+ communities, Aboriginal and Torres Strait Islander communities and people with disability.

Many individuals who belong to under-served communities experience issues of compounding, or intersecting, stigma which in turn can prevent help-seeking behaviours. For example, despite making up a significant proportion of Australia's population, CALD communities experience both a mental health literacy gap and compounding cultural stigma around mental illness which can prevent help seeking behaviours.²⁰ A targeted, culturally appropriate stigma-reduction initiative developed in collaboration with CALD organisations and individuals with lived experience is critical to reducing stigma experienced by this population group.

Social determinants of mental health not covered by the Draft Report

Address the impacts of discrimination

Social inequalities, stigma and discrimination have a profound impact upon an individual's mental health. Emerging research illustrates that people often experience intersecting and compounding forms of stigma, which influence their mental and physical health.²¹

LGBTIQ+ people are at much greater risk of mental illness and suicide than heteronormative peers,²² but face significant barriers to accessing mental health care.²³ As such, LGBTIQ+ people should be a priority population for reducing mental illness. Discrimination and exclusion are the key causal factors of mental ill health and suicidality for LGBTIQ+ people,²⁴ therefore addressing discrimination is the most substantive prevention technique for reducing LGBTIQ+ peoples' suicide and mental health disparity.

Mental Health Australia supports the specific recommendations of expert organisations to the Productivity Commission as to how to actively increase the inclusiveness of mental health services.²⁵ The Productivity Commission should go further and develop recommendations in its Final Report to reduce discrimination and prejudice against excluded, marginalised and under-served population groups. The Productivity Commission should also recommend ensuring independent, systemic advocacy through equitable funding for health peak bodies, including

¹⁹ Mental Health Council of Australia (2011) *Consumer and Carer Experiences of Stigma from Mental Health and Other Health Professionals*

²⁰ Mental Health Australia, Federation of Ethnic Communities Councils of Australia and National Ethnic Disability Alliance (2019) *Inclusive Mental Health Reform: Highlighting issues and opportunities for Australians from culturally and linguistically diverse backgrounds.*

²¹ Tural et al., (2019) 'Challenges and opportunities in examining and addressing intersectional stigma and health,' *BMC Medicine*, 17:7, <https://doi.org/10.1186/s12916-018-1246-9>.

²² National LGBTI Health Alliance (2016) *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People.*

²³ Waling, A., Lim, G., Dhalla, S., Lyons, A. & Bourne, A. (2019). *Understanding LGBTI+ lives in crisis.*

²⁴ National LGBTI Health Alliance (2019, *Submission on the Productivity Commission Review of the Economic Benefits of Improving Mental Health*, p10.

²⁵ National LGBTI Health Alliance (2019) *Submission on the Productivity Commission Review of the Economic Benefits of Improving Mental Health*; ACON (2019), *Mental Health Inquiry and Sexuality and Gender Diverse People (Submission on the Productivity Commission Review of the Economic Benefits of Improving Mental Health)*; Mental Health Australia, Federation of Ethnic Communities Councils of Australia and National Ethnic Disability Alliance (2019) *Inclusive Mental Health Reform: Highlighting issues and opportunities for Australians from culturally and linguistically diverse backgrounds.*



health peak bodies representing under-served population groups. Systemic advocacy and representation of voices from diverse communities is necessary to shift the culture of discrimination and exclusion across the service system.

Address the impact of trauma

Research indicates the impact of childhood trauma can be resolved through appropriate treatment, services and support.²⁶ 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 costs to governments as a result of the impact of unaddressed or inappropriately addressed childhood adversities and trauma are substantial.²⁷ In its Final Report, the Productivity Commission should outline how trauma can adequately be addressed through all mental health services, in line with established guidelines.²⁸

Address disparities in access to physical health care for people living with mental illness

Four out of every five people living with mental illness have a co-existing physical illness.²⁹ While people living with mental illness often experience poorer physical health, they also receive less and lower quality health care.³⁰ As outlined in the *Equally Well Consensus Statement*, the interactions between physical and mental illness significantly increase preventable health care costs. This interaction impacts quality and longevity of life, and economic and social participation. The *Equally Well Consensus Statement* outlines actions to address disparities in access to physical health care for people living with mental illness. The Productivity Commission's Final Report should incorporate these actions in its recommendations, to build a holistic care system and progress towards equitable access to all health services.

Expand effective initiatives to reduce social isolation

In the Draft Report, the Productivity Commission considers the strong association between social isolation and poor mental health but the recommendations do not adequately reflect this. The Productivity Commission should explore community based models to inform its recommendations in the Final Report. The Final Report should acknowledge the significant work undertaken through these models to address social isolation, particularly through peer work and the community mental health sector, and recommend expansion of effective initiatives.

²⁶ Kezelman C, Hossack N, Stavropoulos P (2015) *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia*.

²⁷ Kezelman et al. (2015) *Ibid*.

²⁸ Kezelman C, Stavropoulos P (2012) *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery*.

²⁹ National Mental Health Commission (2016), *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*, p10.

³⁰ National Mental Health Commission (2016) *Ibid*.



Principle 4: invest in early intervention and prevention

Charter 2020 key messages

Programs and supports that intervene early to prevent people from becoming mentally ill and stop emerging mental illnesses from becoming more severe. Early intervention and prevention is a cost-effective, long-term investment into Australia's mental wealth in 20 years' time. Early intervention should not be limited to the early years of life, but rather should occur across the lifespan. Additionally, awareness campaigns and the promotion of mental health are critical forms of prevention.

Overview of the Draft Report

Mental Health Australia welcomes the Productivity Commission's support for further investment in prevention and early intervention. The Draft Report makes recommendations in several key areas in relation to early intervention across social determinants and health care. Perhaps the most significant recommendation is that a 'Wellbeing Leader' be employed in each school (Rec 17.5). There are also recommendations focusing on mental health services for preschool children and their families (Rec 17.2). The Productivity Commission also recommends Australia move towards universal screening for perinatal mental illness (Rec 17.1).

Reducing stigma and addressing social determinants of mental health are very important components of early intervention and prevention (see Principle 3).

The Productivity Commission also suggests that its recommendations in relation to the 'missing middle' represent a kind of early intervention, in that meeting the need for community services would serve to prevent crisis (see Principle 7).

Key considerations for the Final Report

Early intervention and prevention areas covered in the Draft Report

Education: increase the links between the education and mental health systems

The Productivity Commission's strong focus on education in its Draft Report is predicated on the new expectation of the education system's role in actively supporting students' mental health and wellbeing. However, the Draft Report cites concern with existing school 'wellbeing programs'. The Productivity Commission makes several suggestions, including that each school employ a designated 'Wellbeing Leader'. The role of the Wellbeing Leader will need to be considered further, particularly in relation to connections into the mental health system when specialist assistance is required.



Interaction between health, education and social care is already problematic and teacher workloads are already contentious. The Final Report will need to consider incentivising effective cooperation in managing mental health needs after the school bell.

In the Final Report, the Productivity Commission should also make recommendations for the expansion of the availability of community mental health services for young people in the education system (see Principle 7).

Early intervention and prevention areas not covered in the Draft Report

Meet the need for mental health services for children under 12 years old

While acknowledging that 64% of adults living with mental illness experienced onset of mental health issues before the age of 21, the Productivity Commission does not acknowledge that the same report shows over 25% of people living with mental illness experienced onset before age 12.³¹ However, there is an immense gap in services for children under 12 years old experiencing symptoms of mental illness.

Interventions must be beyond early identification through the education system, and include significant investment in expanding mental health services for this cohort. The Final Report should recommend that significant investment is needed in early childhood and family support.

The Final Report should also recommend greater transparency in data collection and reporting of mental illness experienced by children under 12, to better inform service design to meet the needs of this cohort.

Addressing the impact of trauma

Appropriate services to support recovery from adverse childhood experiences and trauma is fundamental in preventing further and recurring psychological distress and mental illness. This is discussed in Principle 3 above.

Support families

While experience of mental illness and journeys of recovery are felt by family and carers, mental health funding models tend to focus on individual interventions. Early intervention and prevention initiatives must consider a person's context in holistic ways. This means considering the nature and degree of social, informal and family supports someone has. There is emerging evidence in relation to family-focussed interventions, showing the potential value of more holistic support.³²

Mental Health Australia supports the Productivity Commission's draft recommendation to expand screening for perinatal mental illness, and include fathers and partners in this screening. Further recommendations acknowledging the significant role of families and benefits of family-focussed interventions should be made in the Final Report.

³¹ Australian Bureau of Statistics (2008) *National Survey of Mental Health and Wellbeing 2007*, in COAG Health Council (2009), *Fourth National Mental Health Plan*, p16.

³² Carr A (2018) 'The Effectiveness Of Family Therapy And Systematic Interventions For Child-Focussed Problems,' *Journal of Family Therapy*.



Intervene early in the experience of mental illness

As most people who experience mental illness develop symptoms early in life, early intervention and prevention has focused on the younger years. However, early intervention across the lifespan and early intervention during an episode of mental ill health are imperative in preventing negative impacts of mental illness. With fundamental changes to funding models in transition to the NDIS, community mental health services do not have the same capacity as previously to respond quickly to prevent development of mental illness or mental health crises. The Productivity Commission's preferred future funding model must ensure expansion of community mental health services, including low intensity supports to prevent deterioration and support recovery, and to enable services to intervene early in an episode of mental illness (see Principle 7). Early intervention will only be possible where services have appropriate workforce and resources to extend beyond just supporting people experiencing severe crisis.



Principle 5: fund Indigenous mental health, wellbeing and suicide prevention according to need

Charter 2020 key messages

Include dedicated strategic responses which are co-designed and co-implemented with Indigenous leaders, consumers and communities. This should be guided by the *Gayaa Dhuwi (Proud Spirit) Declaration*, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, and the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013*.

- Indigenous leadership is essential to promote the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people and communities. This goes beyond co-design with Indigenous people, and includes funding of Aboriginal organisations to autonomously design, develop and implement services that meet the needs of their people.
- All proposed policy, system and practice changes across the full spectrum of mental health and suicide prevention should be considered in terms of their effect on Aboriginal and Torres Strait Islander people and communities.
- The vastly disproportionate impact of suicide, including amongst children and youth, in Aboriginal communities demonstrates a need for investment in community-led solutions.
- Solutions that promote Indigenous people's connection to culture are essential, alongside culturally safe clinical services.

Overview of the Draft Report

The Productivity Commission's proposed approach to improving Aboriginal and Torres Strait Islander mental health, wellbeing and suicide prevention is underpinned by two strategic proposals:

- Expedite development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Rec 22.2)
- Within the next two years, develop a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated *Implementation Plan* to guide suicide prevention activities in Indigenous communities, with Aboriginal and Torres Strait Islander organisations to be preferred providers under the strategy (Rec 21.2).



In addition, the Productivity Commission notes the importance of consulting with Aboriginal and Torres Strait Islander people or organisations which represent them in relation to evaluation, monitoring and reporting against these strategic plans (see Rec 22.5, 25.4).

In relation to specific services, the Productivity Commission recommends:

- The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people (Rec 20.3)
- Aboriginal and Torres Strait Islander people in correctional facilities should have access to mental health supports and services that are culturally appropriate and designed by Aboriginal and Torres Strait Islander people (Rec 16.4).

In addition, the Productivity Commission notes the importance of tailoring other recommended programs to meet the specific needs of Aboriginal and Torres Strait Islander people. For example, in developing a systematic approach to support police to respond to mental health crisis situations (Rec 16.1), and in strengthening the ability of schools to assist students and deliver an effective social and emotional learning curriculum (Rec 17.3).

Key considerations for the Final Report

Mental Health Australia acknowledges the guidance of the National Aboriginal and Torres Strait Islander Leadership in Mental Health in developing this section of the submission.

Mental Health Australia welcomes the Productivity Commission's emphasis on ensuring Aboriginal and Torres Strait Islander people are at the forefront of making decisions about their own social and emotional wellbeing. While Mental Health Australia supports each of the recommendations in the Draft Report relating to Indigenous mental health, overall the recommendations are not enough to change the status quo. Leadership of reform efforts relating to Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention should be formally and firmly placed in the hands of Aboriginal and Torres Strait Islander peoples. The Productivity Commission needs to further bolster its recommendations in its Final Report to better reflect the Indigenous leadership now operating in the mental health and suicide prevention space.

At the national level, the establishment of Gayaa Dhuwi (Proud Spirit) Australia, a national Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention peak body,³³ provides momentous opportunities for change. In its Final Report the Productivity Commission must recognise and cement the role of this new body, along with organisations such as the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, in *leading* mental health reform and increasing the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. This includes ensuring adequate funding to carry out these duties.

Ensure Aboriginal and Torres Strait Islander people and their representative leaders in mental health lead all future reform efforts in relevant areas of the mental health system

The responsibility to implement both the *Gayaa Dhuwi (Proud Spirit) Declaration* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health*

³³ Minister Hunt (9 Sep 2019) *Media Release: National action on Indigenous mental illness and suicide prevention*



and Social and Emotional Wellbeing 2017-2023 is conferred on all governments in the *Fifth National Mental Health and Suicide Prevention Plan*.

While the Draft Report acknowledges the *Gayaa Dhuwi (Proud Spirit) Declaration*, it should receive greater emphasis in the Final Report, with practical recommendations as to how to infuse the mental health system with the five principles in the *Gayaa Dhuwi Declaration*. This will include implementing a 'best of both worlds' approach to Indigenous mental health, which supports both Indigenous peoples' connection to culture and cultural healing, and access to culturally safe and competent clinical mental health services. Mental Health Australia recommends the Productivity Commission works with, and is guided by, Gayaa Dhuwi (Proud Spirit) Australia to develop these recommendations.³⁴

The Productivity Commission notes in several places in the Draft Report the importance of engaging with Aboriginal and Torres Strait Islander people to best understand how to design and assess services that are culturally safe and meet their needs. However, as discussed above, with the establishment of Gayaa Dhuwi (Proud Spirit) Australia, the Productivity Commission's Final Report should reflect a shift from previously limited and amorphous models of engagement with Aboriginal and Torres Strait Islander people in relation to mental health services, to entrusting *ownership* of design and evaluation processes to Indigenous organisations.

Evaluation processes should be led by Gayaa Dhuwi (Proud Spirit) Australia at the national level and Aboriginal and Torres Strait Islander people and communities. Any evaluation of services' cultural safety must privilege the voices and experiences of Aboriginal and Torres Strait Islander people as service consumers. Any proposed policy, system and practice changes across the full spectrum of mental health and suicide prevention related activity should also be considered in terms of their effect on Aboriginal and Torres Strait Islander people and communities.

Develop and implement initiatives to improve the social determinants of mental health, with a particular focus on Aboriginal and Torres Strait Islander people

Reducing the disparity in mental illness and suicide rates between Aboriginal and Torres Strait Islander and non-Indigenous Australians requires addressing historical determinants of health caused by the colonisation process. This includes acknowledging, and addressing, intergenerational trauma from the Stolen Generations practices and assimilation policies, and the frequent re-traumatisation and situational trauma arising from Indigenous peoples' contemporary experiences of racism, incarceration, family violence and other events. It must comprehensively address social inequality and poverty, which are the result of colonisation practices, and the context for much traumatic exposure.

The Productivity Commission should provide more specific recommendations on how national systems might better address these social determinants of Indigenous mental ill health and suicide. In this context, overarching developments including treaty, constitutional reform and refreshed commitments to the COAG *Closing the Gap Strategy* could be expected to have some positive mental health impacts.

The disproportionate number of Indigenous people (including children and youth) who take their own lives is a national tragedy. As highlighted in the 2019 WA Coroner's Report into the suicide

³⁴ Extensive consultation on implementation of the Gayaa Dhuwi Declaration has been undertaken by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (the precursor body to Gayaa Dhuwi Australia) in 2018-19, and should be considered



deaths of 13 young people in Western Australia, the disproportionately high rate of suicide is directly related to trauma, both intergenerational and situational.³⁵ The Productivity Commission's Final Report should be informed by the work of expert organisations in reducing the experiences and impacts of trauma and suicide in Aboriginal and Torres Strait Islander communities. The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group has been working to develop the outline of a national strategic response to trauma in the Indigenous population, in addition to related responses such as addressing the high Indigenous imprisonment rates through a trauma and mental health lens.

Considerable work has also been undertaken by the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (which continues as the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention), to summarise the evidence base for what works in Indigenous community-led suicide prevention, including responses to trauma and the social determinants of health that are 'upstream' risk factors for suicide.³⁶

Provide needs-based funding to Aboriginal and Torres Strait Islander mental health services

Whatever funding model the Productivity Commission recommends, it must deliver funding equity for Aboriginal and Torres Strait Islander mental health services in line with the level of need.

Longer term funding contracts (five to eight years) and/or rolling funding models should become standard, so that services may better engage in long-term strategic planning which has a multitude of positive effects (see Principle 7 for further discussion).

The Productivity Commission's favoured funding model must support the delivery of place-based Aboriginal and Torres Strait Islander community services.³⁷ Among these, the preferred model remains delivery by, or through, Aboriginal Community Controlled Health Services (ACCHSs). Where such services do not exist, established ACCHSs should be supported to provide extended outreach services to communities where a separate service might not otherwise be viable. Mainstream services could support these efforts by co-locating suitably locally culturally competent staff, including Indigenous staff, to ACCHSs.

Should the Productivity Commission preference a model where PHNs or similar bodies receive funding to distribute to other services in a local area, it is critical that the model ensures funding flows through to ACCHSs in an efficient way. One way to increase efficiency could be to deliver funding directly to ACCHSs, rather than being mediated through an additional, non-Indigenous body with significant other responsibilities (such as PHNs). If funding is required to flow indirectly through a non-Indigenous body, the model must include transparent accountability measures from the body to the Aboriginal and Torres Strait Islander communities.

³⁵ Coroner's Court of Western Australia (2019) *Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region*

³⁶ Dudgeon P et al. (2016) *Solutions That Work: What The Evidence and Our People Tell Us Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report*. Crawley: University of Western Australia, https://www.atsispep.sis.uwa.edu.au/_data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf.

³⁷ National Aboriginal and Torres Strait Islander Leadership in Mental Health (2020) *Gayaa Dhuwi (Proud Spirit) Declaration and Indigenous Governance Framework – Implementation Workshops Report*. Forthcoming.



Fund expedited implementation of existing frameworks and strategies so as to bolster services and initiatives which are culturally safe and support self-determination of Aboriginal and Torres Strait Islander people

Broadly, the Productivity Commission states in its Draft Report this should occur through broadening roles in governance within the mental health system and expanding the role of Indigenous controlled organisations in planning and delivery of mental health and suicide prevention services. As already discussed, such implementation planning and evaluation should be the role of Gayaa Dhuwi (Proud Spirit) Australia at the national level.

In its Final Report, the Productivity Commission should also recommend needs-based funding specifically earmarked for developing and operationalising an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* under the leadership of Gayaa Dhuwi (Proud Spirit) Australia.

Fund opportunities for Aboriginal and Torres Strait Islander people to engage in the mental health workforce, along with ongoing capability training throughout their career

The Draft Report includes minimal commentary about the Aboriginal Torres Strait Islander mental health and related workforces, aside from discussion of Aboriginal and Torres Strait Islander-specific health services. As set out in the *Gayaa Dhuwi (Proud Spirit) Declaration*, it is critical that Aboriginal and Torres Strait Islander people populate mental health and related workforces of *both* mainstream and ACCHSs, at levels which match the mental health needs of Indigenous people. The Draft Report otherwise perpetuates the siloing of Aboriginal and Torres Strait Islander people within dedicated services, rather than working towards a significant Indigenous presence within mainstream services such that both mainstream and dedicated services are together able to address Indigenous mental health and related challenges (see Principle 6 for further discussion). Further, the Final Report needs to consider how to better engage Aboriginal and Torres Strait Islander people across the workforce spectrum, not just in identified positions (see Principle 9 for further discussion).

Raising Indigenous employment across the spectrum of mental health and related services and programs will require strategic and tangible actions, rather than aspirational statements.

Strategic action might include:

- Setting employment targets with population parity as a minimum goal (i.e. the percentage of Aboriginal and Torres Strait Islander people in the health workforce equals the percentage of the Aboriginal and Torres Strait Islander people of the population).
- Setting population – worker ratio targets in addition to the above. For example, the NSW *Aboriginal Mental Health and Wellbeing Plan 2006-2010* included a target to achieve across the NSW mental health system a staff ratio of one Aboriginal mental health worker or professional per 500 Indigenous people in the population.
- Introducing accountability measures for professional bodies, education institutions, and employers to work towards to meet these targets. To this end, all governments should support an Indigenous mental health profession expansion program similar to that of the Leaders in Indigenous Medical Education (LIME) Network, which has resulted in Indigenous population parity for entry into Australian medical schools.



Principle 6: provide integrated, comprehensive support services and programs

Charter 2020 key messages

Implement full suites of services and programs required to support mental health and ensure intensive, team based and integrated care is available for all those experiencing a mental health crisis, and addressing the needs of people who have historically missed out, such as culturally and linguistically diverse populations, LGBTIQ+ populations, and people living with intellectual disability.

Australia's mental health system requires a clear architecture that is adaptable to local circumstances. The fragmented nature of the current system has created large gaps through which many Australians are falling. There is a 'missing middle' between primary care and crisis support. An integrated, comprehensive support system is needed to support continuity of care, and streamline consumer care pathways.

Overview of the Draft Report

Mental Health Australia welcomes the Productivity Commission's recommendation about collaboration as an underpinning pillar in the architecture of a reformed system.

- The Australian Government and state and territory governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding (Rec 23.3).

To deliver on this structural reform, the Productivity Commission acknowledges a need to overhaul the current approaches to regional mental health planning and commissioning. Two options are presented: 'renovate' or 'rebuild.'

- The 'renovate' model involves increasing the capacity of PHNs to plan and respond to local needs, working with their state or territory authorities.
- The 'rebuild' model calls for the establishment of a new level of governance altogether – Regional Commissioning Authorities (RCA).

The 'rebuild' model is preferred by the Productivity Commission, suggesting it could effectively pool resources and surmount traditional funding silos. However it is unclear what skills, resources and capacity are required to build professional, systemic consumer and carer advice to the proposed RCAs (See Principle 2 for more discussion on this point).



Some key issues to consider here are how, under either structure, community mental health services and psychosocial services in particular fit into regional models of care. The Draft Report suggests activity-based funding could be applied to community mental health services to “both improve their efficiency and reduce incentives to prioritise hospital-based care” (Vol 1, p47). The Productivity Commission recommends a review of proposed activity-based funding classification for mental health care (Rec 23.1).

The Productivity Commission contemplates how to better integrate care through mainstream service reform. It recommends a nominated primary treating clinician will take responsibility for management of a new single care plan:

- Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers (Rec 10.3).

This recommendation is proposed to address some traditionally difficult issues, such as data sharing between providers, consent and privacy, carer rights, follow-up and, of course, necessary financial incentives. This recommendation is related to the Productivity Commission’s second key recommendation made to better integrate care through structural reform. The Productivity Commission recommends in Rec 10.4:

- All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed.

The Draft Report acknowledges the unique needs of different parts of the community, though specific recommendations are harder to discern:

- The Australian, state and territory governments should reconfigure the mental health system to give all Australians access to mental health care, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate (Rec 5.9).

The Draft Report grapples with some of the major issues impeding integrated and comprehensive support services and programs but again could go further in suggesting solutions. Where solutions are still unclear to the Productivity Commission, it should recommend what further information and research is needed to generate solutions and provide guidance on who is responsible for finding these solutions and in what timeframe.

Key considerations for the Final Report

Recommend structural reform to incentivise integration that builds on lessons learnt through Primary Health Networks commissioning of mental health services

The Productivity Commission rightly acknowledges structural reform is needed to better connect and integrate services and programs and address governance, accountability and funding issues. Noting the Productivity Commission’s preference for the ‘rebuild’ model, Mental Health Australia urges the Productivity Commission to include in its Final Report its vision for an ideal future system, being mindful to balance health and social care and support.

Mental Health Australia can see benefits and disadvantages to both the ‘renovate’ and the ‘rebuild’ models. We remain agnostic about which structural model the Productivity Commission should recommend. However, it is clear that whatever the favoured model, it must be shaped by



lessons learnt through recent reforms. The regional commissioning of mental health services through PHNs offers significant lessons for future mental health system reform, as outlined by reports of the Primary Health Network Advisory Panel on Mental Health.³⁸ Key features of any system underpinning regional mental health commissioning must be:

- clear role delineation and excellent coordination of planning between the federal and jurisdictional governments
- a clear imperative for system integration based around shared commitment to outcomes
- genuine integration with physical health systems and social care and welfare systems
- co-design processes informed by:
 - the lived experiences of consumers, their carers (as appropriate) and families
 - experts and advisors with an excellent understanding of and deep expertise in health and social care to improve mental health
 - views from representatives across the spectrum of the workforce
- mechanisms to promote national consistency based on evidence (including non-traditional forms of evidence)
- flexible use of funds to enable place-based approaches to thrive.

The Productivity Commission should also have regard to the longer term need to facilitate better coordination of mental health services with intersecting services, such as aged care and disability support services. Structural reforms to enable holistic, person-centred care must account for collaboration and integration across these intersecting services.

The Productivity Commission should not be bound by considering the merits of only its interim models. If there is another model, or a blended model, suggested in response to the Draft Report which meets the aforementioned features, the Productivity Commission should consider that model in its Final Report.

Better articulate what the ideal future state of integrated and comprehensive mainstream services looks like, identify gaps between this and current state, and develop a tangible path for reform

The Productivity Commission must articulate its vision for the integrated and comprehensive system and services of the future

Mental Health Australia appreciates the Productivity Commission's acknowledgement that a truly consumer-designed, integrated and comprehensive system is a significant shift from the current siloed, disparate system. Underpinning a difficulty in achieving this reform is the lack of a clear vision which sets out what an ideal future system looks like.

Mental Health Australia urges the Productivity Commission to articulate in the Final Report its vision for the future mental health system. It is imperative an ambitious destination is clearly articulated to ensure the community, governments and service providers make real progress in moving towards a better system. Alternatively, if the Productivity Commission is of the opinion

³⁸ PHN Advisory Panel on Mental Health (2019) *Reform and System Transformation: A Five Year Horizon for PHNs*; PHN Advisory Panel on Mental Health (2019) *Report of the PHN Advisory Panel on Mental Health*.



that it cannot articulate this vision at this time, it should make clear why this is the case and what more is needed to define the ideal future state.

The single care plan model potentially has significant benefits, but is not without risk

One step towards a more integrated, comprehensive system is through the single care plan model proposed in the Draft Report (Rec 10.3). While single care plans sound promising, under the model proposed in the Draft Report, they are clearly designed to be managed in clinical settings, by clinicians working on behalf of ‘their’ patient.

It is difficult to imagine how this model would be person-led. Many consumers will strongly question the appropriateness of only affording a primary treating clinician responsibility over the plan; this model does not align with the broader intent of a better integrated system. With increasing evidence about the value of non-clinical interventions, consumers will also likely question whether clinicians are best placed to deliver this model.

The proposed model brings up a series of questions, which Mental Health Australia would like to see considered in the Final Report:

- How will consumers retain control of single care plans and ensure they articulate and align with their own desired recovery goals?
- What are the implications for professional role delineation arising from a single care plan?
- Can non-clinicians manage the plans? If not, why not?
- How would non-health services and e-health services be included?
- What will be carers’ rights and responsibilities under the plans?
- What IT platform would be used to hold the plans? Would this provide adequate protections and consumer access?

Care coordinators will be critical to rolling out the reformed system and ensuring the inclusion of under-served population groups

In addition to providing coordination services for consumers (and carers as appropriate), care coordinators’ remit should also include the provision of supported decision-making services. Consumers and carers will need support to transition to consumer-and-carer-led care as informed choice is predisposed on an assumed level of health literacy (see Principle 2 for further discussion on person-led care). This transition and upskilling should be guided by care coordinators to ensure equitable access to a variety of services regardless of health literacy levels. In practice, supported decision-making and upskilling services should be provided together where logical.

Mental Health Australia supports the Productivity Commission’s recommendation “all people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them” (Rec 10.4). Mental Health Australia suggests the scope of eligibility for care coordinators should be broadened beyond ‘severe and persistent’ to ensure the reformed system does not entrench the lack of access to services for those with moderate mental illness, the ‘missing middle’. Severity of illness does not necessarily correlate to intensity of care or support services required, nor does it necessarily take into account co-morbidities which will require care coordination for consumers to receive truly integrated care and support across the mental health, health and social care systems.



Cross service information sharing to integrate digital records, services, programs and tools is integral for creating a comprehensive system

Underpinning integration and collaboration in a reformed system is a radical shift from the current silos and singularity mindset. An integrated, person-centred system will be reliant on information management systems that strongly protect consumers' data and privacy, while allowing them to grant access to shared information to chosen health professionals. Without information sharing, consumers unnecessarily bear the burden associated with seeking new services and have to tell their story again and again, which reduces help-seeking behaviours. The Productivity Commission should provide guidance on increasing the possibility of consumer-consented information sharing to reduce this burden. In doing so, the Productivity Commission should be mindful of privacy concerns raised by consumers and mistrust of centralised databases following the roll out of My Health Record.

In designing the ideal system, the Productivity Commission must ensure it is considering the medium and long-term future. To future-proof the new system, it is critical that services embrace the digital age. To do this, services require adequate resourcing for non-human materials and tools. Mental Health Australia commends the Productivity Commission on its emphasis on increasing use of online treatment tools (Rec 6.1) and online navigation platforms which offer information and pathways into the mental health system (Rec 10.2).

Ensure the needs and experiences of consumers and carers, including under-served population groups, drive reform towards an integrated and comprehensive system

At-risk population groups and people who have historically "missed out" must be included in system design

The Draft Report includes a well-articulated and sensitive discussion about the differing needs of diverse population groups and the need for a reformed system to both respond to, and acknowledge, the varied experiences of consumers and carers. In the Final Report, the Productivity Commission should strengthen this discussion with an explicit recommendation that consumer and carer groups involved in system and service design must include individuals who belong to diverse population groups (or more than one population group). An affirmative approach to intersectional representation in system and service design is critical to building a reformed system for all Australians.

For example, there is little connection, coordination and communication between mental health services and social services for people from CALD backgrounds. This creates fractured and disjointed service experience for CALD consumers and carers who may already be finding it difficult to navigate the health system.

The Framework for Mental Health Services in Multicultural Australia provides specific strategies and guidance to ensure collaboration and integration with CALD community and specialist services. Implementation of the Framework, directed through a National Agreement, would ensure that all mental health services implement measures to improve service integration for CALD people.

Online services can allow individuals within CALD communities to find clinicians who speak their language and/or understand their cultural norms and values around mental health and wellbeing. However, it is imperative these support services are co-designed with CALD communities to ensure they are culturally relevant.



Mental Health Australia encourages the Productivity Commission to refer to its additional submission, jointly authored with the Federation of Ethnic Communities' Councils of Australia and the National Ethnic Disability Alliance for further recommendations relating to CALD communities.

Ensure availability of individual and systemic advocacy for historically excluded population groups

As discussed in relation to Principle 3, advocacy for people and population groups that experience systemic exclusion and discrimination is vital to system reform and improving health outcomes. The Productivity Commission should develop recommendations to ensure independent, systemic advocacy for vulnerable groups is enabled through equitable funding for health peak bodies, and ensure availability of advocacy for individuals when interacting with the health system.

Without this funding to ensure minority groups are represented and have a voice to influence national policy, the system will perpetuate the silencing of marginalised communities. Including these voices will mean the system better reflects the composition of Australian communities, and increases the responsiveness of mental health and other services.



Principle 7: expand community based mental health care

Charter 2020 key messages

Ensure there are psychosocial programs and team based care options to provide community based care and to avoid hospitalisation wherever possible. Australia is capable of a world class community mental health system that is supported by two tiers of government.

The lack of community based mental health services across the country is leading people into crisis responses, with many Australians relying on emergency services for support. Expansion of Australia's community based mental health services will ensure that all Australians receive the right care, at the right time, in the right place across metropolitan, regional and rural locations.

Overview of the Draft Report

The Productivity Commission's Draft Report acknowledges the major gap in mental health services between primary and acute care, and the impact of this on personal wellbeing and over-reliance on crisis services. The report falls short however from offering a specific recommendation to grow community mental health in order to realise a world class national mental health system that would keep people out of hospital.

The existing service gap

The Draft Report sees the gap between primary and acute care through a rather narrow lens and as the result of unclear delineation between the responsibilities of levels of government, and funding arrangements that incentivise direction of resources to acute care (Vol 2, p280, 928). Analysis of this issue is focussed on the shortfall in both psychosocial support services and specialised clinical care provided in the community.

Using the *National Mental Health Services Planning Framework* (NMHSPF), the Productivity Commission calculates clinical community services are 28% below benchmark and the number of available non-acute beds is less than 60% of benchmark (with considerable differences across states). Even these drastic shortfalls are likely to be underestimates, as it is unclear whether the NMHSPF benchmarks adequately account for optimal community mental health service delivery.

The Draft Report also notes the very large service gap in psychosocial support services (Vol 2, p430) with estimates that 684,000 Australians require some form of psychosocial support, 64,000 of whom will access services through the NDIS, and 290,000 of whom who will require considerable ongoing support. It does not however make a specific recommendation as to the expansion of such services to assist these people.



Community mental health funding arrangements and quantum

The Draft Report notes the current funding arrangements for psychosocial support services as inefficient and duplicative. The Productivity Commission found “the large service gap that existed before the NDIS ... is becoming more acute, [and] can be bridged in two ways. The first is to make the existing funding work more efficiently, while the second is to increase funding overall” (Vol 2, p454). However, the Draft Report stops short of explicitly recommending increased funding, saying “while system changes can improve funding efficiency, the overall level of funding may need to increase as well” (Vol 2, p454).

The Draft Report argues for changing the eligibility requirements for Continuity of Supports so people do not have to be rejected from the NDIS before they are able to access services, ensuring people continue to be supported during an application process for the NDIS, and are able to continue accessing support through the National Psychosocial Support Measure if they choose not to apply for the NDIS. The report also calls for the Australian Government to make public the anticipated long-term arrangements for psychosocial support for people not eligible for the NDIS. Mental Health Australia supports these recommendations.

For community based services outside the NDIS, the Draft Report articulates a sound understanding of the impact of short-term funding arrangements – particularly for consistency in staff, and the flow-on impact for consumers. Longer term contracts facilitate stability and certainty for staff and consumers, which is very important for psychosocial recovery (Vol 2, p427). The Productivity Commission has recommended the Australian and state and territory governments should extend the funding cycle length for psychosocial supports to a minimum of five years. Mental Health Australia supports this recommendation.

The Draft Report also considers incentives for private health insurers to fund services that prevent hospitalisation. The Draft Report recommends regulations to increase the scope for private insurers to fund programs to prevent avoidable mental health-related hospitalisations. Mental Health Australia can see the benefits of potentially increasing the number of funders and therefore the amount of funding to services that assist people to avoid hospital. However, there could also be significant unintended consequences such as further muddying responsibility for funding community based mental health, and increasing inequities in access to care, if appropriate safeguards are not considered alongside this considerable shift in policy.

National Disability Insurance Scheme and other psychosocial support services

The Report includes an overview of the shortcomings of the NDIS for people with psychosocial disability regarding psychosocial supports provided through the NDIS. This includes the strenuous application process, fewer people with psychosocial disability participating in the NDIS than expected, unclear interface with mainstream services, and comparatively poorer experiences once into the NDIS. The Draft Report acknowledges work underway to improve the interaction of people with psychosocial disability with the NDIS, and recommends the psychosocial disability stream should be fully rolled out by the end of 2020. Mental Health Australia is supportive of this recommendation and has been working closely with the National Disability Insurance Agency to see the recommendations of the NDIS Psychosocial Stream Working Group implemented. This includes providing assertive outreach for people with psychosocial disability to engage with the NDIS, improve the way the NDIS responds to the episodic nature of psychosocial disability, and enhancing recovery oriented practices across the NDIS for participants with psychosocial disability.



Key considerations for the Final Report

Outline a clear plan for governments to significantly expand successful services across the community mental health sector

A world class mental health system balances clinical and social care and support.³⁹ The strong calls for de-institutionalisation and funding of community mental health in the 1980s⁴⁰ and 90s⁴¹ resulted over time in the closure of most long stay mental health institutions, but not in adequate investment in community mental health to meet the resulting need.⁴² Recognising this, the National Mental Health Commission states as central to its vision for the national mental health and suicide prevention system “a revision towards a cohesive community-based approach”.⁴³

To realise a world class mental health system, the Productivity Commission’s Final Report should recommend the urgent expansion of community based mental health support. This should be part of a grand vision to grow a strong community mental health sector, proficient at ensuring people can engage in treatment and recovery support in the community, minimising the need for in-hospital acute care.

The omission of such recommendations in the Productivity Commission’s Draft Report could be due to a lack of visibility of the community mental health sector. There is a lack of nationally consistent data collected about the community mental health service system, including: the people it services, the service types it provides, the workforce involved in delivering these services, and the outcomes achieved through delivery of these services. The Draft Report appears to have been predicated largely on the *National Mental Health Service Planning Framework*, which may not have adequate focus on or representation of community mental health services.

There are a range of varying explanations about the scope of community mental health services, which increases the complexity of the task before the Productivity Commission. For example, the National Mental Health Commission’s *Vision 2030* consultation document describes balanced community care as “access to care in their community in the least restrictive environment possible”.⁴⁴ The National Mental Health Commission takes the broad perspective that “this approach is not about one type of care, or one type of service, but about the way that we deliver all aspects of prevention, assessment, treatment and recovery”.⁴⁵

Community Mental Health Australia acknowledges the changing nature of community mental health services stating that “the distinction between clinical and non-clinical mental health services is no-longer helpful”⁴⁶ due to changing dimensions of services. For example, some clinical services are delivered in a community setting and some community-owned organisations employ clinicians. In fact, Community Mental Health Australia states “a comprehensive mapping

³⁹ 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.

⁴⁰ Richmond, D. (1983) *Report of the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*.

⁴¹ Burdekin, B. (1993) *Report of the National Inquiry into the Human Rights of People with Mental Illness*.

⁴² See for example the Evaluation of the 2nd National Mental Health Plan 1998-2003 and the National Mental Health Commission’s *Review of Mental Health Programmes and Services* in 2014.

⁴³ National Mental Health Commission (2019) *Vision 2030: Key Concepts Consultation Paper*, p10.

⁴⁴ National Mental Health Commission (2019) *Vision 2030: Key Concepts Consultation Paper*, p10.

⁴⁵ National Mental Health Commission (2019) *Ibid*.

⁴⁶ Community Mental Health Australia (2019) *Submission on the Productivity Commission Review of the Economic Benefits of Improving Mental Health*, p9.



of all services is required building upon the work already done by [PHNs], the Australian Institute of Health and Welfare and in the *National Mental Health Service Planning Framework*".⁴⁷

Those addressing the issue from a more clinical framework might see community mental health as outpatient services traditionally delivered through a biomedical framework under the responsibility of state and territory governments. The Productivity Commission's Draft Report certainly appears to focus on this aspect of community mental health.

Mental Health Australia would advocate for a broader interpretation of what community mental health services should encompass. For example:

- psychosocial recovery support funded by the federal, state and territory governments (this can include one-on-one recovery work, group sessions and/or centre-based activities such as clubhouses)
- prevention and early intervention services
- care planning and coordination
- state and territory funded community mental health centres (often clinically focussed)
- Australian Government-funded adult mental health hubs, currently under development
- services funded through the PHN mental health flexible funding pool, including mental health nursing, psychological therapies and telehealth services
- private psychological services delivered by clinicians in private practice, and
- mental health services provided through general practice.

What is clear is that the Productivity Commission's explanation of the 'missing middle' as having resulted from unclear boundaries between jurisdictions and funding arrangements that incentivise direction of resources to acute care (Vol 2, p280, 290), is an accurate but inadequate interpretation of the issue. The Final Report needs to more clearly articulate how these recommendations will impact on this cohort. There is a need for both better visibility of this portion of the mental health sector and its workforce (discussed under Principle 8) as well as urgently addressing its chronic underfunding and complex service navigation.

Map and expand community based mental health care

The Productivity Commission's Final Report should outline a clear plan for governments to significantly expand successful services across the community mental health sector. This plan should include:

- mapping community mental health services
- mapping the community mental health workforce (see Principle 8)
- testing the assumptions underpinning the NMHSPF with the community mental health sector (see Principle 8), and
- developing a work plan to expand community mental health care to match need.

⁴⁷ Community Mental Health Australia (2019) Ibid p11.



The Final Report should also recommend that while the above-mentioned work is underway, the Australian Government starts work immediately on an ambitious agenda to expand successful community mental health services. This would include testing the design of the recently announced adult mental health hubs with the community mental health sector to ensure they do not default to a clinical biomedical model of care and that they adequately encompass, promote and expand on other forms of community mental health services, including psychosocial support.



Principle 8: support workforce development

Charter 2020 key messages

Invest in systematic workforce development, including peer workers, volunteers, paid and unpaid carers, community workers and clinicians.

Australia needs a *National Mental Health Workforce Strategy* that is developed in consultation with and agreed with the sector. Critical to this strategy is consideration of:

- Australia's rapidly growing peer support workforce;
- the physical and emotional safety parameters required to enable safe and productive working environments for staff across the mental health workforce;
- funding arrangements which attract mental health workforce to grow in regional and remote areas and to work with harder to reach people, such as those experiencing homelessness;
- the impact of short-term and individualised funding arrangements on workforce stability and job security, and
- new data collection requirements to enable the community mental health sector to be better accounted for in workforce planning.

Overview of the Draft Report

The Productivity Commission's approach to mental health workforce development, outlined in the Draft Report, appears to be solidly entrenched in a biomedical approach to mental health service delivery, with little consideration for the community mental health sector. It appears to be firmly focussed on closing the most pressing gaps within the current mental health workforce, rather than anticipating an aspirational new system and proposing workforce development to match. Mental Health Australia believes the Final Report should address both of these critically important areas.

The Productivity Commission's overarching recommendation is that the forthcoming *National Mental Health Workforce Strategy* align health workforce skills, availability and location with the need for mental health services (Rec 11.1). This places great hope on, and in some ways defers much decision making to, the *National Mental Health Workforce Strategy*, a strategy the sector is yet to be consulted about.

In relation to health-specific professions, the Report recommends strategies to increase the numbers of psychiatrists and mental health nurses in particular, noting the significant workforce shortages experienced across these professions (Rec 11.2, 11.3). In addition, it makes recommendations about how to upskill general practitioner (GP) mental health expertise, particularly in relation to mental health medication management (Rec 11.5). While Mental Health



Australia is in favour of access to psychiatry expertise to support GPs (Rec 5.1), previous attempts at GP education in the mental health area have had limited success unless they are incentivised.

The Draft Report also outlines issues in relation to the culture of staff working within the mental health sector and makes key recommendations around “exposing health students and practising health professionals to people with a mental illness... outside a clinical environment” and “rebalancing where trainees undertake clinical placements and internships...” (Rec 11.6). However, these recommendations fall short of directly addressing cultural change within health settings.

In addition, the Draft Report offers recommendations to increase access to health professionals in rural and remote areas (Rec 11.7), but it does not address attracting the mental health workforce to work with other people typically considered hard to reach, for example people experiencing homelessness or complex needs.

Key considerations for the Final Report

Although the Draft Report’s workforce recommendations are sound, they are not sufficient. They represent a narrow and health-centric view of the mental health workforce. Not only does this miss an opportunity to re-establish a community mental health workforce, it also fails to acknowledge the cross sector workforces requiring mental health skill development such as justice, housing, social services and education.

While Mental Health Australia welcomes the recommendations, which are necessary to strengthen Australia’s clinical mental health services, it does highlight a significant omission in relation to development of the community mental health workforce. The Productivity Commission’s recommendations in relation to strengthening the peer workforce are particularly welcome but not sufficient to address the workforce development needs of the community mental health sector more broadly.

This is a sector which has been under significant strain due to recent but now long running major national transitions both to the NDIS and from national to regional commissioning through PHNs. Anecdotal evidence from service providers suggests this has resulted in difficulty in retaining staff, increased casualisation, and has necessitated hiring on attributes rather than requiring qualifications (such as the Mental Health Certificate IV).

Develop a new definition for non-specialised community mental health services

At present, the Australian Institute of Health and Welfare only collects data related to specialised community mental health care. It is defined as being government-funded and -operated specialised mental health care. It is provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics. The data collected is predominately related only to specialist mental health care services.

A new definition is required for non-specialised community mental health care to capture this work in the non-government sector. Similarly, the mental health workforce data only reports on psychiatrists, mental health nurses and psychologists.

It is difficult to envisage an improved and aspirational mental health system without more focus on the community mental health workforce, one which is recovery-focussed, community-based and keeps people out of hospital. In the longer term, this type of system may even lead to less



pressure on the clinical workforce, easing some of the critical mental health workforce shortages noted above.

Include community mental health workforce as part of the National Mental Health Workforce Strategy

The *National Mental Health Workforce Strategy* is still in development and provides an opportunity to expand its objectives to include the peer and community mental health workforces, and be broad and inclusive across professions and sectors.

In order for this to be undertaken, a more detailed understanding of what constitutes the community mental health workforce is required, including the scope of their work and the sectors where they are employed. The intersection with the NDIS and its support for people with a psychosocial disability is critical and will need to be further examined as part of this process.

The lack of a coherent and interconnected systemic model for the delivery of community mental health services has made it difficult for the Productivity Commission to evaluate and determine the economic value of community-based services as part of the mental health system. This reflects years of inattention from state and territory governments.

While the lack of workforce data is a significant issue for the Productivity Commission's deliberations, there is an abundance of economic and social data that tells us that keeping people out of hospital-based services will save money, and that people prefer to get support in the community.⁴⁸

It will also be important to engage with professional bodies to better align scopes of practice that support improved team-based care and greater flexibility to meet service demands. In particular, rural and remote areas, where it is difficult to sustain the mental health workforce, need to be able to use the limited practitioners as flexibly as possible while still achieving good treatment outcomes.

Revise the National Mental Health Services Planning Framework to include community mental health sector workers

The *National Mental Health Services Planning Framework* was designed to help plan, coordinate and resource mental health services to meet population needs. It is an evidence-based framework providing national average benchmarks for optimal service delivery across the full spectrum of mental health services in Australia. While only a select number of people have access to the framework, it is understood to be populated with existing workforce data of major mental health professions and some, but not all, community mental health practitioner roles.

In order to better inform workforce planning, the *National Mental Health Services Planning Framework* needs to incorporate a more comprehensive picture of community mental health sector workers in non-government areas. To inform this work, there needs to be agreement on what constitutes community mental health services, which could be undertaken as part of the National Mental Health Workforce Strategy.

⁴⁸ KPMG (2019) *Delivering healthcare services closer to home: An International look at out of hospital, community-based healthcare services*



Recommend actions to increase diversity and cultural responsiveness of mental health workforce

Australia's mental health workforce needs to be responsive to the needs of all population groups, including people from diverse genders, sexualities, cultures and backgrounds. In its Final Report, the Productivity Commission should include recommendations that would increase the responsiveness of mental health services to diversity as a core component of the *National Mental Health Workforce Strategy*. In turn, it must be a core component of future planning, targeting both workforce training and inclusive recruitment and development. Priority populations should include individuals from Aboriginal and Torres Strait Islander communities, LGBTIQ+ communities, CALD communities and people with disability.

Recommend cross-disciplinary training for the mental health workforce

The distinction between the clinical and non-clinical workforce is a significant barrier to improving access and continuity of services for people with more complex mental illnesses and needs to be addressed. A lack of interdisciplinary practice in the unmet delivery of mental health treatments through incentivised MBS payments has contributed to fragmentation of the mental health service system.

The psychosocial and the broader community mental health sector workforces need to be seen as integral components of the mental health workforce sector and their training should be considered in a similar way to that of the medical and allied health professions. In the Final Report, the Productivity Commission should recommend increased use of cross-disciplinary training as one mechanism to help address this issue through identification of training pillars such as physical health, trauma and addiction.

The primary mental health care sector is delivered mainly by private providers working in silos with little emphasis on multidisciplinary team approaches to support people with more complex mental health issues. The majority of their professional training is focused on specific treatment interventions with little emphasis on team based cross professional development, which only strengthens these silos of service delivery.

The Productivity Commission should recommend addressing the need for an agreed framework to guide interdisciplinary team service delivery and improve capability and team competence. The framework and training needs to be developed in a person-centred approach that is less divided between clinical and non-clinical roles.

In addition to cross-disciplinary training within the mental health workforce, the Productivity Commission should provide recommendations about how to upskill the broader health workforce in how to work with the mental health workforce in interdisciplinary teams.

Consider establishing a Centre of Mental Health Workforce Development

The mental health workforce would benefit from the establishment of a national centre of evidence-based workforce development similar to that of Te Pou o te Whakaaro Nui in New Zealand that supports the mental health, addiction and disability sectors in that country. Such a cross sectoral workforce planning and training centre could be the driver of workforce changes and strategies to meet future challenges in delivering a person-led mental health service system. This would include undertaking research, developing and coordinating education and training for



service providers and trainers, as well as providing resources, tools and support to improve service delivery.

Such a centre could also be the catalyst for developing supporting workforce strategies to better manage future disasters as experienced by the devastation caused by recent bushfires. This could include the development of contingency plans to ensure that there is a workforce capable of meeting the needs of these communities without impacting upon current service delivery.

Incorporate incentives to improve mental health workforce geographical distribution

The Productivity Commission's recommendations to increase the mental health workforce need to include strategies to address the geographic maldistribution of mental health professionals. This is an issue that affects most health professionals to varying degrees and impacts significantly upon access to mental health services for people living in rural areas.

Finding a solution to this is complex as part of the problem is the MBS funding system that rewards practitioners working in heavily populated areas. The Productivity Commission should consider novel options for incentivising more equitable geographic distribution of mental health professionals. Pooled funding options to fund salaried mental health professionals in less populated areas where MBS is not financially beneficial enough to conduct private practice may help. However, there are also lifestyle and career barriers that would also need to be considered as part of a package of benefits to encourage long term rural placements.



Principle 9: build an evidence based, accountable and responsive system

Charter 2020 key messages

Ensure constant research and evaluation, transparent monitoring of prevalence, availability of services and programs, system performance and gaps. Ensure target and timely response to identified gaps, system failures and poor performance.

There is a need for:

- more formal evaluation requirements and independent monitoring of outcomes, specifically against the *Fifth National Mental Health Plan*
- a centralised *Mental Health Outcomes Framework* for community-based and clinical mental health services that measures outcomes across the social determinants for mental health
- formalised and consistent allocation of evaluation funding for all pilot programs to monitor program outcomes, improve accountability, and contribute to the country's evidence base of effective mental health interventions.

Overview of the Draft Report

The Draft Report's acknowledgment of the need for much stronger accountability is both clear and welcome. However, it should be remembered the Productivity Commission's preferred option is a fundamental rebuild of mental health funding arrangements with new state and territory RCAs given new responsibilities. Ensuring these new arrangements are supported by an appropriate and properly resourced system of accountability for quality improvement would be a challenge.

Reforms to accountability are a central part of the Draft Report (Reform Area 5). The Draft Report acknowledges the limited accountability for mental health outcomes currently, with "vast amounts" of information collected but poorly applied for the purpose of systemic quality improvement (Vol 1, p47). The Draft Report calls for routine surveys of mental health and wellbeing, and also suggests the need for urgent improvements to accountability in relation to suicide prevention.

Responsibility for improving this situation, according to the Draft Report, would be met through a significant re-design of the role of the National Mental Health Commission to become an interjurisdictional statutory authority charged with systemic oversight. How this could be achieved while delivering independence is not clear in the Draft Report, and should be articulated in the Final Report. The Draft Report recommends the National Mental Health



Commission “should not advocate, defend or publicly canvass the merits of governments’ or oppositions’ policies” (Vol 1, p102).

New accountability arrangements would be underpinned by a new *National Mental Health and Suicide Prevention Agreement*, a new *National Mental Health Strategy* and expansion of the scope of the COAG Health Council to ensure fuller consideration of the social determinants of mental health (covered in more detail under Principle 1). The Draft Report acknowledges the importance of new data linkage capacities, to enable this fuller picture to be established.

Key considerations for the Final Report

Introduce real time consumer and carer driven outcomes measurement

Fundamental to the reform of mental health services delivery is the use of outcome measures that are focussed on mental health consumers’ and carers’ personal experiences of care. If under a true consumer- and carer- driven mental health system the value of a service is determined by their own experience, then it is imperative a system is implemented that measures that experience.

Efforts to date on the measurement of outcomes have been dogged by data-driven barriers to developing a one size fits all system within a data infrastructure that is inflexible, complex and expensive. The majority of people now have personal digital devices, and there are a plethora of existing online tools that are simple, cheap and effective in capturing user experiences. These types of platforms can provide immediate and transparent feedback that is consumer- and carer-driven.

The current mental health system is largely outcomes blind. Consumers and carers do not have access to relevant information to choose which providers and services to access (if they have a choice at all). Government and PHN service planners rely almost solely on input-based activity measures provided by the *National Mental Health Planning Framework*, which is populated with existing health focussed workforce and epidemiological data. This approach relies on improving the coverage of existing service types to meet consumer and carer needs. A forward-thinking model would also support innovative service development with ongoing mapping of consumer and carer needs. Putting outcome measurement that is consumer and carer controlled at the centre of service planning and delivery is critical to implementing the reforms outlined in the Draft Report. The final step in this reform is committing to public reporting of these outcomes so consumers and carers have greater visibility over the outcomes achieved by the services they are using.

The Draft Report acknowledges this major reform will need to be implemented over time. However, immediate steps can begin through developing regionally focussed outcome data collections via PHNs. These would utilise personal digital devices and existing outcome measurement digital platforms that are accessible, affordable and effective in collecting user feedback.

Mental Health Australia suggests the Productivity Commission recommends a range of innovative consumer-driven outcome-based measurement pilots are rolled out across a select number of PHNs across the next two years. The outcomes of these pilots should then inform consumer-driven outcome measurement tools that are established nationally.



Increase accountability for responding to priority populations through better data collection

The paucity of the data regarding under-served population groups such as LGBTIQ+ and CALD communities across Australia inhibits the responsiveness and accountability of the mental health system for these populations.⁴⁹

The Productivity Commission should make recommendations to increase the evidence, data collection and research base about Aboriginal and Torres Strait Islander, LGBTIQ+ and CALD communities (including refugees and new migrants) that adequately represents their experiences, to increase the responsiveness and adequacy of services to these populations.

Increase capability of mental health system to respond to disasters and large-scale traumatic events

Unfortunately Australians have recently experienced large-scale traumatic events including the 2019-2020 national bushfire crisis, other severe weather events and terror attacks. Mental health professionals have an important role to play in supporting individuals and communities to recover from such tragedies. The Productivity Commission should recommend Australian and state and territory governments develop a mental health response strategy for disaster and mass traumatic events, so that we can most effectively and efficiently provide support for affected communities at these times.

Development of this strategy should include workforce planning to ensure there is 'surge capacity' within the mental health workforce to respond to large-scale traumatic events, while continuing to meet existing demand for mental health services. Strategic planning should consider how best to respond to immediate and ongoing mental health needs of affected communities.

As discussed in Principle 8, this could be one of the responsibilities of a new centre for mental health workforce development.

⁴⁹ National LGBTI Health Alliance (2019) *Submission on the Productivity Commission Review of the Economic Benefits of Improving Mental Health*.



Conclusion

The Productivity Commission's extensive Draft Report outlines the necessity and complexity of mental health reform. The Productivity Commission is to be commended for the breadth and depth of its considerations to date, and its genuine engagement with stakeholders.

The Draft Report provides a solid foundation to build upon, outlining how current systems should be improved to better meet the needs of Australians experiencing mental illness. But it is not enough to do what we are doing now but better. Mental Health Australia urges the Productivity Commission to seize this opportunity to set out an ambitious agenda for mental health reform, which drives prevention and establishes a recovery-oriented service system to improve Australia's mental health and wellbeing.

This ambitious agenda must clearly set out a world class mental health system, which balances clinical and social care and support, led by mental health consumers and carers. In doing so, the Final Report must recommend tangible structures to ensure consumer- and carer- led design, significant growth of community mental health services, and address the social determinants of mental health. This system should be aligned with the principles agreed to by the mental health sector in *Charter 2020: Time to Fix Mental Health*, and be complementary with the National Mental Health Commission's *Vision 2030* and specific strategies for priority populations. In addition to its Final Report, the Productivity Commission should develop and release a 'roadmap for action' to clearly articulate the short, medium and longer term priorities and actions arising from the Final Report.

Mental Health Australia looks forward to assisting the Productivity Commission further as it finalises this momentous Inquiry. Even more so, Mental Health Australia eagerly anticipates working with others to implement an ambitious set of recommendations set out in the Final Report to meaningfully improve the mental health and wellbeing of our nation now and into the future.



About

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector. Our aim is to achieve better mental health for all Australians by building awareness of mental health issues; influencing social policy; conducting relevant research; and carrying out regular consultation to represent the best interests of our members, partners and the community.



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.

Mental Health Australia Ltd
9-11 Napier Close
Deakin ACT 2600
ABN 57 600 066 635

P 02 6285 3100
F 02 6285 2166
E info@mhaustralia.org
W mhaustralia.org