

# **Submission to the Productivity Commission's Inquiry into Mental Health**



## About us

The Mitchell Institute for Education and Health Policy at Victoria University is one of the country's leading education and health policy think tanks and trusted thought leaders. Our focus is on improving our education and health systems so more Australians can engage with and benefit from these services, supporting a healthier, fairer and more productive society.

The Australian Health Policy Collaboration is led by the Mitchell Institute at Victoria University and brings together leading health organisations and chronic disease experts to translate rigorous research into good policy. The national collaboration has developed health targets and indicators for preventable chronic diseases designed to contribute to reducing the health impacts of chronic conditions on the Australian population.

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## Overview

This submission focusses on the work of the Mitchell Institute which has identified limitations in the take-up of available and robust evidence on what works to maintain, protect and improve the mental health of individuals. The Mitchell Institute also purposefully considers the intersection of education with health outcomes for individuals. This submission draws on those aspects of our work that we suggest provide useful material for the Commission's further consideration in the development of the Commission's Final Report. It builds on the Australian Health Policy Collaboration's submission (a network of leading Australian chronic disease experts and organisation led by the Mitchell Institute) which argued that coherent action at various levels, from government to the clinical front line is required to promote mental health and to achieve better outcomes for people with poor mental health.

The Mitchell Institute endorses the Commission's view that early childhood is the time when early intervention to support social and emotional development in vulnerable children should occur. Early childhood is the most crucial developmental period for health and wellbeing; it is the foundation for later years and is a critical opportunity to establish good health and education outcomes for life. Adverse psychosocial exposures in early childhood, particularly for children in families and communities experiencing socioeconomic disadvantage, can predispose individuals to anxiety, depression, poor emotional regulation and other psychological problems (Sweeny 2014). Adverse childhood experiences can affect brain development and have been shown to be associated with a range of negative outcomes, including lower levels of education, unemployment, mental and physical health issues and even premature death (Felitti et al 1998, Anda et al 2002 and 2004, Chapman et al 2007). Research shows that these adverse experiences rarely occur in isolation and each additional negative experience has been shown to have a multiplier effect on the probability of poor outcomes (Chapman et al 2007). There is evidence showing that there are very strong economic cases to be made for a greater level of investment in addressing established risks and vulnerabilities in early childhood (Sweeny 2014). The Commission's proposal for screening in early childhood requires consideration of the investment required, and the service models that will be effective.

There is strong evidence that education is a key driver of positive physical and mental health outcomes (Department of Education and Training 2019). This occurs through a variety of behavioural, economic and social mechanisms (Center on Society and Health 2014). There is evidence that higher levels of educational attainment is associated with improved adult mental health (Kosik et al 2018, Chevalier and Feinstein 2006). The reverse is also true, with research showing that non-completion of school is associated with poorer physical and mental health (Black 2007).

This underscores the importance of increasing educational attainment to improving health outcomes. Disparities in learning occur early, are more pronounced among disadvantaged children and many children are not able to catch up (Lamb et al 2015). Moreover, research conservatively estimates that upwards of 50,000 school aged Australians are detached from any educational program or institution at any given time (Watterston and O'Connell 2019). School dropout is a particular issue for young people with poor mental health (Oxygen Youth Health Research Centre 2014, Bowman et al 2017). Adolescence is a key period when many mental health conditions first occur, which has the potential to disrupt a person's engagement in schooling. As highlighted by the Productivity Commission, greater effort is required to ensure young people who have disengaged or are at risk of disengaging from school are supported back into education. Given the long term benefits of improved educational attainment on health, this is true for both people with and without mental illness. Further policy development should also occur in relation to identifying and intervening early with children at risk of leaving school prior to completion. Importantly, policies should be designed to work with families on supporting young people as well as addressing any potential issues in the home environment.

Attainment is just one way that education can support good mental health. ECEC services and schools also play a pivotal role in promoting positive social and emotional development, preventing

poor mental health and supporting children and young people with poor mental health. The introduction of a dedicated wellbeing lead in schools has the potential to lift teacher capacity, support improved take up and high-fidelity implementation of evidence-based practices, as well as enabling seamless connection between students and community mental health services. The Mitchell Institute would encourage the Productivity Commission to analyse existing Commonwealth, State and Territory policies against the suggested architecture and reforms in order to highlight why existing policies are adequate/inadequate and identifying the gaps. This is likely to improve the ability of school system administrators to understand why and how their existing policies should be altered and what new reforms are required.

The reforms that the Productivity Commission is proposing to improve early childhood and school education services will require additional investment. Further consideration should be given to how this cost will be distributed across schools and ECEC services. The prevalence of mental health issues is higher in some parts of Australia, particularly in socioeconomically disadvantaged and regional areas. The cost of addressing these issues therefore disproportionately impacts on schools and ECEC services serving these communities. Although the Commonwealth has committed to a needs based funding model, many schools are still receiving funding well below the funding standard that has been set, in other words below the level of funding that governments have said is required. For example, in 2017 Victorian government schools received 82 per cent of the School Resourcing Standard (Daley et al 2018). In addition, ECEC services serving disadvantaged populations are less likely to be meeting or exceeding quality standards. Improving the quality of these services will be key to capitalising on their potential to promote healthy social and emotional development and prevent poor mental health. Moreover, Victoria is the only jurisdiction to have implemented needs-based funding for ECEC services. Further consideration of appropriate funding models and levels is required in order to adequately fund schools and ECEC services that are supporting communities with a higher prevalence of mental health issues.

The Mitchell Institute endorses the Commission's focus on increasing the participation of people with mental illness in education and work. People with a mental illness are over-represented in national unemployment statistics and are more likely not to complete schooling. Unemployment and the associated financial duress exert a substantial toll on the mental and physical health and wellbeing of individuals with a mental illness and impose a high cost in lost productivity on the economy. Supported vocational education and employment programs deliver positive employment outcomes for people with moderate, severe and persistent mental illness. Scaling up and better integrating these programs is an urgent priority (Lindberg et al 2016). The service model used should be chosen based on its ability to deliver high fidelity services. While not without its challenges, integrating a vocational specialist in a community mental health service appears more likely to do this. Additional research should be undertaken to explore the efficacy of these models in enabling people with poor mental health that have low levels of educational attainment to pursue further training.

The physical health of individuals with poor mental health is often compromised. People with mental illness have high rates of multiple chronic physical health conditions and are more likely to die prematurely from a chronic physical health condition (Sweeny et al 2014, Harris and Nichols 2019). Investment in regular screening for risk factors for cardiovascular and other chronic diseases for people with mental illness is recommended, together with routine mental health checks for people with chronic physical disease as this is a risk factor for the development of poor mental health (*ibid*.).

The Mitchell Institute supports the Productivity Commission's focus on improving data collections at a population level and at a school level. Improving the quality and supply of rich data insights is key to evaluating and improving Australia's efforts to develop effective policy and provide a stronger public health system (Calder et al 2018). The current government commitment to an Intergenerational Mental and Physical Health Study is welcomed. A well-functioning health system should incorporate regular collection of national population health data to inform health service planning and to ensure the adequacy of Australia's health services into the future (*ibid*). The Mitchell Institute national policy collaboration has recommended that the Australian Health Survey (2011-13) which collected and reported on a comprehensive collection of health data, should be

repeated every six years. The Intergenerational Mental and Physical Health Survey should build on the Australian Health Survey to ensure continuity of information to enable trends to be monitored for policy and service planning information to be effective. The Intergenerational Survey, if it is to become the national survey vehicle to monitor physical and mental health over time, needs to be based on collected data rather than self-reported data.

As the Commission notes, regularly collecting high quality data for a nationally consistent indicator of school students' mental health will enable schools and education system administrators to develop, implement and evaluate policy more effectively. The Mitchell Institute would encourage the Commission to consider a broader approach to health data collection, reflecting on the interconnected nature of physical and mental health and a person's environment. Each State and Territory could commit to collecting a consistent set of indicators across these domains linked to unique student identifiers to enable data linkage. This would facilitate a better understanding of changes in children and young people's health as well as the connection between their wellbeing and other outcomes, such as literacy achievement and/or attendance data that is already collected. It would provide a more nuanced picture of students that moves beyond the traditional focus on achievement, improve the capacity to tailor efforts to local circumstances, and enable more accurate evaluation of the impact of initiatives on student wellbeing. Where appropriate, consideration should be given to replacing or altering existing data collections in order to minimise the impost on students and schools.

Gender is recognised as a risk factor in the development of mental disorders. Women and men have marked variations in patterns of distress and in service utilisation (Duggan 2016). Depression is a leading cause of the non-fatal burden of disease for women in Australia. Despite the availability of a body of evidence on the importance of gender, mental health policy in Australia is gender-blind (*ibid.*). Lack of recognition of gender in health policy and in the provision of services ignores critical factors in both the development and progression of diseases and for the provision of effective, preventive interventions and treatments. The Mitchell Institute urges the Commission to include, in the final report of the Inquiry, consideration of the impact gender has on mental health outcomes and access to services.

Noting the recommendation in the Productivity Commission's draft report that a National Mental Health Commission be established, the Mitchell Institute concurs that there is a need for fundamental reform to care coordination, governance and funding arrangements (Calder et al 2019). However, the Mitchell Institute would propose the establishment of a single national steward for health services including mental and physical health, reflecting the recommendations of a number of national health reviews that have been commissioned and conducted over the past almost 40 years. Successive national health reviews have called for the strengthening of the role of primary care with priority given to better quality outcomes and outcome measurement with funding arrangements to support prevention, management and support of chronic health conditions. Many reviews have recommended national stewardship arrangements to cut through the structural problems affecting health outcomes. Given the consistency and unambiguity of the long line of national reviews of health services, the Mitchell Institute recommends that the Productivity Commission consider the potential benefits to mental health funding and service provision of an integrated national health commission with a mandate to remove siloes both between physical and mental health services and between levels of government in the provision of those services, to improve the physical and mental health outcomes of the Australian population and to improve national productivity through reduced duplication.

The role of the workforce is significant, in both health and education, with respect to improving mental health outcomes for the Australian population. In health, the workforce issues considered by various national reviews have highlighted the need for a national coordinated approach to health workforce planning and regulation. While governments have invested and continue to invest in ongoing research, infrastructure and workforce to support a greater emphasis on primary and community care and on interconnectivity between all parts of the health care sector with other social care sectors, the processes that are in place remain disconnected and uncoordinated (Calder et al 2019). Indeed, as one of the slower countries to adopt changed scope of practice

and/or new health workforce roles, under-utilisation of workforce skills is exacerbating the current problems and pressures in health services (*ibid*).

The recommendations relating to the education workforce have the potential to significantly improve the promotion of healthy behaviours, prevention of poor mental health, as well as the early intervention and treatment of mental illness when it occurs. However, there are design issues that require further consideration in order to realise these benefits. The Mitchell Institute would encourage the commission to further explore the supply of suitably qualified staff for the wellbeing lead position and the supply of suitable mental health services for schools to partner with, particularly in regional and remote locations. As noted in the draft report, there is strong evidence about the inequitable distribution of mental health services. It will be important that schools in regional and disadvantaged communities have access to appropriate services and suitably qualified staff.

The Mitchell Institute urges the Commission to give further consideration to the role of education and health workforces as building blocks – key enablers – of the provision of effective and efficient health and education services with capability to support mental health and wellbeing, and to respond to mental illness in the Australian community.

The Mitchell Institute provides this submission to the Productivity Commission with the intention of further assisting the Commission's consideration of governance, structural and financial arrangements that would reduce the complex, inefficient and costly arrangements that currently exist.

## Early Childhood – the critical beginnings for good and poor mental health throughout life

The Mitchell Institute endorses the Reform Objective: Better use of childhood services to identify and enable early intervention for social and emotional development risks and offers for consideration in Draft Recommendation 17.1 the following options for enhanced early childhood services and outcomes.

There is a strong link between early childhood socioeconomic status and lifetime health and wellbeing outcomes and the evidence clearly points to the need for investment and services that address the health risks for children in families and communities experiencing significant socioeconomic disadvantage (Sweeny 2014). Programs have been trialled or implemented for a period of time that have demonstrated large returns on investment, such as the Communities for Children program that targeted pre-school and primary school aged children; the Positive Parenting program for vulnerable families and the Reconnect program targeting an older cohort of children experiencing disadvantage and family dysfunction (*ibid.*).

A current barrier to effective early childhood policies is the fragmentation of responsibility for funding, service delivery and outcomes. Different aspects of early childhood fall under the jurisdiction of Commonwealth, state or local government and can sit within the portfolios of health, education, social services, child protection and justice. This siloed approach leads to duplication, disconnection and poor continuity; health, education and child protection policies around early childhood in particular need to be integrated (Leung 2014). Whilst some circumstances in each sector or portfolio warrant specific services and policies, what is missing and considered essential is a focus on common outcomes for children, requiring an integrating policy framework.

Parents, families, and communities, and the way each interacts with a child, are central to early childhood outcomes. Both parents and the parenting environment are crucial. There may be lessons to learn from other countries such as the Nordic nations, where public funding supports engagement with parents early and is sustained through to infancy, providing support and facilitating connectedness with other parents. The evidence shows that by supporting parents in their own right to address issues around education, mental and physical health and wellbeing, and reducing or eliminating trauma, the benefits are passed on directly to the child (Leung 2014). Ultimately, improving the circumstances and experiences of the parent does so for the child.

Early childhood education and care (ECEC) settings represent an untapped opportunity to improve children's health outcomes, providing avenues for collaboration across all levels of government, and across health and education portfolios. More than half of Australian children aged 2-4 participate in ECEC, and more than 90% of children attend preschool in the year before they start school. Many ECEC services integrate families and communities in service provision. As noted by the review, social and emotional development is a core component of the curriculum and teacher development processes. For these reasons, ECEC services offer the opportunity to provide integrated and holistic support for positive social and emotional development, including key foundational skills associated with positive mental health. Evidence suggests that health promotion interventions in ECEC settings can be effective, particularly where parents and experts are engaged, where programs and implementation are high quality, and where interventions are embedded and sustained. But data also shows that there is significant room for improvement in how children's services – and the sector as a whole – approach and embed health promotion in ECEC programs.

The consistency and quality of health promotion across the ECEC sector could be improved by: (1) Investing in innovation and research, with a particular focus on families of greatest disadvantage, and collaboration between health and ECEC systems and providers; (2) Working with key stakeholders to develop a model of excellence in health promotion in ECEC, including national investment in tools and content to support this; (3) Integrating a focus on ECEC, and ECEC strategies, into the national health strategies currently being developed (Noble et al 2019). High quality ECEC services are a key avenue to support strong social and emotional development.

The quality of ECEC services is key to their effectiveness in supporting strong social and emotional development. However, there is evidence that socioeconomically disadvantaged children are more likely to have poor mental health and the ECEC services they attend are lower quality (ACECQA 2019). It is important that efforts to improve the social and emotional development of children through ECEC services take into account the higher prevalence of mental health difficulties among low socioeconomic populations and lower quality of services in disadvantaged areas. Further consideration should be given to appropriately funding services that are serving high needs children.

The Mitchell Institute urges the Commission to give further consideration to the evidence of benefit, including return on investment, of evidence-informed programs that have demonstrated positive improvement in the health and wellbeing of vulnerable children. During the past decade, there has been a large increase in the rate of children receiving child protection services as well as the rate of child abuse and neglect substantiations (AIHW 2015, AIHW 2019). Studies have shown that adverse childhood experiences can affect brain development and are linked with significant increases in the probability of a range of negative outcomes, including mental and physical health issues, involvement in the criminal justice system and premature death (Felitti et al 1998, Anda et al 2002 and 2004, Chapman et al 2007). As the Commission notes, there is a strong evidence base showing positive impact of the Early Years Education Program on the IQ, resilience and social and emotional development of highly vulnerable children (Tseng et al 2019). Research has also highlighted the Tasmanian child and family centres as a promising model to address inequalities in child development (Taylor et al 2017). The Mitchell Institute encourages the Productivity Commission to undertake modelling of the return on investing in effective programs for highly vulnerable children through reduced future government expenditure and increased productivity.

#### **Recommendation 1:**

The consistency and quality of health promotion across the ECEC sector could be improved by:

1. Investing in innovation and research, with a particular focus on families of greatest disadvantage, and collaboration between health and ECEC systems and providers;
2. Working with key stakeholders to develop a model of excellence in health promotion in ECEC, including national investment in tools and content to support this;
3. Integrating a focus on ECEC, and ECEC strategies, into the national health strategies currently being developed

#### **Recommendation 2:**

It is important that efforts to improve the social and emotional development of children through ECEC services take into account the higher prevalence of mental health difficulties among low socioeconomic populations and lower quality of services in disadvantaged areas. Further consideration should be given to appropriately funding services that are serving high needs children.

#### **Recommendation 3:**

The Mitchell Institute urges the Commission to give further consideration to the evidence of benefit, including return on investment, of evidence-informed and available programs and interventions that have demonstrated positive improvement in the health and wellbeing of vulnerable children.

#### **Recommendation 4:**

Undertake modelling of the return on investing in effective programs for highly vulnerable children through reduced future government expenditure and increased productivity.

# The role of education in supporting mental health for children and adolescents and through life

## Information request

Information request 3.1 – Education activities that support mental health and wellbeing

*We are seeking information or methodologies that would help us to estimate the cost of activities undertaken by educational institutions in supporting mental health and wellbeing of students.*

## Mitchell Institute for Education and Health Policy response

Schools receive funding for health and wellbeing programs. They also receive an amount of core funding and they have significant discretion on how this is used, although the level of autonomy on funding use differs between states and school sectors. Additionally, disaggregating what constitutes health spending and whether this is counted as supporting mental health and wellbeing will further complicate estimation. The Mitchell Institute suggests:

1. Ask system administrators to provide an annual estimate of centrally funded programs focused on mental health.
2. In addition to estimate above, sample a representative group of Independent schools, Catholic schools and government schools to understand their expenditure on health and wellbeing supports. Clearly define what spending is in scope and out of scope.

## Draft Recommendation 17.5 — Wellbeing Leaders in Schools

All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support.

In the short term (in the next 2 years)

- State and Territory Governments should review existing programs that support school wellbeing initiatives, and establish which funding could be redirected towards the employment of school wellbeing leaders in government schools.

In the medium term (over 2 – 5 years)

- All schools should have a dedicated wellbeing leader. In larger schools, this should be a full-time position.
- Where government schools can demonstrate that they already employ a staff member in an equivalent position, and are delivering effective mental health and wellbeing programs, they should be able to access the equivalent funding to be used for additional investment in social and emotional wellbeing.

The Mitchell Institute endorses the Productivity Commission's focus on education in supporting the mental health of Australians, particularly the emphasis on supporting positive mental health, prevention and early intervention. Education is fundamental to long term health outcomes. It is an up-stream determinant and critical to improving health equity. The relationship between education and improved health occurs through a variety of behavioural, economic and social mechanisms (Center on Society and Health 2014, OECD 2006, Heise and Meyer 2004). More highly educated people have better health knowledge, are more likely to engage in health promoting behaviours, less likely to engage in health risk behaviours and more likely to access health services. They are more likely to work in higher paid positions, work in less hazardous environments, have better employment conditions and have the resources to access higher quality healthcare. Education is also linked to the development of skills and attributes that support positive physical and mental health, such as traits that help people to form healthy relationships and build social networks.

There is evidence that higher levels of educational attainment is associated with improved adult mental health (Kosik et al 2018, Chevalier and Feinstein 2006). The reverse is also true, with research showing that non-completion of school is associated with poorer physical and mental health (Black 2007).

For these reasons, further emphasis could be placed on improving approaches to addressing school disengagement and early leaving. It is estimated that at least 50,000 Australian students of school aged are not connected with education at any point in time (Watterston and O'Connell 2019). There are a range of well-known risk factors that are associated with a greater likelihood of early leaving (*ibid.*, Robinson and Meredith 2013). Some risk factors for early school leaving, such as chronic absenteeism, are identifiable from very early in a person's schooling. Studies have found that early school leavers tend to have more absences from the beginning of their schooling (Cook et al 2017). However, current approaches to addressing disengagement often occur either as students are disengaging or after they have disengaged. While the importance of reaching out to students that have fallen out of the school system should not be understated and can be improved, there are a range of warning signs and risk factors that could be used more effectively to intervene and provide support earlier. In addition, greater effort should be made to engage with families in order to provide necessary support to students and address any issues in the home environment that may be contributing to their disengagement.

As highlighted by the Productivity Commission, school is an important opportunity to focus on prevention of poor mental health and supporting good mental health. The Mitchell Institute endorses the Commission's focus on improving teacher capacity to deliver curriculum designed to support good mental health and health promotion, embedding a focus on wellbeing in schools, supporting high fidelity implementation of evidence-based programs, and enabling collaboration with local health services. However, the Mitchell Institute would encourage consideration of several workforce implications of the recommended reforms. Further work is also required to understand to what extent schools are currently employing a wellbeing lead and the strengths, challenges, and gaps of existing approaches, as well as the extent of training that is needed to develop this workforce. In addition, the Productivity Commission should explore the ability to recruit such a workforce, particularly in disadvantaged areas, difficult to staff locations and schools that have a higher proportion of students with poor mental health. This analysis of the supply of an appropriately qualified and knowledgeable wellbeing lead workforce should inform the development of any training programs that are needed.

The Mitchell Institute supports the Productivity Commission's model of school and community mental health service partnerships. The mental health wellbeing lead that is described in the report will be crucial in developing seamless connection between young people and mental health services. In addition to ensuring the supply of adequately trained staff for the wellbeing lead position, it will also be important that there are appropriate local mental health services available for the health and wellbeing lead to collaborate with.

As noted in the Productivity Commission's draft report, there are shortages of key mental health workforces, particularly in parts of regional and rural Australia. Evidence from a recent Mitchell Institute report shows that the geographic distribution of Medicare payments does not match the pattern and distribution of healthcare needs. For example, health care needs are greater in rural and remote areas but payments made through the MBS are clustered in cities and inner regional areas (Harris et al 2019). Additionally, analysis of Medicare subsidised mental health service use demonstrates socioeconomic and geographic disparities, with lower use among disadvantaged populations (Meadows et al 2015). Problematically, poor mental health is more common among regional and socioeconomically disadvantaged populations. This lack of alignment with the highest areas of need means these services are therefore not equitably or efficiently distributed.

It is likely that this inequitable distribution of services will raise challenges in developing collaborative relationships between schools and health services in some parts of Australia. It will be important to understand current as well as future shortages in order analyse approaches to intervening in the training and employment markets. Training, attracting and retaining regional

health workforces is a long standing challenge. There is research showing that social connectedness and life enjoyment as well as remuneration, professional development and opportunities to further your career are all important parts of why people choose to work in particular locations. Efforts to address rural and regional workforce attraction and retention should take a whole-of-person approach (Cosgrave et al 2018) and focus on both the social and economic drivers.

The Mitchell Institute would encourage the Productivity Commission to further consider the funding implications of the recommended reforms. As noted in the draft report, the Commonwealth has committed to implementing a needs based funding model. This model recognises the schools with greater levels of disadvantage and higher numbers of students with disabilities have higher delivery costs. However, according to recent analysis, many schools are receiving less than the funding model suggests they need (Daley et al 2018). Adding additional staffing costs, along with the other efforts described in the draft report, will likely increase the cost of service provision. In addition, some schools with higher levels of need associated with mental health challenges are likely to face a higher cost burden. It will be important to address these funding implications to ensure the impact of reforms is realised.

**Recommendation 5:**

To reduce the number of students leaving school early, the Mitchell Institute recommends the use of known risk factors and early warning signs, such as chronic absenteeism in primary school, in order to identify students who need additional support and enable early intervention.

**Recommendation 6:**

Undertake an analysis of the supply of:

- a suitably knowledgeable and skilled wellbeing lead workforce, particularly in disadvantaged and hard to staff locations
- appropriate mental health services for schools to partner with in regional areas.

Use this workforce analysis to inform the development any required training market and/or labour market interventions.

**Recommendation 7:**

Further analysis of the implications of the Productivity Commission's reforms on the existing school funding model, particularly in relation to the impact on schools with higher levels of need.

# The role of vocational education and employment in reducing unemployment and improving psychosocial wellbeing for people with mental illness

## Information Request 14.1 – Individual Placement and Support Expansion Options

The Productivity Commission is seeking further information about the pros and cons of the two distinct options for expanding the Individual Placement and Support (IPS) model of employment support. The options are:

- direct employment of IPS employment specialists by State and Territory Government community mental health services. This could be supported by additional Australian Government funding
- a new Australian Government-administered contract for IPS providers, based on fee-for-service compensation and subject to strict adherence to the IPS model (including that a partnership is in place with a State and Territory Government community mental health service).

What are the pros and cons of each option? Which is your preferred option and why? If the direct employment option is pursued, how should State and Territory Local Hospital Networks be funded to deliver the service?

## Mitchell Institute for Education and Health Policy response

The most appropriate model should be predicated on which option is most likely to provide IPS with high fidelity.

This review contends that while both options have merit, directly employing an IPS employment specialist in a community mental health service is likely to lead to a higher fidelity model of IPS. However, this service delivery method is not without its challenges, implementation should include efforts to:

- provide training to clinical teams so that clinical judgements don't prevent receipt of IPS employment support based on assessments of people not being work ready;
- maintain connections between employment specialists, industry information and employers;
- ensure people with a mental illness are able to access evidence-based IPS employment services through traditional pathways, such as requirements to receive social security payments; and
- ensuring activity requirements for Commonwealth social security payments capture efforts to pursue work through State and Territory mental health services.

People with a mental illness are over-represented in national unemployment statistics. Unemployment and the associated financial duress exert a significant toll on the mental and physical health and wellbeing of Australians with a mental illness and cost an estimated \$2.5 billion due to lost productivity each year. The Australian Health Policy Collaboration (AHPC), a national network of experts supported by the Mitchell Institute, agreed in 2015 that a national target for improved mental health in the Australian population should be that the employment gap for people with mental illness be halved by 2025 (McNamara et al 2015). The subsequent AHPC report, *Getting Australia's Health on Track*, 2016, proposed that investment in vocational programs to support employment and education were the most effective strategies to achieve this target (Lindberg et al 2016). The second edition of the Targets and Indicators report published in 2019 has affirmed the targets for improved participation in employment and education for people living with mental illness (McNamara et al 2019).

As noted by the Commission, supported vocational programs, such as Individual Placement and Support (IPS) programs, have been shown to be highly effective. Focused on rapid job placement

in positions matched to individual preferences with ongoing job support, the program goals are to achieve competitive employment for people with mental illness. Some international programs integrate mental health treatment services with employment services. Such programs have been found to be cost-effective. There are structural barriers inhibiting employment opportunities for people with mental illness that should be redressed such as financial disincentives through social security arrangements.

While IPS is clearly an effective model of vocational support for people with a mental illness, there remain challenges relating to implementation in Australia (Waghorn and Hielscher 2015, Carr and Waghorn 2013, Orygen Youth Health 2014). Research on the barriers to the introduction of the IPS model raise a range of issues, primarily related to integration of employment services with mental health services, isolation of employment staff, eligibility and access issues, and funding arrangements. The most appropriate model should be predicated on which option is most likely to provide IPS with high fidelity and therefore achieve the best employment outcomes.

Employing vocational specialists in community mental health services could provide an effective remedy for some of these issues but is not without its challenges. A key element of the IPS model is the integration of vocational support with the mental health services. Employment is seen as a core part of the person's rehabilitative treatment. Employing a vocational specialist in a mental health service will enable this staff member to more fully integrate in clinical treatment meetings and embed vocational rehabilitation in these discussions. However, it will be important to provide sufficient training to clinical teams to ensure that clinical judgements about work readiness are not used as a justification to stop a person engaging in IPS, as this is contrary to the evidence-based program principles. It will also be important to enable the vocational specialist to maintain connections with industry groups and employers. In addition, care will need to be taken to enable people with a mental illness who are not receiving treatment from a community mental health service and come into contact with employment services through traditional pathways (e.g. Centrelink) are still able to access the IPS model. Conversely, people accessing IPS through a community mental health service will need to have this captured by any activity requirements for Commonwealth social security payments.

The alternative model proposed, a new Commonwealth-administered contract for IPS providers, also has strengths and weaknesses. It would enable people with a mental illness accessing employment services through traditional pathways to easily engage with an evidence-based model of support. This is important as it could enable the service to capture a large number of job seekers with mental illness. However, it does raise a series of challenges in relation to fidelity with the IPS model. It may be difficult for an employment specialist working for a separate organisation to truly integrate with a mental health service. Currently, there are no incentives or policies that enable these services to get together and collaborate on the treatment and vocational rehabilitation of patients/clients. There are also significant cultural differences between these service types and, as noted by the Productivity Commission, they are run by different levels of government. Additionally, fee for service contracts can hinder the implementation of high-fidelity IPS by incentivising inflated caseloads, and the 'parking' of job seekers in order to maximise service fees. In addition, funding arrangements that create artificial deadlines for the provision of support are counterproductive to enabling long term work sustainability, the rehabilitative aspect of the vocational support, and the IPS principle of time unlimited support. Any potential contract would need to be significantly different to existing employment services. The contracts would need to be built around outcome payments and incentivised ongoing support. The contract would also need to set absolute quality standards that stipulate minimum service provision requirements and assess the fidelity of services against the evidence-based IPS model.

In addition to effective vocational support, policies to enable people with poor mental health to engage in post-school education are critical. Around 75 per cent of mental disorders occur before the age of 25. This can have a significant impact on a person's ability to remain engaged in school and tertiary education. Research suggests that 40 per cent of young people with depression or anxiety disorders are not finishing school (Bowman et al 2017). In addition, demand for post-school qualifications is high and growing, illustrated by the strong association between employment, earnings and vocational and higher education qualifications (ABS 2016). While

efforts to improve school completion are key, pathways back into education for those who do drop out are also needed. There need to be adequate and effective pathways to enable people with mental illness to participate in learning and gain the skills they need for work. Vocational education, including adult education can provide people with the skills they need for their long-term employment goals. In Victoria, the adult community education sector provides an important option for people who need to build foundational skills in order to pursue their education and employment goals. Improving school completion as well as providing appropriate pathways back into education are key to supporting the work goals of people with poor mental health and reducing their overrepresentation in unemployment statistics. A recent trial of IPS in Victoria showed the model could potentially be used to support people experiencing mental ill-health to achieve their educational goals (Killackey et al 2017). Further research should be conducted to explore this option further.

**Recommendation 8:**

Further explore policy actions that would address these issues above, including:

- Implementation of adequate, sustainable and high-fidelity IPS programs nationally for people with moderate, severe and persistent mental illness
- Provision of incentives to increase program fidelity to existing evidence and to the program principles
- Address service and policy barriers that inhibit employment and constrain the implementation of supported vocational programs
- Investment in school completion programs for students with mental illness and development of the evidence base to support delivery of effective supported education programs as pathways to employment.

## Physical and mental health comorbidities

Approximately 2.4 million Australians live with both a mental health condition and a chronic physical health condition. One in two Australians live with a chronic condition and **three in four** people with mental health conditions live with a second, third or fourth chronic disease (Harris et al 2018).

People with mental illness, particularly individuals with severe mental illness such as schizophrenia and bipolar disorder, do not live as long as those without mental illness. Growing evidence now suggests that individuals with diagnoses across the spectrum of mental disorders have a substantially reduced life expectancy compared with the general population. In Australia, it is estimated that 38% of the chronic disease burden in people living with mental illness is preventable.

As set out in Australia's Mental and Physical Health Tracker Background Paper, "people living with mental health conditions die earlier than the average Australian, and those with severe mental illness die 10–15 years earlier (Harris et al 2018). More than three quarters of the excess mortality comes from chronic physical health conditions. Many of these early deaths are preventable." This is based on research focused on people who access psychiatric services, rather than the complete cohort of over four million Australians who report mental health conditions. Data on early deaths for the complete cohort are not available. Data on life expectancy for people with severe mental illness comes from a Western Australian study of trends for psychiatric patients and the general population in that state (Rosenbaum et al 2014). The data have been validated with comparable international studies (Willcox 2015), and accepted by Australian governments in setting policy directions.

The known modifiable risk factors for poor health – smoking, nutrition, alcohol consumption and physical activity – are shared across both physical and mental health conditions. Despite people with chronic mental illness having more contact with health professionals than other people, research shows that this cohort have a significantly higher prevalence of key risk factors for cardiovascular disease. In Australia, the two leading causes of early death for people living with mental ill health are cardiovascular diseases and cancer (Harris et al 2018, Harris and Nichols 2019). Notably, these conditions have improved for the general population in recent decades, yet the relative outcomes for people with severe mental illness have worsened. There is growing evidence that integrated care is required to provide people living with mental illness with tailored interventions to address modifiable risk factors to improve their physical health.

Prioritising and addressing the shared modifiable risk factors will not only prevent the onset of new conditions for the general population and improve population health outcomes, but is likely to have the greatest impact on reducing overall chronic disease burden.

The Mitchell Institute is currently working on a policy roadmap which will outline and detail a suite of priority policies to improve the lives of those living with a mental health condition. This roadmap will be developed together with leading mental health experts.

### Recommendation 9:

The Mitchell Institute strongly supports an explicit focus and an integrated approach to improving health outcomes for people with coexisting mental and physical conditions in the final report.

## Better data for better decisions

### DRAFT RECOMMENDATION 25.2 — ROUTINE NATIONAL SURVEYS OF MENTAL HEALTH

#### *In the long term (over 5 – 10 years)*

The Australian Government should support the ABS to conduct a National Survey of Mental Health and Wellbeing no less frequently than every 10 years.

The survey design should enable consistent comparisons across time, and aim to routinely collect information on:

- prevalence of mental illness
- service use by people with mental illness, and
- outcomes of people with mental illness and their carers.

The survey design should ensure that it adequately represents vulnerable population sub-groups who may have diverse needs. Opportunities for linking the survey data with other datasets should be considered.

The Mitchell Institute supports this recommendation (recommendation 25.2) and suggests that the *National Survey of Mental Health and Wellbeing* be conducted in conjunction with the recent announcement of the *Intergenerational Mental and Physical Health Study*. The Study will include four surveys over three years covering mental health and wellbeing, people's health characteristics and chronic health conditions, nutrition and physical activity and various health measures involving the collection of voluntary blood and urine samples.

In our 2018 report, *Better Data for Better Decisions: The Case for an Australian Health Survey* (Calder et al 2018), we recommend investment in a survey of anthropometric, biomedical and environmental measures and risk factors for preventable chronic diseases survey to be conducted regularly to provide valuable data that tracks changes in health needs and risk factors. The first survey to collect such data was the *Australian Health Survey* conducted during 2011-12 by the Australian Bureau of Statistics (ABS). We recommend this survey be conducted **every six years** in conjunction with the current *National Health Survey*.

Many agencies such as the ABS, Australian Institute of Health and Welfare, state and territory agencies and a range of other organisations collect regular and valuable data from health systems, patients and financing systems. Despite the high value of these data collections, there is significant duplication of health surveys and data between governments and service sectors, and a diversity of methods and data sets. A well-functioning health system should incorporate regular collection of national population health data to inform health service planning and to ensure adequacy of Australia's health services into the future. Despite almost half of the Australian population living with a chronic condition and escalating health care costs and rising prevalence of preventable diseases, there is no on-going commitment to comprehensive population measurement of risk factors for preventable chronic diseases. For example, there was a 20 year gap between national surveys that investigated population nutritional status (the 1995 *National Nutrition Survey* and the *Australian Health Survey 2011-13*), and yet diet-related diseases are profoundly shaping our health care needs in both childhood (Brown et al 2017) and adult (Colagiuri et al 2010) health.

The ongoing *National Health Survey* and the *Aboriginal and Torres Strait Islander Health Survey* for example provide regular data on population health. However, they are largely based on self-reported information obtained through interviews. These surveys are a less reliable and accurate approach to the measurement of risk factors for chronic disease including blood pressure, cholesterol and diabetes mellitus and nutritional intake than the collection methods and surveillance standards of the *Australian Health Survey 2011-13*.

In comparison to international standards, Australia is lagging behind in data collection and management. The Productivity Commission's *Shifting the Dial* report (2017) found that Australia is not keeping up with international best practice.

The *Health Survey for England* (HSE) has been providing critical information to inform national health policies since 1991. Collected yearly, HSE monitors trends in the nation's health and care about children and adults. A series of core questions covering general health, hypertension and diabetes, social care, health-related behaviours such as smoking and alcohol consumption, biomedical measures including blood pressure, height and weight and analysis of blood and saliva samples are collected from a sample size of 10,000 including 2,000 children (Productivity Commission 2017). The HSE is just one example of the array of surveys being regularly collected in the United Kingdom (UK) and one reason why the UK is recognised internationally as a world-class source of public health intelligence.

An evaluation of the *Australian Health Survey 2011-13* (ABS 2017) found that stakeholders had keen enthusiasm and appreciation of the uses of the data. This data continues to be utilised in research and policy documents despite being almost 10 years old. The cost of the three components of the *Australian Health Survey* was \$54.3 million (*ibid.*). This investment has provided invaluable data for hundreds of health experts, planners, researchers, industry, government agencies and communities to identify and begin to respond to the range of risk factors for chronic diseases in the Australian community, increasing the efficiency and effectiveness of preventive health interventions.

As the Commission notes, collecting consistent and reliable data on school students' mental health will enable schools and education system administrators to develop, implement and evaluate policy more effectively. The Mitchell Institute would encourage the Commission to consider a broader approach to health data collection that reflects the interconnected nature of physical and mental health and a person's environment. The collection of data should capture both factors that contribute to good health (e.g. physical activity, resilience and social connectedness), factors that contribute to poor health (e.g. bullying, smoking and drug use) as well as the presence of poor health (e.g. weight issues and psychological distress). Ideally, this data would be linked to a unique student identifier and include measures that enable comparability with the data collected in early childhood (i.e. the Australian Early Development Census). This would facilitate a better understanding of changes in children and young people's health as well as the connection between their wellbeing and other outcomes, such as literacy achievement and/or attendance. For schools, this offers the opportunity to capture a more nuanced picture of their school community's strengths and needs that moves beyond the traditional focus on achievement and engagement. For education system administrators, it offers the opportunity to better understand the connection between wellbeing and engagement and achievement, develop place-based policy solutions to local challenges, and more accurately evaluate the impact of wellbeing programs on student outcomes. In order to minimise the impost on students and schools, consideration should be given to replacing existing data collections, particularly where they are low quality, not comparable across jurisdictions, duplicative or underutilised.

**Recommendation 10:**

The National Survey of Mental Health and Wellbeing should be encompassed within the proposed Intergenerational Mental and Physical Health Study.

**Recommendation 11:**

The Intergenerational Mental and Physical Health Study should be established as a permanent, routine survey conducted every six years. This study should involve biomedical, nutritional and physical activity measures.

**Recommendation 12:**

The proposal to collect data on school students' social and emotional wellbeing should be broadened to reflect the relationship between mental and physical health and the impact of ecological factors. The data should be linked to a unique student identifier and measures should be comparable to those collected in early childhood.

# Australia's health system: too complex to navigate

## DRAFT RECOMMENDATION 23.3 — STRUCTURAL REFORM IS NECESSARY

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

## INFORMATION REQUEST 23.1 — ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

*The Productivity Commission has proposed two distinct models for the architecture of the future mental health system:*

*The Renovate model, which embraces current efforts at cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs).*

*The Rebuild model, under which State and Territory Governments would establish 'Regional Commissioning Authorities' that pool funds from all tiers of government and commission nearly all mental healthcare (Regional Commissioning Authorities would take over PHNs' mental health commissioning responsibilities and also commission more acute mental healthcare) and psychosocial and carer supports (outside the NDIS) for people living within their catchment areas.*

*At this stage, the Rebuild model is the Commission's preferred approach.*

*How could the Rebuild model be improved on? Are the proposed governance arrangements appropriate? Should RCAs also hold funding for, and commission, alcohol and other drug services?*

*If you consider the Renovate model or another alternate approach is preferable, please describe why, and outline any variations you consider would be an improvement.*

The Productivity Commission rightfully points out that structural reform is necessary. However, reform is required not only for the mental health system but for the health system more broadly. Whilst the Australian health care system performs well by international standards and is recognised as one of the best in the Organisation for Economic Cooperation and Development (OECD), since the early 2000s, changes such as an ageing population, increasing rates of chronic disease (Australian Government Department of Health 2019), rising healthcare costs and inequities (Dixit Sambasivan 2018) has put the Australian health system under pressure so that it now falls well short of the goals of Medicare – the establishment of funding arrangements to provide a system of healthcare that is meant to be simple, fair and affordable.

These issues are compounded by the complexity of private health insurance and private health care services, and by a series of amendments, workarounds, superimposed fixes and band aids applied to Australia's health funding arrangements and services system from multiple sources over many years, resulting in health service arrangements that are too complex for individuals – and some health professionals – to navigate.

In an analysis of 16 major reviews into Australia's health system over the last 35 years, the Mitchell Institute found that all 16 reviews have consistently identified the ways health services are led, funded and designed across Australia as the major contributors to Australia's complex and often inefficient health system. This report, [Australia's health system: too complex to navigate 2018](#) reiterates that the roadmap for action to fix many of the well-known problems in Australian health care is clearly stated through these reviews. Reviews have agreed that:

- without **structural change** to the way in which health care is delivered and financed, the Australian health care system will continue to struggle to meet contemporary needs and expectations of its citizens
- until the current complexity of the system, particularly **financing, is re-designed**, patient journeys will be inefficient, less than effective and time-consuming. Health care providers will continue to create workarounds to minimise structural inefficiencies and barriers. Patient costs will continue to escalate and health outcomes for some population groups will continue to be compromised
- without significant change in **current funding agreements** and in **service models**, investment in prevention to improve health and reduce preventable disease will languish as the poor relative of high cost reactive healthcare services and investments
- the role of **primary care needs to be strengthened** with priority given to better quality outcomes and outcome measurement. Funding models need to support prevention, management and support of chronic health conditions.

The Mitchell Institute report identified two priority areas that reviews had affirmed as key reform strategies:

1. Establishment of a permanent **national stewardship structure** to develop and oversee the implementation of a long-term plan for the health system, based on realising the goals of Medicare. A permanent national stewardship structure – potentially a National Health Commission would be jointly owned by national, state and territory governments and would have responsibility for policy advice to governments on three major priorities addressing critical health care priorities and components of an efficient and effective health system:
  - achieving singular stewardship across all levels of government
  - the ongoing strengthening of primary care through more integrated and easy to access services
  - a sustained focus on prevention at all levels of health care.
2. Restructuring of the **financing of healthcare** arrangements to provide simpler and efficient health care, more focused on outcomes and quality while providing the incentives for the right care to the right people at the right time. This would include consideration of:
  - the coverage of a publicly funded universal insurance system, together with the role of private health insurance, in the context of funding care for chronic conditions
  - the basis of reimbursement to providers to encourage sustained prevention, early detection and management of chronic diseases and coordination of services to reduce duplication and more effective use of information.

Whilst the Productivity Commission's recommendation to establish Regional Commission Authorities (RCAs) would be helpful to alleviate inefficiencies, duplication and gaps, the Mitchell Institute reiterates the need for a national stewardship structure for the whole system in which the RCAs would be appropriate delivery level agencies. The most recent attempts to clarify and rationalise roles and responsibilities between the Commonwealth and State health departments was through the *Reform of the Federation* process which was aborted in 2016.

The Mitchell Institute agrees that Primary Health Networks (PHNs) should no longer commission mental health care as part of the rebuild model. PHNs should collaborate with local health districts to decide where and how to spend funds from the pooled funds transferred to the RCAs. This pooled funding model would provide a stronger focus on prevention with flexibility at the regional level. These funds should also be used to encourage collaboration and the development of innovative chronic disease prevention activities at a local health district level as recommended in *Shifting the Dial 2017* (*Productivity Commission 2017*).

The Mitchell Institute shares the Productivity Commission's concerns that current funding agreements in the mental health system contribute to poor consumer outcomes and a mix of services that is inefficient. We also agree with the Productivity Commission's recommendation for

a rebuild model (recommendation 23.3) and note that this recommendation is in-line with a previous recommendation by the Productivity Commission in *Shifting the Dial 2017* report. However, the Mitchell Institute suggests that recommendation 23.3 should be expanded to consider:

- a shift away from fee-for-service to blended payments
- service design and delivery.

The Productivity Commission's rebuild model addresses some key challenges within the Australian health system such as stewardship and service design, however, it omits or rather, doesn't address other key challenges such as health workforce and quality and safety required for an efficient health system. These other key challenges may be beyond the scope of the draft report but are certainly ongoing structural flaws within the current health system. , Failure to address these will mean that the system will continue to have gaps in services and differential access due to rationing and slow changes to allocations between areas and diseases; it will not become simpler to navigate and its administrative costs for all participants will not be reduced.

**Recommendation 13:**

The Mitchell Institute calls for a national stewardship structure to develop and oversee the implementation of a long-term plan for the health system, based on realising the goals of Medicare.

**Recommendation 14:**

The Productivity Commission should consider expanding recommendation 23.3 to incorporate blended payments and improving health service design and delivery.

## The influence of gender in mental illness and in mental health outcomes

The Mitchell Institute health program published a report on Investing in Women's Mental Health, in 2016, arguing the case that gender matters in health policy and in practice (Duggan 2016).

The report noted the steadily increasing body of evidence that shows gender disparities in incidence, complaint presentation, symptoms and prognosis in many health problems, including in the incidence, prevalence and experience of mental ill-health. The paper considers the evidence that women's mental health is influenced by biological, psychosocial, economic and environmental factors.

In particular, evidence shows that some mental illnesses are more prevalent in women; that women use mental health services more frequently than men, and that women would like a broader range of treatment options than are available currently. Whilst it is an undisputed fact that women's mental health needs are significantly different from those of men, and therefore require different responses, the evidence has mostly not been translated into mainstream health policy or practice.

The consequences of mental ill health against women were identified as including:

- Direct effects such as disability, reduced life expectancy and impoverishment of individual women, with knock-on effects for children and other family members
- Indirect effects including unemployment, reduced productivity, increasing costs of healthcare and welfare transfer
- Costs associated with child abuse and neglect.

The report proposed a comprehensive policy approach to improving women's mental health across the life-course, requiring identification of gendered risk factors, including the impact of social inequalities on mental health and the impact of life experiences such as intergenerational trauma, racism, violence and abuse.

The report recommended three strategies to improve policy and practice in women's mental health services:

1. Investment in the evidence base, through research into the causes and consequences of women's mental distress and what works to prevent and manage it more effectively.
2. Development and preliminary implementation of a strategic approach to embedding capability for gender-sensitive practice for mental health specialists, primary care clinicians and staff in community and secondary health care, including maternal and children health services and hospitals.
3. Development of locally and regionally relevant, gender-sensitive care pathways, including integrated service models capable of responding holistically to girls and women across the life course.

The report set five major policy goals:

1. Responding to the life-course mental health needs of women
2. Integrating responses to physical and mental health
3. Meeting the needs of women with severe mental illnesses
4. Mainstreaming a preventative approach
5. Investing in research and service innovation.

**Recommendation 15:**

The Mitchell Institute urges the Productivity Commission to consider the influences of gender on mental health and mental health care in its final report, including the following three strategies to improve policy and practice in women's mental health services:

1. Investment in the evidence base, through research into the causes and consequences of women's mental distress and what works to prevent and manage it more effectively
2. Development and preliminary implementation of a strategic approach to embedding capability for gender-sensitive practice for mental health specialists, primary care clinicians and staff in community and secondary health care, including maternal and children health services and hospitals.
3. Development of locally and regionally relevant, gender-sensitive care pathways, including integrated service models capable of responding holistically to girls and women across the life course.

## **Appendix I: list of recommendations**

### **Recommendation 1:**

The consistency and quality of health promotion across the ECEC sector could be improved by:

1. Investing in innovation and research, with a particular focus on families of greatest disadvantage, and collaboration between health and ECEC systems and providers;
2. Working with key stakeholders to develop a model of excellence in health promotion in ECEC, including national investment in tools and content to support this;
3. Integrating a focus on ECEC, and ECEC strategies, into the national health strategies currently being developed

### **Recommendation 2:**

It is important that efforts to improve the social and emotional development of children through ECEC services take into account the higher prevalence of mental health difficulties among low socioeconomic populations and lower quality of services in disadvantaged areas. Further consideration should be given to appropriately funding services that are serving high needs children.

### **Recommendation 3:**

The Mitchell Institute urges the Commission to give further consideration to the evidence of benefit, including return on investment, of evidence-informed and available programs and interventions that have demonstrated positive improvement in the health and wellbeing of vulnerable children.

### **Recommendation 4:**

Undertake modelling of the return on investing in effective programs for highly vulnerable children through reduced future government expenditure and increased productivity.

### **Recommendation 5:**

To reduce the number of students leaving school early, the Mitchell Institute recommends the use of known risk factors and early warning signs, such as chronic absenteeism in primary school, in order to identify students who need additional support and enable early intervention.

### **Recommendation 6:**

Undertake an analysis of the supply of:

- a suitably knowledgeable and skilled wellbeing lead workforce, particularly in disadvantaged and hard to staff locations
- appropriate mental health services for schools to partner with in regional areas.

Use this workforce analysis to inform the development any required training market and/or labour market interventions.

### **Recommendation 7:**

Further analysis of the implications of the Productivity Commission's reforms on the existing school funding model, particularly in relation to the impact on schools with higher levels of need.

### **Recommendation 8:**

Further explore policy actions that would address these issues above, including:

- Implementation of adequate, sustainable and high-fidelity IPS programs nationally for people with moderate, severe and persistent mental illness
- Provision of incentives to increase program fidelity to existing evidence and to the program principles
- Address service and policy barriers that inhibit employment and constrain the implementation of supported vocational programs

- Investment in school completion programs for students with mental illness and development of the evidence base to support delivery of effective supported education programs as pathways to employment.

**Recommendation 9:**

The Mitchell Institute strongly supports an explicit focus and an integrated approach to improving health outcomes for people with coexisting mental and physical conditions in the final report.

**Recommendation 10:**

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