



Catholic Social
Services **Australia**

Submission to the Productivity Commission

Inquiry into The Social and Economic Benefits
of Improving Mental Health

April 2019

The national network of Catholic social services



Contact us

GPO Box 1947, Canberra ACT 2601
Level 2 Favier House, 51 Cooyong St, Braddon ACT 2612
T 02 6285 1366,

Brenton Prosser PhD, Director Research

www.cssa.org.au



Contents

Executive Summary	4
Recommendations.....	5
Overview.....	6
Mental health remains a challenge and priority for government.....	6
The focus of this submission is social determinants and the interface with social services	7
CSSA’s expertise draws from a network of social service providers that span Australia	7
CSSA supports the submissions by Mental Health Australia and Catholic Health Australia.....	8
Submission to the Inquiry	9
1. Social services address the determinants that drive and compound mental illness.....	9
2. The current operation of PHNs can entrench biomedical responses to mental health	11
3. The NDIS psychosocial disability stream currently lacks the skilled workers to support it	14
4. Information asymmetries compromise services and maintain demand outside the NDIS	16
Conclusion.....	18



Executive Summary

The improved mental health of Australians has been a national priority for over 25 years. Over that time, there has been increased government effort to support health and suicide prevention services. Despite these efforts, many people are still not receiving the support they need.

This submission finds that:

- Social services are essential for holistic, comprehensive and tailored responses to the diverse mental health needs of individuals because they both build on biomedical supports to enhance social and economic participation, and because they address the social barriers to otherwise successful clinical interventions;
- Federal Government devolution of mental health policy risks less support for social services through lack of continuity in service, opaque commissioning and reduced funding;
- Consumer driven social service funding models present specific challenges around information asymmetry, service equity and client agency in relation to mental illness;
- Ongoing support and quarantined funding for the viability of Australia's social services system is a key pillar for the effective functioning of its mental health system into the future.

The following recommendations are made in support of these findings.

Recommendations

CSSA and its membership call for the Commission to include the following actions within its Inquiry.

Issue	Recommendation
Medicalisation and the operations of PHNs	1. That the Commission request the Australian Government to further quarantine PHN funding to ensure commissioning to community and social service providers who specialise in addressing the social determinants of mental health.
	2. That the Commission call for national and local PHN indicators to be refined to report specifically on the level of commissioning and collaboration with allied health and social service providers.
	3. That the Commission request the Australian Institute of Health and Welfare report on PHN mental health commissioning and collaboration to allow national benchmarking and transparency.
The need for a psychosocial support skills workforce	4. That the Commission pay particular attention to the extent that variability in GP referrals and commissioning result in people with more complex conditions accessing services where staff do not have the advanced skills and social services are stretched.
	5. That the Commission explore the social and economic benefits from expanded support and training in psychosocial support amongst professionals.
	6. That the Commission call on the Australian Government to provide additional funding to support evidence based programs that will establish the scope of new psychosocial service models and to develop aligned training and accreditation programs.
Information asymmetry and demand outside the NDIS	7. That the Commission call on the Australian Government to commission research into the differing extent of information asymmetry and barriers across the spectrum of mental disorders (and cross referenced by different forms of vulnerability).
	8. That the Commission call on the Australian Government to commission research into how different groups who face additional barriers to accessing information on mental health supports (such as CALD, disability, refugee and older Australians) do so.
	9. That the Commission include in this Inquiry an assessment of the impact of improved information and education about mental health services on social and economic participation.

Overview

Catholic Social Services Australia (CSSA) is pleased to make a submission to the Productivity Commission's Inquiry into the *Social and Economic Benefits of Improving Mental Health*.

CSSA supports the Commission's decision to examine how sectors beyond health (including social services) can contribute to improving mental health, economic participation and productivity. The focus of this submission is the interface between mental health and social services, particularly in relation to the impact of current policy on social service support. Drawing on our membership's decades of experience and expertise in mental health, disability, psychosocial and social service support, this submission focuses on issues that speak to the Commission's broader plan.

Mental health remains a challenge and priority for government

The improved mental health of Australians has been a national priority for over 25 years. Over that time, there has been increased public awareness of the impact of mental illness and the role of all governments in supporting access to mental health and suicide prevention services. Despite these efforts, many people are still not receiving the support they need to maintain mental health or recover from mental illness.

The Australian Bureau of Statistics (ABS) estimates that approximately half of all Australians will experience a mental illness episode at some point in their lifetime. Around twenty percent of adults will experience a common form of mental illness each year. Australian Institute of Health and Welfare (AIHW) data indicates that 18 million GP encounters were mental health related in 2015, while MBS data report 3.2 million specific mental health encounters each year. The AIHW also estimates that for three percent of Australians, around 730,000 people, their mental disorder is severe.

The individual impact of mental illness can be great. This includes poorer physical health and wellbeing, reduced living standards and life expectancy, difficulties in the workplace and diverse individual experiences of service delivery. The social impact of mental health can include psychological distress, stigma, discrimination and social exclusion. Social factors also compound the severity of impact of mental illness, especially amongst vulnerable groups and in regional communities. The impact on families is also great, both because of the stress that is caused and the central role of family members as carers and care coordinators.

The economic cost of mental illness and unsupported psychosocial disability is also high. A 2014 report commissioned by the Royal Australian & New Zealand College of Psychiatrists estimated that the cost of severe mental illness in Australia was \$56.7 billion per year. The National Mental Health Commission (NMHC) also confirmed that the full economic cost of mental illness in Australia was around \$60 billion in 2016. This cost can take the form of lost productivity, greater access to taxpayer-funded health services (including admissions to hospital which could have been preventable through robust early intervention), increased welfare expenditure and social disruption (such as criminality). A recent estimate by KPMG put the direct cost of mental illness to the workforce at almost \$13 billion per year.

Clearly, the improvement of mental health to support individual and carer wellbeing, social participation, enhanced productivity and economic growth continues to be a national priority.



The focus of this submission is social determinants and the interface with social services

In Australia, the framework for mental health service delivery is a highly complex mixture of public and private systems, with funding shared between the Australian, state and territory governments, individuals and private health insurers. This is a result of the complex, clustered and comorbid nature of mental health conditions, where single interventions, programs or initiatives are rarely successful in isolation. The broad terms of reference of this Inquiry reflect this complexity.

This broad scope is consistent with evidence that there are many factors in addition to clinical and healthcare that should be targeted in order to improve mental health (such as early intervention). Drawing on our rich and practical expertise in mental health and social services delivery, CSSA and its member agencies strongly support the broad approach adopted by this Inquiry.

In this submission, we stress the importance of specifically addressing the social determinants of poor mental health and psychosocial disability to make inroads into this previously intractable national challenge. By targeting inefficiencies at the interface between government policy, the NDIS and social service support, we aim for a systematic and coordinated approach to mental health in Australia.

CSSA's expertise draws from a network of social service providers that span Australia

CSSA is the Catholic Church's peak national body for social services. For over 60 years, CSSA has assisted member agencies work towards a fairer, more inclusive society that reflects and supports the dignity, equality and participation of all people. Each year, CSSA's national social services network supports around 450,000 disadvantaged Australians. Our 50 member agencies spanning 650 sites nationally employ around 15,000 people.

Together we support people across the full range of social issues, including those living in poverty, vulnerable children, people in out of home care, families experiencing relationship challenges, people with disabilities, people who are homeless, people experiencing drug and alcohol issues, Indigenous Australians and older Australians, as well as refugees and people who are seeking asylum. While all of these services potentially address the social determinants of mental health, more than two thirds of our members provide psychosocial disability and mental health supports.

CSSA's vision is to ensure that Australia is a place where all people are treated with respect and have the opportunity to fully participate and contribute, as well as have the assistance they need to live a dignified, healthy and meaningful life. CSSA supports the Commission's Inquiry because extending social and economic participation to all Australians is part of the core of our mission and work.

Specifically, the expertise that CSSA's network offers this Inquiry is:

- A deep understanding of the social determinants of health and mental health;
- A truly national perspective that spans metropolitan, regional, rural and remote communities; and
- A broad range of expertise that covers mental health, psychosocial support and wrap around service delivery, as well as NDIS, PHN commissioned, allied health and community mental health services.

The content of this submission draws on this expertise and consultation with our membership.



CSSA supports the submissions by Mental Health Australia and Catholic Health Australia
As participants in the consultation process conducted by Mental Health Australia (MHA) and Catholic Health Australia (CHA) in support of this Inquiry, CSSA thoroughly endorses the content of their submissions.

The information that follows is intended to both complement these submissions and highlight particular additional issues of specific importance to CSSA's members.

Submission to the Inquiry

1. Social services address the determinants that drive and compound mental illness

According to the World Health Organisation (WHO), mental illness is shaped by the social, economic, and physical environments in which people live.¹ Its *Commission on the Social Determinants of Health* found that the lower a person's socioeconomic position the worse their health and mental health, unequal access to health, education, housing and work are identified as key causes.² In short, where people are born, live and work is the single most important determinant of good mental health.

The negative impact of social determinants can be two-fold. First, people are more likely to experience mental illness, while second, they are less likely to be able to access mental health and social support services due to their location or circumstances. This is particularly relevant in regional and remote areas of Australia. Submissions to the recent Senate Committee Inquiry into mental health services in rural and remote Australia reported that people with mental health illness are more likely to have experienced disadvantage or live in poverty. Meanwhile, almost 27 per cent of people who are homeless are estimated to have mental health issues,³ while around 20 per cent of the Indigenous disease burden is caused by mental health and substance use disorders.⁴

Not only does social disadvantage contribute to higher levels of poor mental health, the severity of the mental illness can be compounded by a range of social factors. These can include stigma, discrimination and social isolation. Further, multiple forms of social disadvantage have a multiplying effects. These can limit access to social and economic participation significantly.

The National Framework for Recovery-Orientated Mental Health Services⁵ includes amongst its Core Principles that services recognise and account for elements that affect an individual's wellbeing, including social and cultural contexts. It also emphasises holistic care and psychosocial support as an underpinning capability for these Principles. This approach understands enduring and complex mental health conditions as a cluster of biomedical, psychosocial and social factors that are interrelated and must be addressed in unison. To neglect any one or address them in isolation will risk undermining interventions that might otherwise be successful.

Social services play a vital role in the provision of psychosocial and social supports to ensure holistic and effective interventions at all levels of primary, secondary and tertiary care. It is not adequate nor appropriate for health services to provide care or intervention in isolation. Achieving long-term outcomes for patients/clients, requires an integrated co-ordinated response including health, social services, justice system, and usually education (for children and young people). Further, such supports use the window of opportunity that clinical, biomedical and allied health interventions create to build the skills and confidence that are required for social inclusion and enhanced economic participation. Social service providers are pivotal to addressing the social determinants of mental health because of the role they play to enable these approaches.

¹ WHO (2014). Social determinants of mental health. Geneva, World Health Organization,

² WHO (2008). Closing the gap in a generation. Geneva. World Health Organization.

³ <https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-2016-17/contents/client-groups-of-interest/clients-with-a-current-mental-health-issue>

⁴ <https://www.aihw.gov.au/reports-data/population-groups/indigenous-australians/overview>

⁵ <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra>



As this submission illustrates, recent reports from CSSA's membership give cause for concern about their reduced capacity and capability to play this vital role.

In late 2018, CSSA conducted a survey across its national membership. This survey involved over 100 hours of interviews with 60 executives and leaders in member organisations. The scope of this survey was broad and included all social services delivered by Catholic providers across the nation (including mental health). Further, in early 2019, CSSA formed a national consortium of 15 member agencies who are currently delivering mental health services through the NDIS. This consortium included members operating in metropolitan, regional and remote Australia. The extensive deliberations of this group have also fed into this submission.

2. The current operation of PHNs can entrench biomedical responses to mental health

The [Fifth National Mental Health and Suicide Prevention Plan](#) committed all governments to work together to achieve integration in planning and service delivery at a regional level, particularly through collaboration between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs). With responsibility for regional planning, coordinated funding and commissioning of mental health services, the national network of 31 PHNs are a key mechanism for the Australian Government's support of mental health and suicide prevention. Currently, PHNs manage approximately 10 per cent of the Australian Government's expenditure in mental health. They are briefed with the support of new innovative models of care for local mental health services supported by flexible funding.

Flexible funding is provided to enable PHNs to respond to regional priorities by commissioning services. Currently, around 60 per cent of funding to PHNs is flexible. This flexible funding component includes provision for a range of low intensity youth services to severe/complex adult mental health services. This flexible funding incorporates the previous Access to Allied Psychological Services (ATAPS), Mental Health Services in Rural and Remote Areas (MHSRRA) and Mental Health Nurse Incentive Program (MHNIP). It is expected that PHNs will invest this flexible funding into programs that will continue the principles and success of these previous initiatives while meeting the specific needs of their communities. The remaining fixed funding is tied to youth psychosis initiatives, headspace and specific support for Aboriginal and Torres Strait Islander mental health.

The outcomes for this funding is through national and local performance indicators. National indicators reflect government priorities and are selected because of their alignment with PHN objectives. Local indicators are also produced by each PHN. These indicators are orientated around a stepped care system approach. As part of their ongoing processes, PHNs are expected to select, periodically review and revise their indicators. There is also a partnership between the Commonwealth and local PHNs to create a national minimum data set that will collect new information to support more effective mental health care.

Since the establishment of PHNs in July 2015, challenges and concerns have been raised about their implementation and operation in relation to mental health. In May 2017, a [PHN Advisory Panel on Mental Health](#) was convened to provide advice to the Minister for Health about these concerns and the progress of mental health reform. This Panel identified issues around funding, the speed of implementation, variation between PHN's in services and inconsistent stakeholder engagement and a lack of clarity around commissioning and decommissioning. The Panel also noted that the reforms implemented through PHNs have impacted a range of groups in the mental health sector, including mental health nurses and other service professionals.

All of the above concerns have been highlighted in CSSA's consultation with its member agencies. While a few member representatives reported PHNs entering into productive relationships with local health and social service partners, the majority reported that PHNs increasingly refer to clinical specialists and recommission services to a clinically orientated medical model or through their own, newly established service entities. Further, the shift from block funding to user-pays in health and social services leaves a coordination-services funding gap. Local GPs and PHNs, among whom understanding of and support for holistic approaches varies greatly, are now the go-to for coordination services. Even a supportive local GP can struggle to coordinate a tailored package, and

it gets harder still when price-settings are reduced, cheaper service models are required, and there is less time for face-to-face involvement with patients.⁶ Conversely, our members report that social service support workers and managers are providing unpaid coordination and case management support for people whose condition is too chronic for their GP but not chronic enough for hospital – but this support is inconsistent. Without a constant carer or coach, and in the face of complex systems, there is a real chance that the only available response will be a medical one.

Our members note poor coordination and lack of collaboration between Federal, state and territory funded services, which runs contrary to the emphasis within the Fifth Plan. They also widely report the withdrawal of State and Territory support for mental health and funding for community mental health services to be both creating policy gaps that people fall through and a threat to their service viability. Any falling away of community and social service supports around the NDIS will contribute to what its designer Bruce Bonyhady⁷ has described as the steep cliffs emerging around the scheme. This is where there is increased pressure from people who are deemed ineligible to enter the scheme due to lack of other supports. Such practices also have the potential to further entrench the medicalisation of mental health conditions.

Previous Australian research has demonstrated how gaps in policy can result in higher rates of medication use. In particular, longitudinal studies of psychostimulant use for Attention Deficit Hyperactivity Disorder (ADHD) in Australia found higher usage in lower socioeconomic regions,⁸ a situation contrary to the situation in the United States and most other western nations. The main contributor to this situation in the nineties was federal eligibility not being matched with affordable and accessible allied health, social and community services for low income families.⁹ This left GPs and clinicians as the main professionals with the capacity to intervene through subsidised medical, clinical and pharmaceutical interventions. This was found to be part of significant medicalisation and rapid growth of this prominent youth mental disorder in Australia.¹⁰

This is not to suggest that biomedical and clinical treatment is inappropriate for mental health conditions. However in the case of mental health, historical precedent, current policy arrangement and social factors can all encourage biomedical interventions as the first or only response. The stigma around mental health and a focus on general practitioners as the gateway to services provides a disincentive that may be a deterrent for some individuals (e.g. men in rural locations) to seek information and support early. When assistance is sought, it will be once it has escalated which increases the likelihood that clinical or emergency intervention. The innovative work of some PHNs to address this and encourage soft entry to services was highlighted by case studies within the recent submission by the Commonwealth Department of Health to the Senate Inquiry into regional and remote mental health access.¹¹ However, with variability in PHN responses, the challenges around psychosocial services within the NDIS and a decline in support by the states and territories for community mental health services, there is potentially an ‘all or nothing’ situation with biomedical services (that do not build resilience, coping or social participation skills to keep

⁶ <https://www.themandarin.com.au/104498-medicalisation-nation-australias-growing-public-policy-dependence-on-drugs/>

⁷ <https://www.afr.com/brand/afr-magazine/ndis-what-happens-when-the-powerful-deal-with-disability-20180601-h10u0z>

⁸ Prosser, B & Reid, R (2009), ‘Changes in use of psychostimulant medication in Australia’, *Australian and New Zealand Journal of Psychiatry*, 43, 4, pp. 340-347.

⁹ Prosser, B., Reid, R., Shute, R., & Atkinson, I. (2002). Attention deficit hyperactivity disorder: special education policy and practice in Australia. *Australian Journal of Education*, 46(1), 65-78.

¹⁰ Prosser, B & Graham, L (2018). ‘Historical, cultural and socio-political influences on Australia’s response to ADHD’, in Meredith Bergey and Peter Conrad (eds), *ADHD in Global Perspective*, John Hopkins Press, pp.54-76.

¹¹ Australian Government Department of Health (2018), see p.18ff, available from:

https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Submissions



them out of the health system). CSSA notes the comments made by former Australian of the Year, Professor Patrick McGorry, who recently warned that there are virtually no services available between GP and hospital emergency.¹²

When ways of accessing services, commissioning practices or market pressures supports medicalisation, it runs contrary to holistic best practice, the recovery model and the need to address social determinants. It also potentially creates dependency and longer-term clinical and health costs. Most importantly, it misses the window of opportunity provided by biomedical responses for skills development and greater social and economic participation. For these reasons, in 2017 a [UN Special Report](#) on mental health strongly called for a move away from a predominantly biomedical, psychiatry driven model of mental health.

The MHA have recognised the prominence of the biomedical model in mental health services,¹³ while it played a central role in the recent PHN Advisory Panel. However, the issue of PHNs and their potential role in medicalisation has not been foremost in its past reports and submissions. Hence, CSSA and its members wish to draw this issue to the attention of the Inquiry.

In response to concerns that the funding, demands and current operation relating to PHNs can further entrench biomedical responses to mental health, CSSA and its members recommend the following.

Recommendation 1: That the Commission request the Australian Government to further quarantine PHN funding to ensure commissioning to community and social service providers who specialise in addressing the social determinants of mental health.

Recommendation 2: That the Commission call for national and local PHN indicators to be refined to report specifically on the level of commissioning and collaboration with allied health and social service providers.

Recommendation 3: That the Commission request the Australian Institute of Health and Welfare report on PHN mental health commissioning and collaboration to allow national benchmarking and transparency.

¹² <https://www.smh.com.au/politics/victoria/nothing-between-gp-and-emergency-victoria-s-mental-health-failure-20190227-p510ip.html>

¹³ MHA (2019). 2019 Election Platform, MHA, Canberra.

3. The NDIS psychosocial disability stream currently lacks the skilled workers to support it

The inclusion of mental health and psychosocial disability has been a challenging issue for the NDIS and government. This is because the specific needs of these groups were not central in the design or initial implementation of the scheme. It is because psychosocial disability differs from most other forms of disability in key respects.¹⁴ Further, it does not address the episodic nature of mental illness which does not fit into the NDIS trajectory of recovery. CSSA and its members also note the ongoing challenges around pricing within the scheme and the efforts of the National Disability Insurance Agency (NDIA) to respond.¹⁵

In response, the Commission's 2017 inquiry into NDIS costs recommended that the NDIA implement a 'psychosocial gateway' to improve access to, and use of, supports available under the NDIS. The NDIA has subsequently developed a new 'psychosocial disability stream' for integration into the NDIS.¹⁶

CSSA and its members strongly support this initiative by the Government. However, members also report that there is currently a shortage of workers with relevant psychosocial skills and accreditation to apply in NDIS and community service settings. While certificate and higher level training is currently available in clinical mental health or generalist disability services (including specific accreditation for mental health peer work), these are developed and delivered within disciplinary silos. The introduction of the psychosocial stream within the NDIS has highlighted an important area of need, namely psychosocial supports. These supports are not only important for the daily living, functioning and social participation, they are also important foundations to support the effectiveness and success of acute and chronic interventions.

Further, experience from the Partners in Recovery (PIR) and Personal Helpers and Mentors Support (PHaMS) Programs nationwide demonstrates that NDIS eligible mental health participants may not trust, nor understand, the various support clinical, primary or allied health systems with which they interact.¹⁷ Hence, a workforce is required that can provide understanding of lived experience, can build trust in services and can merge understanding of mental health and disability into best practice psychosocial services. However, at this time, CSSA members report that there is not an adequately skilled workforce in place to maximise the potential of recent policy change towards a psychosocial support stream. In particular, some note that the NDIA price guide for psychosocial supports sets a cap on staff salary that does not reflect the skills required. In effect, clinical services remain accessible, but other supports are not due to experienced staff being 'priced out'.

This is not the first time that workforce issues hindered health policy in Australia. In 2009, the National Health and Hospitals Reform Commission supported national registration for healthcare professions to expand community access for vulnerable groups and address issues around long GP waiting lists. Included amongst these groups were Nurse Practitioners.¹⁸ A review of the National NP Age Care Models of Practice Initiative in 2015 found that despite this promising policy direction, there were not enough appropriately skilled professionals in the right location or the right

¹⁴ Mental Health Australia (2018). National Disability Insurance Scheme: Psychosocial Disability Pathway Report. MHA, Deakin.

¹⁵ Aubusson. K. (2019). NDIS at risk of market failure, providers say. Sydney Morning Herald, March 26, p.6.

¹⁶ <https://www.ndis.gov.au/news/400-government-announces-improved-ndis-mental-health-support>

¹⁷ <https://www.ndis.gov.au/media/329/download>

¹⁸ Middleton, S., Gardner, A., Gardner, G., & Della, P. R. (2011). The status of Australian nurse practitioners: the second national census. *Australian Health Review*, 35(4), 448-454.



incentives or adequate funding models to deliver on this promise.¹⁹ This insight extends across the NP workforce, which is still relatively small in number and subject to issues around recruitment and resistance from other health professionals.²⁰ In short, there has not been a significant advance with this policy initiative due to a lack of a ready workforce and effective training pathways. This example points to a regular challenge within the health and mental health sectors, where policy potential needs to be supported by initiatives to address workforce skill distribution and shortages.

The supply of an adequate disability workforce with psychosocial skills to support all providers within NDIS markets, submarkets and the community is a significant concern for CSSA's members. They also note the significance of longer lifespans in the community and the growing demand this will make for age-appropriate psychosocial supports. These matters have not been foremost amongst the options outlined in the MHA *Optimising psychosocial supports* report.²¹

In response to concerns that the NDIS psychosocial disability stream currently lacks the skilled workers to support it, CSSA and its members recommend the following.

Recommendation 4: That the Commission pay particular attention to the extent that variability in GP referrals and commissioning result in people with more complex conditions accessing services where staff do not have the advanced skills and social services are stretched.

Recommendation 5: That the Commission explore the social and economic benefits from expanded support and training in psychosocial support amongst professionals.

Recommendation 6: That the Commission call on the Australian Government to provide additional funding to support evidence based programs that will establish the scope of new psychosocial service models and to develop aligned training and accreditation programs.

¹⁹ Davey R, Clark S, Goss J, Parker R, Hungerford C, Gibson D (2015), National Evaluation of the Nurse Practitioner — Aged Care Models of Practice Initiative: Summary of Findings, Centre for Research & Action in Public Health, University of Canberra, Canberra.

²⁰ MacLellan, L., Higgins, I., & Levett- Jones, T. (2015). Medical acceptance of the nurse practitioner role in Australia: a decade on. *Journal of the American Association of Nurse Practitioners*, 27(3), 152-159.

²¹ Mental Health Australia, (2018) *Optimising psychosocial supports*, project report, p.10-16.

4. Information asymmetries compromise services and maintain demand outside the NDIS

Increasingly, in Australia and overseas, the social services sector is required to operate according to market based models. These models are designed to give participants more choice and control over the services they receive. Consumer service delivery models are now present in several sectors, with the disability sector being the most advanced through the NDIS scheme.

The delivery of mental health support relies on a mix of government, market and hybrid models. In theory, the needs of people experiencing mental illness are delivered through our universal health care system, Medicare. These people's functional needs are to be supplemented through the NDIS scheme, which include psychosocial supports, while those who are ineligible or those with additional needs are expected to access a range of community mental health supports and social services. In practice, this is a complex and often confusing system, while access to each of these supports relies on accurate information and sound education to be effective.

This has led to concerns about the operation of these arrangements, particularly in relation to market models. One of the chief concerns that has been raised is that clients and providers are not well placed to exercise genuine informed choice and agency due to information asymmetry, lack of awareness of options and limitations in the processes for accessing services. These matters were the subject of the [Commission's 2017 Inquiry](#) into introducing competition and informed user choice. Such concerns were raised by CSSA members as part of consultations, particularly as they related to mental health and psychosocial supports. As one of our interviewees put it:

If our skilled professionals and experienced carers cannot get the information and navigate the system, how do we expect our people with severe and complex mental health needs to be able to?

Further, there are reports of additional challenges with consumer choice models for vulnerable groups due to their disengagement with government systems, limited internet access, lack of access to coordination services, poor health or written literacy and other health issues. Some have argued that these challenges lead to limited agency and choice by these groups. For instance, several CSSA members have noted that when people experience more severe mental health episodes such situations are not conducive to uninhibited choice. In fact, at times decisions about interventions and treatment are consciously taken on their behalf. This highlights the importance of accessible information and education programs for vulnerable groups prior to crisis situations.

In addition to the specific challenges around information and education equity for those with mental health conditions, there are additional compounding factors for those from socially disadvantaged, culturally diverse or non-English speaking backgrounds. These factors make it all the more imperative that groups have the information they need in an accessible form to advocate for their needs and exercise agency. It also highlights the importance of data collection on the different ways that diverse groups access information, as well as evidence-based strategies to address such gaps. This is what the Commission's 2017 Report described as understanding service user populations through better population analysis.²²

MHA has consistently advocated the importance of supported decision-making as an important part of ensuring that consumers and carers have the knowledge that they need to exercise choice and control.²³ However, it is the view of CSSA and its members that a much deeper understanding

²² See. p.21

²³ For example: <https://mhaustralia.org/submission/submission-disability-employment-framework>



of the levels of information asymmetry, capacity to exert agency and differences between different groups, is needed across the spectrum of mental health conditions. Without a foundation of adequate information, government, market and hybrid service models are compromised.

In response to concerns that information asymmetries are compromising services and maintain demand outside the NDIS, CSSA and its members recommend the following.

Recommendation 7: That the Commission call on the Australian Government to commission research into the differing extent of information asymmetry and barriers across the spectrum of mental health disorders (and cross referenced by different forms of vulnerability).

Recommendation 8: That the Commission call on the Australian Government to commission research into how different groups who face additional barriers to accessing information on mental health supports (such as CALD, disability, refugee and older Australians) do so.

Recommendation 9: That the Commission include in this Inquiry an assessment of the impact of improved information and education about mental health services on social and economic participation.



Conclusion

CSSA and its members welcome the broad scope of the Commission's Inquiry, particularly its consideration of how a vibrant social services sector contributes to improving mental health, economic participation and productivity. The focus of this submission has been specific. Namely, the interface between the NDIS, mental health, community and social services, and the future viability of holistic interventions that incorporate responses to social determinants. The insights from this submission draw from our membership's extensive experience in mental health, disability, psychosocial and social service delivery, as well as their commitment to its future viability and success.