

## Productivity Commission inquiry on Mental Health; The Social and Economic Benefits of Improving Mental Health Issues Paper (Issue Paper)

### The Western Australian Mental Health Commission Response

The Mental Health Commission (MHC) strives to establish mental health, alcohol and other drug (AOD) systems that meet the needs of Western Australia's population and deliver quality outcomes for individuals and their families. Our mission is to be a respected leader in commissioning, providing and partnering in the delivery of:

- prevention, promotion and early intervention programs;
- treatment, services and supports; and
- research, policy and system improvements.

The work of the MHC is guided by the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (the Plan), which sets out the optimal mix and level of mental health and AOD services required for the people of Western Australia. The Plan progresses the implementation of state and national strategic priorities for the mental health and AOD sectors.

The Plan provides a guide for investment decisions and priority settings for the MHC and all levels of Government, as well as non-government stakeholders. It is based on rigorous modelling of the optimal mix of mental health, AOD services required for the population of Western Australia.

The Plan is currently being updated. At its foundation, the draft Plan Update 2018 uses two nationally agreed planning tools: the National Mental Health Services Planning Framework (NMHSPF); and the National Drug and Alcohol Service Planning Model (NDASPM).

The draft Plan Update 2018 meets the commitment from the MHC to revisit the service modelling framework using nationally agreed planning tools every two years. This ensures the latest evidence and population demographics are taken into account, and that the Plan's implementation remains responsive to emerging trends.

In 2017-18, the MHC provided \$894.91 million to mental health and AOD services across the five service streams of Prevention, Community Support Services, Community Treatment Services, Community Bed-Based Services and Hospital-Based Services, to work towards delivering the optimal mix and optimal level of mental health and AOD services to the Western Australian community. The MHC provided \$132,349,961 to 111 non-government organisations (NGOs) for the provision of services across the spectrum of care; and \$702,194,456 for the delivery of specialised mental health services in the public health system, through contracts with Health Service Providers (HSPs).

In addition, the MHC delivered counselling, clinical and training services directly, through our Alcohol and Drug Support Service, Next Step Drug and Alcohol Services, and Workforce Development and Strong Spirit Strong Mind Aboriginal Programs (SSMAP) teams.

The following feedback responds to questions posed in the consultation paper that relate specifically to the MHC.

## 2. Questions on structural weaknesses in healthcare

*2.1 Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?*

Structural weaknesses continue to exist within healthcare, leading to fragmented services; and inconsistent funding and evaluation through the various mechanisms of State, Federal and private arrangements. On 1 July 2015, the MHC and the Drug and Alcohol Office amalgamated, establishing an integrated approach to mental health and AOD service delivery for Western Australia. The merger recognises that commonly, drug and alcohol and mental health problems co-exist. Studies estimate that at least 30 to 50 per cent of people with mental health or AOD problems have co-occurring problems.

*Additional information:*

The Issues Paper invites comments on what changes should be made in Australia's health sector to address specific concerns related to mental health, where the issue has a major influence on wellbeing, participation and productivity. In addressing the concentration of resources in costly acute and crisis care, such as emergency departments as described in the Issues Paper, the MHC recognise the need for increased community treatment and support services, this is acknowledged throughout the Plan.

The MHC, through the Plan, has identified that Mental Health Observation Areas (MHOA), or the preferred naming convention of Stabilisation Assessment and Referral Areas (SARA), can assist individuals presenting to emergency departments (EDs), who may not require admission into an inpatient unit, but need close observation and intervention for up to 48 hours, by providing specialised services in a more clinically capable and appropriate environment. This also provides the opportunity to refer individuals to community based services for ongoing support and treatment, thereby maintaining connection to family, employment and education.

SARAs enable the needs of individuals with mental health issues to be met, but can also cater for co-occurring alcohol and other drug (AOD) problems, including complex alcohol and other drug problems.

Currently, the MHC purchases activity for MHOAs, including 6 beds and 2 chairs in Sir Charles Gairdner Hospital (SCGH). A 10 bed MHOA at Joondalup Health Campus (JHC) was opened in February 2018. Planned future MHOAs include 4 beds at Geraldton Health Campus, 8 beds at Royal Perth Hospital (RPH) and, based on analysis completed by the MHC, there is a need for 4 beds and 2 chairs at MPH. This recognises the need to expand MHOA beds from 6 to 40 beds by the end of 2020.

In order to address other structural weaknesses, the MHC and the Western Australian Primary Health Alliance (WAPHA) are working closely together, in line with the Plan's approach of implementing reform by establishing and maintaining partnerships. This approach allows the MHC to work collaboratively with WAPHA on planning and commissioning healthcare services, which are aligned with interests in primary care and the broader healthcare system.

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*2.2 What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?*

The MHC, as noted in the Plan, has identified optimum levels for its service streams, and has been able to respond to gaps and promote focus towards community services, as opposed to hospital based services within mental health. This allows for the continued evaluation of service streams, and ensures service provision is contemporary and effective, similar to the approach of Stepped Models of Care.

The Plan uses two nationally agreed planning tools: the National Mental Health Services Planning Framework and the National Drug and Alcohol Services Planning Model. This ensures the optimal mix of mental health, AOD services required for the population of Western Australia is met.

Further articulation of responsibility for mental health promotion across all levels of government is an important next step.

### 3. Questions on specific health concerns

*3.1 Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?*

Everymind, a leading national Institute dedicated to reducing mental ill-health, reducing suicide and improving well-being, are a self-funding, not for profit organisation that provide responses that have the ability to be scaled nationally and globally. Everymind via initial funding provided by the New South Wales Ministry of Health introduced Prevention First: A Prevention and Promotion Framework for Mental Health, this encourages strategic and coordinated action to prevent mental ill-health and promote mental health and wellbeing. This Framework taking a population health approach to prevention and promotion, and focusses on the health needs of the whole population, as well as for specific broad groups of people. With the objective to reduce the duration and severity of mental ill-health, this model specifies the need for secondary prevention/early intervention to target:

- Groups or individuals at high risk and/or showing early signs of mental ill-health; and
- Individuals experiencing an episode of mental illness.

The mission of the MHC is to commission, provide and partner in the delivery of prevention, promotion and early intervention programs. The MHC's Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025 (Prevention Plan) does recommend reorienting and maintaining relevant services for those 4 to 17 years of age, with a recommended strategy of ensuring early intervention services are provided for children and young people showing early signs of mental health issues, and experiencing AOD-related harm. This may include through Headspace a national leading organisation providing a holistic approach to supporting young people early in life through four core areas: mental health, physical (including sexual) health, AOD services, and work and study support. This would be provided through a national network of 102 headspace centres operate across metropolitan, regional and rural areas of Australia. The look and feel of headspace centres is designed to

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create an environment that young people feel comfortable to access. All services are free or low cost, confidential and youth friendly and include:

- early psychosis interventions;
- brief interventions for young people using alcohol and other drugs;
- early identification of children whose parents have mental health and/or AOD-related issues; and
- collaboration with school-based services to promote and improve help seeking and referrals.

The full Prevention Plan can be viewed at <https://www.mhc.wa.gov.au/about-us/strategic-direction/the-western-australian-mental-health-promotion-mental-illness-alcohol-and-other-drug-prevention-plan-2018-2025/>.

A major five-year study, funded by the National Health and Medical Research Council, found investment in prevention is highly cost-effective. There is strong support across Western Australia for increased, evidence-based and coordinated prevention activity. The Plan places a high priority on the implementation of effective prevention activity across the service spectrum over the next ten years to turn the system around.

The Western Australian Mental Illness Prevention and Mental Health Promotion Consultation Group, comprised of a range of experts, recommended that funding for prevention activity dedicated to mental health should increase to at least five per cent of the MHC budget over the life of the Plan. This equates to \$65 million by the end of 2025 (reported in 2012-13 terms).

An Alcohol and Other Drug Prevention Expert Reference Group estimated there should be 208,000 hours of service on dedicated AOD prevention strategies in 2024-25 which, along with the identified optimal levels of resourcing for evidence-based prevention strategies (such as mass reach education), would represent approximately 10.1 per cent of the budget for AOD. This is in addition to the five per cent MHC budget dedicated to prevention (mental health related).

### *3.2 Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?*

The World Health Organisation (WHO) defines health promotion as “the process of enabling people to increase control over, and to improve their health” (WHO, 1986). Mental health promotion is any action taken to maximise mental health and wellbeing among populations and individuals (Commonwealth Department of Health and Aged Care, 2000).

The Prevention Plan provides a guide for all stakeholders, including the MHC, for the development and implementation of evidence-based and evidence-informed strategies to promote mental health and to prevent mental health, AOD related issues amongst the Western Australian community.

It is acknowledged that action is required across the continuum of prevention, including primary, secondary and tertiary prevention as well as early intervention, however primary prevention is the key focus of the Prevention Plan.

The strategies within the Prevention Plan have been informed by a literature review of best practice in the area of preventative mental health, in order to inform the development of recommendations and a framework that delivers evidence-based mental illness prevention and

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mental health promotion across Western Australia. In order to achieve this, it provides a review of both local and global academic and grey literature in the area of promotion and preventative mental health interventions.

The research commissioned by the MHC on reducing stigma and discrimination in Western Australia will be utilised to inform future initiatives that create positive attitudinal and behaviour change towards people with mental illness.

To create greater public awareness and united action around mental health and wellbeing and reduce the risk of suicide, the MHC launched a new stateside public education campaign, Think Mental Health (TMH), across social media, radio and television. TMH, a key initiative of Suicide Prevention 2020: Together we can save lives (Suicide Prevention 2020) is dedicated to de-stigmatising mental health issues and assisting the Western Australian community to navigate the range of mental health services available.

Other TMH Campaign highlights throughout 2017-18 included:

- A new Drug Aware 'Safer Events and Venues' campaign, The Medix, ran during 2017-18. It won the Best of Year creative award at the 2018 Campaign Brief Awards for 'Use of Data'; and
- Awareness of the Drug Aware Meth Can Take Control campaign further increased, with 77 per cent of 17 to 25 year olds surveyed aware of the campaign. This is the highest awareness rate achieved for any Drug Aware campaign since the program commenced in 1996.

The Strong Spirit Strong Mind Aboriginal Programs Metro Project also ran a public AOD education campaign in 2017-18 that consisted of outdoor, social media, online, radio and digital media. A post-campaign evaluation of 167 Aboriginal young people found 69 per cent were more aware of where to get help from AOD support services after being exposed to the campaign, compared to 40 per cent in the previous evaluation.

*3.3 What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?*

Suicide Prevention 2020 provides a strategy for prevention based on suicide statistics in Western Australia; contributing factors to suicide across life stages; and evidence-based prevention and intervention approaches. It was developed utilising current data, research, evaluation and reports on The Western Australian Suicide Prevention Strategy 2009-2013 and the expertise of members of the Ministerial Council for Suicide Prevention.

Suicide is a public health issue that requires coordinated and combined efforts from all levels of government, health care systems, clinicians, workplaces, education and corporate sectors, community groups, insurers and the media; along with family, friends and peer networks. Best practice principles have guided the development of Suicide Prevention 2020, and its associated action areas include allocating resources where they are most needed and in a coordinated way. It is noteworthy that the Suicide Prevention 2020 strategy is currently being evaluated, to support the evaluation of the strategy a full time Evaluation officer position has been created within the MHC for the duration of the strategy. This position exists for the

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purpose of coordinating external evaluations associated with Suicide prevention 2020, as well as evaluating the projects funded under Suicide Prevention 2020, and undertaking the evaluation of the overall strategy. The Evaluation Officer has ongoing contact with the Ministerial Council for Suicide Prevention (MCSP), to provide feedback on the Suicide Prevention activities, and the Evaluation Reference Group (ERG) in order to ensure appropriate and independent expertise is available to support the evaluation process. To guide the evaluation, the Suicide Prevention 2020 Evaluation Plan was developed in collaboration with the WA Department of Treasury and with feedback from the ERG.

*3.5 What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*

The Plan describes a model of service as the preferred way services are to be delivered using international, national and local evidence-based best practice principles. When implemented, models of service positively impact standardisation, quality, organisational effectiveness, efficiency and every individual's experience of services.

The Western Australian Government's Mental Health Policy at the 2017 Election included a commitment to establish Recovery Colleges in Western Australia. \$200 000 was allocated to fund the development of a Model of Service and business case. The Model of Service and Business plan contains significant inclusion of the evidence base developed from the UK and European Recovery Colleges.

The MHC suggests a literature review be carried out to further progress this issue and understands that this work is currently being undertaken by the National Mental Health Commission.

### 4. Questions on health workforce and informal carers

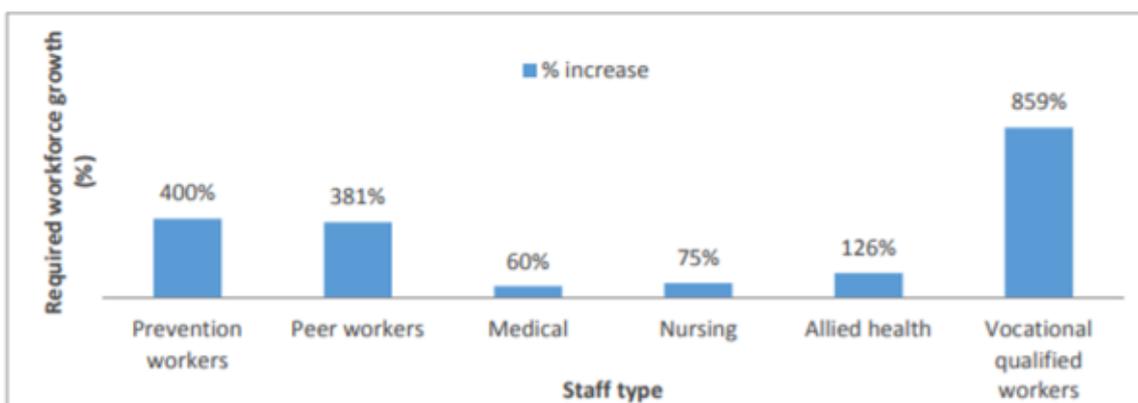
*4.1 Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?*

The MHC has developed the draft Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2019-2025 (Workforce Strategic Framework), which includes a number of suggested strategies to assist in the mental health and AOD workforce.

With ongoing state and national reforms, there is a large focus on increasing the provision of community-based services. State and national documents and consultations have identified challenges and issues affecting the workforce such as: staff shortages across various professions; and aging workforce; increased expectations placed on staff; a requirement to increase work roles such as the peer workforce; work overload and stress; and a requirement to remain up to date and responsive to changing funding models as well as dynamic health and social issues.

A growth in community-based services requires an increase in suitably qualified community-based staff, see figure one. Community-based services, as identified in the Plan, this includes Peer workers, who have a core role in the workforce, are likely to continue to grow in the future and play a positive role within the mental health and AOD workforce.

Figure 1<sup>1</sup>: 2025 optimal service mental health workforce growth requirements



The MHC commissioned Western Australian Association for Mental Health (WAAMH) to identify future workforce development requirements and issues in the non-government mental health sector including peer workers, consumers and carers. The WAAMH workforce project report includes a summary of consultation results and provides 38 recommendations to address the identified current and future workforce issues.

The WAAMH workforce project report can be viewed here, <https://waamh.org.au/assets/documents/sector-development/waamh-workforce-development-report.pdf>.

The methodology of the project consisted of a review of national and local policies, research and workforce related materials; agency consultations including face-to-face and telephone interviews; worker and agency surveys for agency staff such as Chief Executive Officers, managers, co-ordinators and the general mental health workforce; an online consumer, family and carer survey; and mapping of advertised mental health jobs in the NGO sector of Western Australia.

A priority area of the Workforce Strategic Framework includes support for the current and future workforce to deliver high-quality, modern, culturally appropriate and secure, services and programs. A key strategy of this priority is to increase the supply of trained staff to fill growing workforce roles, such as Peer Workers and Prevention workers. It is therefore recommended that:

- tertiary courses and scholarships for growing specialist work areas, such as peer work (for example, the Cert IV Mental Health Peer Work) be established and promoted;
- if appropriate, support consumer, carer, family and peer worker access to access recovery college courses and programs in order to develop their skills; and

<sup>1</sup> Data in Figure 2 to 4 is based on the modelling output and baseline data collected to inform the development of the Plan, released in 2015. Mental health baseline FTE figures relating to community treatment services were taken from a 2013 survey of Department of Health, therefore only include Government employees. Where baseline information was not available, proportions based on 2025 figures were applied. AOD baseline figures include government and non-government FTE. The Plan modelling is currently being updated therefore the data in these figures will change.

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- make available appropriate training, development, guidelines and resources to support staff in growing specialist work areas (for example peer work and prevention).

The Western Australian Peer Supporters Network (WAPSN) was established in 2014 to advance peer support and peer work roles across a range of sectors and community contexts, and to act as an interim peer workforce association. The WAPSN is a collaborative news sharing, learning and networking forum to connect people who are practicing, or aspire to practice, peer support in formal roles (peer support workers) and informal roles (peer supporters). The WAPSN also promotes and facilitates peer support and peer work voice, through advice, consultation and sector representation, and has 300 members.

Auspiced by Consumers of Mental Health Western Australia (CoMHWA) with funding support from the MHC of Western Australia, the WAPSN collaborates with consumer/individual, peer worker, carer, family and service champions to promote and advocate for peer workforce growth and development in a range of sectors.

In addition, in order to effectively coordinate suicide prevention activities (The Fifth National Mental Health and Suicide Prevention Plan Priority Area 2 (Effective suicide prevention)) across Western Australia, the MHC has identified the need for community based suicide prevention coordinators. The MHC has introduced 10 Suicide Prevention Coordinators to work directly with local and regional stakeholders across the Western Australian health regions.

*4.2 What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?*

The Workforce Strategic Framework includes a number of suggested actions to improve recruitment and retention within the regional and remote mental health and AOD workforce, for example:

- Encourage the development and use of regional recruitment initiatives and incentives (for example, housing, access to education and health services) to attract people to mental health and AOD careers, including initiatives to recruit professionally registered staff with high level clinical and professional skills.

It is acknowledged throughout the Workforce Strategic Framework that the recruitment and retention challenges are particularly present amongst regional and remote areas. The use of tele-health and importance of evolving technology is also emphasised within the draft Workforce Strategic Framework.

There are a number of strategies within the draft Workforce Strategic Framework which if implemented by stakeholders, can address issues relating to recruitment and retention of the regional and remote workforce, hence addressing shortages. For example:

- Promote multiple pathways to professional registration to increase the recruitment of professional registered workers in regional and remote areas.
- Encourage the development and use of regional recruitment initiatives and incentives (for example, housing, access to education and health services) to engage people in mental health and AOD careers, including initiatives to recruit professionally registered staff with high-level clinical and professional skills.

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- Promote the benefits of up-skilling, training and supporting local community members to obtain relevant knowledge and skills to fill relevant mental health and AOD roles.
- Encourage and support regional and remote agencies to form consortia in order to access and fund training and development opportunities.
- Support regions to coordinate localised training opportunities.

### *4.4 What could be done to reduce stress and turnover among mental health workers?*

The MHC has partnered with The University of Western Australia's Centre for Transformative Work Design to support the development of a comprehensive set of mental health support resources for Western Australia workplaces.

The assessment tools, training modules, educational materials and other resources to be developed will assist workplaces to promote positive mental health and wellbeing, and support employee mental health.

Further, the draft Workforce Strategic Framework provides a number of strategies and suggested actions to improve retention and recruitment within the mental health workforce, for example:

- Establish and provide additional placements in the mental health and AOD sectors, including in regional and remote areas;
- Develop, implement and monitor staff satisfaction and organisational culture; and
- Enhance the availability of succession planning for staff and management.

The Prevention Plan provides a guide for all stakeholders, including the MHC, for the development and implementation of evidence-based and evidence-informed strategies to promote mental health and prevent mental health, alcohol and other drug-related issues amongst the Western Australian community. The Prevention Plan includes a number of suggested strategies to positively impact the workplace, including the suggestion to modify stressful occupational environments. This can be done by enhancing job control and conditions, job design, encouraging workload management, clarifying roles and implementing policies to tackle bullying, harassment and discrimination.

### *4.5 How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?*

The draft Workforce Strategic Framework emphasises that suitably skilled peer workers are an important part of the workforce and an essential element of the service system, particularly in relation to keeping people well and supporting recovery. It includes a number of suggested strategies for the development of such a workforce, for example, ensuring appropriate training and development opportunities are available to the mental health and AOD workforce. Ensuring appropriate training and development opportunities are made available to the mental health workforce, including peer workers, is an essential step to increasing uptake and attendance.

Further, in its feedback to the draft Workforce Strategic Framework, WAAMH indicated a need for the development of a training and development framework, and guidance about effective models and practice for the supervision of peer workers and the lived experience workforce.

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*4.6 What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?*

A guiding principle of the Plan is to develop a mental health system that ensures informal carers feel more supported in their caring roles, and that their rights and responsibilities are recognised. Key strategies identified in the Plan include: strengthening personalised community support services alongside community treatment and community bed-based services, and improving the ability of consumers and carers to navigate the system; the development of a high quality, personalised, effective and efficient community support service sector that provides carers and families with support for their own wellbeing, improving the availability of timely, accurate and reliable information for carers and families, and their inclusion in the care, support and treatment of individuals, expanding access to information and support and, importantly, flexible respite for carers and families, ensuring all community treatment services include carers in relevant treatment decisions, are family inclusive, and trauma informed, and improving community-based mental health crisis and emergency response services.

Since 2017, the MHC has commissioned a local community based mental health carer and family and support service to implement and trial the nationally developed Practical Guide for Working with Carers of People with a Mental Illness, to evaluate the Guide's usefulness in improving and increasing effective engagement with carers and families within inpatient and community mental health settings. The Guide created by a consortium of experts in mental health care aims to provide practical assistance for providers across public, private hospital and community settings to work effectively with carers and families. Implementation of the Guide has involved embedding the Guide standards and strategies within the identified trial sites. Early anecdotal evidence demonstrates the effectiveness of the Guide in improving services awareness of the importance of involving carers and their capability to work more effectively with carers.

### 5. Questions on housing and homelessness

*5.1 What approaches can governments at all levels and non-government organisations adopt to improve:*

- *support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability?*
- *integration between services for housing, homelessness and mental health?*
- *housing support for people experiencing mental illness who are discharged from institutions, such as hospitals or correctional facilities?*
- *flexibility of social housing to respond to the needs of people experiencing mental illness?*
- *other areas of the housing system to improve mental health outcomes?*

The Plan identified the requirement to develop a system-wide multi-agency accommodation and support strategy to address the needs of individuals with mental health and/or AOD problems.

The MHC has developed a draft Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018-2025 (Accommodation and Support Strategy).

The draft Accommodation and Support Strategy provides a framework to guide stakeholders in the development of appropriate accommodation and support for people with mental health and AOD issues, and recognises the need for the collective effort of stakeholders to achieve change.

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Its vision is that Western Australians with mental health and/or AOD issues will have timely access to a range of appropriate accommodation and support options to meet their personal and cultural needs, enabling their recovery. It is underpinned by the following principles: individual rights; personalised; inclusive communities; effective system-wide partnerships; and continuous improvement.

The Accommodation and Support Strategy recognises that the lack of appropriate accommodation and support options leads to bed blockages in hospitals and correctional facilities.

Five key focus areas and their associated actions have been proposed in the Accommodation and Support Strategy and include:

1. Increased access to appropriate, affordable, safe, long-term accommodation;
2. Establishment of strategic collaborative partnerships;
3. Provision of contemporary housing and support models;
4. Provision of planning, education and training; and
5. Provision of data and research to improve accommodation and support responses.

The implementation of the Accommodation and Support Strategy will require the collective efforts of Governments, the private sector, the not-for-profit sector and the community. The MHC will develop its own implementation plan based on its own responsibilities and identified priority areas for action.

The Accommodation and Support Strategy is currently being refined by the MHC based on feedback received through a recent public consultation process. The final Accommodation and Support Strategy is anticipated to be released in mid-2019.

### *5.2 What evidence can we draw on to assess the efficiency and effectiveness of approaches to housing and homelessness for those with mental ill-health?*

One of the overarching principles of the Accommodation and Support Strategy is Continuous Improvement. Accommodation and support options will be aligned to best practice standards and initiatives. There will be system-wide quality controls and measures in place to monitor, track, review and improve the system and options available.

### *5.3 What overseas practices for improving the housing stability of those with mental illness should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*

Contemporary Service models outlined in the Accommodation and Support Strategy are largely based in Australia. However the Accommodation and Support Strategy supports a Housing First approach which is a strategic response to homelessness that prioritises permanent and stable housing for people experiencing homelessness. The model began in the United States of America in the 1990's and has been adopted by several European countries and Canada. Recently the New Zealand government announced a homelessness package which included funding towards Housing First Programs. There have been considerable evaluations done on the effectiveness of this model and its positive impact on people experiencing homelessness.

## 6. Questions on social services

### *6.1 How could non-clinical mental health support services be better coordinated with clinical mental health services?*

The Mental Health Network is an independent entity that operates under the governance of and with the support of the MHC. The Mental Health Network is jointly sponsored by the MHC and the Department of Health (DoH) and was launched in October 2014.

The Mental Health Network aims to improve outcomes for people with mental health issues by enabling consumers, families/carers, health professionals, health and community services, and the MHC and DoH, to engage and collaborate effectively, to inform mental health policy and reform, and to strengthen and increase coordination of care and support across Western Australia.

### *6.2 Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?*

The Productivity Commission and National Mental Health Commission estimate that the number of people with severe mental illness in Australia is 690,000. Of this group, 290,000 people experience greater severity and complexity, with 64,000 expected to be eligible for the NDIS.

From 1 July 2019 services available for people not supported through the NDIS include:

- Commonwealth psychosocial services Partners in Recovery (PIR), Personal Helpers and Mentors, and Day to Day Living programs will be recontracted until 30 June 2020. The Commonwealth has anticipated that people accessing these services will either become an NDIS participant or if not eligible for the NDIS access the Commonwealth Continuity of Support service expected to commence on 1 July 2019.
- National Psychosocial Support Measure Services, from 1 July 2019. The Commonwealth has committed \$2.3 million per year in Western Australia for the Primary Health Networks to commission new psychosocial support (known as National Psychosocial Support (NPS) measure) for people with severe mental illness.

In addition the State Government provides approximately \$70.5M in funding to the MHC to commission a wide range of psychosocial services (outlined below). The MHC is working in partnership with the Primary Health Network.

#### *Gaps in Service*

- In Western Australia the rollout of the NDIS is slower than predicted, with the Council of Australian Government December 2018 quarterly report showing the NDIS intake rate of people with psychosocial disability was 696 in contrast to the predicted 1023 people. This places pressure on supports outside of NDIS.
- In addition, the Mind the Gap report (2018) outlines that some people with psychosocial disability, who likely meet NDIS eligibility, may be reluctant to engage or apply for the NDIS or experience difficulty with application process, accessing assessments and then actioning the approved plan supports. This places pressure on supports outside of NDIS.

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### *6.3 What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the National Disability Insurance Scheme (NDIS)?*

The MHC has a ten year strategic policy document Mental Health 2020: Making it personal and everybody's business (Mental Health 2020) that sets out priority areas for action, and provides a framework to address these issues. These directions impact upon every aspect of the current mental health system – enhancing high quality and established treatment services, building on fledgling supports and developing innovative recovery and early intervention services where there are few or none available. The reform directions align with state government directions to create a person focused, whole of government approach to mental health, and a strengthened community sector that is well placed to deliver individualised supports and services. The reform directions are also consistent with national directions driving reform across Australia, with a strong focus on early intervention and recovery. Mental Health 2020 focuses on nine action areas: good planning, services working together, a good home, getting help early, specific populations, justice, preventing suicide, maintaining a sustainable workforce and a high quality system.

The MHC continues to provide funding to NGOs and hospital service providers for a range of strategies and supports. This includes:

- People accessing the four MHC programs identified as in-kind funding in the NDIS; and
- The following wide range of services commissioned (approximately \$70.5M) from various NGOs. The MHC works in partnership with the Primary Health Network and these services and programs form part of the MHC's contribution to the National Psychosocial Services Measures:
  - Community mental health step up/step down services;
  - Personalised Supports;
  - Respite Services;
  - Family and Carer Supports;
  - Group Support Activities;
  - Individual Advocacy;
  - Mutual Support and Self Help;
  - Education, Employment and Training; and
  - Accommodation Support Services.

## 7. Questions on social participation and inclusion

### *7.1 In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?*

The MHC funds Act, Belong, Commit (ABC), which aims to increase individual and community wellbeing by increasing and strengthening connections between community members. This is done by encouraging participation in family, cultures, community events and organisations, and increasing collaboration between community organisations that offer

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activities conducive to good mental health and wellbeing. ABC is an evidence-based campaign developed primarily from research undertaken by Curtin University into people's perceptions of mental health and the behaviours they believed protected and promoted good mental health.

Following a successful pilot phase in six regional communities in Western Australian (2005–2007), the campaign was expanded state-wide.

Evaluations in 2016, 2017 and 2018 shows the campaign has the capacity to sensitise people to the belief that there are things we can and should do to look after our mental wellbeing; to change attitudes towards mental health and mental illness; reduce stigma associated with mental illness; and encourage people to engage in behaviours to boost their mental health.

The MHC funds Connect Groups which provides practical assistance to a variety of support groups in the community. A literature review was commissioned by Connect Groups in 2016 into the Effectiveness of Self Help and Support Groups in Health Promotion. Mental Health Week has a focus on promoting wellbeing and connection through discussions and activities that support good mental health.

The MHCs TMH Campaign is a key initiative of the Suicide Prevention 2020 strategy. The TMH Men's Campaign (the Men's Campaign) was launched in November 2017 with the primary target group of men aged 25 to 54 years. Men were chosen as the focus of the Campaign because three out of four deaths by suicide are male.

- The TMH Program, and its Men's campaign, were launched in November 2017 and are part of a comprehensive approach in Western Australia that aims to build mental health and wellbeing, and reduce mental health issues with a view to reducing Western Australia's suicide rate.
- The TMH Campaign focus is on assisting the Western Australian community to connect with the best information, supports and services for each individual's particular situation.
- Evaluation results have shown the TMH Campaign has strong levels of approval and resonance with the target audience.
- The Men's campaign results show that males, who saw the Men's Campaign, were significantly more likely to have spoken about their mental health needs with a family member, friend, or professional than those who had not seen the Men's Campaign.

### *7.2 What role do NGO's play in supporting mental health through social inclusion and participation, and what more should they do?*

NGOs provide programs and services such as volunteering opportunities; support and friendship groups; sport and physical activities (walking, hiking, dancing, etc.); themed events and conferences; festivals and fetes; that directly or indirectly support mental health through social inclusion and participation.

### *7.3 Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?*

The Plan identifies a number of groups that are at greater risk of developing or being impacted by mental health, AOD problems, including: young people; Aboriginal people and communities; older adults; people from culturally and linguistically diverse (CALD) backgrounds; Fly-in Fly-Out

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workers; people from regional areas; and many other groups. In the case of Aboriginal-specific programs, this may include cultural rehabilitation and healing programs.

As such, evidence-based appropriately targeted prevention strategies will be developed in partnership with key groups over the next ten years.

For example, Suicide Prevention 2020 seeks to balance investment in community awareness and stigma reduction, mental health and suicide prevention training and coordinated services for high risk groups, through the provision of activity across six key action areas:

- greater public awareness and united action across the community;
- local support and community prevention across the lifespan;
- coordinated and targeted responses for high-risk groups;
- shared responsibility across government, private and non-government sectors to build mentally healthy workplaces;
- increased suicide prevention training; and
- timely data and evidence to improve responses and services.

The MHC recommends that to track and measure change, performance reporting aggregations should occur for these sub-groups (where possible).

### *7.4 What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?*

The ABC 2018 Evaluation Report outlines the impact on mental health from a number of social participation and inclusion activities. Their measures include connectedness; meaning and purpose; usefulness; increased personal value; reduced feelings of loneliness; decreased symptoms of mental health problems and feeling happier.

## 8. Questions on Justice

### *8.1 What mental health supports earlier in life are most effective in reducing contact with the justice system?*

A major focus in the Plan includes increasing service capacity to meet the needs of young people, and this includes the expansion of dedicated youth mental health and AOD services across all service streams. Dedicated forensic services for young people are a high priority, in particular: prevention and early intervention programs; specialised assessment; liaison with mainstream services; in-reach to police lock-ups; community forensic services; forensic inpatient services; in-reach to juvenile detention centres; and transition care (between the detention centre and community).

The provision of forensic best practice interventions, tailored for young people, provides the best chance of reducing future contact with the criminal justice system.

A guiding principle of the Plan is that, where possible, services need to assist individuals to avoid coming into contact with the criminal justice system in the first instance; and individuals who do come into contact with the criminal justice system have the right to receive the same access and quality of care as the general population at all stages of their involvement with the criminal justice system.

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The Plan identifies the need to research an evidence-base, and to establish forensic focused prevention programs, which reduce the risk of individuals coming into contact with the criminal justice system.

### *8.3 Where are the gaps in mental health services for people in the justice system including while incarcerated?*

The national modelling tools used to develop the Plan do not include the provision for modelling forensic services. To account for this, forensic services required for Western Australia, as identified in the Plan, were developed jointly by the MHC, the former Drug and Alcohol Office (now amalgamated with the MHC), the DoH and the former Department of Corrective Services (now Department of Justice (DoJ)). This planning occurred in extensive consultation with the Forensic Mental Health Planning Group, the former Drug and Alcohol Office Treatment and Support Expert Group, and engagement with consumers, carers and support persons.

As modelling for forensic services does not form part of the national modelling tools currently, the estimated levels of service required were not revised as part of the modelling update in the draft Plan Update 2018.

A national modelling tool for forensic services is currently being developed, and the MHC will work with the DoJ, DoH and relevant stakeholders to further develop the modelling of forensic services once the tool is finalised. This will assist in further identifying the gap between current levels of service and optimal levels, based on an evidence-based modelling tool.

The Plan recognises the need to significantly increase the number of inpatient forensic mental health beds in Western Australia. In particular, there is a need to establish dedicated forensic inpatient mental health beds for youth, and for women. Currently, the 30-bed inpatient facility at the Frankland Centre, Graylands Hospital, caters for all detainees (of which the prison population in Western Australia is almost 7,000) and individuals subject to orders under the *Criminal Law Mentally Impaired Accused Act 1996*. The Plan identifies the need to increase the number of acute inpatient forensic mental health beds from 30 to 62 by the end of 2025.

Currently, there are five forensic subacute mental health beds in Western Australia. The Plan identifies that this needs to increase to 30 beds by the end of 2025.

Consideration of additional secure forensic acute and subacute mental health beds and associated funding will be addressed as part of the staged decommissioning and reconfiguration of services at Graylands Hospital.

In addition, there are currently no dedicated in-prison mental health facilities in Western Australia, with the Plan identifying a need for 70 in-prison mental health/AOD beds by the end of 2025. In 2018, the DoJ established a 77 bed women's AOD rehabilitation prison at Wandoo Rehabilitation Prison. Plans are also underway for a 128 bed AOD rehabilitation prison for men at Casuarina prison.

The DoJ is also currently considering options for the establishment of mental health subacute facilities at Bandyup Women's Prison (approximately 30 beds) and Casuarina Prison (for men) (approximately 64 beds).

Forensic community services refer to mental health in-reach into police lock-ups; court diversion programs and forensic mental health, AOD community services. The draft Plan Update 2018 identifies that as at 30 June 2017, 36,000 hours per year of community forensic mental health

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services were provided in Western Australia. The Plan identifies the need for this to increase to 140,000 hours by the end of 2025.

### *8.3 What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions?*

As stated in 8.1, the Plan identifies the need for research into, and the establishment of, evidence-based forensic focused prevention programs, which reduce the risk of individuals coming into contact with the criminal justice system.

The Mental Health Court Diversion and Support Program (Program) is led by the MHC in partnership with the DoJ, Health Service Providers and the Western Australia Police. The Program has two components, Start Court (adult program, aged 18 and above) and Links (children's program, aged 10 to 17 years), operating within the Perth Metropolitan courts. This service reduces the likelihood of unmet mental health needs escalating, progressing to a chronic state and therefore creating an increased dependency on government services.

The adult component of the Program, the Start Court, is a dedicated Magistrate's Court for people with mental health issues. The Start Court offers eligible participants a program that combines regular judicial supervision with access to clinical mental health services, support for behavioural change including AOD treatment and counselling, and non-clinical community based psychosocial support. Participation occurs at the pre-sentence stage of the justice process and engagement with the Program is taken into account during sentencing.

Links provides a consultation liaison model of support and linkage with appropriate service providers for young people appearing before the Perth Children's Court aged 10 to 17 years. Links is a community based multi-stakeholder program for young people and their families with serious mental health and emotional needs, who appear before the Perth Children's Court. The Links team has two components: a clinical team that is based within the Court, and a non-government provider community support team that provides intensive case management in the community. The multi-disciplinary Links team provide assessments, case management, and information for the Court, reports, and referrals to relevant services.

Offenders participating in Links or Start Court are assisted to identify their mental health and psychosocial needs, and underlying factors that contribute to their offending behaviour. These needs are addressed through access to a clinical mental health and a non-clinical community support team. Working in a dedicated multidisciplinary manner, the Program teams support participants to identify their individual needs and personal goals. The holistic and responsive wrap-around provision of mental health services embedded in the justice process enables the individual to embark on a path to recovery, one which reorients them towards improved health and wellbeing and reduced re-offending. The Program also provides a holistic response to co-occurring alcohol and drug problems, with inbuilt capacity for referral to specialist AOD services where a need is identified.

The Program provides cost avoidance and value for money in diversion away from custodial sanctions, and unnecessary inpatient mental health admissions. In doing so, it improves participants' health and wellbeing, makes the community safer, and produces savings to Government through reduced demand for costly prison, corrections and acute mental health services.

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A 2018 Evaluation of Start Court indicated positive results with 92 per cent of Start Court participants experiencing improvement in their health and wellbeing, and 68 per cent of Start Court participants show improvement in suicidality. Between 1 July 2016 to 30 April 2018, Links received 803 referrals, and from which, 690 (86%) formal mental health assessments were completed.

When the police come into contact with individuals with mental health problems, there is an opportunity to divert people towards suitable treatment and support. As such, the MHC, in partnership with Western Australia Police, and Health Service Providers has established the Mental Health Co-Response service (MHCR). This service enables Police and mental health clinicians to share information and jointly attend crisis situations where mental illness is identified as a likely factor.

The MHCR has strengthened the partnership between Western Australia Police and mental health services, which has led to improved overall mental health and wellbeing outcomes for consumers. This MHCR aims to keep people in the community, connecting them to mental health services and other services.

Since the commencement of the service (18 January 2016 to 14 January 2018 – Trial period), a total of 1,216 referrals have been made; 139 to mental health court liaison services; 383 to external mental health services; and 901 to mental health and other community services.

*Additional information: Our Priorities: Sharing Prosperity*

On 20 February 2019, the Premier, Hon Mark McGowan MLA announced a number of State priorities requiring a whole-of-government approach. 'Our Priorities: Sharing Prosperity' establishes 12 key priorities to address important issues facing Western Australia. They include measurable targets, to hold the State Government to account, and will require sustained focus by Government, working in collaboration with industry and the community.

The MHC is involved in three of the six priorities. Specifically in relation to question eight is the priority, a Safer Community. This aims to reduce youth reoffending by diverting young people most at risk of re-entering the criminal justice system and illicit drug use in the community with future objectives including the development of cross-agency action plans. The target set for this priority is by 2022-23 no more than 50% of young offenders return to detention within two years of release.

### 13. Questions on mentally healthy workplaces

*13.1 What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?*

Within the Prevention Plan there are number of evidence-informed strategies which can support mentally healthy workplaces, including to develop tailored workplace prevention activities that include:

- genuine staff involvement;
- employee assistance programs and other support programs (for example, Mental Health First Aid);

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- modification of stressful occupational environments through enhancing job control and conditions, job design, encouraging a manageable workload;
- management, clarifying roles and implementing policies to tackle bullying, harassment and discrimination;
- policies to enhance employment such as paid parental leave;
- policies and resources that promote employee engagement through good work design, thereby optimising the wellbeing and performance of employees; and
- policies that address AOD use in the workplace.

The implementation of the Prevention Plan will play an important role in facilitating mentally health workforces across the State.

*13.2 Are employers pursuing the potential gains from increased investment in workplace mental health which have been identified in past studies? If so, which employers are doing this and how? If not, why are the potential gains not being pursued by employers?*

From the PC Issues Paper, the gains are reduced absenteeism, presentism, reduced productivity at work and workers compensation claims. There is no data that has been collected to determine what impact the MHC Healthy Workplace Strategy has had on these areas at this stage and it would be an important academic exercise to determine what employers are doing more broadly. The Western Australian Government maintains policies and toolkits for psychologically safe and healthy workplaces, such as the Psychologically Safe and Healthy Workplaces Risk Management Approach Toolkit.

Anecdotally, government and business are turning employee-development focal points to mental wellbeing as a prevention measure, in addition to programs and activities to improve employee physical, spiritual and social wellbeing.

From a MHC perspective, the MHC acknowledges the benefits of good workplace health and wellbeing. The MHC has invested in a Healthy Workplace Strategy and Wellness Committee. Events are rolled out throughout the calendar year. Events have included meditation and mindfulness, yoga, step challenge, employee health check. The MHC has appointed trained voluntary Mental Health First Aiders and an Employee Assistance Provider that offers confidential counselling services to employees and their immediate family members. Employees have received training in workload management and building resilience, supervisor training - personal resilience and building resilience in teams. Mental Health First Aid training is available to all employees.

*13.3 What are some practical ways that workplaces could be more flexible for carers of people with a mental illness? What examples are there of best practice and innovation by employers?*

Key principles of the draft Workforce Strategic Framework include ensuring the preferences of carers are appropriately reflected, and that all staff (including those who are carers) are actively involved in workforce planning and development issues.

In addition, consultation and collaboration with peak bodies and organisations that support and advocate for carers could be beneficial in ensuring workplaces are flexible and supportive of carers and their requirements.

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### *13.4 How can workplace interventions be adapted to increase their likelihood of having a net benefit for small businesses?*

Whilst the MHC is not directly involved with small businesses, the MHC does provide funding to Act Belong Commit, which raises awareness and encourages participation in activities that promote good mental health, strengthen individual resilience and reduce stigma associated with mental illness. Act Belong Commit has a number of resources to support individuals and organisations to promote and achieve good mental health, including information on how to create a mentally healthy workplace.

It is estimated mental health conditions cost Australian workplaces approximately \$11 billion per year through absenteeism, presentism (reduced productivity at work) and compensation claims\*. Following the ABC philosophy can play a key role in improving these figures.

\* Beyondblue and Price Waterhouse Coopers (2014). Creating a mentally healthy workplace: Return on investment analysis, Retrieved from [www.headsup.org.au/docs/default-source/resources/beyondblue\\_workplaceroi\\_finalreport\\_may-2014.pdf](http://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf)

### *13.5 What role do industry associations, professional groups, governments and other parties currently play in supporting small businesses and other employers to make their workplaces mentally healthy? What more should they do?*

The MHC commissioned the development of the Western Australian Workplace Mental Health Standards as part of the statewide suicide prevention strategy, Suicide Prevention 2020. These standards will form part of the University of Western Australia's Thrive@Work project to serve as a set of voluntary guidelines for workplaces to become mentally healthy.

The assessment tools, training modules, educational materials and other resources to be developed as part of the Thrive@Work project will assist workplaces to promote positive mental health and wellbeing, and support employee mental health.

Further exploration of how the Thrive@Work program can be implemented throughout the State would make a positive impact on the mental health of the workforce.

### *13.7 Are existing workers' compensation schemes adequate to deal with mental health problems in the workplace? How could workers' compensation arrangements, including insurance premiums, be made more reflective of the mental-health risk profile of workplaces?*

For Western Australia Government agencies, psychological and psychiatric injury is covered by the Western Australia Government insurer RiskCover. Under the relevant Western Australian legislation, such injuries are assessed and managed much in the same way as bodily injuries. However, claims are assessed firstly on the basis that they have arisen out of employment. Case law suggests they are usually not compensable where the onset of the condition relates to dismissal, retrenchment, demotion, discipline or transfer, unless the employer acts harshly or in an unsafe or unreasonable way. This is not unlike other jurisdictions, where the relevant legislation expressly excludes psychiatric or psychological disorders in the course of reasonable management action; a workers expectation or perception of reasonable management action; or action by the Workers Compensation regulator. Available information suggests that Workers compensation insurance premiums for industry groups do reflect an employer's workers compensation claims history and risk profile as to premiums.

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*13.8 What overseas practices for supporting mental health in workplaces should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*

The MHC recommends a literature review is completed to consider this question.

However the following is provided:

The National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard) was developed in response to the fact that mental health problems and illnesses are the leading cause of short and long-term disability in Canada, and the toll on Canadian workers and workplaces is substantial. Championed by the Mental Health Commission of Canada, and developed by the Canadian Standards Association and the Bureau de normalisation du Quebec, the Standard was released in 2013, after four years of development.

The Standard provides a detailed and comprehensive framework to help organisations, of all types, guide their current and future efforts in a way that provides the best return on investment. The Standard is guided by a number of principles including (but not limited to):

- psychological health and safety is a shared responsibility among all workplace stakeholders, and commensurate with the authority of the stakeholder;
- the workplace is based on mutually respectful relationships among the organisation, its management, its workers, and worker representatives, which includes maintaining the confidentiality of sensitive information;
- individuals have a responsibility towards their own health and behaviour; and
- a primary focus on psychological health, safety, awareness, and promotion as well as the development of knowledge and skills for those persons managing work arrangements, organisation, processes, and/or people.

The Centre for Transformative Work Design, funded by the MHC, has considered all aspects of the Standard, and the many supporting resources and free tools included, when formulating the operational plan for the activities and resources to be developed in support of the state-wide Thrive@Work strategy.

### 15. Questions on coordination and integration

*15.1 How effective are the governance and institutional arrangements for mental health in Australia in achieving the objectives agreed by COAG Health Council in the Fifth Plan? How can they be improved?*

Following the eight targeted objectives in the Fifth Plan, the Plan describes a systemic integration ensuring service delivery is comprehensive, cohesive, accessible, responsive, and optimises the use of limited resources. An effective and integrated system is essential to ensure individuals do not fall through the gaps across the service continuum and when transitioning between services, and that each individual receives the appropriate level of care and support to meet their needs.

*15.2 To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?*

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Collaboration, coordination and partnerships with clear accountability and protocols will result in more responsive and integrated support for people. A multi-sectoral approach with relevant service areas and sectors will also reduce fragmentation of supports such as housing, employment services and general health services. It will also contribute to reducing the number of people falling through gaps in services and decreasing overlaps and service duplication.

The System-Wide Reform section in the Plan includes details on how system integration and navigation will be improved. Improving communication and integration is also the responsibility of service providers. The 'one stop shop' service is an example of facilitating service navigation.

### *15.3 What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?*

There are many barriers including funding, competing demands, variation in objectives, demographics. Examples of how these may be overcome are described in the Plan. An integrated system requires new and effective ways of working together within and across traditional boundaries, so that services are coordinated. The Plan identifies the following as critical to the success of working in a coordinated and integrated way: clarity around shared roles and responsibilities; having compatible information technology; sharing information appropriately; flexibility around service outcomes, including shared outcomes and reporting arrangements; minimising bureaucracy; and avoiding duplication of administration.

### *15.4 Is the suite of documents that comprises the National Mental Health Strategy effectively guiding mental health reform? Does it provide government and non-government stakeholders with clear and coherent policy direction? If not, what changes could be made?*

Detailed planning and the implementation of a range of workforce initiatives and programs is required to ensure that there is the right number and mix of suitably qualified and skilled staff to effectively deliver the services and programs outlined in the Plan. This includes aligning with, and building upon, existing State and national workforce strategies, this includes the National Mental Health Strategy. Further development of the national community mental health strategy should include a blend of clinical, psychological and social support and joined up approaches between tertiary and primary care.

### *15.5 Are there aspects of mental health governance where roles and responsibilities are unclear or absent? Are the mechanisms for holding government decision-makers accountable for system performance sufficiently well-defined?*

Organisational effectiveness and efficiency can be improved through a range of strategies to standardise and improve the safety and quality of the system. Commissioning services would require providers to demonstrate:

- safety and quality assurance mechanisms, including safeguarding practices for vulnerable people;
- appropriate benchmarks of quality and responsiveness;
- evidence-based models of service that are effective, efficient and are capable of delivering quality care in a financially constrained environment;
- acceptable outcomes in terms of length of stay, treatment episodes completed as planned, readmission rates, and continuing care following discharge; and

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- the use of standardised documentation (both non-electronic and electronic) across the system to improve efficiency and access to key information.

In Western Australian, both the Department of Health and the MHC are implementing a range of strategies to support system development and growth. The MHC would largely do this through its policy setting and commissioning role as well as through sponsoring sector development and information/knowledge sharing initiatives. The MHC is working with the WAPHA to ensure coordinated approaches to commissioning and to reduce duplication.

### 16. Questions on funding arrangements

*16.1 What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?*

In the absence of suitable alternatives, there remains a shortfall in supply in community based services, and hence hospital services are currently experiencing higher demand. At present, expenditure on mental health services is heavily reliant on costly acute services, and there is an urgent need to expand the system to boost community based services and supported accommodation.

Hospital services will not experience excessive demand if all elements of the mental health and AOD service system are in balance and at reasonable levels relative to the optimal levels. While expanding services that focus on prevention, community based care and supported accommodation will ultimately reduce the use of higher cost hospital-based services. Responding to the increased demand remains a challenge within the context of a fiscally constrained environment.

Reducing hospital based services to re-allocate funding to community services is not feasible in the current circumstance where demand already exceeds supply of hospital-based services. As more community-based services are established, demand will even out across services, and hospital services will not experience excess demand.

Since 2013-14, the MHC's expenditure in the mental health, AOD sector has increased significantly, by 21 per cent from \$742 million in 2013-14 to \$895 million in 2017-18.

Increasing access to community services will keep people well, out of hospital and connected to their family, friends and community. However, until a more balanced system is developed, hospital services will continue to experience excess demand and, consequently reducing hospital services to increase community services is not feasible. Increasing community based services will even out demand across services, and hospitals will ultimately not experience excess demand.

The MHC recommends a detailed literature review be conducted to examine what the drivers are of the growth in mental health expenditure in Australia.

*16.3 How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?*

The Western Australian Government has recently reformed contracting and purchasing of community services to put more focus on co-design of services between NGO and government, and longer contract terms. This reform is centre-led from a specialist procurement functional

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area within the Department of Finance. Changes to the key policy (Delivering Community Services in Partnership) were developed in collaboration between state government agencies, peak bodies and NGO representatives.

*16.4 Are the current arrangements for commissioning and funding mental health services- such as through government departments, PHNs or non-government bodies – delivering the best outcomes for consumers? If not, how can they be improved?*

The MHC is committed to the implementation of the Delivering Community Services in Partnership Policy, which applies to all government agencies in Western Australia that provide funding for, or purchase community services from not-for-profit organisations. The aim of the policy is to improve outcomes for all Western Australians by building genuine partnerships between government and community organisation to identify community needs, identifying community needs, identifying the most strategic response to meet those needs and focusing on the achievement and outcomes.

In addition, the implementation of the Mental Health 2020 and the Plan aligns with the State Government directions to create a person focused, collaborative approach to service delivery. This approach will underpin all contracted services, and supports people who experience mental health problems and/or mental illness and their families and/or carers, regardless of a service providers not-for-profit or profit status.

### 17. Questions on monitoring and reporting outcomes

*17.1 Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?*

The Mental Health Information Strategy Standing Committee (MHISSC) provides advice regarding the appropriate measures for monitoring mental health services. All jurisdictions are represented on this committee, and data is either provided through the National Minimum Data Sets or ad hoc requests. Relevant information from MHISSC also feeds into other relevant decision making forums such as the Safety Quality Partnership Standing Committee (SQPSC).

*17.2 Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?*

In Western Australia both mental health clinical and NGO services are required to meet the National Standards for Mental Health Services (NSMHS) through an external accreditation body. For clinical services (and licensed psychiatric hostels) they are also required to meet the National Safety and Quality Health Service Standards (NSQHS) and the Chief Psychiatrist's clinical standards. The other States and Territories in Australia have previously been applying both the NSMHS and NSQHS for mental health clinical services. However, recent changes introduced by the Australian Commission on Safety and Quality in Health Care (the Commission) has changed the accreditation process, so that the two standards can no longer be assessed through one survey, and must be assessed separately, regardless of the majority of criteria for the NSMHS being mapped to the NSQHS.

As a result, several States have commented that they will be removing the requirement for Mental Health clinical services to meet the NSMHS. Western Australia has received an exemption from the requirement for the two separate surveys as the *Mental Health Act 2014* (s.515) prescribes the Chief Psychiatrist with the responsibility to monitor the treatment and

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care of mental health patients within Western Australia, and the Chief Psychiatrist has nominated the NSMHS. The Commission considers that implementation of the second edition of the NSQHS Standards provides a robust framework for safety and quality in mental health services. However, the MHC has reservations about this position, with some essential criteria in the NSMHS not mapped to the NSQHS.

While National Minimum Data Sets (NMDS's) require state-funded specialised services to report on accreditation against national mental health standards, the data does not provide assurances that quality is maintained, or that continuous improvement processes are applied. For NGOs, the MHC obtains copies of the accreditation reports but again this does not confirm or ensure ongoing continuous improvement practices.

The MHC examines KPIs (such as 28-day re-admission and 7-day post discharge follow-up) on a monthly basis to provide some indication that appropriate standards are being maintained. However, these do not cover the full spectrum of national standards.

In addition, In December 2016 the Council of Australian Governments (COAG) Disability Reform Council recently released the NDIS Quality and Safeguarding Framework.

The aim of the Framework is to ensure nationally consistent mechanisms are in place to protect NDIS participants from harm. They are designed to assist participants to exercise choice and control, and establish expectations for service providers to deliver safe and high-quality support.

### *17.3 Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?*

The MHC is a Commissioning body independent of the operations. As part of service agreements, funded services report against a broad range of indicators, which are measured against service targets. Through the contract management process, services that are not meeting targets are asked to explain and the MHC works with the service on meeting targets in future. This also applies to the mandatory requirement in Western Australia for independent accreditation of services against the NSMHS. Services may be decommissioned when they underperform over a long period, or if they refuse to achieve accreditation.

The Fifth Plan includes a range of actions, including that Governments will ensure service delivery systems monitor the safety and quality of their services and make information on service quality performance publically available (this is required to be completed by the end of 2021). This action should result in improved oversight and potentially foster a more continuous improvement focus within services. The national Report on Government Services and Mental Health Services in Australia (AIHW) provide the necessary comparatives with other jurisdictions for setting benchmarks. The MHISSC provides advice regarding the appropriate measures for monitoring purposes.

### *17.4 Which agency or agencies are best placed to administer measurement and reporting of outcomes?*

The MHC, as the purchaser of specialised mental health services in Western Australia, is well placed to measure patient outcomes and does this on a regular basis. Nationally, bodies such as the National Mental Health Commission should be the lead agency on overall mental health outcome reporting across Australia. To ensure robust reporting, a mix of both technical and policy based skills are required with a strong multidisciplinary focus.

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*17.5 What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?*

The MHC recommends that consultation with consumers and carers occurs to address this question. The MHC regularly includes consumers and carers through the evaluation of existing programs, and new tools such as the Your Experience of Service survey is being implemented, both within Western Australia, as well as Australia wide to further capture consumer and carer experience of service.

*17.7 To what extent is currently collected information used to improve service efficiency and effectiveness?*

The MHC regularly monitors the performance of its funded providers to improve service efficiency and effectiveness. This is both from a contract management perspective and a safety and quality perspective.