

Productivity Commission mental health inquiry

Victorian Government

Second Submission –

Response to the Draft Report

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Introduction

The Victorian Government acknowledges the work of the Productivity Commission in delivering its Draft Report and welcomes the opportunity to provide a second submission towards this important inquiry.

Our first submission flagged the intersection between our own Royal Commission into Victoria's Mental Health System (the Royal Commission) and the Productivity Commission's work, based on their respective terms of reference.

As has been noted, both reports identify the urgent need for reform.

Both reports recognise a mental health system that has fundamentally failed in ensuring people get the care they need.

And both reports acknowledge the cost of collective failure to our society – and our economy.

As the Productivity Commission itself noted, mental illness costs our nation around \$180 billion a year – or \$500 million a day.

That cost ultimately filters down to employers and businesses, with Victoria's Royal Commission estimating poor mental health resulted in \$1.6 billion in lost productivity, with a further \$4.8 billion lost in foregone wages.

Worksafe – Victoria's agency dedicated to workplace health and safety – also estimates that one in five workers will experience mental illness or injury every year.

And in 2018-2019, mental injury claims made to WorkSafe were expected to reach \$550-700 million.

That number is expected to grow even further, with mental injuries estimated to increase 34 per cent by 2030, compared to an expected 12 per cent increase for physical injuries.

The cost of inaction, however, isn't just measured in dollars. All too often, it's measured in human lives.

In Victoria alone, poor mental health will affect more than one million people each year, with nearly half of all Victorians experiencing mental illness in their lifetime.

Over the past decade, 6,181 lives have been lost to suicide in our state. And across our nation, suicide continues to be the leading cause of death for Australians, aged between 15 and 44.

That number is particularly staggering in rural and regional communities, with data suggesting the suicide rate is around 40 per cent higher.

And yet, the truth is, this is an issue that hasn't been taken seriously enough.

It's why we established our nation's first Royal Commission into mental health – and it's why we remain committed to working with the Commonwealth in advancing vital reform.

The Royal Commission's Interim Report, tabled on 28 November 2019, provides a path forward in transforming our mental health system.

Critically, the Royal Commission's Interim Report recommends immediate action in priority areas, including acute mental health beds, suicide prevention, additional assistance for Aboriginal Victorians, and support for the mental health workforce.

We have committed to implementing each and every one of these recommendations in full.

Together, the findings of the Draft Report and the Interim Report provide an unprecedented opportunity to work collectively in delivering coordinated, integrated mental health services that will benefit every family and every community.

Victoria looks forward to working with the Commonwealth and will consider any recommendations made by the Productivity Commission in the context of our current priorities and the Royal Commission's Final Report.

In the meantime, we encourage the Productivity Commission to consider the following overarching areas in relation to the Commonwealth's role:

- greater investment in mental health and related services
- co-investment and partnership opportunities
- improved access to mental health services
- enhancing the reach and coordination of population and place-based mental health promotion initiatives
- enhancing support for Aboriginal and Torres Strait Islander Australians
- addressing stable and affordable housing, particularly for people with mental illness
- alignment with the work of the Royal Commission into Victoria's Mental Health System to date, including the Interim Report released in November 2019.

As ever, we continue to encourage the Commonwealth to take up these opportunities, working with us as we set out to build the mental health system our families, friends, colleagues and communities deserve.

Relationship between the inquiry and Victoria's Royal Commission

1. The Royal Commission was established on 22 February 2019 to inquire into how Victoria's mental health system can most effectively prevent mental illness, and deliver treatment, care and support so that all those in the Victorian community can experience their best mental health, now and into the future.
2. Released on 28 November 2019, the Interim Report highlights Victoria's mental health system is under considerable strain. An estimated 105,000 Victorians living with severe mental illness are not currently receiving care from specialist clinical mental health services in the public or private systems.
3. The Interim Report made nine recommendations aimed at addressing urgent problems and building the foundations for structural reform. It has a strong focus on developing a system that is co-designed with people with lived experience. The recommendations are:
 - a. establishing a new Collaborative Centre for Mental Health and Wellbeing
 - b. establishing 170 youth and adult acute mental health beds to address critical demand pressures
 - c. enhancing follow-up care and support for people after a suicide attempt through expanding the Hospital Outreach Post-suicidal Engagement (HOPE) program
 - d. expanding social and emotional wellbeing services state-wide in Aboriginal Community-Controlled Health Organisations (ACCHOs)
 - e. establishing Victoria's first residential service designed and delivered by people with lived experience

- f. expanding the consumer and family-carer lived experience workforces and enhancing workplace supports for their practice,
 - g. preparing for workforce reform and addressing workforce shortages by developing new training pathways and recruitment strategies
 - h. introducing a new approach to mental health investment, including a new revenue mechanism (levy or tax) and a dedicated capital investment fund for the mental health system
 - i. establishing a new Mental Health Implementation Office that will operate for two years and work closely with the Royal Commission to implement its recommendations.
4. The Victorian Government has commenced work implementing the recommendations of the Royal Commission. This includes the establishment of Mental Health Reform Victoria (MHRV) on 3 February 2020. MHRV is the administrative office of government charged with implementing the Royal Commission's recommendations over the next two years.
 5. The Royal Commission's Final Report, to be delivered by the end of October 2020, is likely to include recommendations that propose fundamental, sustainable and enduring system redesign and reform.
 6. It is important the Royal Commission is able to continue its important inquiry without prejudice. Therefore, our second submission does not provide endorsement of specific recommendations made by the Productivity Commission in its Draft Report but does note those we support in principle. We know the Royal Commission will have regard to the final report from the Productivity Commission as it crafts its own final report, due in October 2020.
 7. Our second submission comments on the similarities between the Draft Report and Interim Report, some of the specific draft recommendations of the Productivity Commission and highlights potential areas for the Productivity Commission to explore further in its Final Report.

Shared findings

8. Both reports identify similar challenges facing the mental health system in Australia including:
 - An underinvestment in the mental health system, which has been grossly disproportionate compared with physical health.
 - The complexity and fragmentation of the system, which contributes to navigation difficulties and causes delays in obtaining care, resulting in people often receiving limited and disjointed care.
 - A need for clearer roles and responsibilities for the Commonwealth, States and Territories.
 - A marked gap in service provision, with a large and growing group of people with mental illness (the 'missing middle') who are too complex, or their mental illness is too severe and/or enduring to be treated through primary care alone, however they are not ill enough to meet the strict criteria for entry into specialist mental health services.
 - The difficulties people experience when seeking mental health services in rural and regional areas.

- Aboriginal communities continue to experience racism and live with the effects of trauma wrought by colonisation and post-invasion government activity.
 - Families and carers are often left out, not provided relevant information or excluded from the treatment of their loved ones.
 - A lack of access to mental health services that is contributing to suicide rates.
 - Services can be insensitive to an individual's cultural or social needs, or simply unable to provide the right kind of treatment, care and support.
 - A lack of workforce supply, which is most evident in shortages of psychiatrists in some areas and mental health nurses.
 - Services that are too often designed by clinicians, with a focus on medical models, when they should be collaboratively designed in partnership with people with lived experience, who understand their own needs.
 - A lack of appropriate structures and supports for the lived experience workforce.
9. The reports outline a number of shared solutions to address these challenges such as the stepped care model as a framework for the delivery of mental health care, the need for more coordinated, integrated services, importance of universal access to aftercare support for people who have attempted suicide and the need to deliver social and emotional learning to support children and young people who are increasingly adversely affected by mental health.
10. Fully realising the benefits of the two inquiries will require a shared, enduring commitment by the Commonwealth and Victoria and significant collaboration, coordination and funding. This is particularly important in relation to delivering integrated, seamless and high-quality care through a stepped care approach.

The Productivity Commission's draft findings and recommendations

11. The Productivity Commission estimated the cost to the Australian economy of mental ill-health and suicide is up to \$180 billion per year (or \$500 million per day). This includes costs associated with diminished health and reduced life expectancy (\$130 billion) as well mental health and support service delivery, lower economic participation, lost productivity and replacing the costs of carers.
12. The Productivity Commission's Draft Report outlines significant reforms to support improved outcomes. The Productivity Commission estimated the total benefits of implementing reforms to be up to \$11 billion per year as a result of increased economic participation of people with mental ill-health.
13. Victoria supports the general direction of the report; however, further information is required around the rationale for some recommendations, particularly the proposed reforms to the architecture of the mental health system, including flexible and pooled funding arrangements.
14. We believe improving the mental health system is a shared responsibility between States and Territories and the Commonwealth. A number of recommendations touch on policy areas that the States and Territories are solely or partially responsible for. In many instances, Victoria is already implementing actions that align closely with the Productivity Commission's recommendations or seek to achieve the same outcome. These are explored in further detail in the following sections.

Reform can benefit Australia economically but requires investment

15. The Interim Report and Draft Report estimate the high cost of poor mental health and suicide and the economic case for improving the mental health system.
16. The Royal Commission estimated that the economic cost of poor mental health to Victoria was \$14.2 billion in 2018-19. This includes:
 - \$4.8 billion in lost wages (\$3.2 billion after welfare payments received), the equivalent of 1.1 per cent of gross state product 2018-19
 - \$3.7 billion in unpaid care provided by families and carers
 - \$1.9 billion a year in costs to employers (\$1.6 billion due to lost productivity and \$0.3 billion due to workplace injury).
17. Other costs include out-of-pocket costs incurred by individuals, mental health and other services funded by Victorian and Commonwealth governments and private health insurers.
18. The Royal Commission noted the full cost of poor mental health – including the social and personal costs – is far higher.
19. The Interim Report notes increased investment in Victoria's mental health system would provide a range of benefits for all Victorians – particularly people living with mental illness and their families and carers.
20. The Royal Commission found that a 15 per cent reduction in the 'level of need' experienced by Victorians diagnosed with mental illness – via providing improved treatment, care and support – would deliver \$1.1 billion in additional economic activity in the Victorian economy (not accounting for costs incurred to achieve reforms). This economic benefit would be delivered through higher workforce participation and greater productivity at work.
21. The Royal Commission noted timely access to quality care, with improved early intervention and prevention, will reduce or delay the onset of mental illness and enable people to live full and contributing lives – participating in education, employment and communities. This in turn provides economic benefits for Victoria.
22. Improved engagement in paid work benefits employers, who would have access to a more productive and larger workers than is currently the case, and through flow-on increase in demand for goods and services. Governments would also indirectly benefit from higher tax revenue resulting from the increase in economic output.
23. Victoria notes that while the Draft Report identified opportunities to improve efficiencies, such as better use of online technology and care coordination, it did not contain advice on the best means to fund the proposed recommendations or a pathway to deliver the reforms.
24. To deliver the ambitious reforms outlined in the Productivity Commission Report, significant Commonwealth funding would be required. While Victoria has limited capacity to raise additional revenue to support this level of reform, we have committed to implementing the Royal Commission's recommendation to design and implement a new approach to mental health investment to ensure sustainable funding for Victoria's mental health system.
25. As underfunding of mental health services is an issue affecting all states and territories, Victoria recommends the Commonwealth consider a similar approach to fund the

recommendations of the Productivity Commission's Final Report. This mechanism could be designed in way to incentivise practice change that aligns with the Productivity Commission's final recommendations.

The principles for a reformed mental health system


26. There is strong alignment on the fundamental principles underpinning an effective, robust mental health system with both reports acknowledging the 'stepped care model' as the major framework for mental health systems in Australia today.
27. The stepped care model is a strong, evidence-informed blueprint for future system reform that will deliver person-centred mental health treatment and care, targeting the needs of the individual at any stage of illness, including before a person becomes unwell. We know however, that successful implementation of the model has proved challenging.
28. This is reflected by missed opportunities to intervene prior to a crisis and unclear referral pathways. Inadequate coordination means consumers are 'bounced' around the system or miss out on the care they need altogether.
29. Other common aspects of a reformed mental health system we consider important include:
 - placing the consumer at its centre, including empowering them to take part in the mental health system, from making decisions about their own care to contributing to policy design and program delivery
 - greater recognition of families and carers, who often provide significant supports as part of treatment and discharge planning
 - seamless delivery and continuity of services with primary care services at one end and acute services at the other, so that people no longer fall through cracks between different levels and types of services
 - services that respond to the individual needs of consumers and carers, including culturally informed, safe and inclusive services for Aboriginal people and diverse populations
 - timely access to the level of care that best suits an individual's treatment needs, particularly for people living in regional and rural areas
 - an adequately resourced, skilled and motivated workforce available in areas of need
 - an appropriately supported, recognised and valued peer workforce.


Response to specific recommendations

30. The following section focuses on areas of the Productivity Commission's Draft Report that were addressed through specific recommendations in the Royal Commission's Interim Report (for example, suicide prevention and the mental health workforce) or are policy areas that Victoria is solely or partially responsible for.

Suicide prevention


31. Both reports recognise a previous suicide attempt is the strongest risk factor for subsequent suicide and recommend expanding follow-up care and support for people following a suicide attempt.

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32. The Royal Commission recommends the statewide rollout of the Hospital Outreach Post-suicidal Engagement (HOPE) program through recurrent funding to all area mental health services. To facilitate access to HOPE, it also recommends the statewide rollout be complemented by:
 - broadening referral pathways to include people receiving care from community-based clinical mental health services
 - providing additional clinical outreach services in each sub-regional health networked to a regional health service HOPE program to provide support for people living in rural and regional areas
 - extending service delivery hours.
 33. The Royal Commission also recommends the creation, delivery and evaluation of the first phase of a new assertive outreach and follow-up care service for children and young people who have self-harmed or who are at risk of suicide.
 34. Victoria notes the Productivity Commission's Draft Report emphasises providing universal access to aftercare and recommends referral pathways to aftercare for anyone who presents to a hospital, general practitioner (GP) or other government service following a suicide attempt. Similarly, the Royal Commission recommends referral sources for HOPE be expanded beyond hospital-based referrals to include community-based clinical mental health services, in order to support more people. Further consideration should be given to how an integrated and consistent model of care will be supported nationally, including its relationship to the National Mental Health Commission's Vision 2030 document.
 35. The draft recommendation that governments should offer effective aftercare to anyone who presents to a hospital following a suicide attempt is supported-in principle. We welcome further information from the Productivity Commission on the implementation of expanded referrals through GPs and other government services to move towards universal access.
 36. There is opportunity to build on the existing bilateral agreement between the Commonwealth and Victoria to collaboratively contribute to ensuring universal access to aftercare and post-discharge services for people following a suicide attempt.
 37. The Productivity Commission should further examine more 'upstream' approaches to suicide prevention that consider the social determinants of health, people at risk of mental illness and suicide who may not be experiencing a crisis and people facing situational distress who may not have a mental illness.
 38. Community-based, 'upstream' approaches to suicide prevention enable primary prevention and early intervention strategies to address multiple levels of need across settings and cohorts. Community-based suicide prevention builds capacity in a range of individuals and groups to recognise and appropriately respond to early warning signs of suicidality.
 39. Victoria seeks more detail on the Productivity Commission's view on the most effective and efficient funding roles and responsibilities for suicide prevention between the Commonwealth (inclusive of primary health networks), States and Territories, and the level of funding required to realise the shared vision of many governments of working towards zero suicides. In particular, further details are required on the funding increase needed, the proposed model or scope of suicide prevention programs and how they will be delivered collaboratively between Commonwealth, States and Territories to ensure that any programs do not duplicate or seek to redirect efforts without close planning and consultation with states and territories.

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40. Victoria recommends the Commonwealth consider formally adopting a national suicide prevention target and measure its progress in implementing reforms recommended by the Productivity Commission and the National Mental Health Commission's Vision 2030.
 41. We understand the current lack of clarity between jurisdictions impedes outcomes. With the expansion of suicide prevention services recommended in both reports, clarity will be even more important to preventing future suicides and self-harm. The new National Partnership Agreement on Mental Health Services would be an effective mechanism for agreeing roles and responsibilities.


Workforce

42. Both the Royal Commission and Productivity Commission recognise that positive outcomes for people living with mental illness are related to a skilled and available workforce that can deliver person-centred care.
43. We know there are pronounced mental health workforce shortages and issues with access to mental health services in rural and regional areas, which are exacerbated by education and training opportunities being largely based in Melbourne.
44. The Royal Commission made recommendations to prepare for workforce reform and address workforce shortages by developing education and training pathways and recruitment strategies that could be considered by the Productivity Commission comprising:
 - offering a minimum 60 funded placements for allied health graduates and 120 additional funded mental health graduate nursing placements each year in areas of high need
 - offering a further 140 scholarships for postgraduate mental health nurses that covers the full cost of study, each year
 - an agreed proportion of junior medical officers to complete a psychiatry rotation from 2021, with it being mandatory by 2023
 - overseas recruitment campaigns, including resources to assist mental health services to recruit internationally, new recruitment partnerships between organisations and mentoring programs for new employees
 - a 'mental health leadership network' with representation across the state and the various disciplines, including lived experience workforces, supported to participate collaboratively in new learning, training and mentorship opportunities
 - collection and publication of the profile of the mental health workforce across all geographic areas, settings disciplines and sub-specialties
 - mechanisms to gather system-wide workforce data.
45. Workforce development is a crucial area of reform and Victoria is already taking steps to improve workforce supply and retention, including encouraging training in priority trades through the Victorian Government's Free TAFE initiative. Workforce is an area that both lends itself to, and will require, close collaboration between States, Territories and the Commonwealth. This is particularly because shortages across the mental health and broader social services workforces (for example, social, children protection and Aboriginal workers) affect most States and Territories.
46. We encourage the Productivity Commission to investigate expanding existing state and territory programs aimed at increasing access to priority courses and training, such as free TAFE and targeted university scholarships. This could include a focus on regional

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- and rural students or students who commit to working in regional and rural areas to address shortages (bonded scholarships).
47. We note the respective reports have different recommendations to increase the supply of mental health professionals. For example, the Productivity Commission recommends increasing the number of psychiatric training placements and supervisors to increase the supply of psychiatrists. Alternatively, the Royal Commission recommends increasing the exposure of junior medical officers to psychiatry rotations.
 48. It is important to Victoria that the requirements for comprehensive post-graduate training for mental health nurses is retained to ensure they are adequately prepared for entry to the mental health workforce. Mental health content in the undergraduate curriculum should be strengthened and consideration could be given to a mental health nurse masters course.
 49. Victoria supports the general directions of the Productivity Commission's workforce recommendations, particularly the need for the National Mental Health Workforce Strategy to specify actions to address any forecast shortages in skills and professions. The Strategy should also consider the time and costs related to growing the mental health workforce.
 50. The Productivity Commission's Final Report could further explore the contribution of specialist psychologists, particularly for high intensity or complex care and multidisciplinary health teams to support integrated service delivery between acute and community settings, facilitating continuity of care and enhancing the workforce's capability and skills.
 51. Consideration should also be given to links between the mental health workforce and specialist service providers, such as those working in family violence and AOD services.

Lived experience (peer) workers

52. Both reports acknowledged that lived experience workers are highly valued by consumers, carers and families. Following Victoria's world leading Royal Commission into Family Violence, prioritising the lived experience has been a central tenant of family violence reform across the state and benefited victim-survivors, the sector and government.
53. In relation to developing the lived experience workforce, the Royal Commission recommends:
 - implementing learning and development pathways, education and training opportunities and optional qualifications for lived experience workers, including adding the Certificate IV in Mental Health Peer Work to the free TAFE course list
 - new organisational structures, capability and programs within services to enable practice supports, including coaching and supervision for lived experience workers
 - a mandatory training program for senior leaders, and induction materials for new staff, to build understanding of the value and expertise of lived experience workers
 - implementing ongoing accountability mechanisms to measure organisational attitudes and the experiences of lived experience workers, including establishing a benchmark in 2020 of the experience of lived experience workers.
54. Victoria considers there is close alignment between the recommendations of the Royal Commission and Productivity Commission in relation to lived experience workers and supports the general directions of the Productivity Commission's recommendations.

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55. The Productivity Commission is encouraged to consider the role of the Commonwealth Government in supporting a new community-based, peer-led model of acute residential care, noting that to be successful, the model requires capital investment to ensure facilities are modern, therapeutic and designed with input from people with lived experience.
 56. Any national review commissioned by the Commonwealth to develop a comprehensive system of qualifications and professional development for lived experience workers should consider the findings and recommendations of the Royal Commission related to the lived experience workforce.
 57. The Productivity Commission could also consider recommendations in its Final Report that focus on building and measuring organisational support for lived experience workers to complement the focus of the national review.

Early identification of risks in families and children

58. The Royal Commission's Interim Report identifies that Victoria's children and young people are adversely affected by mental illness and makes the case for greater investment in and attention to the mental health of children and young people.
59. The Royal Commission also notes a range of social determinants can affect the health of children and young people. For example, children who experience adversity or trauma in childhood, including through child abuse and neglect, family violence, the mental illness of their parents or other caregivers and bullying.
60. Two Royal Commission recommendations focus on young people. This includes the expansion of acute beds and a new youth assertive outreach and follow-up care service, integrated with broader services, including education, which forms part of the recommendation on suicide prevention.
61. Victoria supports the general directions of the recommendations focused on early child and school education and youth economic participation, and welcomes the discussion raised regarding international students' mental health, including suicide prevention.
62. We are progressing initiatives that align with the Productivity Commission's draft recommendation to support the social and emotional development in preschool children. An example is screening children when they start school for developmental and behavioural problems through the [School Entrant Health Questionnaire](#), which includes the Parental Evaluation of Developmental Status (PEDS)
63. Initiatives aligning to the Productivity Commission's draft recommendations for wellbeing leaders in schools are being progressed in Victoria through our 'Mental Health Professionals in Schools' program. We recognise the need for all schools to have access to leading staff who can deliver whole school approaches to wellbeing and mental health primary prevention, in addition to regular access to a trained mental health professional. All Victorian government secondary schools currently have funded secondary welfare coordinators and approximately two-thirds of primary schools have funded primary welfare officers. These follow the model of dedicated school wellbeing leaders recommended by the Productivity Commission. There is an opportunity to expand on the mental health professionals in schools model through national education funding arrangements, including expanding the program into non-government schools.
64. There is potential merit in the COAG Education Council focussing on a strategic national policy approach. Victoria has a strong, evidence-based focus on social and emotional learning in the education system and could share evidence from these programs to help inform a national policy. As chair of the COAG Education Council in 2020, we could

facilitate consideration of this recommendation, working with the Commonwealth and State and Territory education departments.

65. The COAG Education Council may also be best placed to consider any implementation issues associated with the recommendation that national guidelines be used to accredit social and emotional learning programs delivered in schools.
66. Some of the draft recommendations will have significant cost implications for Victoria and other stakeholders, including state and territory regulatory authorities, TAFEs and registered training organisations. It is recommended that the Productivity Commission consider funding options and solutions.

Psychosocial supports

67. The Royal Commission did not make a specific recommendation in the Interim Report on psychosocial support but noted the NDIS is working well for some people with a psychosocial disability the scheme is yet to deliver its full benefit.
68. It identified that fragmentation of community psychosocial services due to the introduction of the National Disability Insurance Scheme (NDIS) and changes to funding arrangements, distorted lines of responsibility and created ambiguities in oversight responsibilities.
69. The Royal Commission recognises that redesign of the mental health system will require consideration of the impact of the NDIS, including arrangements for people with a severe mental illness and associated psychosocial disability who are ineligible for the scheme.
70. We support in principle the Productivity Commission's recommendations focused on improving psychosocial supports, particularly for the NDIS to improve its approach to people with psychosocial disability and its recognition of the supply gap in psychosocial support services. We encourage the Productivity Commission to provide further clarification on the responsibility of the Commonwealth in relation to investment in psychosocial support services for people who are not eligible for the NDIS.
71. We also urge the Productivity Commission to consider findings and recommendations made in its 2017 report into the costs of the NDIS which are yet to be fully acted on or implemented by the Commonwealth Government. This includes in particular:
 - specific challenges faced by people with psychosocial disabilities in accessing the scheme (Finding 3.2, Recommendation 5.3)
 - inadequate pricing of supports and the need to establish an Independent Pricing Authority (Finding 8.1, Recommendation 8.1)
 - addressing finding 2.3 which noted that the NDIS continues to operate under budget, indicating that committed supports are not being fully utilised and that some participants are receiving poor outcomes, or indeed many prospective participants are not able to gain timely eligibility assessments in the first place.
72. The Productivity Commission should also consider the removal of the staffing cap, ensuring there is adequate opportunity for market development.
73. Victoria notes that extending the contract length from a one-year term to a minimum of five years will provide greater funding certainty for providers and improve their ability to recruit a skilled, experienced workforce. Such certainty would assist in ensuring the continued provision of support for consumers who are not eligible for the NDIS and who instead receive Commonwealth funded psychosocial support services. However, we

would need to consider whether such an approach provides sufficient flexibility to introduce any potential changes to models for funding service providers.

74. There are also opportunities to improve the approach to people in contact with the justice system, including where delays to accessing NDIS supports contribute to a person remaining in custody.

Housing services

75. We support the Productivity Commission's focus on housing and homelessness and recognises that implementation would require large investment by Commonwealth, State and Territory governments.
76. The Royal Commission's Interim Report provides considerable evidence about the need for safe and affordable housing to prevent illness and promote recovery. It documents that homelessness, poverty and disadvantage are all significant drivers of mental ill health, and that there is a two-way relationship between demand for mental health services and housing assistance.
77. The Interim Report states people who access public specialist mental health services are more than eight times more likely to access specialist homelessness services and almost five times more likely to access social housing than the Victorian average. A conservative estimate of the flow-on costs to other government services of poor mental health include \$36.7 million in social housing and \$30.3 million in homelessness services.
78. The Interim Report shows that public housing offers the most cost-efficient ongoing cost for housing people with a mental illness, at \$45 per day, compared with a range of alternative accommodation costs including acute hospital care at \$1,164 per day.
79. Since the post-world war II era, national housing agreements have been largely predicated on the Commonwealth Government maintaining primary responsibility for capital construction costs of new housing, whilst the states and territories maintain primary responsibility for operational funding and maintenance.
80. We understand the intersection between the mental health system and related service systems, including housing, will be the subject of further deliberation by the Royal Commission.
81. The Productivity Commission's recommendations are focused on ensuring people with complex needs have access to stable housing and we believe there is a need to address the lack of stable secure housing as a contributing factor for people developing mental illness.
82. A secure safety net of social housing is a key part of this, particularly where the private market does not offer safe, stable and affordable housing. Further investment in social housing is required in Victoria to support tenants with, or at risk of, mental illness, and to ensure the communities in which they live are socially inclusive. Increased Commonwealth investment could amplify efforts the Victorian Government is already making in this area through *Homes for Victorians* and other initiatives.
83. Victoria considers that without sufficient housing stock, a policy of not discharging consumers into homelessness may result in unintended and negative consequences, such as the inappropriate extension of stays in prisons through people being refused bail or parole on the basis that there are no housing options available to them.
84. Addressing these issues will require considerable investment in social housing and other housing strategies, augmented with psychosocial supports to enable people to maintain stable tenancy and support recovery.

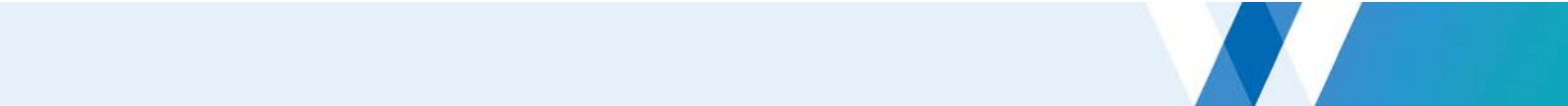
85. The Productivity Commission's Final Report could clarify the responsibilities of the Commonwealth, States and Territories for addressing the undersupply of affordable housing and ensuring access to psychosocial supports. In particular, this should provide commentary on the current levels of funding provided through the existing National Housing and Homelessness Agreement and whether it has been sufficient to deliver new public and community housing at the levels required.

Mentally health workplaces and Workcover

86. The Royal Commission's Interim Report noted that work-related injury resulting in psychological harm current accounts for 11 per cent of workers compensation claims in Victoria and is the second most common cause of workers compensation claims in Australia. Each year, Victorian businesses pay approximately \$263.4 million in workers compensation insurance premiums associated with these claims.
87. Mental health injury claims are usually associated with an above average time off work and higher than average claim costs. SafeWork Australia found over a five year period:
- the typical compensation payment per mental injury claim was \$24,500 compared to \$9,000 for all claims
 - the typical time off work for a mental injury claim was 15.3 weeks compared to 5.5 weeks for all claims.
88. Worksafe Victoria has also indicated that mental injury claims are increasing year on year, reflecting a growing awareness of the importance of mental health in the workplace.
89. The need for a rethink of the approach to regulating workplace mental health is recognised. While occupational health and safety regulations do not contain specific regulations to address risks to psychological health, substantial reform address this concern is underway in intergovernmental forums as well through legislative and regulatory change in Victoria.
90. Victoria supports in principle the Productivity Commission's draft recommendation that clinical supports should be made available through a provisional payments scheme to all mental health-related workers compensation claims. We are currently piloting a provisional payments scheme for eligible former and current emergency services workers and volunteers, which provides payments for medical and like expenses for 13 weeks whilst their claim is assessed.
91. Victoria notes the Productivity Commission's draft recommendation that workplace health and safety agencies should monitor and collect evidence from employer-initiated interventions to create mentally healthy workplaces and improve and protect the mental health of their employees.
92. Victoria notes there is more to do in achieving a well-understood and consistent state of knowledge on how to control the multifaceted nature of psychological hazards and intends to prioritise this work.

Criminal justice

93. We support the general directions of the recommendations focused on mental health screening in custody and is already progressing initiatives that align with the Productivity Commission's draft recommendations.
94. In Victoria, all adult prisoners and young people are required to undergo a mental health screening and assessment upon entering custody. Where mental ill health is identified, relevant referrals and care plans are developed as clinically required. Further to this,

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- Victoria recently introduced a new screening and assessment tool and a case management framework in youth justice centres to better support young people with mental illness.
95. In its initial submission to the Productivity Commission, we recommended the Medicare exclusion for prisoners and young people in youth justice be lifted. Victoria considers this change would facilitate enhanced mental health treatment in custody.
 96. The Productivity Commission noted the lack of data availability on prisoner health, particularly for young people, as a nation-wide issue. Victoria and New South Wales are the only states that conduct annual surveys of the youth justice population. The Australian Institute for Health and Wellbeing has also previously recommended a national data collection mechanism on the health of young people in the justice system.
 97. Data availability for prison health represents an opportunity for the States and the Commonwealth to collaborate on how to build the most effective databases for key information about the health of prison and youth justice populations.
 98. Victoria considers support initiatives should be developed to ensure responses to those experiencing a mental illness are collective responses from police, health and ambulance services.
 99. In some parts of Victoria, collaborative programs (such as the Mental Health and Police (MHaP) response and Police, Ambulance and Clinical Early Response (PACER) program) currently exist where there is a co-response from Victoria Police and mental health clinicians to a person experiencing a mental illness. However, programs like MHaP/PACER have limitations including restricted operating hours and locations.
 100. While further reforms in this area will be subject to the final findings and recommendations of the Royal Commission in October 2020, Victoria will consider the Queensland model referenced by the Productivity Commission, noting expanding clinician support for police would improve frontline police responses to those experiencing mental illness.

Insurance discrimination

101. Victoria supports the Productivity Commission's recommendations focused on increasing awareness of mental illness in the insurance sector and reducing discriminatory practices affecting people with mental illness.
102. Victoria recommends the Commonwealth take a leading role in addressing discrimination in the insurance sector, particularly disincentives for people seeking early support of mental illness. These include increased premium costs or being deemed ineligible for life, travel or health insurance.
103. In its 2019 report, *Fair-minded cover*, the Victorian Equal Opportunity and Human Rights Commission found that in an eight-month period, three travel insurers sold more than 365,000 policies containing terms that discriminated against people with mental health conditions.
104. The report found that there is increasing data available on mental health to help travel insurers accurately identify, manage and price risk for different mental health conditions. However, insurers either did not hold any actuarial or statistical data or, where they did, this data did not support a sufficient basis for the use of blanket mental health exclusions.
105. Insurance discrimination is common and needs to be addressed to ensure that help-seeking is seen as a positive step towards managing a person's mental health, the

same way that a gym membership is often subsidised by health insurers for physical health.

Opportunities for further work

Funding and institutional reform

106. Victoria notes that the Royal Commission has committed to addressing governance and system redesign in its Final Report. Therefore, we have not addressed the matter in detail so as to not pre-empt the recommendations of the Royal Commission.
107. The Productivity Commission recommends significant structural reform to improve coordination of funding and service delivery by all levels of government. This includes reforming governance and commissioning by transitioning public mental health care, primary mental health care and psychosocial supports to regional commissioning authorities (RCAs), with funding controlled by each State or Territory.
108. As noted by the Productivity Commission, the establishment of RCAs would be a significant change to existing governance arrangements. Mental health would be extracted from the National Health Reform Agreement and primary health networks (PHNs) would not have a role in mental health care.
109. While the establishment of RCAs has the potential to support better collaboration between different levels of government, separating mental health governance arrangements from general health governance arrangements would contrast with, and potentially impede, the generally accepted policy direction of integrating the health and mental health systems. This could create barriers for delivering holistic health care.
110. During public hearings, the Royal Commission heard that a reformed mental health system needs to provide access to integrated, evidence-based interventions that consider the whole person and respond to their full range of health needs. This requires consideration of how a new system will operate consistently, within states and territories and nationally.
111. Internationally, many jurisdictions have taken steps to integrate their general and mental health services, supported by governance structures that encourage holistic care. These jurisdictions point to evidence that integrated services improve treatment for co-morbid conditions, reduce stigma and support more coordinated care for consumers.

Suggested focus for the Productivity Commission

112. We believe the Productivity Commission needs to provide further detail on how the new RCAs would be funded, how many are proposed and what coverage they should have. This includes clarifying how RCA funding will be linked to Medicare Benefits Schedule rebates.
113. In making recommendations in this area, the Productivity Commission should recognise each jurisdiction's different funding and service delivery arrangements, including their different reform trajectories, and how these different circumstances could be reflected in any proposed new arrangements.
114. For example, Victoria is currently undertaking work to develop an activity-based funding approach for mental health services, which seeks to increase accountability between what is funded and what is provided to consumers.

Aboriginal social and emotional wellbeing

115. We support the Productivity Commission's recommendations focused on Aboriginal social and emotional wellbeing and recognise the need for Aboriginal community control in delivering mental health and wellbeing services to Aboriginal people.
116. The Royal Commission and Productivity Commission include findings that support self-determining approaches to suicide prevention and improving social and emotional wellbeing for Aboriginal communities.
117. The Royal Commission's Interim Report acknowledges the role of intergenerational trauma and systemic racism in the disproportionately poorer mental health outcomes for Aboriginal people.
118. The Royal Commission recommends expanded social and emotional wellbeing (SEWB) teams across Victoria with teams to be supported by a new Aboriginal Social and Emotional Wellbeing Centre (Centre). This requires:
 - dedicated recurrent funding to establish and expand SEWB teams in Aboriginal Community-controlled Health Organisations (ACCHOs), with statewide coverage within five years
 - scholarships to enable SEWB team members to obtain recognised clinical mental health qualifications (minimum of 30 scholarships awarded over the next five years)
 - recurrent funding for the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to develop and host the new centre (in partnership with experts in Aboriginal mental health). The centre will support research, governance, workforce development, and practice improvements.
119. This recommendation reflects a commitment to self-determination and Aboriginal control in developing culturally appropriate mental health and wellbeing services. Evidence shows self-determination is crucial to improve health and social outcomes for Aboriginal people.
120. This is articulated best in the '*Uluru Statement from the Heart*', written by the 2017 National Constitutional Convention, seeking recognition of structural inequalities that continue to significantly impact the social and emotional wellbeing of Aboriginal and Torres Strait Islander people across Australia. We encourage the Productivity Commission to place necessary emphasis on the importance of self-determination and support a positive resolution to the question of Constitutional recognition for First Nations people.
121. Victoria considers there is an opportunity for the Commonwealth and Victoria to collaborate on the implementation of the Royal Commission recommendation, including jointly supporting Aboriginal and Torres Strait Islander organisations as the preferred providers of social and emotional wellbeing initiatives.

Suggested focus for the Productivity Commission

122. The Productivity Commission's Final Report should further the following to improve the social and emotional wellbeing of Aboriginal people:
 - prioritising culture, including investment in connection to culture as a protective factor
 - addressing trauma and supporting healing, particularly for members of Stolen Generations and people experiencing intergenerational trauma
 - addressing racism and promoting cultural safety

- transferring power and resources to Aboriginal communities.

Translating research into practice

123. The Royal Commission notes Victoria has a gap in translating evidence into practice and recommended establishing a Victorian Collaborative Centre for Mental Health and Wellbeing. The collaborative centre will:
- drive exemplary practice for the full and effective participation and inclusion of people with lived experience across the mental health system
 - conduct interdisciplinary, translational research into new treatments and models of care and support to inform service delivery, policy and law making
 - educate the mental health workforce through practice improvement, training and professional development programs
 - provide adult clinical and non-clinical services to its local population.
108. Victoria recognises that comprehensive and collaborative centres have been adopted globally to respond to health challenges such as cancer, cardiac and communicable diseases. Cancer centres have been successful in bridging gaps between research and clinical care, and there is evidence that people treated in these centres have better outcomes.
109. In Victoria, the Victorian Comprehensive Cancer Centre (VCCC), which was established in partnership with the Commonwealth, has increased access to educational and training initiatives and leveraged considerable funding for clinical trials.
110. We believe there is significant potential for the Victorian Collaborative Centre for Mental Health and Wellbeing to lead the nation in mental health and wellbeing research, emphasising the opportunity to connect to services to ensure that knowledge is translated into everyday practice as a key element. This includes promoting the importance of lived experience roles in the workforce throughout the mental health system in Victoria and nationally.
111. Similar to the VCCC, there are opportunities for the Victorian Collaborative Centre for Mental Health and Wellbeing to be established in partnership with the Commonwealth.

Suggested focus for the Productivity Commission

112. There is an opportunity for the Productivity Commission's Final Report to have a greater focus on translating research into new treatments and models of care. This includes drawing on the recommendation of the Royal Commission related to establishing a collaborative centre.
113. The Productivity Commission should be encouraged to look into the Commonwealth Government's existing role in medical research funding and evaluate the adequacy of funding for mental health research through existing grants programs. Further, the Commission should investigate the role of the Commonwealth Government in a new Victorian Collaborative Central for Mental Health, to ensure the centre realises its full potential as a national centre for research and translational practice.

Prevention of mental illness and promotion of wellbeing

114. We consider the Productivity Commission's Draft Report has a strong focus on early intervention in mental illness but less so on prevention. Although social determinants are considered in the Draft Report, this is largely when mental health conditions have already developed. Further, although key social determinants, such as family and

domestic violence, are referenced in both volumes of the report, there is no mention of these in the Overview and Recommendations.

115. Victoria notes that the Royal Commission's Interim Report recognises the role of social determinants in increasing or decreasing the prospect of psychological distress, mental illness and suicide. These include a person's social and cultural characteristics, environment events and neighbourhood, economic and demographic factors.

Suggested focus for the Productivity Commission

116. There would be benefit in the Productivity Commission's Final Report having a greater focus on:
- the social determinants of health, and prevention more broadly, including trauma, homelessness, poverty, family and domestic violence, child protection and out-of-home care, noting that in all areas of homelessness, poverty and trauma, substance use is represented as a contributing factor. This should include a reflection on how government services and policies, such as recent Centrelink debt collection programs, can lead to further degradation of the mental health of vulnerable people, therefore increasing their reliance on other government services. A focus on the social determinants of mental health would enhance service delivery across service systems, contributing to improved mental health outcomes through non-mental health services
 - the risk factors of specific cohorts. For example, although the Draft Report finds LGBTIQ people experience high rates of mental illness, the Overview Document and Recommendations do not directly refer to LGBTIQ people. LGBTIQ people also experience disproportionate rates of suicide compared to the broader community as well as discrimination, stigma, exclusion, barriers to accessing mental health services and higher rates of family violence and violence.
 - providing clear definitions of prevention in clinical and non-clinical settings. There also needs to be recognition that early intervention and prevention require different skillsets to address the issues
 - cultural determinants for cultural groups and how to support training of workforces to be culturally safe and aware of unconscious bias
 - investment in initiatives to support connection to culture for Aboriginal people - connection to culture is a protective factor and preventative measure, both specifically within the mental health space and also across a range of social determinants of mental health
 - the mental health needs of offenders in the community, particularly opportunities to:
 - improve access to mental health and related services for offenders who are in the community, whether on bail or on community-based orders, or following their release
 - take an early intervention approach for those who have had early contact with the justice system through low-level offending and are at risk of deteriorating mental health and escalating offending behaviour
 - the long-term benefits of investing in wellbeing.

Welfare system support

117. While the Productivity Commission's Draft Report made recommendations on workers compensation schemes and income support, it did not consider whether people living with mental illness are appropriately supported by the welfare system.
118. We support-in-principle the Productivity Commission's Draft Report recommendations to improve employment support services for job seekers on income support who are experiencing mental illness.
119. The Royal Commission notes that people with mental illness are waiting longer and becoming sicker before they can gain access to mental health services, during which time they can become disconnected from supports that help their recovery, such as stable employment and housing.
120. The Royal Commission found that an estimated 104,200 fewer Victorians of working age with a mental illness are in paid employment than should be expected, which translates to an estimated \$4.8 billion in lost wages.
121. Additionally, the weekly median income of carers is reported to be 42 per cent lower than that of non-carers, and more than one-third of carers are thought to be concerned about job loss because of their caring role.
122. The Victorian Government considers that efforts by States and Territories to improve mental health outcomes are reliant upon sufficient Commonwealth investment to ensure people who cannot work due to their mental illness (or caring responsibilities) do not encounter further social challenges, including homelessness.

Suggested focus for the Productivity Commission

123. We encourage the Productivity Commission to further consider how the national welfare system could provide a guaranteed level of support for people with diagnoses of mental illness, and ensure that this is a key recommendation of their final report, recognising the social safety net as a foundation for prevention and recovery from illness.