



# ACT GOVERNMENT RESPONSE

**Productivity Commission's inquiry  
into the social and economic  
benefits of improving mental health**

April 2019

**ACT GOVERNMENT RESPONSE- Productivity Commission’s inquiry into the social and economic benefits of improving mental health.**

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# ACT GOVERNMENT RESPONSE- Productivity Commission's inquiry into the social and economic benefits of improving mental health.

## EXECUTIVE SUMMARY

Australia's mental health sector has undergone considerable reform over the past 30 years. However, the growing socio-economic impact of mental ill-health in the ACT, and the significant burden imposed on individuals and the community, make it clear that further reform is needed. As such, the ACT Government welcomes the Productivity Commission's Issues Paper, *The Social and Economic Benefits of Improving Mental Health*, and the questions it poses.

In considering how we maintain and protect the mental health and wellbeing of the community, it is crucial to recognise that social and economic determinants, such as housing, employment, transport, education, contact with the justice system, culture and family are as influential as clinical interventions at a population level.

Acute and crisis services are clearly an integral part of a health system, although they are not the entirety of a system. The ACT Government believes that to address the demand for health services a much broader approach to our health outcomes is required; one which fully comprehends how the circumstances in which people live their lives shape their health outcomes. For a high performing mental health system to be sustainable, we need to give more consideration than we ever have before to how we address the determinants of health and wellbeing, that clinical services cannot address by themselves. We need to challenge the orthodoxy that to improve health outcomes, we always need to consider investment in acute services as the first step.

The mental health and wellbeing of our communities is determined by a complex interplay of factors. This includes everything from people's genetic disposition to developing mental illness, the nature of the place in which they live, what happens in their life, the lives of those close to them and to their wider community.

Given that this is recognised and evidenced in the literature, it stands to reason that our response to the challenges faced should be multimodal too. This provides us with the opportunity to address factors influencing health outcomes in the wider community, workplaces, places of education, while improving clinical services capacity.

In establishing the Office for Mental Health and Wellbeing (The Office), the ACT Government is leading the way in this thinking. The Office has an explicit mandate to consider whole of government approaches to mental health and wellbeing. This means that as much as we consider the role of clinical services, we need to understand how matters such as town planning practices influence health outcomes, whether people can use accessible public transport to get to where they need to be and whether people are able to find and keep somewhere safe to live, that meets their needs. This whole of Government approach acknowledges that these wider issues are not only within the remit of mental health services to address, and that a coordinated approach in public policy planning that uses evidence is the way forward.

The ACT Government supports the concept that multiple strategies are required to adequately address mental health and wellbeing, with only a part of that response being around clinical services.

Whilst the ACT Government believes that we require universal strategies that target the whole of our community, we fully acknowledge that there are particularly vulnerable groups that require more targeted responses.

We are clear that part of that strategic approach should be about building mental health literacy and resilience in people, particularly the early stages of life. We should not seek to develop a mental health system that pathologises normal human emotions, but rather offers early help when those

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emotional difficulties may lead to something more substantial. The philosophy of right care, right time and right place should drive all we do.

The ACT Government has made a recent commitment to develop its own wellbeing index, similar to developments in comparable countries, that seeks to understand more about how a place and our sense of place influences how people feel<sup>1</sup>.

As part of this, the ACT Government is growing a mental health service system that is broader than clinical services, recognises how the circumstances in which people live their lives shape their health outcomes and seeks to positively influence those circumstances. It seeks to provide a well-integrated support structure that supports people to stay well and have access to the right services at the right time.

However, the ACT Government considers that the way we pay for health services, as distinct from what health services we pay for, also warrants thought. Like many parts of Australia and many other advanced healthcare systems, the ACT largely pays for healthcare through the Activity Based Funding (ABF) mechanism. The ACT Government would support an examination of how ABF could better provide the right incentives to foster different models of care.

The mental health service system needs to be seen in the broader context of those factors which influence our mental health and wellbeing. Mental health and wellbeing promotion, prevention, and early intervention are crucial elements of the continuum of care through to acute services, rehabilitation and recovery. This includes how we think about investment in education, housing, transport and justice and how it may lead to an improvement in overall wellbeing.

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<sup>1</sup> <https://www.canberratimes.com.au/politics/act/act-government-to-introduce-wellbeing-index-20190101-p50p39.html>

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# A MULTISECTORAL APPROACH TO MENTAL HEALTH

## Creating a national whole-of-government approach to mental health

Mental health and well-being are influenced by a range of social, economic, political, cultural and ecological factors at the individual, familial, community and structural levels<sup>2,3,4</sup>. This provides an opportunity for strategic policy, outside the traditional realms of health policy, that can promote positive mental health and well-being and prevent and alleviate mental illness.

Research has emphasised the relationship between social disadvantage, chronic exposure to stress and the subsequent impacts on mental health and well-being. A study based in New Zealand found that the level of high psychological distress among the most disadvantaged decile of the population was 24.3 per cent, compared to the average of 5.8 per cent across all deciles or of 0.8 per cent in the least disadvantaged decile<sup>5</sup>. Importantly, evidence suggests that positive mental health and wellbeing are correlated with a reduced burden on acute and primary healthcare services and a reduction in reliance on social support systems<sup>4</sup>.

To achieve the best outcomes for mental health and wellbeing, it is imperative that we take a holistic approach to our community and the circumstances in which they live their lives. The complex interplay between these economic and social determinants, such as housing, family circumstances and access to employment, demands the prioritisation and integration of mental health and wellbeing strategies within all public policies across different sectors, agencies and community groups.

The ACT Government is committed to broadening the understanding of community mental health and well-being and, therefore, the target areas for policy and intervention. We further recognise that a concerted effort in improving mental health will require a paradigm shift whereby the goal is not only to reduce the incidence of mental illness, but to also promote mental well-being as a preventative and protective approach. In the ACT we understand that improved outcomes in health and well-being will strengthen our community, increase our productivity and allow the ACT economy to thrive. A national whole-of-government approach that recognises the social and economic determinants of mental health has the potential to improve underlying community mental health and provide opportunities for early intervention, reducing the overall impact of mental illness.

The Fifth National Mental Health and Suicide Prevention Plan (the 5<sup>th</sup> Plan), released in 2017, identifies the improved integration of mental health services as a key priority area<sup>6</sup>. However, this centres around regional mental health system planning which, while undoubtedly important, does not recognise the need to adjust the course of mental health system planning to address the economic and social determinants of mental health. The ACT Government has sought to address this gap at the Territory level by establishing the Office for Mental Health and Wellbeing, which seeks to provide coordination across government directorates and the community to create a mentally healthy community. However, achieving effective change will require nationally led and coordinated positions and action.

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<sup>2</sup> World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014.

<sup>3</sup> Allen, J., Balfour, R., Bell, R. & Marmot, M. 2014, “Social determinants of mental health”, *International Review of Psychiatry*, 26 (4).

<sup>4</sup> Welsh, J., Ford, L., Strazdins, L. & Friel, S. Addressing the social determinants of inequities in mental wellbeing of children and adolescents. Carlton South, VicHealth, 2015.

<sup>5</sup> Foulds J., Wells, J., Mulder, R. (2014). The association between material living standard and psychological distress. Results from a New Zealand population survey. *International Journal of Social Psychiatry* 60: 766-771.

<sup>6</sup> Department of Health, (2017). The Fifth National Mental Health and Suicide Prevention Plan, Canberra ACT.

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### **Policy opportunities**

A coordinated national approach to creating a mentally healthy Australia will not only have social and economic benefits in the long-term, it will also reduce demand on the mental health care system and allow investments to be redirected to other areas of need. This, we believe, can only be achieved by national whole-of-government approaches that seek to address the social and economic determinants of mental health. This will support the ACT to continue its work in creating a mentally healthy ACT community.

#### Support policies that reduce social and economic disadvantage

Inequities in health outcomes are reflective of peoples experience of social disadvantage in society<sup>3,4,7,8</sup>. This presents a policy opportunity to foster positive mental health and well-being and improve mental health outcomes for those with existing mental illness, or at risk of developing mental illness. Policy action that will improve daily life, including increased access to meaningful employment, access to education, welfare and social support, better support for people within and exiting the justice system, access to quality healthcare, reducing the impacts of social disadvantage for minority groups, ensuring there is secure and affordable housing and a healthy ecological environment are all important areas for consideration<sup>2,4</sup>.

#### Mental health in all policy

In recognising the potent nature of social and economic disadvantage on mental health there is need for all sectors to be held to account for mental health outcomes and for promoting mentally healthy communities<sup>9</sup>. Currently the exclusive responsibility for mental health outcomes and increases in rates of suicide or mental illness seems to rest with clinical services and the healthcare system. Further to this, there is a channelling of funding towards clinical services, such as the numbers of doctors and nurses, and additional clinical research to understand and address the growing burden of mental illness. However, this clinical focus does not address the factors outside the traditional purview of health departments that are affecting people’s mental health and wellbeing and driving them to crisis. This contradiction in priorities is clearly inadequate when considering the established relationship between social and economic conditions and mental health outcomes.

To improve overall mental health and wellbeing we therefore advocate for a national approach to consider mental health as a core consideration in all policies. Federal Government can take leadership in ensuring that mental health becomes a priority consideration in all policy areas, and that the impacts on mental health becomes a key indication in the monitoring and evaluation of these policies.

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<sup>7</sup> McCallum, S.m., Batterham, P.J., Calear, A.L., Sunderland, M. & Carragher, N. 2018, “Reductions on quality of life and increased economic burden associated with mental disorders in an Australian adult sample”, *Australian Health Review*, d.o.i:10.1071/AH16276.

<sup>8</sup> Jenkins R, Minoletti A. (2017). Chapter 4: Prioritizing health equity. Found in, *Health in All Policies*. Minister of Social Affairs and Health, (2017), Finland.

<sup>9</sup> CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organisation.

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### MENTAL HEALTH IN THE ACT

The ACT, like many other jurisdictions, is experiencing growing demand for mental health services. In responding to these challenges, the ACT Government is committed to achieving a stronger, more integrated and more effective approach to mental health. In November 2016, the ACT Government appointed the ACT's first Minister for Mental Health, in a clear statement recognising the importance of mental health.

In June 2018, the Office for Mental Health and Wellbeing (the Office) was established in the ACT to drive better coordination and integration across mental health services, provide system wide-oversight, drive opportunities for quality improvements and create a more person-centred approach to mental health and well-being in the ACT. A key element of the Office's approach is raising awareness of the various social and economic determinants that impact the mental health of the ACT community and ensuring whole of government commitment to address these determinants.

The Office will act as a catalyst for change to capitalise on opportunities to improve the mental health and wellbeing of all Canberrans and to provide meaningful action and reporting. The ACT Government established the Office in recognition of the current complex layering of mental health support across non-government, private practice, clinical, non-clinical, and funding from two levels of government as well as private funding, which inherently poses significant barriers to such reform. The Office is building a long-term whole of government strategic approach that aims to reduce the development of mental disorder and to ensure that people experiencing poor mental health can access the most appropriate support at the right place and right time.

According to current data, mental illness affects around one in five Australians every year, equating to around 76,000 ACT residents. Of this population, around 11,000 ACT residents are likely to have an anxiety disorder, 5000 an affective disorder and 4000 a substance use disorder (noting people may have more than one illness in a 12-month period)<sup>10</sup>. The statistics below, taken from the ACT Chief Health Officer's Report 2018, highlight some of the challenges faced by our community<sup>11</sup>:

- mental illness is a leading cause of chronic disease in the ACT;
- anxiety disorders contribute to 5.1 per cent of the burden of disease;
- depressive disorders contribute to 2.7 per cent of the burden of disease;
- younger Canberrans (18-24 years) are the most likely cohort to experience psychological distress;
- women report significantly poorer emotional health than males in both the 20s and 40s age cohorts;
- 76 per cent of self-harm hospitalisations in 2015-16 were female;
- almost 50 per cent of self-harm hospitalisations in 2015-16 were young Canberrans aged 10 to 24 years;
- in 2015, the suicide rate for ACT men was more than three times higher than that of females; and
- 58 people died by suicide in the ACT in 2017.

When considering these statistics, it is important to note that the level of distress in the Aboriginal and Torres Strait Islander population of the ACT presents a different profile with a higher level of need for that group of people. According to the *Primary Health Network Core and Mental Health Needs Assessment Reporting Template (15 November 2017)*<sup>12</sup>:

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<sup>10</sup> Mental Health Services in Australia, Australian Institute of Health and Wellbeing. Retrieved from:

<https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary/prevalence-and-policies>

<sup>11</sup> ACT Health. (2018). Healthy Canberra: Australian Capital Territory Chief Health Officer's Report 2018. Canberra: ACT Government.

<sup>12</sup> *Primary Health Network Core and Mental Health Needs Assessment Reporting Template, 15 November 2017*. Retrieved from: <https://www.chnact.org.au/sites/default/files/ACT-PHN-Core-and-Mental-Health-Needs-Assessment-reporting-template.pdf>

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- almost one third of Aboriginal and Torres Strait Islander people over 18 years reported having high to very high levels of psychological distress. This percentage is 3.4 times higher than that experienced by non-Indigenous people in the ACT;
- the ACT rate of hospitalisation for mental illness in Aboriginal and Torres Strait Islander people is 23 per 1000 population. This is 2.3 times higher than for the non-Indigenous population; and
- Aboriginal and Torres Strait Islander people access community mental health services at a rate of 1711 contacts per 1000 population. This is 2.6 times higher than for the non-Indigenous ACT community.

### Mental Health Services in the ACT

Most of the mental health care funded in the ACT is a shared responsibility between the Capital Health Network (CHN), which is the ACT's Primary Health Network (PHN), Canberra Health Services (CHS) and the ACT Health Directorate (ACT Health). The Commonwealth Government also makes significant investment into mental health service provision in the ACT, particularly as a funder of the Medicare Benefits Schedule (MBS) that people will utilise to access care. CHS provides clinical mental health services, which are complemented by ACT Health funded mental health programs provided by non-government organisations. The ACT Government's significant investment in community organisations is one of the highest in the country<sup>13</sup>. The importance of this investment is supported by the National Mental Health Commission's *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services*, which recommends shifting funding priorities, from hospitals and income support, to community and primary health care services<sup>14</sup>. The benefit of this shift in investment lies in the potential prevention and/or reduction of acute inpatient admissions if the person is well supported in their community. This offers opportunities for greater service diversification, but also challenges for systemic integration.

Recent mental health reforms at the Commonwealth Government level, including the 5<sup>th</sup> Plan, emphasise the need to develop regional or local approaches to mental health service design, working closely with service users and providers. In most cases, this arrangement relies on cooperation between PHNs working with multiple local health districts. Canberra offers a unique opportunity because there is only one PHN covering a small geographical area with simple and efficient communication lines between the CHN, the ACT Government and the local sector as key funders and mental health service providers.

In 2018 the CHN, ACT Health and CHS began working together, along with other ACT mental health stakeholders, including consumers, carers, community organisations and researchers, to develop an ACT Mental Health and Suicide Prevention Plan (the ACT MH & SP Plan) that works for the whole community. The new ACT MH & SP Plan will guide the identification of priorities, planning and activity in Mental Health and Suicide Prevention services over coming years. Its development provides an opportunity for the CHN and ACT Health to work in partnership to identify and respond to areas of need in a coordinated and integrated way. Under the 5<sup>th</sup> Plan, the ACT Government is committed to finalising a joint ACT Plan by 2020.

Concurrently, ACT Health has been developing a territory-wide services framework to be supported by a range of Service Specialty Plans (SSPs). The SSPs will sit under a broader strategic framework and address different areas of health, including mental health, explaining how each service intends to meet the needs identified in the broader framework. ACT Health has also been working on the ACT Health Strategic Framework for Mental Health and Suicide Prevention, which provides information about the service landscape, a gap analysis, and ACT Health priorities and activities

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<sup>13</sup> Report on Government Services 2018, Part E, Chapter 13 – Mental Health Management. Retrieved from: <https://www.pc.gov.au/research/ongoing/report-on-government-services/2018/health/mental-health-management>

<sup>14</sup> NMHC (2014) The National Review of Mental Health Programmes and Services. Sydney: NMHC.



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identified against the 5<sup>th</sup> Plan. This sets out Canberra’s mental health service needs and key gaps into the future, which in-turn informs other planning, for example the CHN’s commissioning activities.

### **Supporting a stronger mental health workforce**

The performance of any healthcare system depends on its workforce. However, building and maintaining a qualified mental health workforce is a key challenge to overcome. The NMHC have identified a multidisciplinary mental health workforce as one that consists of mental health nurses, general practitioners, psychiatrists, pharmacists, psychologists and allied health professionals, Aboriginal health workers, peer workers and health educators<sup>15</sup>.

All mental health workforces around the world have a strong focus on counteracting high staff turnover. This turnover can have its roots in the high workloads of mental health staff, which can lead to stress and burnout, but also difficulties with career path and in the limited time and opportunities available for training.

However, the age of the current mental health workforce is also of particular importance. For example, according to the 2019 Report on Government Services, 19 percent of employed psychiatrists in Australia are over the age of 65. In addition, 32.7 percent of mental health nurses are over the age of 55<sup>16</sup>. These statistics have worrying implications for the future stability of the workforce.

These issues have significant implications for the mental health outcomes for people accessing services as health service employees who are stressed, overworked and under supported are more likely to make errors and be less motivated to respond to individual client needs. Additionally, high turnover can lead to losses of organisational knowledge, disruption to continuity of care and interrupt the implementation of evidence-based practices and policies<sup>17</sup>.

Consequently, it is imperative to work to attract and retain mental health employees. This is obviously a large area with many decisions to be made about different types of healthcare workers. We have, while not being exhaustive, summarised some of the key areas and made recommendations for general strategies supporting the mental health workforce below.

#### **Recruitment and Supply Strategies**

It is not uncommon for Local Hospital Networks (LHNs) to have the funding available to increase their mental health workforce but not be able to attract employees. In fact, the recruitment of mental health employees is a difficult issue to coordinate for many LHNs because they are, in essence, in competition with each other to secure recruitment from the same pools of, often limited, potential employees.

This is a complex space, with a 2017 review of available national policies in Australia finding that there were 17 national, state and territory documents that related to mental health workforce<sup>18</sup>. Currently, the primary policy document concerned with this is the National Mental Health Workforce Strategy 2011 (Workforce Strategy), although elements of this document are out of date since the development of the 5<sup>th</sup> Plan and the transfer of the role of Health Workforce Australia to the Department of Health. It is unclear how this Strategy is reported on and what the outcomes of activities have been.

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<sup>15</sup> NMHC (2018). Monitoring Mental Health and Suicide Prevention Reform: National Report 2018. Sydney.

<sup>16</sup> Productivity Commission, *Mental Health Management tables*, Report on Government Services 2019.

<sup>17</sup> Scanlan J, Meredith P and Poulsen A. (2013) Enhancing retention of occupational therapists working in mental health: Relationships between wellbeing at work and turnover intention. *Australian Occupational Therapy*, 60, 395-403.

<sup>18</sup> Roberts R and Maylea C. (2017). Australian mental health workforce: State and national policy imperatives and implications for workforce development, in 18<sup>th</sup> *International Mental Health Conference*, Gold Coast, 21-23 August 2017, pp. 49-61.

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In the interests of simplifying the framework surrounding the mental health workforce in Australia and of helping to coordinate action, we suggest that, where possible, the commitments and strategies of these policies are collated into a single policy document. This document should emphasise many of the long-term actions that are outlined in these strategies but will also need to have an increased focus on some of the short-term strategies that increase the supply to the mental health workforce.

An example of this could include national recruitment campaigns, which are more effective than local campaigns. This is an approach that is currently being taken by the NHS in England<sup>19</sup>. These campaigns could include the promotion of qualifications related to the mental health workforce, such as nursing or psychiatry subspecialties, through subsidised unit costs or increasing the availability of grants. This would be particularly beneficial strategies for regional universities.

### **Retention**

There are a number of reasons that people who work in mental health may become dissatisfied with, or seek a change in, their work. To reduce turnover, strategies are required to keep people happier in their workplace.

Training is a key consideration for staff development and retention in many of the national policy documents regarding the mental health workforce. While many of these documents emphasise training for the clinical workforce and clinical skills, it has been identified that the training opportunities for leadership positions and for the carer and peer workforces are virtually absent in these frameworks<sup>18</sup>. These are training opportunities that seem critical for implementing the reforms and creating cultural change.

Training programs need to be developed for these groups and afforded the same level of monitoring, and accreditation that other training opportunities are developed under. The development of these programs will need to be made in cooperation with the relevant stakeholder bodies where appropriate, particularly for the carer and peer workforces, such as the National Mental Health Consumer and Carer Forum.

In addition to training opportunities, we also know that workplace violence in mental health settings is a significant issue affecting staff and their ability and willingness to do their work. A key action should be to adopt safer workplace policies and initiatives. This would not only help retention rates of current staff but would also help to make working in mental health a more attractive proposal<sup>20</sup>.

## **Suicide prevention in the ACT**

Suicide prevention is a key priority for the Minister for Mental Health and the Office. A significant component of this commitment is the implementation of the LifeSpan Integrated Suicide Prevention Framework in the ACT (in partnership with Black Dog Institute (BDI)). LifeSpan seeks to build a safety net for the community by connecting and coordinating suicide prevention interventions and programs, building the capacity of the community to better support people in their community.

According to research conducted by BDI, the implementation of LifeSpan<sup>21</sup> in the ACT could lead to a reduction of up to 20 per cent in suicide deaths and 30 per cent in suicide attempts. This will potentially lead to significant savings in terms of the economic cost of suicide and non-fatal suicidal

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<sup>19</sup> National Health Service (NHS). *The NHS Long Term Plan*, 2019, United Kingdom.

<sup>20</sup> Tonso M, Prematunga R, Norris S et al. (2016). Workplace violence in mental health: a Victorian mental health workforce survey. *International Journal of Mental Health Nursing*, 25(5).

<sup>21</sup> <https://www.blackdoginstitute.org.au/research/lifespan>

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behaviour. LifeSpan in the ACT includes a designated indigenous position to work with local communities and health and wellbeing service providers.

One of the nine pillars of LifeSpan is addressing suicidality crisis care and aftercare. In the ACT, The Way Back Service is delivered by Woden Community Service through Beyond Blue and ACT Health. Evidence from BDI indicates that aftercare services, like The Way Back Service, following a suicide attempt can have a significant impact on reducing further suicide attempts. Evidence from BDI indicates that aftercare and crisis care services such as The Way Back Service may reduce suicide attempts by up to 19.8 per cent. This not only benefits the communities affected, but also equates to economic savings through the reduction in acute presentations and supporting people in the community. In addition, the report produced jointly by Mental Health Australia and KPMG estimates that community-based assertive outreach for individuals who have attempted suicide, such as The Way Back Support Service, has a long-term return of 1.8 times the original investment<sup>22</sup>.

Suicide rates in Australia have not declined over the past decade, with recent statistics indicating they are on the rise. According to the latest Australian Bureau of Statistics data, there were 3,128 deaths from suicide across Australia in 2017 which was the highest suicide rate in the past 10 years. For every suicide death, as many as 25 people will attempt suicide.

Currently, the economic cost of suicide and non-fatal suicidal behaviour in Australia is estimated to be \$6.73 billion<sup>23</sup>. For example, in 2014 within the Australian workforce 903 workers died by suicide; 2,303 workers harmed themselves resulting in full incapacity; and 11,242 workers harmed themselves resulting in a short absence from work. In 2017, 165 Aboriginal and Torres Strait Islander persons died as a result of suicide, with a standardised death rate of 25.5 deaths per 100,000 persons<sup>24</sup>. Further, in 2017, suicide remained the leading cause of death for both Aboriginal and Torres Strait Islander and Non-Indigenous children and young people, accounting for 40% of all Indigenous child deaths<sup>24</sup>.

Three quarters of people who die by suicide are male. The highest percentage of deaths occurs in the mid-life period, the 30-49 years age group, accounting for 42 per cent of the sample (National Coronial Information System). In the ACT in 2015, the suicide rate for males was more than three times higher than that for females with 16.4 deaths by suicide per 100,000 males and 5.2 deaths by suicide per 100,000 females<sup>25</sup>.

## **Psychosocial Support and the National Disability Insurance Scheme (NDIS)**

The ACT Government is pleased to see that the NDIS has responded to concerns raised since full scheme implementation, with the development of a Complex Pathway that is designed to assist people with multiple and complex barriers to access, the need for active support coordination and/or complex support needs. In addition, the Psychosocial Disability Stream has been designed to develop the understanding and skill of NDIA staff working with people with psychosocial support needs on their access requests and plan development and reviews. These NDIA initiatives will be gradually

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<sup>22</sup> <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

<sup>23</sup> Kinchin, I and Doran, C.M: The Economic Cost of Suicide and Non-Fatal Suicide Behaviour in the Australian Workforce and the Potential Impact of a Workplace Suicide Prevention Strategy. *Int. J. Environ. Res. Public Health* 2017, 14, 347; doi:10.3390/ijerph14040347 [www.mdpi.com/journal/ijerph](http://www.mdpi.com/journal/ijerph)

<sup>24</sup> <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Intentional%20self-harm%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20people~10>

<sup>25</sup> ACT Health. (2018). *Healthy Canberra: Australian Capital Territory Chief Health Officer’s Report 2018*. Canberra: ACT Government

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implemented and will provide opportunities to address a number of issues that have been identified by jurisdictions.

Psychosocial disability support for people who are not eligible for a NDIS funded individual support plan is an area of work that has recently taken greater focus. The Mental Health NDIS Sub-Senior Officials Working Group is mapping services that have been retained or established since the transition to the NDIS that provide support services to this group. This will identify gaps and opportunities across jurisdictions.

The Psychosocial Support Measure Bilateral Agreement has allowed ACT agencies to take a collaborative approach to the commissioning of services. ACT Health and the CHN have partnered with other key agencies to assess funding bids that will address gaps in current services and align with priorities of the 5<sup>th</sup> Plan. Two new programs have been commissioned as a result of this measure.

The NDIS has been a major paradigm shift for the ACT's health system and particularly community sector provider organisations. The ACT was a trial site for the NDIS and agreed to implement a phased approach over two years to open the scheme up to all eligible ACT residents. Considerable work was done through the NDIS Taskforce to develop partnerships and protocols that would optimise access to the scheme for people in need of disability support, including psychosocial support.

Despite the work done with individuals and organisations to help them adapt to this new approach, significant challenges were faced by people receiving psychosocial support and the mental health service system, especially community organisations, who had been involved in previously providing psychosocial and recovery-oriented support programs under a block funding model.

When the NDIS was introduced nationally in 2016, much of the innovative work that had been implemented by the ACT Taskforce, in partnership with services, was transitioned to a national approach. ACT Government has received consistent feedback to indicate that the challenges faced in the ACT include:

- There are barriers to accessing the NDIS and there is a perception of a lack of flexibility of the NDIS to reach out to people with complex disability in need of supports. Difficulties have also been experienced with planning and reviews, as well as process related delays.
- There is a perception of a lack of expertise in the NDIA, demonstrating inadequate understanding of psychosocial disability, including the importance of collaboration with the individual and their key supports; greater understanding of the impact of psychosocial disability and the adequacy of plans, funding and what the impact of inadequate plans might mean for individuals.
- The pricing structure for disability support services has a significant impact on the sustainability, quality and effectiveness of providers of psychosocial supports, and is a major issue. The introduction of the NDIS brings with it a philosophical move towards a more market-based approach to paying for disability support. However, in true markets price points are established by market forces and the users of given goods or services decide as to whether a particular price is appropriate. The NDIS is a quasi-market, where providers do not set their price points; those price points are set by a central regulator. The ACT Government has received significant advocacy from the local NGO services provider market to indicate that the price points currently in place are not enough to provide a quality service.
- There are philosophical tensions between the language of permanent disability in the NDIS and the concept of mental health recovery. It remains a moot point as to whether sufficient progress has been made in translating a disability support model to ensure practices that are empowering and promote recovery. This has a peculiar incentive where people may be

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'punished' for their condition improving, by packages being stripped back. This model does not really respect the episodic nature of mental illness.

- There are difficulties in finding suitable accommodation for people where their NDIS package can be implemented. A more defined role for the NDIS is needed around access to accommodation and the transition to accommodation.
- The need to build in support coordination including funding for services to assist people in the period leading up to their engagement with the NDIS.
- Concerns remain regarding psychosocial support services and programs for people who are not eligible for the NDIS, including information linkages and capacity building and implementation of the Bilateral Psychosocial Support Measure; and the loss of social support programs, especially group programs, with open access since the rollout of the NDIS.<sup>262728</sup>

Since 2014, the ACT mental health community service landscape has been through dramatic changes. The ACT Government has received advocacy that indicates that gaps exist in the new landscape and peoples' experience of the NDIS ranges from positively life changing to inadequate. State, Territory and Commonwealth governments have committed to addressing the challenges identified and working groups have been created to progress some of this work. The ACT Government has taken the lead on work to improve the interface between the NDIS and mainstream mental health and is able to incorporate some of the lessons from the ACT trial.

The NDIS has an important role to ensure people in need of psychosocial supports, due to a mental illness, can participate meaningfully in their home life, leisure, study and work. For a small percentage of people this will take the form of individual support packages, but across the spectrum of mental health issues the NDIS, Commonwealth and jurisdictions need to ensure that adequate pathways exist that will allow all people that experience mental health issues to live a contributing life. The benefits of getting the mix of NDIS and other mental health support programs right includes the promotion of individual wellbeing, preventing relapse and reducing reliance on clinical mental health services with greater inclusion and participation across the community. It is not only important in terms of participation and productivity but is a powerful factor in a person's mental health recovery.

## Community perspectives on improving mental health and wellbeing

The Office, ACT Health and CHS are working closely with the community sector in the ACT. The Office is consistently working with peak mental health non-government organisations to hold sector-wide workshops on the future for mental health and wellbeing in the ACT. The workshops identified some of the key elements essential to optimise the mental health and wellbeing of all people in the ACT. These include:

- a strong focus on prevention and early support within a compassionate and accepting community.
- support to access and maintain stable housing, social participation, and employment in mentally health workplaces.

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26 Mental Health Community Coalition ACT (2018) When the NDIS came to the ACT: A story of Hope and Disruption in the Mental Health Sector, Canberra, ACT, Australia. <https://mhccact.org.au/wp-content/uploads/2018/06/FINAL-NDISreport-WebVersion-18June18.pdf>

27 Smith-Merry, J, N. Hancock, A. Bresnan, I. Yen, J. Gilroy, G. Llewellyn (2018) Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Final Report: Stakeholder identified gaps and solutions. University of Sydney: Lidcombe. <http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf>

28 Furst, M.A., Salinas-Perez, J.A., Salvador Carulla, L., (2018) Organisational impact of the National Disability Insurance Scheme transition on mental health care providers: the experience in the Australian Capital Territory, Australian Psychiatry, Vol 26(6) 590-594

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- Integrated clinical and non-clinical services in accessible, safe and welcoming environments which are delivered in a person-centred and trauma informed approach.

Feedback to the ACT Government indicates that the ACT community would like to see a national move from the current complex, siloed service system that has grown in an ad hoc way to a strategic long-term approach that includes prevention, early support, community and inpatient services and delivers supports across the community in a holistic integrated way that wraps around individuals seamlessly.

### **Informal carers – economic impacts of care**

Family members and carers of people with mental health issues play a vital role in the mental health sector and the economic complexity of mental health carers needs to be fully addressed. Mind Australia’s commissioned study<sup>29</sup> estimated the annual replacement cost for all informal mental health care in Australia at \$13.2 billion. However, carers provide a unique type of care that is wrap around and tailored to the needs of the individual and therefore is difficult to replace. There is merit in considering the real cost of care provided through informal carers including the costs associated with carers being out of the workforce, the cost on Australia’s welfare system including through reduced superannuation, the emotional cost of caring for someone and the potential cost when carers are also consumers.

Mental health carers report higher levels of carer stress than other non-mental health carers and are more likely to experience mental health issues themselves<sup>30</sup>. Mental health carers face multiple barriers to acquiring help, especially when the person they care for is lacking insight to their illness or does not want to engage with services. Additionally, carers who are in the position to do so will often finance supports for their loved one due to gaps in the system – this is especially true of accommodation and transport.

### **Changes to how informal carers are supported**

Family members and carers play a vital role in early intervention, recovery and preventing deterioration of mental health. They need to be included in the process of mental health care planning and provided with appropriate information and support to undertake this role. Carers also report their exclusion from participation in mental health care. Barriers to inclusion are often reported to be confidentiality and mental health legislation, the individualised approach to mental health care that fails to see the broader community around the person and negative attitudes across the mental health service system. The cost impact of this exclusion warrants greater consideration.

Carers report that the rolling of much of the Commonwealth funded support into the NDIS has created significant challenges for them. The new Integrated Carer Support Services<sup>31</sup> is not likely to target those carers who are still coping and are early in their caring role to build capacity to prolong their wellness. Carers supporting people who might be eligible but will not agree to access the NDIS or may be ineligible are not able to access this support. Mental health carers are requesting support to undertake their role that is independent of their care recipient’s decision to accept or not accept support from any part of the sector.

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<sup>29</sup> Diminic et al (2017) *The economic value of informal mental health caring in Australia*. Available at: [https://www.mindaustralia.org.au/sites/default/files/publications/The\\_economic\\_value\\_of\\_informal\\_mental\\_health\\_caring\\_in\\_Australia\\_summary\\_report.pdf](https://www.mindaustralia.org.au/sites/default/files/publications/The_economic_value_of_informal_mental_health_caring_in_Australia_summary_report.pdf)

<sup>30</sup> Berk, L., & Berk, M. (2015). Who cares about carers? *Australian & New Zealand Journal of Psychiatry*, 49(10), 936–937.

<sup>31</sup> <https://www.dss.gov.au/disability-and-carers/programmes-services/for-carers/integrated-plan-for-carer-support-services>

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# THE SOCIAL AND ECONOMIC DETERMINANTS OF MENTAL HEALTH

In its Issues Paper, the Productivity Commission correctly identifies that the social and economic participation of people with poor mental health is more limited than that of the general community. However, it is crucial to understand that poor mental health has its precursor in the social and economic circumstances in which people live their lives.

Consequently, to properly address the growing economic burden of mental health issues a much broader approach to our health outcomes will be required than the historical response, which has seen increased funding on healthcare workers and hospital resources. As outlined above, this approach must effectively integrate mental health into the core policy and implementation actions across whole of government policy areas.

The following section describes several of the social and economic determinants that the Productivity Commission identifies as influential to mental health in their Issues Paper. However, we have identified several additional factors that were not considered in this Issues Paper that should be considered in whole of government action to improve mental health, such as climate change.

## **Housing, homelessness and mental health**

The ACT Government recognises the central role that suitable and affordable housing plays for the lives of individuals, as well as the importance of intersections between housing, health, mental health, disability, family safety and justice services.

The ACT government is committed to improving housing in the ACT through the 2018 ACT Housing Strategy and its five goals:

- Providing an equitable, diverse and sustainable supply of housing for the Canberra community;
- Reducing homelessness;
- Strengthening social housing assistance;
- Increasing affordable rental housing; and
- Increasing affordable home ownership.

In doing so, the ACT Government has committed to promoting and protecting good mental health and wellbeing in the community. Many people with mental illness are unable to afford stable housing or make their own housing choices, and frequently have problems accessing appropriate housing and difficulty maintaining tenancies because of disruptions caused by their illness.

There is a direct relationship between mental illness and homelessness or insecure housing, as mental illness is exacerbated by homelessness and insecurity of housing is exacerbated by mental illness. In 2017-18, 39.4 per cent of the 4,026 people who sought assistance from the specialist homelessness services in the ACT experienced mental health issues<sup>32</sup>.

This direct relationship is also demonstrated in the AIHW's Sleeping Rough Report which states that people who present sleeping rough and presciently receive homelessness services over extended periods report high levels of mental ill-health (77.5 per cent), a mental health diagnosis (68.7 per cent), and/or problematic drug/alcohol use (63.3 per cent). Those who cycled in and out of services every couple of years also reported high levels of mental ill-health (54.9 per cent), a mental health diagnosis (45.6 per cent) and/or problematic drug/alcohol use (39.8 per cent). However, the number

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<sup>32</sup> Australian Institute of Health and Welfare (2019) Specialist homelessness services annual report 2017–18

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of people who required homelessness services for a short time reported much lower levels of mental ill-health (29.4 per cent), a mental health diagnosis (22.6 per cent) and/or problematic drug/alcohol use (19.4 per cent)<sup>33</sup>.

The ACT Government has developed several initiatives to improve access to suitable housing and reduce homelessness in the ACT, including improving specialist homelessness early intervention services and increasing the amount of supported accommodation available.

Early intervention and prevention are crucial to support people who are at housing security risk and to prevent them from falling into crisis. Intervening early to prevent homelessness is particularly important for young people and children, as research shows that a person who experiences homelessness as a child is more likely to become homeless in their adult years<sup>34</sup>.

The ACT Government and partners have redesigned the ACT specialist homelessness service system, to improve early intervention resourcing to prevent people from becoming homeless. These improvements have led to significant reduction in the number of people already experiencing homelessness presenting to specialist homelessness services in 2016-17, compared to 2015-16. During this time homelessness rose nationally by 11 per cent while dropping in the ACT by 8 per cent between the 2011 and 2016 Census.

There is an emerging and important body of research which demonstrates the benefits of supportive housing provision, in particular housing first approaches<sup>35</sup>. In light of this, and based on the Brisbane Common Ground supportive housing model, the ACT Government established the Common Ground complex and supported accommodation program. The Brisbane Common Ground model found that over a 12-month period, people who were securely housed in permanent supportive housing used \$13,100 less in government funded services compared to the period when they were chronically homeless. This offset did not include broader quality of life or cost benefits that might be attributed to improved health, well-being, labour market participation, increased education and employment outcomes, significant returns to the Government and the community through tax receipts, reduced income support, more superannuation income in retirement and higher gross earnings and spending in the community<sup>35</sup>.

These results have also been reflected in the ACT Common Ground complex where the program has met or exceeded the needs of chronically homeless people. It is noteworthy that in the ACT a significant number of people who were chronically homeless before, have successfully maintained their tenancy over the past two years. Over this time, 35 per cent of tenants have commenced training and 67 per cent accessed new employment. 80 per cent of tenants have sustained their tenancies for more than two years, 90 per cent have engaged with service providers to address personal issues, and 70 per cent were connected with social support or community activities.

Additionally, the ACT Government is currently developing a bespoke supported accommodation property to transition clients who are currently in the ACT mental health system into longer term supported accommodation. This accommodation will provide a higher level of support for Canberrans with mental illness.

The ACT Government has also funded a study into support requirements and accommodation options for people in the ACT with high and complex service needs to support our development of accommodation support models. This study will focus on the needs of those seeking assistance due to experiencing multiple issues including health, mental health, drug/substance or alcohol misuse, or exiting corrections or care. Outcomes from this work may support future development in this area.

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<sup>33</sup> AIHW: Sleeping rough: a profile of Specialist Homelessness Services

<sup>34</sup> University of Melbourne (2012) Journey's Home research report no. 1: Wave 1 findings

<sup>35</sup> Parsell C *et al* (2015). Brisbane Common Ground Evaluation: Final Report, Institute for Social Science Research, University of Queensland, pp. 123-124.



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The ACT Government’s translation of research into practice has resulted in the development of successful evidence based early intervention and supported accommodation initiatives that provide a plethora of benefits to the individual, the ACT community and to the economy. Translation of research into practice and the development of evidence-based initiatives needs to be encouraged and supported through improved resourcing and funding.

### **Justice and community safety**

#### Youth Justice

It is crucial to recognise that early diagnosis and support from care-givers and other important people in the child’s life, are effective in reducing contact with the justice system which may come about from difficulties with mental health. The development of trauma informed approaches by staff working with children can assist in addressing cognitive impairment arising from repeated early childhood trauma and can address risk factors which may lead to offending.

The *Blueprint for Youth Justice in the ACT 2012–22* sets the strategic direction for youth justice in the ACT. The ten-year strategy focuses on reducing youth crime by addressing the underlying causes and promoting early intervention, prevention and diversion of young people from the youth justice system. Future challenges include improving Aboriginal and Torres Strait Islander outcomes, intergenerational transmission of offending, early adolescence and risk of offending, disability and through care. Since the development of the Blueprint, there has been a significant reduction in the number of young people engaged with the ACT youth justice system.

In the ACT, the Bimberi Youth Justice Centre works in partnership with Justice Health Services, including Forensic Mental Health and the Education Directorate through its Murrumbidgee Education and Training Centre (METC), to provide services to young people on site. All young people in Bimberi attend education or training each school day and METC provides a range of programs including recognised certificate courses, tutoring and transitional support back into the community. The Child and Youth Protection Services integrated case management model and rehabilitation program support prevention of young people reoffending.

#### Criminal Justice System

People with mental illness are over-represented in the justice system. According to the AIHW<sup>36</sup>, 49 percent of detainees have reported being told by a health professional that they have a mental health disorder and 27 per cent reported currently being on medication for a mental health disorder. In the ACT, the 2016 ACT Detainee Health and Wellbeing Survey was completed by 23 per cent of the detainee population and 54 per cent reported a current and/or previous diagnosis of a mental health concern and 21 per cent of respondents reported a previous mental health inpatient admission.

People with mental illness often experience social exclusion and multiple forms of disadvantage. This can result in legal problems developing in connection with, for example, housing, financial, health, family, law and consumer issues.<sup>37</sup>

The ACT Government has developed a criminal justice system cost model which is able to calculate the cost of a person travelling through the criminal justice system. The work of Professor Eileen Baldry (University of New South Wales) on the costs of disadvantage is also informative.<sup>38</sup> It is clear that significant costs can be avoided by acting to limit the contact people with mental illness have with the criminal justice system.

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<sup>36</sup> AIHW 2015 The health of Australia’s prisoners

<sup>37</sup> Coumarelos C, et al (2012). *Legal Australia-wide survey: legal need in Australia*. Law and Justice Foundation of New South Wales, Sydney, NSW.

<sup>38</sup> Baldry E, et al (2012). *Lifecourse institutional costs of homelessness for vulnerable groups*. Department of Families, Housing, Community Services and Indigenous Affairs, Canberra, ACT.

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Research indicates that the younger a person is when they have contact with the justice system the greater the risk of that person re-offending.<sup>39</sup> By identifying early interventions and diversions from the justice system, significant progress could be made in the lifetime trajectory of people.

There are several initiatives already operating in the ACT which aim to assist people with mental illness who come into contact with the justice system. These include:

- ACT Policing has introduced more training for operational staff and are working in partnership with ACT Health to improve responses to people with mental health issues.
- The ACT Government is developing a Disability Justice Strategy which aims to achieve equal access to justice for people with disability, including people with psychosocial disability.
- The ACT Courts and Tribunal has a Courts and Tribunal Assistance Officer who works with court and tribunal users who have disabilities to make reasonable adjustments to ensure its services are accessible to all members of the community.
- All detainees are provided with screening questions regarding mental health needs as part of normal admission to custody processes. Canberra Health Services (Justice Health Division) and ACT Corrective Services work collaboratively under a memorandum of understanding to ensure detainees needs are supported.
- The ACT Government is supporting the continuation of Canberra Community Law's Socio-Legal Practice Clinic. This focuses on preventing homelessness by providing intensive legal and social case work for the centre's most vulnerable clients.
- The Winnunga Nimmityjah Aboriginal Health and Community Service provides both outreach social support and dedicated in-reach health services within the AMC, operating under a standalone and defined model of care.

In seeking to address the over-representation of people with mental health issues within the justice system, initiatives to support their social inclusion are important. Access to stable and appropriate housing, supports to navigate and participate in the justice system (including accessible information), access to legal services and access to social services are all essential.

It is important to note that the social stigma against seeking support is likely to be amplified in the custodial environment. There is a need to continue activities that aim to reduce stigma and encourage help-seeking behaviours.

There is scope for early intervention opportunities that will contribute to the reduction of people living with a mental health condition returning to the criminal justice system. Short durations of support for detainees with a low to moderate level of mental illness may be of assistance to recently incarcerated and recently released detainees to assist with transition periods.

If a detainee has been accessing non-government or private mental health supports in the community, these supports may not be easily accessible from prison. This may be due to the limited availability of practitioners/organisations to attend the prison and the high costs of accessing some services. Although provision of mental health services by telephone is increasing, this can be impractical when limited to 10-minute calls from telephones located in common areas. Increasingly, the Alexander Maconochie Centre in the ACT is addressing this for detainees by offering telephone calls for counselling support services that are available in private areas with no timeframe limitations.

When supervising offenders in the community, ACT Corrective Services seeks informed consent from each offender to contact support services. Should an offender choose to refuse to provide consent, this can limit both the continuity and quality of services provided.

The interplay between mental health and alcohol and drug usage affects a person with a mental illness's engagement in the justice system. These people often require specialist support that needs

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<sup>39</sup> Weatherburn D, Cush R, Saunders P (2007). *Screening juvenile offenders for further assessment and intervention*. NSW Bureau of Crime Statistics and Research, Sydney.

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to transition with the person through their entry to and exit from custody. They may also be vulnerable in prison populations and may engage in crime to support alcohol and drug habits and social connections. The breaking of this cycle can be challenging and require ongoing, professional supports of significant duration.

A history of significant past trauma can severely impact an individual’s engagement with the justice system. This is especially relevant to women offenders in the justice system and trauma informed focuses are vital to ensure appropriate and optimal engagement opportunities. ACT Corrective Services has created a women’s care team, that provides support for female detainees and that carefully considers trauma.

History of trauma is also relevant for anyone with experiences of past childhood sexual abuse. In-line with this, key recommendations from the Final Report from the Royal Commission into Institutional Responses to Child Sexual Abuse emphasised the need for the criminal justice system to be properly resourced to support the mental health of complainants and victims. Recommendations of the Final Report also include strengthening connections, and ensuring reportable conduct schemes, across all relevant agencies, including police, education, health and child protection.

In addition, the justice and services systems need to operate in a cohesive and coordinated fashion across Australian jurisdictions and within the individual jurisdictions. Health, justice and social service agencies need to be able to appropriately share information to ensure people with mental health issues receive the treatment, advice, supports and services they need.

As a major regional centre, there appears to be fluid movement by offenders to and from ACT and the surrounding New South Wales (NSW). This can result in the offender being charged with offences in both jurisdictions. As sentences from different states/territories cannot be served concurrently at this time, offenders can face extradition and/or additional prison time upon release from one jurisdiction. This may also mean that people serve time in a facility away from their family and support networks. Acknowledging the often-fluid nature of societal movement within Australia, this can result in disjointed and disconnected services for offenders and their families. A disconnect between services can contribute to an individual’s disengagement from vital services and may increase their risk of returning to a criminal justice system.

## **Transport**

There is some evidence that existing transportation subsidies may be a public health policy instrument to improve the mental health and social engagement of older people, and this may be applicable to other groups in the community<sup>40</sup>. Social isolation and loneliness have been identified as risk factors for depression in older age. Evaluation of a program in England that provided free public transport travel to people aged 60 and over found that there was an increase in use of public transport, reduced depressive symptoms, reduced feelings of loneliness, and increased regular contact with children and friends<sup>40</sup>.

## **Family Safety and Child Protection**

The Issues Paper acknowledges the social determinants that must be considered when seeking to reduce the social and economic burden associated with mental illness. People exposed to Domestic and Family Violence (DFV) experience worse health outcomes than those who are not exposed, such that DFV contributes more to burden of disease for women aged 18-44, than any other factor.

Research has highlighted there is a relationship between mental illness and DFV. This relationship is complex: being exposed to DFV can impact negatively on mental health, and poor mental health is

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<sup>40</sup> Reinhard E, et al. *J Epidemiol Community Health* 2018;72:361–368. doi:10.1136/jech-2017-210038

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related to perpetration of DFV. There is added complexity when considering the financial impacts of DFV on an individual and issues of homelessness.

Research by Price Waterhouse Coopers<sup>41</sup>, published in 2015 provided an estimate of the costs to the community and individuals as a result of DFV:

- The cost of violence against women, of which the vast majority is domestic and family violence, is high and increasing in Australia and currently stands at \$21.7 billion a year.
- Victims bear the primary burden of this cost.
- Governments (national and state and territory) bear the second biggest cost burden, estimated at \$7.8 billion a year, comprising health, administration and social welfare costs.
- State and territory governments bear 10 per cent of the total cost (around \$2.2 billion).
- The health costs, including cost of immediate and longer-term physical and psychological treatment, associated with violence against women are estimated at \$617.2 million, annually.

The relationships between mental illness, domestic and family violence and homelessness means that if we are to affect change in one then we must take action in all. Further research followed by wide dissemination of research findings in this area is recommended.

To address some of these issues, the ACT Government initiated, *A Step Up for Our Kids: Out of Home Care Strategy (2015-2020)* a therapeutic trauma-informed care system. This systemic approach aims to focus on trauma-informed therapeutic approaches to working with children and young people, and in particular focus on a child or young person's developmental age (as opposed to chronological age). This therapeutic trauma-informed care system also focuses on the importance of building safe and secure relationships as a means of recovery for children and young people who are exposed to situations that increase their risk of experiencing not only trauma and disrupted attachments, but also developing mental health problems.

As part of *A Step Up for Our Kids*, therapeutic assessments and plans have been developed for every child and young person in care. The goal of having these plans in place is that they will focus on supporting the child's development, building self-regulation of emotions, establishing healthy relationships, identifying appropriate cultural responses to trauma, addressing any trauma-related behaviours and developing social skills.

A Trauma Recovery Service, Melaleuca Place, also commenced operation on 1 July 2014 as part of *A Step Up for Our Kids*, which provides high-quality, trauma-informed therapeutic services to children from birth to age 12, who have experienced abuse and neglect, and who are current clients of statutory services.

A consideration for better mental health outcomes is how to continue improving the way the broader health and human services system meets the needs of children and young people who have experienced trauma.

## **Education**

The Mental Health of Children and Adolescents Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Australian Government Department of Health 2015) provided an update on the wellbeing and mental health of children and young people in Australia. The report indicates that 11.5 percent of students used school based mental health

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<sup>41</sup> Price Waterhouse Coopers (2015) A high price to pay: The economic case for preventing violence against women. Our Watch and VicHealth: Melbourne

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services in 2014 for emotional and behavioural issues and the percentage of students with a diagnosed mental health disorder who accessed school based mental health support increased from 19.2 percent in 1998 to 54 percent in 2015.

It is often at school where signs of mental illness are first noticed, this highlights the important role schools can play in identifying emerging mental illness and referring to enabling clinical services.

ACT school psychologists work with students, educators and families to support the academic achievement, positive behaviour, mental health and wellbeing of students, especially those who struggle with barriers to learning. School psychologists help schools and families address some of the biggest challenges in education: improving and individualising instruction to close the achievement gap, preventing disengagement, creating safe and positive school climates and strengthening family-school partnerships. The ACT Government recognises the important role school psychologists play in supporting students, and in 2016 increased funding for 20 additional psychologists was made available to be established incrementally over a three-year period.

All ACT public schools are required to have a Social Emotional Learning (SEL) programs. The implementation of these programs at individual schools is at different stages of maturity and the Education Directorate continues to strengthen and embed these programs consistently across all schools. SEL programs assist students to acquire and effectively apply the knowledge, attitudes and skills necessary to understand and manage their emotions, to show empathy for others and to establish and maintain positive, respectful relationships. School psychologists are involved in supporting these programs as part of broader school wellbeing teams, which can include youth workers, social workers, teaching staff and external providers. A meta-analysis of school interventions indicates that students receiving high quality, multiyear and integrated SEL’s demonstrate positive outcomes in relation to their interpersonal relationships, attitudes and behaviours, emotional distress, drug and alcohol use and academic performance<sup>42</sup>.

While there are significant supports in place for students in schools, it is often the referral pathways and linkages to clinical services that require further support. Canberra, like a number of regional areas, has limited access to specialist services for students with developmental trauma and outreach service provision for vulnerable families.

Stronger integration and connection between different services including community, government and primary care systems would benefit students. As an example, students who continually do not attend school due to mental ill-health need to be adequately supported to successfully re-engage in education, this can often present in case management and wrap around supports being required that transcend the services that education provides.

In the ACT teachers have access to training, in-house and through external providers and national initiatives. Be You is the first framework that will be rolling out training to beginning teachers. The ACT Education Directorate’s Student Engagement branch offers advice to schools on approaches and programs that helps with their skill building that makes them aware and responsive to the mental health needs of students in schools. From a system funding point of view, the Medicare rebate system is not optimal to provide the needed assessment and intervention to children and families with complex presentations. It also does not cover cognitive and learning assessments. This is particularly an issue in ensuring equity in accessing services. There are limited services that will support children and young people whose family are dealing with issues of separation or divorce for those impacted by family violence. These issues have considerable impact on students’ mental health and potentially their educational achievement.

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<sup>42</sup> Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D. & Schellinger, K. B.. 2011. The Impact of Enhancing Students’ Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions. *Child Development*, Vol 82, No 1, pg 405-432)

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### **The Canberra Institute of Technology (CIT)**

The availability of effective and accessible mental health supports is as important for students in tertiary education as it is for students in primary and secondary. The CIT, which is a TAFE-equivalent for the ACT that provides vocational education, has a number of examples of these supports.

CIT provides support services for a wide range of students, which includes those with mental health needs. CIT Counselling staff and Disability staff regularly work with students to provide reasonable adjustments to assist students to continue their studies. In particular, where students’ mental health conditions may worsen and require hospitalisation, CIT works to ensure they can return to study when well without penalty.

The Counsellors work to assist students to address issues they may have, develop strategies to reduce the impact of any conditions and we also provide online and hardcopy wellbeing fact sheets for students and resources with links to apps for mental health, links to services relating to mental health.

In addition to counselling support, CIT offers a range of courses that aim to educate students how to understand and support the mental health of others. Key among these are the Mental Health First Aid (MHFA) courses, which are delivered by an accredited MHFA Australia instructor and provide students with strategies to provide first aid to people who are development mental health problems or experiencing mental health crisis. This includes an Aboriginal and Torres Strait Islander MHFA course that is offered by CIT Yurauna, which is the CIT’s dedicated Aboriginal and Torres Strait Islander Centre of Excellence.

## **Arts and Culture**

In 2018 the Department of Communications and the Arts, in partnership with state and territory governments under the Meeting of Cultural Ministers remit, undertook national consultation to inform a renewed National Arts and Disability Strategy. Of the respondents who identified as living with a disability, living with mental illness was the most common. Common themes from the consultation included: artists and arts workers with a disability contribute to Australia’s cultural life, but there are barriers to arts employment; overwhelmingly, people with disability indicated that going to arts events increases their wellbeing and happiness and makes for a richer and more meaningful life; and people with disability, carers and organisations said that creative and cultural activity is not always accessible. These broad themes show the role that arts culture plays in mental health and wellbeing.

While it is known that early intervention regarding mental health and wellbeing saves money in the long term, there is a lack of evidence in the Australian context to quantify this. However, several international examples demonstrate how arts and culture create social and economic benefits by improving mental health and wellbeing.

The UK Parliamentary Group on Creative Health produced a report with statistics on the economic and social benefits of improving mental health from the perspective of arts and culture<sup>43</sup>. Some key findings include: visual and performing arts in healthcare environments help to reduce sickness, anxiety and stress; after engaging with the arts, 82% of people in deprived communities in London enjoyed greater wellbeing; arts therapies have been found to alleviate anxiety, depression and stress while increasing resilience and wellbeing; an arts on prescription project has shown a 37% drop in GP consultation rates and a 27% reduction in hospital admissions, which represents a saving of £216 per patient; a social return on investment of between £4 and £11 has been calculated for every £1 invested in “arts on prescription”.

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<sup>43</sup> All-Party Parliamentary Group on Arts, Health and Wellbeing, Creative Health: The Arts for Health and Wellbeing, UK, July 2017

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The Gloucestershire Clinical Commissioning Group (CCG) have developed an example of such an arts on prescription sector support program. This involved the implementation of a series of 12 feasibility projects, each costing in the region of £10,000, which have been developed across the life course, exploring whether arts-based approaches can help in the self-management of a range of chronic health conditions including type 1 diabetes, dementia, cancer, chronic pain, obesity, depression and anxiety. This use of non-medical interventions for a range of physical and mental health needs is described by the CCG as a form of ‘social prescribing plus’. These types of social prescribing programs, which are becoming more common in the UK, involve the linking of patients through medical professionals to social support provided by community organisations<sup>44</sup>. These programs are targeted at reducing primary demand on healthcare services while improving some of the social determinants of health, such as social connectedness. In this way, such an arts on prescription program could prove beneficial in Australian settings.

### **Aboriginal and Torres Strait Islander people**

Connecting to culture through art is associated with positive outcomes for Aboriginal and Torres Strait Islander peoples. Australia Council for the Arts research shows that engagement with First Nations arts and cultural expression has an inter-relationship with measures of subjective wellbeing related to empowerment and community connectedness<sup>45</sup>. Findings from the Interplay project, a multi-year project by the Cooperative Research Centre for Remote Economic Participation suggest that empowerment is a causal link between practising culture and employment outcomes and that culture is the foundation upon which – through empowerment – pathways lead to better outcomes in education, employment and wellbeing<sup>46</sup>. Findings from Interplay also determine that wellbeing is a holistic system of complex interrelationships.

The Australia Council worked with researchers from the ANU Centre for Aboriginal Economic Policy Research on new analysis of the National Aboriginal and Torres Strait Islander Social Survey about Indigenous Australians’ engagement with First Nations arts, festivals, languages and broadcasting and attendance at cultural venues and events. The analysis in the report shows that among Aboriginal and Torres Strait Islander people, better outcomes for socioeconomic indicators such as employment, education and income are positively associated with participation in arts and cultural expression<sup>47</sup>.

## **Aboriginal and Torres Strait Islander People**

The ACT Aboriginal and Torres Strait Islander Agreement 2019-2028 (the Agreement)<sup>48</sup> includes four core focus areas and six strategic priorities. The core areas are children and young people; cultural integrity; inclusive community and community leadership. The strategic priorities are connecting the community; life long learning; economic participation; health and wellbeing; housing and justice. Each of these areas can directly impact on mental health outcomes for Aboriginal and Torres Strait Islander people. The Agreement is between the ACT Government and the Aboriginal and Torres Strait Islander Elected Body and is underpinned by the principle of self-determination. It includes tangible actions to address these priority areas and improve life outcomes for Aboriginal and Torres Strait Islander people in the ACT.

The Agreement acknowledges that strong connection to country holds spiritual, social, historical, cultural and economic importance for Aboriginal and Torres Strait Islander peoples. While the

<sup>44</sup> Dayson, C. (2017). Social prescribing ‘plus’: a model of asset-based collaborative innovation? *People, Place and Policy*: 11(2).

<sup>45</sup> Australia Council for the Arts, Living Culture: First Nations Arts Participation and Wellbeing at <https://www.australiacouncil.gov.au/research/living-culture/#Key-story-1>

<sup>46</sup> Interrelationships: Bringing together stories and numbers at <https://old.crc-rep.com/wellbeingframework/INTERRELATIONSHIPS.html>

<sup>47</sup> Biddle, N. and Crawford, H. 2017, *Indigenous participation in arts and cultural expressions and the relationship with wellbeing: Results from the 2014-15 National Aboriginal and Torres Strait Islander Social Survey*, CAEPR Working Paper No. 117/2017 at <http://caepr.cass.anu.edu.au/research/publications/indigenous-participation-arts-and-cultural-expression-and-relationship>

<sup>48</sup> ACT Aboriginal and Torres Strait Islander Agreement 2019–2028 at <https://www.communityservices.act.gov.au/atsia/agreement-2019-2028>

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Productivity Commission issues paper acknowledges the higher rates of mental health and suicide rates of Aboriginal and Torres Strait Islander people, there needs to be greater analysis of why this occurs and what are the triggers for Aboriginal and Torres Strait Islander people, such as inter-generational trauma and social isolation or exclusion. It is important to acknowledge the core of the issues, so that appropriate initiatives can be put in place.

In 2008, the Council of Australian Governments (COAG) launched a national plan to improve health, education and employment outcomes for Aboriginal and Torres Strait Islander people.

That plan was the national Closing the Gap strategy and it includes seven targets – focussing on health and improving life expectancy, education and employment. Ten years on, just three of those seven targets have been met. Life expectancy among Indigenous people remains ten years less than non-Indigenous people.

Indigenous communities are at greater risk of psychological distress and suicide, yet none of the targets in the plan specifically focus on mental health, maintaining social and emotional wellbeing or preventing suicide.

The Federal Government is reviewing the Closing the Gap Strategy, including its targets and processes with an expected endorsement by COAG mid-2019.

This is a chance for every state and territory, as well as the Federal Government, to take a new united approach to improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

Taking steps to improve mental health among Indigenous communities is critical in its own right, but it is also a lynchpin to achieving other targets within the Closing the Gap Strategy, such as improving school attendance and employment rates.

## **LGTBIQ mental health**

### Social Participation & Inclusion

The ACT Government is committed to ensuring that that the ACT is the most progressive jurisdiction in the nation. There is a significant challenge for all governments in ensuring that all Australians can live in circumstances that are conducive to good mental health.

People who identify as LGBTIQ experience poorer mental health outcomes and have higher risk of suicidal behaviours than their peers. There is also a heightened risk of mental health diagnosis, psychological distress, self-harm, suicide ideation, and suicide attempts.

This elevated risk of mental-ill health and suicidality among LGBTIQ communities is not related to sexuality, gender identity or intersex characteristics in and of themselves, but are due to the psychological distress that can occur because of experiences of discrimination, prejudice, abuse and exclusion in relation to their LGBTIQ identity, experience or history<sup>49</sup>.

The ACT Government established the Office for LGBTIQ Affairs to support the goal of making the ACT the most LGBTIQ welcoming and inclusive jurisdiction in Australia. The Office is currently developing a whole of government and community LGBTIQ strategy to support the inclusion of LGBTIQ people – this means ensuring full access to the social, political, economic, and cultural opportunities and experiences that non-LGBTIQ people have. Addressing societal prejudice is arguably the best prevention measure for LGBTIQ person suicide and self-harm that can be achieved.

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<sup>49</sup> Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People, prepared by the National LGBTI Health Alliance



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Ensuring LGBTIQ inclusive mental health services within the ACT is a priority. As set out in the National Lesbian, Gay, Bisexual, Transgender, and Intersex Mental Health and Suicide Prevention Strategy, this requires:

- Inclusive and accessible care – ensuring LGBTIQ people experience equitable access to mental health and suicide prevention services and receive support that is appropriate to their experiences and responsive to their needs.
- Evidence, data collection and research – increasing the evidence base and knowledge about LGBTIQ populations that adequately represents their histories, lives, experiences, identities, and relationships.
- Diversity of LGBTIQ population – the diversity within and between LGBTIQ populations is recognised and responded to with strategies that take into account their individual and unique needs.
- Intersectionality and social inclusion – LGBTIQ people and communities from across all populations, locations and life stages receive information, services and support that is relevant to their identities and lived experiences.
- Skilled and knowledgeable workforce – the mental health and suicide prevention sectors paid and volunteer workforces are knowledgeable regarding LGBTIQ people and communities, and are skilled, confident and competent in responding to their support needs.
- Promotion and prevention – mental health promotion, mental illness prevention and suicide prevention programs, activities and campaigns address the underlying factors that compound the mental health outcomes for LGBTIQ populations.

It is important to note that the inclusion of LGBTIQ people is linked to economic performance. Several studies have shown that inclusion is strongly correlated with GDP per capita. Inclusion benefits LGBTIQ individuals, as well the broader community – both socially and economically.

### LGBTIQ Mental Health in Australia

To date, Australian national evidence on the health and wellbeing of LGBTIQ populations relies upon a growing, but limited number of smaller scale studies that target LGBTIQ people and communities, or parts thereof. While uniquely valuable, these small studies can have methodological issues relating to representative data collection and have a limited ability to provide a comprehensive data set for analysis. Currently available data is therefore unable to represent a holistic picture of LGBTIQ people in Australia, nor is it able to fully explore the experience or impact of intersecting identities.

This means that it is difficult to compare rates and the burden of mental illness and suicidal behaviours between the Lesbian, Gay, Bisexual, Transgender, Intersex, and non-LGBTIQ populations. It makes it even more difficult to consider how sexuality, intersex variations, gender and other social determinants intersect with other minority populations involving culture, disability, faith or location.<sup>50</sup>

Transgender and intersex people are among the most marginalised, socially isolated and discriminated against individuals in the ACT. Trans Pathways, the largest study ever conducted of the mental health and care pathways of trans and gender diverse young people in Australia, indicates trans young people in the ACT are at very high risk for poor mental health, self-harming and suicide attempts. Around three in every four transgender youth in Canberra have experienced anxiety or depression. Rates of self-harm and suicidality are extremely high in this group with 78.9% ever self-harming and 42.1% ever attempting suicide (the Australian average is less than 3% ever attempting suicide). Older transgender people find it difficult to access health services with 60% feeling isolated

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<sup>50</sup> National LGBTI Health Alliance, Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy, 2016.

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from medical and mental health services, and 42% having reached out for a service provider who did not understand or respect their gender identity. Problems with health services included GPs lacking education about gender diversity, not knowing where to refer trans clients, and transphobia.

The Office for LGBTIQ Affairs in its community consultations has heard that there is a clear and urgent need for increased psychosocial support services provided by peer-led community-based services, such as those provided by A Gender Agenda and the AIDS Action Council of the ACT Inc.

### Social and economic benefits of ‘inclusion’

Social “exclusion” is defined as a multi-dimensional dynamic by which LGBTIQ people are denied resources, rights, and opportunities to participate in the typical relationships that are available to most people within the economic, political, social and cultural spheres. “Inclusion” switches the focus to situations in which LGBTIQ people have full access to the social, political, economic, and cultural opportunities and experiences that non- LGBTIQ people have.<sup>51</sup>

Discrimination and exclusion are the key causal factors of mental-ill health and suicidality for LGBTIQ people. Addressing societal prejudice is arguably the best prevention measure for LGBTIQ person suicide and self-harm that can be achieved<sup>50</sup>.

A large and growing body of research documents the violence, discrimination, and social stigma experienced by LGBTIQ people. These experiences at the individual level limit LGBTIQ people’s access to jobs, to schooling, to *health care services*, to political participation, and to participation in their families, for example. All of those effects create barriers to full participation in the economy for LGBTIQ people, which could also reduce economic outputs more generally<sup>51</sup>.

### Supporting LGBTIQ inclusion in the ACT

- The Office for LGBTIQ Affairs within the Chief Ministers, Treasury and Economic Development Directorate was established in 2017. The Office for LGBTIQ Affairs:
  - Coordinates a whole of government approach for promoting Canberra as the most welcoming and inclusive city in the country.
  - Engages relevant areas of government with subject matter expertise to implement legislative reform, promote inclusive events, and appropriately target services for LGBTIQ people.
  - Supports and engages with the LGBTIQ Ministerial Advisory Council on matters where the government is seeking advice and guidance.
  - Provides policy advice to the Chief Minister on LGBTIQ matters.
- Some key progress made to date:
  - Development of a whole of territory and government LGBTIQ strategy (to be released June/July 2019)
  - The establishment of an intergovernmental LGBTIQ working group to support development and delivery of policy, programs and services that are LGBTIQ inclusive and competent

The Office for LGBTIQ Affairs has commissioned a review of ACT legislation to identify any other areas of discrimination against LGBTIQ Canberrans in our existing legislation, and to develop a reform package accordingly. This audit is due to be completed by May 2019.

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<sup>51</sup> M.V.Badgett, Andrew Park & Andrew Flores, Links Between Economic Development and new measures for LGBT Inclusion’, March 2018.

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### Climate change and mental health

Australia's unique geoclimatic features makes it one of the most vulnerable countries to the impacts of climate change, due to its hot dry climate and environmental extremes. In Australia, we have experienced unexpected variations in weather patterns and in the growing incidence of extreme weather events including heatwaves, droughts, bushfires and flooding, which are having significant consequences on communities, the economy, and the health and wellbeing of the Australian population<sup>52</sup>.

The ACT has not been exempt from these impacts with a series of unprecedented heatwaves over the past few summers, droughts, bushfires, and flooding. The dry conditions have resulted in bushfires destroying local environments and homes. It is well established that climate change related variations in weather patterns have consequences for the environment and are hazardous to public health<sup>53</sup>, however there is also increasing recognition of the importance of acknowledging climate change as a determinant of mental health.

The relationship between climate and mental health is reciprocal whereby adverse climate conditions can have negative mental health impacts on individuals and communities, and non-adverse climate conditions can be conducive to facilitating a mentally healthy environment. Weather related natural disasters can induce symptoms ranging from stress and distress to more serious clinical disorders including anxiety, depression and post-traumatic stress disorder<sup>54,55</sup>. Secondary impacts of climate or weather-related natural disasters might include loss of homes, jobs, loved ones and social networks; the need for relocation, life disruption, feelings of loss, feelings of grief or bereavement; increased substance use or misuse, suicidal thoughts, increased aggression and violence; changes to food security, financial worries, family distress, dysfunction; and the increased incidence of domestic violence, particularly towards women<sup>53,54,55</sup>. For those who already experience mental illness or disorder, climate change can further exacerbate existing symptoms. Further to this, extreme heat can impact the effectiveness of some anti-psychotic drugs. Other vulnerable groups include those who are already at risk of social disadvantage, including children; women, pregnant women and post-partum mothers; the elderly; the economically disadvantaged; emergency workers and first responders; and the homeless. There is also recognition that certain cultural groups, including Aboriginal and Torres Strait Islander people, who have strong connection to the land and environment may suffer adverse impacts to their mental health as these weather-related disasters continue.

There is an increasing body of Australian-based research that has been documenting the adverse impacts of climate change on mental health and suicide rates. Australian data has found a correlation between the mean annual maximum temperatures and the increased rates of suicides for both males and females across states and territories<sup>52</sup>. Another study based in South Australia found that hot days have a damaging effect on the whole population equivalent to that of unemployment and it predicts hospitalisation for self-harm<sup>56</sup>. Australian firefighters have also been studied with findings suggesting that of those with post-traumatic stress disorder, 77 per cent also presented with simultaneously occurring mental health conditions like depression, panic disorders or phobic

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52 Hanna, E G & McIver, L J 2018, "Climate change: a brief overview of the science and health impacts for Australia", *Medical Journal of Australia*, 208 (7), 311-315.

53 François Bourque & Ashlee Cunsolo Willox (2014) Climate change: The next challenge for public mental health?, *International Review of Psychiatry*, 26:4, 415-422, DOI:10.3109/09540261.2014.925851.

54 Clayton, S., Manning, C. M., Krygsman, K., & Speiser, M. (2017). *Mental Health and Our Changing Climate: Impacts, Implications, and Guidance*. Washington, D.C.: American Psychological Association, and ecoAmerica.

55 Dodgen, D., Donato, N., Kelly, A., La Greca, J., Morganstein, J., Reser, J., Ruzek, S., Schweitzer, M.M., Shimamoto, K., Thigpen Tart, and R. Ursano, 2016: Ch. 8: Mental Health and Well-Being. *The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment*. U.S. Global Change Research Program, Washington, DC, 217-246. <http://dx.doi.org/10.7930/J0TX3C9H>.

56 Williams, S., Nitschke, M., Sullivan, T., Tucker, G.R., Weinstein, P., Pisaniello, D.L., Parton, K.A. & Bi, P. 2012, "Health and health in Adelaide, South Australia: Assessment of heat thresholds and temperature relationships", *Science of the Total Environment*, 414, 126-133.

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disorders<sup>55</sup>.

In addition to the impacts of climate related weather disaster, the very threat of climate change and its potentially detrimental effects is impacting mental health outcomes. Mental health professionals have reported an increasing number of patients presenting with “eco-anxiety” or “climate-change anxiety” which describes feelings of stress, anxiety, dread and uncertainty about the future<sup>55,57</sup>. On a more positive note, these studies have also identified that there are benefits to mental health and wellbeing from engagement with climate change adaptation and mitigation actions<sup>55</sup>.

### Climate Change action in the ACT

As incidences of climate related disasters increase there will be a consequential increase in the number of persons requiring services, both those who already live with mental illness, and those who will develop mental health problems, placing further burden on our mental health care system.

The ACT Government is taking action on Climate Change, including the impact on mental health and, through the new Climate Change Strategy, monitoring progress against resilience indicators including climate-related health impacts and costs. Part of the new climate change strategy will be a living infrastructure plan, which will help ensure we reduce heat island effects, provide cool areas for recreation even in a heating climate, and maintain a connection with nature which is a key to the mental health of our populace. This will also involve repeating a longitudinal survey to measure the resilience of the community and monitor change over time. This feedback will enable targeting of policy and programs to increase the resilience, thereby reducing vulnerability of those most at risk to the impacts of climate change. The ACT has comprehensive Climate Change Strategies that explicitly consider health issues and the links between health and other sectors as part of the many actions within the strategies.

### Policy opportunities for the Federal Government for Climate Change and Mental Health

The ACT Government supports the view that urgent policy action is required to move towards renewable energy sources to restore a safe and healthy climate. These will bring important public health benefits, including to mental health. Clean energy is not only climate friendly, but also will reduce the burden of mental health and physical health. The Medical Journal of Australia, in partnership with Lancet published the “Countdown on health and climate change: Australian policy inaction threatens lives”<sup>58</sup> that asserts that there is significant scope for policy action by all levels of government on the public health risks and opportunities associated with climate change in Australia, including mental health impacts of climate change. In addition, a recent report by the American Psychological Association and ecoAmerica<sup>54</sup> emphasises that climate solutions benefit mental health. They argue that action on climate change adaptation and mitigation will not only have lasting benefits to the physical and mental health of the population but will also posit benefits to the economy.

Key areas of policy opportunity and intervention to support better mental health outcomes include:

- Setting targets to reduce greenhouse gas emissions.
- Investing in research to identify, map and examine populations particularly vulnerable to the mental health impacts of climate change, and use this data to inform the development of appropriate resilience-building measures in all communities.
- Build capacity in the mental health sector to better support the needs of those who experience adverse mental health outcomes from climate related disasters and other climate change related mental health issues. These should include mental health supports being part of emergency relief efforts during climate related weather disasters.

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57 Clayton, S., Manning, C. M., Krygsman, K., & Speiser, M. (2017). *Mental Health and Our Changing Climate: Impacts, Implications, and Guidance*. Washington, D.C.: American Psychological Association, and ecoAmerica.

58 Zhang, Y., Beggs, P.J., Bambrick, H., Berry, H.L., Linnenluecke, M.K., Trueck, S., Alders, R., Bi, P., Boylan, S.M., Green, D., Guo, Y., Hanigan, I.C., Hanna, E.G., Malik, A., Morgan, G.G., Stevenson, M., Tong, S., Watts, N., & Capon, A.G. 2018, “The MJA- Lancet Countdown on health and climate change: Australian Policy inaction threatens lives”, *The Medical Journal of Australia*, 209, 11, doi:10.5694/mja18.00789.

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### Substance Abuse

Comorbidity, or the co-occurrence, of mental illness and substance use disorders are prevalent in Australia. While it is difficult to quantify the exact occurrence of comorbidity, an Australian systematic review found that current mental disorders co-occurred in between 47 to 100% of patients in substance use treatment clinics. While the prevalence ranged widely between these studies, it still demonstrates a high rate of comorbidity in the community<sup>59</sup>.

People with comorbid mental health and substance abuse disorders clinically present with complex psychological symptoms that have the potential to interfere with treatment for both disorders. To illustrate, there are few differences between the acute symptoms of schizophrenia with substance use and substance-induced psychosis<sup>60</sup>. People with comorbid disorders also experience longer lengths of stay in emergency departments, higher rates of relapse and are more often the subjects of premature discharge from inpatient units<sup>61</sup>. Together, these facts have important negative implications for the health and wellbeing outcomes of this population and point to the need to provide adequate health services.

The impacts of these comorbidities also extend to people's family and community dislocation, and their reliance on welfare and social support due to poverty, unemployment and lack of adequate housing<sup>62</sup>. As a result, efforts to improve the provision of effective services for the treatment and care of comorbidities would help to improve the social and economic participation of this population.

However, in Australia the provision of specialist mental health services and alcohol and other drug services has historically been separated physically, administratively and philosophically<sup>60</sup>. This can mean that patients receive attention only for either their mental health or substance disorder, depending on where they present. Consequently, while clinicians and workers often have the best intentions for helping people with comorbidities, they can be limited in their abilities to act due to constraints in mental health or substance abuse services and the linkages that exist between them<sup>62</sup>.

The provision of optimal comorbidity treatment and care services is associated with a higher level of stability for people across both their mental health and substance disorders, with lower risks of relapse, greater independence and family wellbeing<sup>62</sup>.

It is clear that effective comorbidity treatment and care has the potential to provide better rates of improvement in population mental health and to increase the social and economic participation and contribution of people with comorbid conditions. Consequently, the ACT Government believes that the Productivity Commission should consider substance use disorders as in-scope for this inquiry and develop recommendations for how to effectively manage comorbidities with mental illness.

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<sup>59</sup> Kingston R, Marek C. (2016). A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. *Drug and Alcohol Review*, 36: 527-539.

<sup>60</sup> Gordon A. (2008) Comorbidity of mental disorders and substance use: a brief guide for the primary care clinician. *Department of Health and Ageing*, Canberra.

<sup>61</sup> Manuel J, Gandy M, Rieker D. (2015). Trends in hospital discharges and dispositions for episodes of co-occurring severe mental illness and substance use disorders. *Administration and policy in mental health and mental health services research*: 42(2), 168-175.

<sup>62</sup> de Crespigny *et al*, (2015). Service provider barriers to treatment and care for people with mental health and alcohol and other drug comorbidity in a metropolitan region of South Australia, *Advances in Dual Diagnosis*, 8(3), 120-128.

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### SHIFTING TO BALANCING THE FUNDING PARADIGM

It is noteworthy that, despite the continued increases in mental health expenditure and resourcing in Australia over the past decades, there appears to be little decline in the prevalence of mental health problems and suicide<sup>63,64</sup>. This effect has been observed across Australia, Canada, England and the United States according to a recent review<sup>65</sup>, which found that the prevalence of mood and anxiety disorders had not decreased despite large increases in the provision of treatment, particularly antidepressants.

This gives us pause to reflect on the model of the mental health system in Australia, how it is funded and, importantly, what improvements can be made to reduce the prevalence and burden of mental illness.

#### Activity Based Funding

As healthcare systems grow and develop, policymakers strive to create funding models for healthcare services to promote efficiency, quality of care and activity, while maintaining equitable access to healthcare service<sup>66</sup>. The decisions underlying these funding models are often technical and complex, with their own benefits and challenges.

In Australia, healthcare services are primarily funded through Activity Based Funding (ABF). Under ABF, providers receive a set amount of funding for each episode of patient care, according to the setting and type of care, equal to the national average cost for patients with a particular condition or undergoing a particular procedure<sup>67</sup>.

Essentially, under ABF, a hospital or healthcare provider's revenue is linked to their activity.

In Australia, admitted and community mental health services are provided with funding under the Australian Mental Health Care Classification (AMHCC), which is developed and overseen by the Independent Hospital Pricing Authority (IHPA). Currently, IHPA has not outlined how residential mental health services will best be funded under the AMHCC and so are not currently under ABF.

It is important to note that ABF is strictly a funding and purchasing model and cannot achieve better, efficient and more timely care by itself.

#### ABF and Mental Health

ABF payment systems for acute hospitals, in combination with capitation or overall budgets for primary and community health care, are recognised as not properly supporting shifts out of care or co-ordination between hospitals and community-based providers. In addition, ABF does not provide a financial framework to support, or directly incentivise, new ways of delivering care for people with long-term conditions<sup>67</sup>. Nor does it contribute significantly to hospital avoidance.

In these ways, it can be seen that ABF does not intuitively promote the provision of mental health supports across all healthcare service settings, such as primary care and community care, in a stepped care approach.

The ACT Government would support consideration of how the ABF model could be applied to incentivise hospital avoidance and community-based care.

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<sup>63</sup> Jorm A. (2018). Australia's 'Better Access' scheme: Has it had an impact on population mental health? *Australian & New Zealand Journal of Psychiatry*, 52(11), 1057-1062.

<sup>64</sup> Australian Institute of Health and Welfare, *Mental health services Australia*, 2018.

<sup>65</sup> Jorm, A., Patten, S., Brugha, T., Mojtabai, R. (2017). Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry*, 16, 90-99.

<sup>66</sup> Palmer K, Agoritsas T, Martin D, et al. (2014). Activity-Based Funding of Hospitals and its impact on mortality, readmission, discharge destination, severity of illness and volume of care: a systematic review and meta-analysis. *Plos One*, 9(10), e109975.

<sup>67</sup> Wand A. (2014). Activity-based funding: implications for mental health services and consultation-liaison psychiatry. *Australasian Psychiatry*, 22(3), 272-276.

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Several comparable healthcare systems have introduced pilot projects to consider funding for a whole pathway or episode of care for a particular condition, to create a more streamlined and integrated mental health service system. For example, in the United States, pilots of 'bundled payments' for particular episode treatment groups have been used that encompass physician, acute hospital, post-acute inpatient and ambulatory care costs from referral or admission to recovery for an extended episode of care. These pilots have been in addition to the existing ABF frameworks for health care.

For chronic obstructive pulmonary disease management, the Netherlands has completed a large-scale initiative to contract doctor-led care groups under adjusted capitation payments for a year of care. This scheme sought to reduce fragmentation within primary care and bridge the divide between primary and specialist care. The bundled payment was administered by a central contracting body, called the care group. Initial findings of the payment mechanism found benefits in case-collaboration of providers, care co-ordination and compliance with clinical guidelines.

However, the ACT Government recognises that these experiments with bundled treatment have highlighted challenges. These include a significant up-front investment of time and resources to establish the systems and, in particular, tackle the complex challenge of defining what particular care pathways should include, as agreed by clinicians and health professionals.

These are important aspects to consider when contemplating how we utilise the ABF framework for mental health services. However, well considered trials to whole of episode bundled payments in Australia could help to increase care-coordination and integration between mental health services.

### Priorities of Funding

As we have discussed earlier, the NMHC advocates for shifting the focus of healthcare funding towards community care and early intervention<sup>14</sup>. However, the mechanics of how this can be achieved has received comparably little attention.

The ACT Government would support consideration of the example of funding allocation outlined by the Long Term Plan, released by the English National Health Service (NHS) in January 2019<sup>68</sup>. This Plan commits the NHS to increasing investment in primary medical and community health services as a share of the total NHS revenue across the next five years. This means that for the NHS, the funding for primary and community health services is guaranteed to grow faster than the rising NHS budget overall.

## **Structural issues**

The Federal Government is a funder of primary care; it is not a system manager. In recent years, attempts have been made to address this, with the development of Primary Health Networks. It seems that their development is fundamentally based on Primary Care Trusts in England and primary care organisations in New Zealand. Australia's federated government makes this a difficult comparison and the Government has established PHNs, expecting the same functions, without the same enabling structure.

Primary Care Organisations in New Zealand and England are increasingly funded on a capitation basis, where they have a clear fiscal interest in their population avoiding acute care whenever possible. This cannot be said for PHNs and there is no financial incentive to prevent hospitalisation. Further, PHNs have no contractual power over general practice or primary care to enforce new standards or new directions.

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<sup>68</sup> National Health Service (NHS). *The NHS Long Term Plan*, 2019, United Kingdom.

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The fact that many PHNs also have a constitution providing primary care practitioners with membership rights, places PHNs in a difficult position of leading the development of the primary care system, yet also advocating for its members.

### **Developing early intervention services**

The ACT Government is committed to supporting and promoting mental health and wellbeing in the ACT. We have a strong history of partnering with the community sector to deliver community-based mental health services to help provide wrap-around support for individuals. Primary care and community-based programs are an essential part of wrap around care and form the foundations of the stepped care continuum. Collectively these services aim to keep Canberrans as well as possible for as long as possible, promote resilience and support mental health and wellbeing in the community.

The ACT Government would point to the following examples of where it is currently funding early intervention programs:

- **Post & Antenatal Depression Support & Information (PANDSI) -**  
PANDSI provide a range of services which support, educate and inform families in the Canberra and ACT region who are experiencing Antenatal Depression, Postnatal Depression or Anxiety. PANDSI are funded to provide self-help groups providing support for women and their families suffering from ante and/or postnatal mental illness. In addition, PANDSI provide an education and information service around ante and/or postnatal mental illness to the community mental health sector including GPs. The work of PANDSI is complementary to the service provision of the Canberra Health Services Perinatal Mental Health Consultation Service. This community based non-government organisation, primarily funded by ACT Health, assists families on their pathway to recovery, works with the community to reduce stigma and benefits the wider society. This good quality early intervention service aims to support and protect the long-term mental health of mothers, fathers, babies and families.
- **Detention Exit Community (Intensive, Transitional) Outreach Support Program (DECO) -**  
DECO is a short term (up to 18 months) intense transitional support for individuals with a diagnosed mental illness who are exiting detention and transitioning back to the community. DECO is a joint initiative between ACT Health and the community sector mental health provider Wellways Australia (Wellways). Wellways works with the ACT Forensic Mental Health Service (FMHS) to provide the treatment and support services required to assist people leaving detention and re-establish them in the community. Where appropriate, this service assists the person to connect with alcohol and other drugs services; longer term mental health support providers; employment; housing; education; and other social connections. DECO also provides, where appropriate, living and self-management skills training. The support that DECO offers improves the mental health of those exiting detention and helps to reduce recidivism rates in the ACT.
- **Menslink provides support services for young men aged 10 to 25 who are experiencing, or who are at risk of, personal, family and/or school problems. These support services include counselling and mentoring that assist with relationship difficulties, anger management, bullying concerns, impulse control or mild depression and anxiety. This not only helps the young people receiving services, but also helps their family and the community around them. A review of the Menslink counselling and mentoring services, conducted by the University of Canberra in 2018, found that the life satisfaction of participants rose substantially during the time of engagement with Menslink and continued to improve afterwards<sup>69</sup>. In recognition of**

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<sup>69</sup> Neill, J.T. (2018). Long-term Impacts of Menslink Counselling and Mentoring. University of Canberra.



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its benefits to the community, Menslink currently receives funding from the ACT Government via a collaboration between the ACT Health and Community Services Directorates.

Modern healthcare systems have become effective at responding to crisis, but have not developed to be as effective at preventing crisis. However, international literature demonstrates that a hallmark of high performing healthcare systems is a well-developed, accessible and highly integrated primary care system.

The ACT Government would support any work that could be undertaken to consider approaches that better integrate health care services, to provide better access to early intervention that can prevent serious illness, or the support required to manage a long-term condition. This health service delivery gap will continue to be filled by secondary and tertiary health services who will either be required to continuously expand their costly services or people will have to wait until they are in crisis to be able to access services. National hospital activity data for 2016-2017 indicates a consistent increase, on average 2 per cent per year, of patients requiring inpatient care<sup>70</sup>. The growing need for acute care and the limited capacity of hospital services increases the imperative for the health system to provide care for more people at an earlier stage of their illness trajectory.

Primary care is an essential component of a stepped care system. General Practitioners (GPs) are involved in each level of care from the primary point of contact for people experiencing mental health issues, to playing a pivotal role in mental health screening and ongoing care management for patients with mental illness (Figure 1). Not only should people be able to access this primary care for mental health care and support, but they should be encouraged to if they have concerns about their mental health and wellbeing.

As mental health is the most common reason people present to general practitioners in Australia<sup>71</sup> any barrier which reduces access to or the quality of this early intervention and healthcare service should be removed. However current care arrangements do not encourage help seeking behaviours and practitioners are not always able to provide enough treatment or support for the management of mental health concerns or illness. Under the current care arrangements there are systemic barriers which discourage help seeking and early intervention access to GPs.

One of the most significant barriers to people accessing primary and early intervention care is out-of-pocket cost. The ACT has the second highest percentage of people deferring visits to GPs due to cost (7.1 per cent compared to the national average of 4.1 per cent)<sup>71</sup>. Individuals requiring a Mental Health Treatment Plan can access Medicare rebates for up to 10 sessions of psychological therapy per year, however they must pay gap payments to access this early intervention care. These gap payments are significant, over \$40 per visit per GP appointment and up to \$100 per session with a psychologist. These out-of-pocket costs are greatly increased as individuals attend more frequent GP and psychologist appointments. If individuals are not able to pay these costs they are unable to access this primary level mental health treatment and support.

Although no health system can prevent every crisis, a better resourced and coordinated system may be able to reduce the length or depth of a crisis. By improving our ‘systems thinking’ with regard to primary care, it is possible to prevent some people developing a more serious illness and/or deteriorating to the point where they require hospital care. For those who have accessed specialist services, more integrated primary care can help to facilitate discharge and assist people with ongoing management of their condition, providing a holistic approach with the potential to respond quickly to

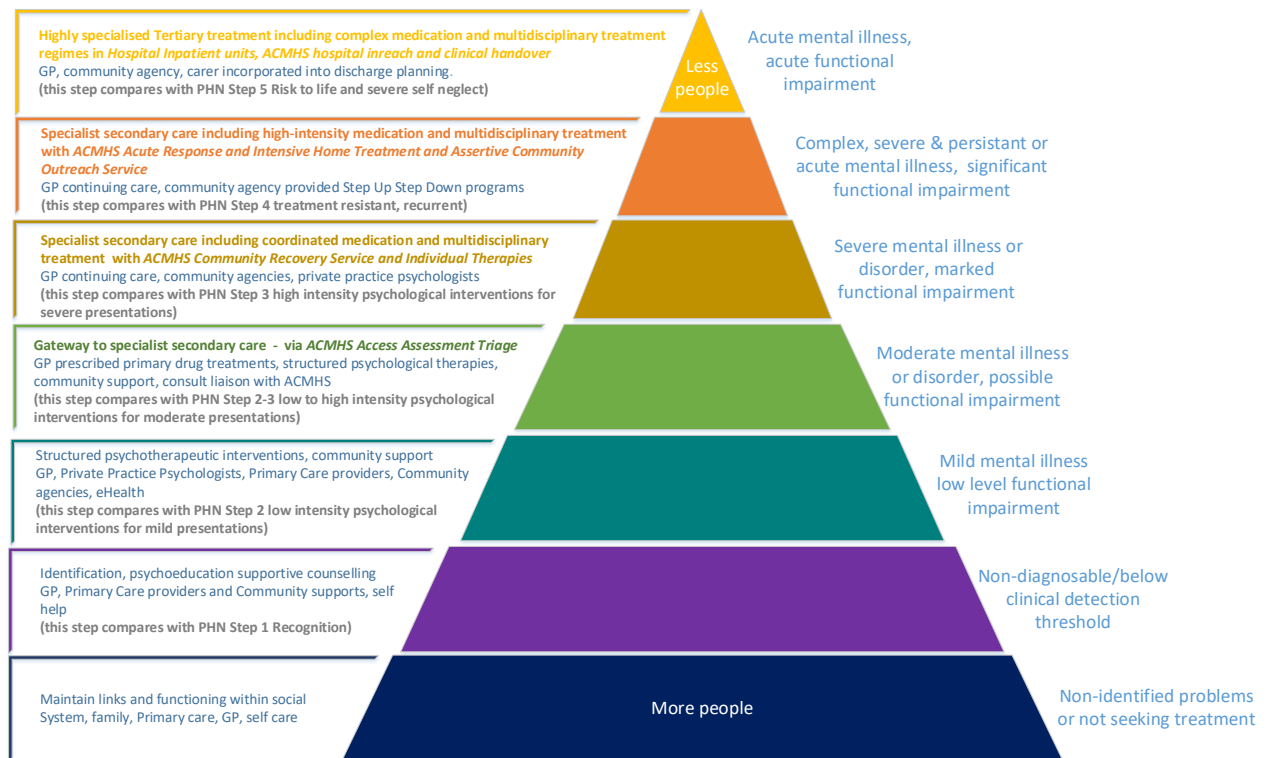
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<sup>70</sup> Australian Institute of Health and Welfare 2018, Admitted patient care 2016-2017: Australian hospital statistics, Health services series no. 84, Cat no. HSE 201, Canberra AIHW.

<sup>71</sup> Royal Australian College of General Practitioners, General Practice: Health of the Nation 2018. East Melbourne, Vic: RACGP, 2018. <https://www.racgp.org.au/FSDEDEV/media/documents/Specialper cent20events/Health-of-the-Nation-2018-Report.pdf> .

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relapse and address a range of other health issues as they arise. This approach has applicability across a range of chronic health conditions including diabetes, COPD and mental illness.



**Figure 1** Stepped Care Model for Adult Community Mental Health Services (Adapted from Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programs and Services, 2015; NICE 2011 *Stepped Care Model for People with Common Mental Health Disorders*; and Project Report on the Redesign of the ACMHS MoC O’Halloran et al 2015<sup>72</sup>)

Strong integration between primary, secondary and tertiary services is increasingly being recognised as beneficial for providing important preventative and proactive health services to people with complex and ongoing treatment needs and reducing burden on the healthcare system. Integrated care is brought about through a range of strategies and methods at the funding, administrative, organisational, service delivery and clinical levels to create connectivity, alignment and collaboration within and between the different sections of the health system. The goal of this approach is to enhance quality of care, quality of life, consumer satisfaction, and better efficiency in the healthcare system. The World Health Organisation (WHO) has endorsed integrated care as a beneficial policy direction and there are an increasing number of integrated care projects being trialled internationally<sup>73</sup>.

In international literature there is a growing consensus that a person-centred, integrated primary care system, is the first-line approach to meet the treatment and support needs for people with multiple and complex service needs to improve their health outcomes and consequently reduce the demand on secondary and tertiary services<sup>73</sup>. A recent discussion paper by the Royal Australian College of Physicians<sup>74</sup> emphasised the role of specialist physicians, including general practice specialists, in the management of complex illnesses. This includes for those who may have episodic

<sup>72</sup> Project Report on the Redesign of the ACMHS MoC Paul O’Halloran MHINDS, Alan Rosen, Paul Fanning. June 2015

<sup>73</sup> Productivity Commission, Report on Government Services 2018, Chapter 10 Part E Primary and Community Health, Australian Government, 2018 <https://www.pc.gov.au/research/ongoing/report-on-government-services/2018/health/primary-and-community-health>.

<sup>74</sup> Royal Australian College of Physicians, Integrated Care: Physicians supporting better patient outcomes discussion paper, Royal Australian College of Physicians, 2018.

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acute presentations, those who require longitudinal care and those with multiple and complex conditions. They further highlight the key role primary care services can play in relation to specific diagnostic groups that may be sources of pressure on the limited resources in healthcare systems.

Closer examination of international case studies in the recent Productivity Commission's Productivity Review of Integrated Care<sup>73</sup> reported strong gains in health outcomes for people and a reduction in care costs typically attributed to reduced hospital and emergency room utilisation<sup>75</sup>, and improvements in the experience of care. The most comparable example was a co-ordinated care program in Canterbury, New Zealand. In the early 2000s the Christchurch Hospital in Canterbury often reached full capacity, preventing it from taking on further patients, and the Canterbury District Health Board was in financial deficit. Since initiating reforms, including defined referral pathways; telephone support for general practitioners; and specialist teams to take pressure off emergency departments and support the care of people in their homes and through their GPs, the hospital rarely reaches full capacity with the age-standardised hospital admission rate dropping to 30 per cent below the New Zealand average. Further, there was a reversal of its budget position from a deficit of 1 to 3 per cent to an underlying surplus of over 1 per cent in 2011-2012.

In Kinzigtal, Germany, transition to integrated care models halved mortality rates after two and a half years for those who participated in the program when compared with non-participants. They also reported improvements in quality of care, particularly for those with complex care needs, such as vascular dementia, where there was a decline in the prescription of non-recommended drugs by 7 percent, in comparison to only 1.1 percent in the control population. They also reported generating savings of 16.9 per cent between 2006 and 2010 which was achieved through reduced emergency hospital admissions.

### **Effective monitoring and data analysis**

The current range of complex reporting mechanisms for mental health data across Australia present a range of challenges to a comprehensive inclusive monitoring and reporting process. The data comes from a relatively complex web of sources, ranging from data gained through national and state surveys to local service provision data collection systems. Consumer and carer reported experiences of care are just starting to be collected systemically.

Data collection and analysis is currently undertaken for a variety of purposes including:

- reporting through statistical collections;
- reporting of outcomes at national and state level;
- reporting against achievements made under National, State and Regional Mental Health Plans;
- reporting of services, supports and funding levels at national and state level;
- to guide service improvements; and
- for research and development purposes.

The new Australian Health Performance Framework<sup>76</sup> provides an overarching mechanism which provides a single, enduring framework to assess the Australian health care system, its inputs processes and outcomes. The National Mental Health Performance Framework<sup>77</sup> developed in 2005 is a key strategy for facilitating a culture of continuous quality improvement in mental health service delivery. AIHW provides the report online and updates progressively.

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<sup>75</sup> Nolte, E & Pitchforth, E 2014, *What is the evidence on the economic impacts of integrated care?*, World Health Organisation, Copenhagen, Denmark.

<sup>76</sup> AIHW, *Australia's Health 2018* at <https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.aspx?inline=true>

<sup>77</sup> AIHW, *National Mental Health Performance Framework* at <https://meteor.aihw.gov.au/content/index.phtml/itemId/584825>:

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National monitoring and reporting on mental health and suicide prevention is also a core role of the independent National Mental Health Commission. The National Mental Health Commission produce an annual national report. In 2018 the Nous Groups report “Mental health and suicide prevention Monitoring and Reporting Framework” set out a proposed approach that the Commission could take in fulfilling this role. While this report addresses a broad framework for the Commission it does not fully cover the breadth and depth of monitoring and reporting required. In addition, substantial work needs to be undertaken to develop the tools and mechanisms for data collection. State and Territory Governments also have separate reporting frameworks for mental health. These often draw upon the data from the national collections as well as local data collections.

There would be significant benefit to clarifying the different roles of reporting agencies (AIHW, ABS, ROGS, National Mental Health Commission) to reduce duplication and to streamline and enhance the overall reporting and analysis. It is recommended that a single national multilayer reporting and monitoring framework be developed which clarifies and incorporates the different agencies roles.

### Improving data collections and data quality

As noted by the Productivity Commission, there are still gaps in the data reporting and gaps between what is collected and what might be considered desirable to collect. The following are recommendations for enhancing data collections and quality:

- A streamlined and coordinated national data collection system including a national minimum data set across all sectors that enable multiple uses for the data. “Collect once – use often”.
- National standards for data collection that can be incorporated into electronic clinical and non-clinical recording systems.
- Consideration be given to Mental Health Australia and KPMG report’s recommendation to “measure the impact of primary care on the use of secondary care by linking the new Primary Mental Health Care Data set to wider health and social data sets<sup>78</sup>.”
- Ongoing commitment to national / state population-based data collections that are robust enough to enable effective analysis at state/territory and sub-population levels.
- Data from non-government community mental health services be integrated into a universal minimum data collection set (or similar). Data collected from community providers needs to be commensurate with funding levels.
- Data collected to be provided back to sources in a format that makes the data useful for strategic and service development.
- Training of the mental health workforce to increase data awareness and improve the quality of data collected as well as to increase understanding of the data’s relevance to clinical and service system delivery improvement and on how to effectively use the data.
- Improved real time feedback of data that has immediate relevance to services delivery. This might include consumer and carer feedback collections (such as the YES, Your Experience Survey, and MH CES, Mental Health Carer Experience Survey).
- Changing the focus of data collection and key indicators to measure mental health outcomes rather than service input numbers.

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<sup>78</sup> <https://mhaustralia.org/publication/investing-save-kpmg-and-mental-health-australia-report-may-2018>

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### **Incorporating research and academia**

Research plays a vital role in the ongoing development of effective responses to promote mental health and address mental illness. The mental health of the community depends on a strong connection between the community, people experiencing mental health concerns and their family and carers, non-government organisations, government and research institutions.

Strategic and operational planning needs to be underpinned by evidence. There needs to be a two-way flow of information from research to the sector and from real life issues back to research. Interconnecting these sectors will be critical to achieving significant progress in improving the mental health of our community.

### **CONCLUDING REMARKS**

The ACT Government believes that there are key strategic principals, outlined above, that should guide the development of the approach to mental health in Australia. The ACT Government does not believe that a continuation of the existing policy approach, where an improvement to health outcomes is inextricably linked to investment in clinical services, is sustainable or evidence based.

Consequently, it is necessary to challenge the orthodoxy that health outcomes can only be improved solely through clinical services and, instead, recognise that many of the key determinants of health outcomes are outside the traditional remit of health services.

To address this, it is crucial to ensure that the social and economic determinants of mental health and wellbeing are addressed. The ACT Government is working towards this, particularly with the establishment of the Office for Mental Health and Wellbeing.

The ACT Government also believes that, in terms of mental health care, a funding mechanism that can be interpreted as incentivising clinical activity in acute facilities, is potentially at odds with the goals that should be set in relation to mental health. The ACT Government would support a program of work that considers how funding mechanisms that are more capitation and risk based, can be developed in Australia.

The ACT Government notes the promising developments made in comparable health systems in relation to integrated care and recommends that close consideration is paid to how integrated care models could be introduced to Australia. Given the ACT's 'city state' nature, the ACT Government would be willing to be considered as a potential early adopter in developing these models.



**ACT**  
Government

April 2019