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The Productivity Commission

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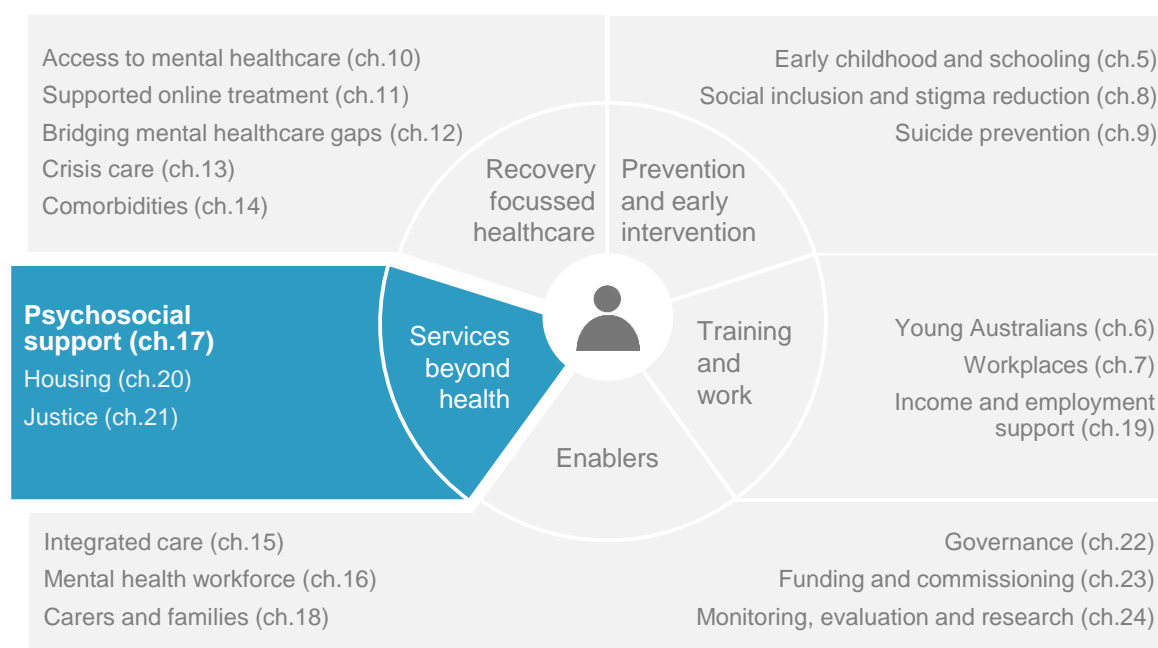
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PART IV – RE-ORIENTING SERVICES AND SUPPORTS BEYOND HEALTH

17 Psychosocial support – recovery and living in the community



Improving psychosocial supports matters because...

- Psychosocial supports — which include a range of services to help people manage daily activities, rebuild and maintain connections, build social skills and participate in education and employment — can facilitate recovery in the community for people experiencing mental ill-health.
- Not everyone who needs psychosocial supports is able to access them. Significant service gaps stem from ad hoc funding arrangements, short funding cycles and lack of economies of scale.
- The transition of service provision to the National Disability Insurance Scheme (NDIS) has led to uncertainty for both service providers and consumers, which may affect access to services.

RECOMMENDATION 17 — IMPROVE THE AVAILABILITY OF PSYCHOSOCIAL SUPPORTS

The delivery of psychosocial supports — including a range of services to help people manage daily activities, rebuild and maintain social connections, build social skills and participate in education and employment — has been hampered by inefficient funding arrangements and service gaps. This is affecting the recovery of people with mental illness and their families, who can benefit substantially from improved access to psychosocial supports.

As a priority:

- Governments should ensure that all people who have psychosocial needs arising from mental illness receive adequate psychosocial support. To achieve this:
 - The shortfall in the provision of psychosocial supports outside the National Disability Insurance Scheme (NDIS) should be estimated at a regional and State and Territory level. (Action 17.3)
 - Over time, State and Territory Governments, with support from the Australian Government, should increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall. (Action 17.3)

Additional reforms that should be considered:

- As contracts come up for renewal, commissioning agencies should extend the length of the funding cycle for psychosocial supports from a one-year term to a minimum of five years. Commissioning agencies should ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle. (Action 17.1)
- State and Territory Governments and the National Disability Insurance Agency should streamline access to psychosocial supports both for people eligible for supports through the NDIS and for people who choose not to apply for the NDIS or are not eligible. (Action 17.2)
- State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the NDIS. (Action 17.3)

Psychosocial supports help people experiencing or recovering from mental illness to achieve higher levels of wellbeing and engage with their communities. They are mainly delivered by community-based organisations, with funding from the Australian, State and Territory Governments, and the National Disability Insurance Scheme (NDIS), which funds long-term care and support for people with severe or profound disabilities.

Estimates from the National Mental Health Service Planning Framework (NMHSPF) suggest that about 690 000 people with mental illness would benefit from some type of psychosocial support in 2019-20.¹⁶⁶ Among them are 290 000¹⁶⁷ people with severe and persistent mental illness who are most in need of psychosocial support. However, many of these people do not receive any support or the level of support falls short of what is needed.

The provision of psychosocial supports, which has long been affected by inefficient and duplicative funding arrangements, is currently in a state of transition as the NDIS roll out is in progress. The transition to the NDIS, while providing for some, appears to have left a significant gap in service provision for many others. When the NDIS roll out is completed, about 64 000 people with the highest psychosocial needs would access individualised supports through the NDIS. Some people would be able to access services funded by State and Territory Governments — but the Productivity Commission estimates that up to 154 000 people would not be able to receive the services they require, based on current policy settings.

Improving psychosocial supports requires a systemic shift in the way these supports are planned and funded, recognising their importance for consumers in the mental health system and incorporating them into this Inquiry's broader reform agenda. This chapter recommends a number of actions to achieve this. Systemic issues are explored in detail in other chapters, including reforms to governance (chapter 22), overhauling funding arrangements (chapter 23), the integration and coordination of services (chapter 15) and workforce arrangements for the community mental health sector (chapter 16).

In this chapter, section 17.1 explores what psychosocial supports are, why they are important, and who accesses them. Section 17.2 considers how the delivery of mainstream psychosocial supports has been affected by issues arising from funding arrangements and the impact of the transition to the NDIS. Section 17.3 provides a brief overview of the NDIS, discusses the experiences of people with psychosocial disability within the NDIS and what is being done to improve their experience. Section 17.4 presents solutions to improve the delivery of psychosocial supports, including through meeting the shortfall in the provision of psychosocial supports and improving the interface between mainstream psychosocial supports and the NDIS.

¹⁶⁶ There is a larger group of people accessing low intensity psychosocial supports through peer forums and other types of services – these are discussed in chapter 12. This chapter focuses on people who need more intensive psychosocial supports. Additional psychosocial supports are covered in detail in other chapters, such as services aimed at carers (chapter 18), housing (chapter 20) and care coordination (chapter 15).

¹⁶⁷ The Department of Health estimated this at approximately 282 000 people in 2016. Incorporating population growth using the ABS Estimated Resident Population, the number of people with severe and persistent mental illness who are most in need of psychosocial support is estimated to be 290 000 people in 2018-19 (DoH 2017b).

17.1 Programs and services that support recovery

‘Psychosocial’ refers to the interaction between psychological and social or cultural components of life, giving recognition to the potential impacts of mental ill-health on a person’s ability to take part in day-to-day activities (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 7). Accordingly, psychosocial support addresses a person’s emotional, social, mental and spiritual needs (OVCSupport 2020). Psychosocial supports can facilitate recovery in the community for people experiencing mental ill-health at all levels of severity and across a diverse range of backgrounds.

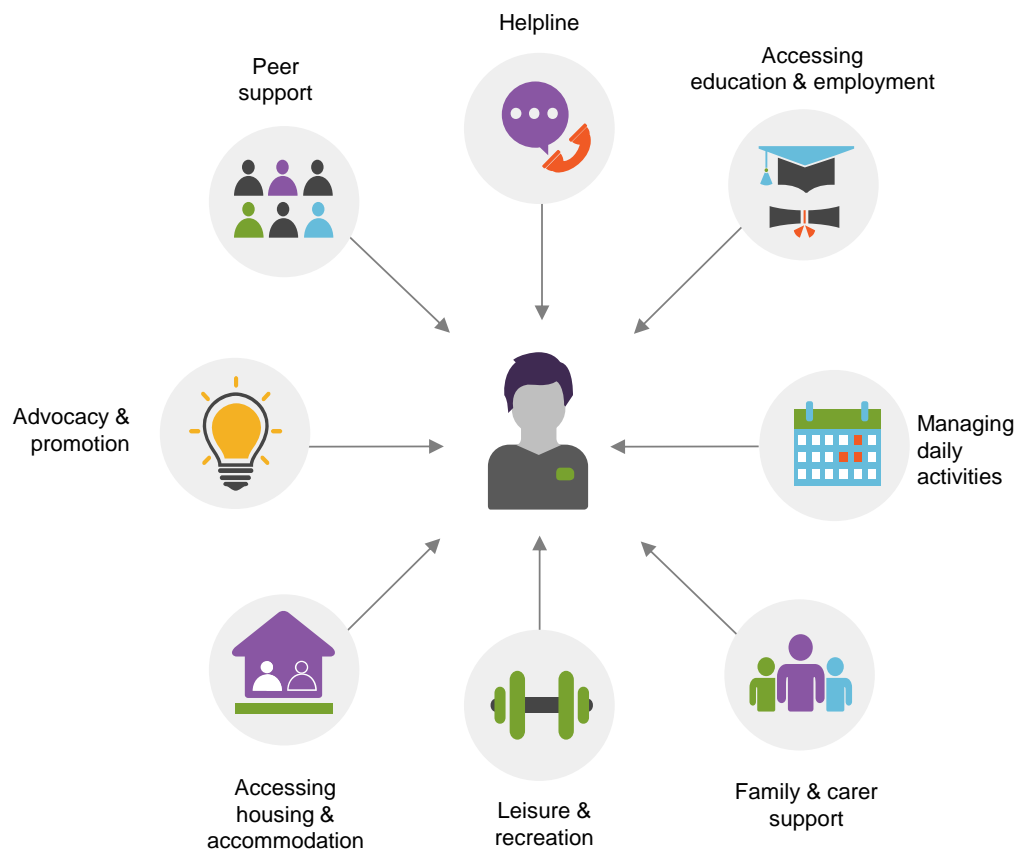
Psychosocial supports for people with mental ill-health are predominantly delivered by non-government organisations (NGOs) and funded by the Australian, State and Territory Governments. The supports provided to people can vary greatly due to personal requirements — as they are targeted to the specific needs of the person — and service availability. Supports include those that assist with participating in the community, managing daily tasks, undertaking work or study; helpline and counselling services; advocacy and promotion; finding accommodation; and improving connections with friends and family (CMHA 2012; NWMPHN 2019; QAMH, sub. 714) (figure 17.1). Supports may be provided through individual, group and community programs (box 17.1).

Psychosocial supports comprise psychosocial disability supports and psychosocial rehabilitation.

- *Psychosocial disability*¹⁶⁸ supports refer to processes, interventions and services that aim to support an individual to maintain their current level of independence. Supports can include those that assist with managing daily living needs, establishing or maintaining a tenancy, rebuilding and maintaining connections, and developing social skills to build friendships and relationships.
- *Psychosocial rehabilitation* aims to enhance and increase skill development, maximising the potential to manage everyday life, participate in the community and increase independence (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 8).

¹⁶⁸ A psychosocial disability is an impairment or restriction, arising due to mental illness, that can limit, for example, an individual’s ability to function, think clearly, enjoy full physical health or manage their social and emotional welfare. However, in this context, the terminology refers to the support being provided, rather than the mental ill-health that a person may experience.

Figure 17.1 How do psychosocial supports provide help?



Source: Community Mental Health Australia (2012); North Western Melbourne PHN (2019).

Rehabilitation focuses on ‘doing with, not for, by supporting people to develop their skills to manage the ups and downs on their own’ (MHCSA, sub. 794, p. 9). Similarly to how someone who is physically injured may require long-term physical rehabilitation to help them recover, people recovering from mental ill-health may require supports to mend and rebuild emotionally, cognitively, practically and socially, helping them to develop or regain skills necessary to be able to fully participate in society (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 8).

The nongovernment agencies across Australia provide thousands of people with psychosocial support to help them live a more fulfilling life in the community ... in between their 30 minute monthly appointment with their psychiatrist or case manager, they have a life to live, and psychosocial support assists them to lead that life. (Joe Calleja, Perth transcript, p. 24)

Psychosocial support is not a quick fix. It is about a relationship building, relationship modelling, it is about identifying and developing skills you already have as an individual, as a partner, as a couple, as a family. (VMIAC, Melbourne transcript, p. 162)

It’s primarily community focused, has family life at its heart and deals with the real world. So we’ve got the personal and interpersonal aspects of a recovery approach or psychosocial support, if you like. Then you’ve got the community level psychosocial supports which connect the people

to stable accommodation, income, vocational support, connect people into clubs, social activities and other activities that lead to social inclusion, participation and contribution to family and community life. (MIFA, Brisbane transcript, p. 20)

Box 17.1 Examples of programs providing psychosocial support

There is a broad range of psychosocial programs funded by Australian and State and Territory Governments. Two examples of Australian Government-funded supports were Personal Helpers and Mentors (PHaMs) and Support for Day to Day Living in the Community (D2DL) programs.

PHaMs provided assistance to people with severe functional limitations resulting from mental illness to participate economically and socially in their communities. PHaMs services provided coordinated access to support services such as housing support, employment and education, independent living skills courses and clinical services (AIHW 2019g). The D2DL program funded organisations that provided structured and socially-based day activities that help to improve the quality of life of individuals with severe and persistent mental illness. These activities included cooking classes, vocational activities, creative arts and social outings (DoHA 2010).

Funding for PHaMs and D2DL transitioned to the NDIS on 1 July 2019 (DoH 2019f; DSS 2019m). Providers of these programs received an extension of funding to support participants to transition over to the NDIS (Fletcher and Hunt 2019).

Examples of State-funded psychosocial support include supportive housing (e.g. the Housing and Accommodation Support Initiative (HASI) in New South Wales, Tasmania and Northern Territory, discussed in detail in chapter 20); psychosocial rehabilitation and support services; centre-based day care; individualised supports (e.g. Early Intervention Psychosocial Support Response in Victoria, and Individualised Community Living Strategy in Western Australia); coordination and case management services (e.g. Lead Support Coordination Service in Tasmania, Integrated Services Response Program in the ACT).

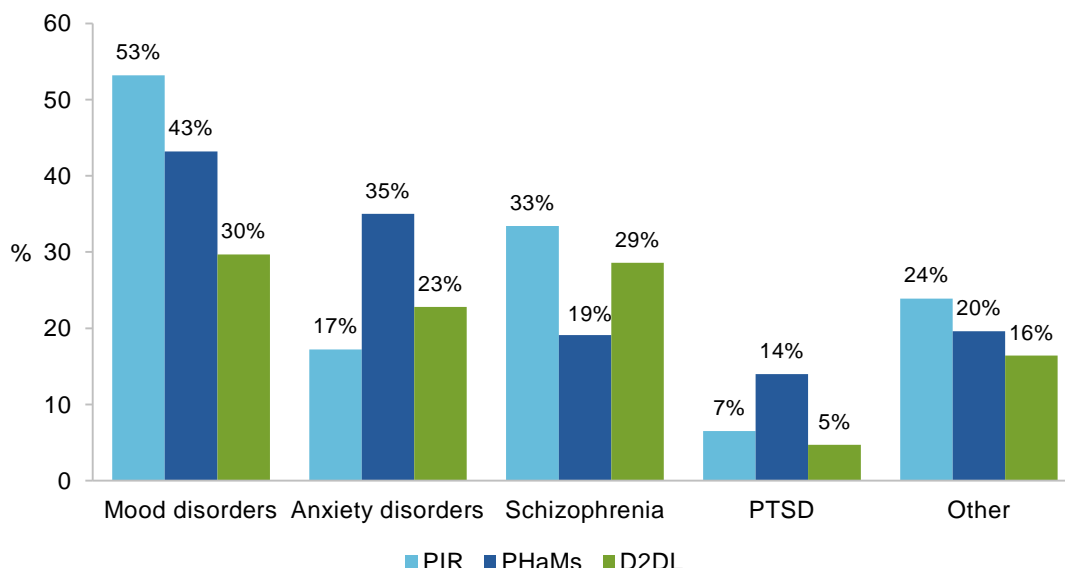
Other examples of programs providing psychosocial support include social inclusion programs, community and drop-in centres, advocacy programs, individual psychosocial rehabilitation, and support services and clubhouses.

Who uses psychosocial supports?

In 2016-17, approximately 90–95 000 people were receiving psychosocial disability support from Australian, State and Territory Government-funded programs (DoH 2017b).¹⁶⁹ While users of psychosocial supports are predominantly people who have mental illness with severe and complex needs, some people with moderate clinical needs also require (sometimes significant) psychosocial supports (Mental Health Australia, sub. 407; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212). Mood disorders and schizophrenia were the most common diagnoses among users of psychosocial supports (figure 17.2). Many have major comorbidities and present complex diagnoses. For example, in 2014-15, an estimated 37.5% of Personal Helpers and Mentors (PHaMs) participants had a physical disability (AIHW 2019g).

¹⁶⁹ This figure does not account for client turnover, which would result in a greater number of people accessing the supports over time.

Figure 17.2 Common mental illness diagnoses of psychosocial support users^{a,b}



^a Participants may be in more than one category and totals sum to greater than 100%. For Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMs), organisations list all diagnoses, while for Support for Day to Day Living in the Community (D2DL), many organisations only keep primary diagnoses, so the number of participants with each diagnoses may be an underestimation for D2DL. ^b Diagnostic data is based on 2678 individuals for PIR, 2257 for PHaMs and 1127 for D2DL.

Source: Community Mental Health Australia and University of Sydney (2019a).

The use of psychosocial supports is not only limited to people experiencing mental illness as psychosocial needs can also arise from social and personal life stressors. Psychosocial supports may be needed by anybody who would benefit from assistance with daily living, rebuilding and maintaining social connections, or skill development. There is some evidence of the efficacy of psychosocial interventions for people experiencing numerous conditions, including cancer, substance use disorder and intellectual disability (Cancer Australia 2020; Dagnan 2007; Grassi, Spiegel and Riba 2017; Hunt et al. 2013). The psychosocial supports referred to in this report are for people whose need for the supports arises from mental ill-health.

Why are psychosocial supports important?

Psychosocial supports play a vital role in enabling those living with mental illness to live well, to recover in their communities, and to counter the stigma and discrimination they may face (Duff et al. 2011; MIFA, sub. 897; Tew et al. 2012; Victorian Government 2019a). Psychosocial supports can empower people to achieve independence, increase control over daily life, and promote self-determination (MHCC, sub. 214; MIFA sub. 897; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212). They are often critical in helping people manage their mental illness.

[I]f we use that analogy of stepping up and stepping down, we imagine a staircase ... psychosocial services are the handrail[s] that help people step up and step down ... the thing that keeps everything stable and allows people ... to just hang on to while they're working stuff out. So it doesn't matter whether they're stepping up or stepping down or just staying where they are at the moment, because where I am is just okay, that handrail is a thing that keeps them safe at that point in time. (Skylight Mental Health, Adelaide transcript, pp. 26–7)

[Psychosocial interventions] have the potential to reduce the experience of impairment and provide early assistance that maximises people with psychosocial disabilities' potential to work, improve their relationships with their families and others, gain new skills, stabilise their housing and self-manage. (Hayes et al. 2016)

Several Inquiry participants spoke of the importance of psychosocial supports to a person's recovery, describing them not only as important foundations to complement and support clinical interventions, but as critical to the effectiveness of clinical care (CSSA, sub. 202; Joe Calleja, Perth transcript, p. 23; MIFA, sub. 897, Brisbane transcript, p. 19; Skylight Mental Health, Adelaide transcript, p. 26; UnitingSA, sub. 807). Psychosocial supports can be particularly effective in promoting recovery, especially when applied early (QAMH, sub. 714; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212).

A person's cultural and linguistic background will affect how they interpret and respond to life experiences (WA DLGSC, sub. 78; RASA, sub. 420). As such, it is important that psychosocial supports are targeted and adapted to address the needs of people from culturally and linguistically diverse (CALD) backgrounds (Mental Health Australia, FECCA and NECA, sub. 524; Mental Health Coalition SA, sub. 794; SAMHC, sub. 477). Culturally capable psychosocial support providers are essential to preventing relapse in people from CALD backgrounds, can provide cultural interpretation and help people integrate into their communities (Rickwood 2006), which can bolster social inclusion (chapter 8).

The provision of psychosocial support not only directly benefits the psychosocial capability of users, but is also associated with benefits to the wider community, such as greater social inclusion, participation and contribution to the community through employment and volunteering (MHACA, sub. 726, p. 1; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212; VMIAC, Melbourne transcript, p. 165).

There can also be benefits to governments, as psychosocial supports may reduce demand for more expensive interventions (LELAN, sub. 771; MHACA, sub. 726; MIFA, sub. 897; QAMH, sub. 714; TeamHEALTH, sub. 756). For example, an evaluation of a South Australian Government-funded psychosocial support service found a 39% reduction in mental health-related hospital admissions and a 16% reduction in the average length of hospital stay for people accessing the service (UnitingSA, sub. 807). The National Mental Health Commission (NMHC 2014b, p. 28) estimated that:

... for people with complex needs, such as a person with severe bipolar disorder, optimal care (based upon greater GP contact, increased support from community mental health teams and continued access to care coordination and psychosocial supports) can yield savings over nine years of \$323,000, with about half of that saving being directly to the states through reduced acute care costs (admissions) ... and about one-third to the Commonwealth.

In the absence of adequate psychosocial supports, people's needs can easily escalate to costlier services.

When these supports are unavailable or break down they can exacerbate or even become the precursor to a period of illness that requires an emergency response that is expensive, can be distressing for consumers and their families, and may contribute to further disengagement with the system. (Mental Health Australia, sub. 407, p. 22)

Currently, there is an overreliance on crisis services, emergency departments and admission to acute or inpatient facilities due to a lack of community mental health support that could intervene early (Fels 2018; Mental Health Commission of New South Wales, sub. 486, p. 11; WAMHC 2015a). This is discussed further in chapter 13.

Who provides psychosocial supports?

Psychosocial supports are provided mainly by NGOs, sometimes referred to as 'community managed organisations', in the community mental health sector (QAMH, sub. 714; MHCC 2015) (box 17.2).¹⁷⁰

These psychosocial supports complement clinical treatment to improve consumer outcomes.

Australia's community mental health (CMH) services are distinct from, yet complement clinical mental health services ... CMH services focus on supporting the recovery goals of consumers through various psychosocial approaches. CMH services offer holistic, person centred support with the many life domains which impact on mental health. (ASU, sub. 177, p. 3)

NGOs provide a wide range of supports, and often are 'best placed to provide essential links into the community and between services', with a 'capacity to run flexible and consumer-centred care' (SCMH 2006, p. 228). The supports they offer encompass a wide range of services that affect people's recovery from mental ill-health.

While a number of organisations are funded to provide targeted services to people with mental illness, many social service organisations support people with mental illness indirectly through the provision of a wide range of social services including homelessness support, children, youth and family support services, alcohol and drug support, employment services and other health and wellbeing services. (NTCOSS, sub. 408, p. 1)

There is no national data collection on psychosocial support providers. The Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set is currently being implemented, but has only been initiated in Western Australia and Queensland (AIHW 2015; CMHA, Sydney transcript, p. 106). Overall, data collection is not comprehensive and possibly inconsistent across jurisdictions. Broader issues and recommendations regarding data collection in mental health are discussed in chapter 24.

¹⁷⁰ 'Psychosocial supports', 'community mental health supports' and 'community mental health services' are often used interchangeably by the sector. Our report considers community mental health services to comprise all mental health services provided outside hospitals (chapters 10, 12, 13).

Box 17.2 Examples of providers of psychosocial supports

Mind Australia is a community-managed specialised mental health service provider that supports people dealing with the day-to-day impacts of mental illness, as well as their families and carers. Mind provides recovery-focused, person-centred support including residential rehabilitation, personalised support, family and carer services, and care coordination. They deliver outreach and residential services in partnerships with clinical agencies. Mind also conducts research and advocacy work.

One Door Mental Health is a mental health recovery organisation providing psychosocial support programs, care coordination, housing, clinical and peer-supported services for people living with severe and complex mental illness across New South Wales. They deliver trauma-informed and recovery-oriented support through the NDIS for people with psychosocial disability.

UnitingSA is a member of the Mental Health Coalition of SA and provides community services, housing and aged care to support people across South Australia. UnitingSA workers provide significant mental health support to people accessing their services that include employment, aged care, family and homelessness services.

Culture in Mind is a multicultural, community-based mental health support and recovery service supporting the mental wellbeing of people from culturally and linguistically diverse (CALD) backgrounds in Brisbane. Their cultural support workers and wellbeing support coordinators work with individuals, family and carers to provide wrap-around culture-based care through individual and group-based programs.

Source: Culture in Mind (2018); Mental Health Australia, the Federation of Ethnic Communities' Councils of Australia and the National Ethnic Disability Alliance, sub. 524; Mind Australia, sub. 380; One Door Mental Health, sub. 856; UnitingSA, sub. 807.

A survey conducted in 2009-10 found that there were 798 organisations in Australia providing psychosocial supports, and it is likely that their number has grown since then. Most providers are small organisations. In 2014-15, the 47 NGOs delivering psychosocial supports across Western Australia had an average of 3.92 (paid) full-time equivalent staff (WAMHC 2016b). A 2019 survey found that, in New South Wales, 83% of the workforce was employed by under one-fifth of the total number of organisations, suggesting that the sector is dominated by a few large NGOs while most are very small (MHCC and HCA 2019).

The community mental health sector's work is often underpinned by staff with lived experience, resulting in greater sensitivity to people's individual needs:

[We] employ skilled professional mental health workers that deliver different types of services within their discipline and scope of practice. Many of our staff have lived experience, which enables our organisations to draw upon their expertise to inform and deliver our services ... The support they provide is flexible and personalised, provided at various intensities as per intensive and moderate, to enable capacity building of individual and family/carer. (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, pp. 16–18)

17.2 The delivery of psychosocial supports is hampered by inefficient funding mechanisms

There is a variety of psychosocial supports available across Australia, funded by both the Australian Government and State and Territory Governments (box 17.1). Prior to the introduction of the NDIS, funding for psychosocial supports was already a complex web of different streams. States and Territories held the primary responsibility for psychosocial support services, including funding, delivering and/or managing specialised mental health services that were then delivered through NGOs. The Australian Government held responsibility for the oversight and funding of a range of additional services and programs that were primarily provided or delivered by private practitioners or NGOs (DoH 2017a).

Current funding arrangements remain largely similar in structure, though there is also some funding through the NDIS (for eligible participants). States and Territories have, to varying degrees, transferred some psychosocial support funding to the NDIS. Most Australian Government funding of psychosocial supports (outside of the NDIS) is now administered through the 31 Primary Health Networks (PHNs), which commission, but do not directly provide, psychosocial supports.

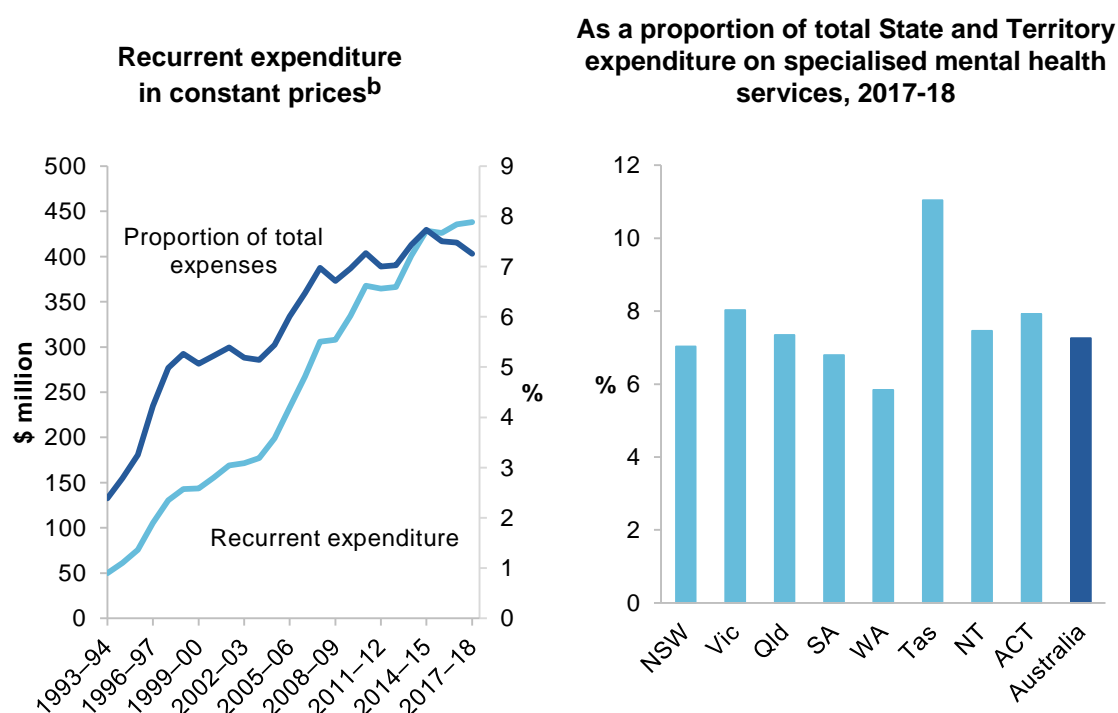
At the State and Territory level, total expenditure on psychosocial supports (approximated by specialised mental health service grants to NGOs)¹⁷¹ has increased ten-fold over the past 25 years, from approximately \$43 million in 1992-93 to \$438 million in 2017-18. The growth in spending on psychosocial supports has outpaced overall growth in State and Territory specialised mental health services — rising from 2% of all specialised mental health services in 1992-93 to 7% in 2017-18 (figure 17.3). However, spending on psychosocial supports is still much lower than spending on State and Territory clinical community ambulatory services, which totalled about \$2.25 billion in 2017-18 (AIHW 2020c, table EXP.1). This is partly a function of clinical services being inherently costlier to administer.

At the Australian Government-level, in 2017-18, about \$170 million was spent on psychosocial programs for which funding was later folded into the NDIS (figure 17.4).

The ways in which psychosocial supports are funded create challenges for consumers and providers. These challenges stem from the very large number of funding channels and short funding cycles. More recently, the transition to the NDIS has created additional uncertainty.

¹⁷¹ Examples of service types included in ‘grants to non-government organisations’ include counselling, advocacy, accommodation, community awareness/health promotion, prevention, independent living skills, education, employment and training, group and mutual support, care coordination, service integration, recreation, respite and self-help (AIHW 2020c, tables EXP.15 and EXP.16).

Figure 17.3 Spending on psychosocial supports has increased over time^a



^a State and Territory spending on psychosocial supports approximated by specialised mental health service expenditure provided as grants to NGOs. ^b Based on national expenditure. Constant prices are referenced to 2017-18 and are adjusted for inflation. Expenditure excludes depreciation.

Source: Productivity Commission estimates based on AIHW (2020c, tables EXP.3).

There are too many funding channels

Many psychosocial support providers receive funding from both Australian, and State and Territory Governments. Sourcing funding from a variety of funding streams allows an organisation to reduce the risk of not being able to continue delivery of some of its functions if one funding source dries up. However, Inquiry participants described these arrangements as ‘wasteful’ (Wellways Australia, sub. 396, p. 25), and reported that the multiple funding channels for psychosocial support may lead to poorer consumer outcomes. From the point of view of providers, multiple funding channels have led to excessive administrative burden and a lack of coordination and cooperation. Wellways Australia (sub. 396) gave the example of one of its regional offices, offering one core service, that sources its funding via four different contracts with three separate funders, each with different administrative requirements.

Excessive administrative burden

Inquiry participants have argued that the current funding arrangements lead to significant costs arising from reporting, compliance and data collection (MHACA, sub. 726; MHCC, Sydney transcript, p. 176). When funding for one organisation comes from various funding streams,

there are greater compliance requirements and more work involved in applying for continuance of funding. This is as different programs, agencies and levels of government may require different reporting at different times and frequencies. These inconsistent compliance obligations result in significant red tape and draw resources away from front-line services (NMHC 2014b). There has also been criticism that ‘reporting requirements for funding [are] often onerous, focusing too much on outputs rather than outcomes’ (MHCC ACT, sub. 517, p. 27).

This compliance burden is further exacerbated by providers not taking advantage of potential economies of scale. The psychosocial supports sector is dominated by a few large NGOs operating nationwide and a large number of small providers. In other sectors, providers would resolve issues resulting from small organisation size by either amalgamating organisations or sharing ‘back-office’ functions. The absence of this in the provision of psychosocial supports may partly reflect the specialisation of some providers (for example, services for people with a particular type of mental illness), the lack of information on who is providing what to whom, and/or the competitive environment created by very short funding cycles (discussed below).

While the administrative requirements can be particularly onerous for smaller organisations, the difficulties are not limited to these:

Without national incentives to have contracts with the same specifications and performance reporting, community organisations that have a national footprint ... face a future where they are overwhelmed by contract administration if their service is to be available across the country. (Grow Australia, sub. 194, p. 4)

Since the establishment of the PHNs, there is the additional regulatory burden for some service providers to report to multiple PHNs. Nationwide, there are 31 PHNs all commissioning psychosocial supports and each has a different set of compliance and reporting requirements. For example, Aftercare (sub. 480, p. 10), a national mental health charity, operates in 16 PHNs with close to 30 State-based organisations, each with different strategies, tender processes, reporting requirements and stakeholder complexities.

Apart from inconsistent reporting requirements, the involvement of multiple levels of government has added considerable confusion (for both providers and consumers) on what services and supports governments are prioritising, to whom and where. The introduction of the PHNs to this space appears to have increased rather than lessened the confusion. The seemingly ad hoc funding of services in a region without coordination with the relevant State or Territory Government is not a new issue, as the National Mental Health Commission review (NMHC 2014b, p. 81) stated:

Concerns also were raised about the lack of clarity in Commonwealth and state and territory roles, including that the Commonwealth’s direct funding of local service providers has been without proper consultation, local planning and engagement, and has created even greater uncertainty for people with lived experience and providers, and even more confusing pathways for people with lived experience.

In chapter 23, the Productivity Commission recommends that State and Territory Governments take on sole responsibility for psychosocial supports outside the NDIS. As well as clarifying

responsibilities, this offers scope to standardise reporting requirements across regions. State and Territory Governments would need to be mindful of any onerous administrative burden on smaller organisations and should look to streamline the reporting requirements or look to create different reporting requirements by size, similar to the approach taken by the Australian Securities and Investments Commission and the Australian Taxation Office.

Lack of coordination and cooperation

Contracting, when done well, creates competition between bidding organisations, encourages innovation and the potential for bids by consortia. Yet some Inquiry participants argued that the competitive nature of current funding arrangements for psychosocial support provision fails to incentivise coordination and cooperation between providers and undermines policy objectives.

[C]ompetition between services [is] driven by questionable assumptions that competitive tendering is a necessary and sufficient pre-condition of innovation and efficiency; typically, however, grants of funding also call on services to act collaboratively — artificially creating a competitive dynamic that can undermine achievement of the policy objectives. (Relationships Australia (National), sub. 103, pp. 11–12)

The lack of coordination and cooperation can lead to limited sharing of innovative practices that could improve consumer outcomes (SA Mental Health Commission, sub. 477). Service providers operating in the same regions are often limited in their ability to plan or work together for the benefit of a common set of consumers; the NSW Government (sub. 551, p. 24) expressed concerns that ‘while these ... arrangements have benefits, they can deter providers from planning, working together and coordinating care for patients’.

This is not only an issue between providers of psychosocial supports. Stakeholders also described disjointed links between services in the psychosocial and clinical spheres, and between NGO-provided psychosocial supports and government-provided supports (SAMHC, sub. 477). The Mental Health Community Coalition of the ACT (sub. 517, p. 23) argued that ‘professional cultural barriers often prevent better integration between clinical and non-clinical mental health services’.

There have been some initiatives to help remedy the situation. For example, in Victoria, the Early Intervention Psychosocial Support Response model explicitly brings together health services and community-managed mental health providers to deliver services to clients with a psychosocial disability (VIC DHHS 2019a). The Northern Territory Department of Health has funded the development of an industry-led workforce strategy for human service sectors, including community mental health, which would require major NGOs in the sector to cooperate with each other (NTHSIP 2019).

The Commission discusses improvements to the coordination between clinical and non-clinical providers in chapter 15, the multiplicity of funding channels in chapter 23, and policy coordination in chapters 22 and 23.

Short funding cycles limit the effectiveness of services

NGOs providing psychosocial supports receive a substantial portion of their funding via short-term government contracts, and annual funding cycles are widespread in the sector. Short funding cycles create certainty for governments as they provide a regular interval for the government to assess the quality of the services being provided and greater flexibility to change funding priorities (PC 2017b). But short funding cycles create a climate of constant uncertainty for providers, significantly inhibiting the provision of services and continuity of care for people with mental illness.

Some of the limitations of short funding cycles for psychosocial support provision include:

- *difficulties in program development and long term planning* — Overly short-term arrangements can be a barrier to planning, implementation and outcomes measurement for existing programs and the creation of new programs. Inquiry participants spoke of the challenges involved in building awareness and trust in the community and trying to invest in long-term partnerships when a contract expiry is looming and ongoing service existence is uncertain. WayAhead Mental Health Association NSW stated:

As a small [not-for-profit] working in the mental health sector, our biggest barrier to program development, partnerships and outcome measurement is the annual funding cycle. Relying on one-year funding rather than 5-year funding restricts long-term planning and the sustainability of our programs. So much effort is put into ensuring we will receive funding for the next financial year, that we are at risk of losing sight on why we are providing certain services. If we had longer term funding, we could put much more effort into ensuring we are delivering the outcomes we are being funded to do and be more accountable for the funds we receive. (sub. 310, p. 6)
- *staffing challenges* — Inquiry participants reported difficulties attracting and retaining qualified staff in an environment lacking job security, which in turn leads to high staff turnover (box 17.3).¹⁷² This is particularly pertinent for services targeting marginalised and/or regional and remote communities where there are already greater barriers to attract qualified and culturally capable staff (Wesley Mission, sub. 840). It can also be a barrier to long-term workforce planning and investment in skill and capability development of staff (MHCC, sub. 920).
- *difficulty developing and maintaining stable and therapeutic relationships with consumers* — There is an inherent mismatch between the short-term nature of current funding arrangements and the long-term investment required to improve psychosocial outcomes (Aftercare, sub. 480). Some providers noted the need to place their consumers in short-term temporary care arrangements while they secure their next round of funding (SAMHC, sub. 477). This leads to uncertainty for both the provider and consumer. The consumer could experience the loss of a support worker, the possibility of multiple transitions of care and increased psychological stress.¹⁷³ This also creates difficulties

¹⁷² For example: Aftercare, sub. 480; ASU, sub. 791; Kim Devlin, sub. 158; Merri Health, sub. 120, sub. 855; Mind Australia, Melbourne transcript, p. 35; Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212.

¹⁷³ For example: EACH, sub. 227; Kim Devlin, sub. 158; Merri Health, sub. 120; Neami National, sub. 254.

working with clients from culturally and linguistically diverse backgrounds, as staff are not afforded the time to develop the transcultural awareness, knowledge and skills that are important to winning the trust of a client (Gabb and McDermott 2008).

- *diverting resources away from the core purpose* — Faced with short-term contracts, providers allocate scarce time and resource to re-tendering instead of delivering and improving services (NCOSS, sub. 143; SAMHC, sub. 477).

While it is difficult to identify the exact costs associated with short funding cycles, Inquiry participants provided evidence to highlight the financial costs associated with just one of the consequences of short funding cycles — higher staff turnover.

It costs about \$30,000 to replace an employee in terms of advertising, recruiting, training, on boarding and providing a shadow shift to a new staff member. There can also be the cost of paying a casual for the period between which the position becomes vacant and is filled. Funding instability, the combination of commissioning models, short-term contracts, delays in contracting and short-term notice periods for the end of contracts, are a key factor underlying staff turnover. (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 21).

Previous reviews have also noted the issue of short contract cycles. The Productivity Commission's 2017 Human Services inquiry recommended that default contract lengths be extended to seven years for most contracts and ten years for service delivery in remote Aboriginal and Torres Strait Islander communities (PC 2017b). At the end of this period, contracts should be retendered to find a balance between providing continuity and retaining the benefits of periodic contestability (NMHC 2014b; PC 2017b).

Longer term contracts would help to mitigate many of the problems discussed. As stated by participants (box 17.3), greater continuity facilitates stability and certainty for the providers and consumers. This is especially important to aid in recovery for psychosocial conditions. Providers also have the opportunity to improve their service delivery with the ability to make longer term plans and invest in staff, relationship building and new initiatives that are necessary to deliver effective services (PC 2017b; Relationships Australia (National), sub. 103). Inquiry participants were strongly supportive of extended cycle lengths.¹⁷⁴

¹⁷⁴ For example: Australian Council of Social Services, sub. 1208; ASU, sub. 791; CHF, sub. 646; Mental Health Australia, sub. 864; MHCC, sub. 920; Mental Health Victoria & Victorian Healthcare Association, sub. 1184; CMHA, sub. 851; National Mental Health Commission, sub. 949; Queenslanders with a Disability Network, sub. 662; Relationships Australia, sub. 831; SA Mental Health Commission, sub. 691, att. B; UnitingSA, sub. 807.

Box 17.3 Participants' views on cycle length

Australian Council of Social Services (ACOSS):

Increasing contract lengths (accompanied by effective service management by funding agencies) would be a cost-free way to impact the quality of service delivery and improve the viability of community sector organisations. They would also provide longer periods for evaluation and outcomes measurement, improving our understanding of the quality of service delivery and the outcomes achieved. (sub. 1208, p. 9)

HelpingMinds:

... short-term funding arrangements for the NGO sector have major implications for clients, staff and organisations. Continuity of care is severely affected on a cyclical basis, during and up to the time at which contracts are renewed or renegotiated. The lack of job security ... forces staff to seek alternate employment due to the uncertain, and often late, contract negotiations. Clients are left with short term, temporary care arrangements that lead to higher levels of psychological distress. The consequences being acute presentations to hospital emergency departments and lengthy inpatient stays.

Longer term funding will also enable organisations to develop programs that target vulnerable and marginalised groups, such as the LGBTQI+ community, Aboriginal people, and people from CALD backgrounds ... these organisations are often small and lack resources needed to develop business strategies within short timeframes ... the need to resource and fund tender submissions significantly reduces capacity to deliver grassroots care ... these cohorts need staff with specialist skillsets – recruitment for short-term contracts is always challenging. (sub. 470, p. 4)

NT Mental Health Coalition:

The uncertainty associated with short-term funding cycles results in a sector which is not equipped to invest in building the long-term partnerships necessary for integrating between services and across professions. Reaching out beyond the mental health sector is even less likely. (sub. 430, p. 5)

SA Mental Health Commission:

... the short term funding models for NGOs and also for specific regional or Aboriginal programs, leads to difficulty attracting and retaining staff and can result in lack of continuity of service provider, inability to forward plan, inability to build relationships which may be critical to longer term program outcomes, and difficulty collecting data to inform these longer term outcomes. (sub. 477, p. 33)

Volunteering Australia:

... there are many organisations working in community mental health that are restricted by short-term grants and funding cycles. These funding arrangements don't allow for the strategic workforce planning required to operate successful programming and service delivery. Volunteering Australia stresses that long-term, ongoing funding is necessary to ensure the best outcomes for consumers. (sub. 412, p. 3)

WayAhead:

One of the ongoing workforce challenges the Mental Health Promotion and Prevention sector faces is funding uncertainty. For quite some time now funding in NSW has been provided on short term contracts, in our case, on annual contracts. Only having short term contracts makes it incredibly hard for our sector to take a longer-term approach to meet the needs of the communities which we serve and adequately plan for the community's longer-term needs. (sub. 704, p. 8)

Some governments have recognised that this is an issue and have begun introducing changes. For example, the Australian Government extended annual funding cycles to three-year funding for PHNs in July 2019 to offer greater job security for staff and continuity of care for consumers (Aubusson 2019; Hunt 2019). However, as far as we are aware, the PHNs have not passed on the benefits of their own longer funding cycles to the services they commission — there is no requirement for the PHNs to enter into longer-term contracts with service providers

(ASU, sub. 177; NMHC 2019b). The Australian Government should require PHNs to enter into longer-term contracts when commissioning psychosocial services.

At the State and Territory level, the Northern Territory Department of Health extended funding for all NGOs for five years to 2022 to support the transition to the NDIS (NT Government, sub. 1220, p. 16). The NT Mental Health Coalition (sub. 430, p. 34) has welcomed this change:

The community mental health sector is encouraged by the NT Department of Health's move to five year Service Agreements and notes that the NT Primary Health Network is working towards three year funding agreements. Longer-term funding arrangements will have a positive impact on staff retention, make programs more sustainable, and have a flow-on effect of strengthening cross-sectoral and inter-sectoral collaboration.

The NT Mental Health Coalition (sub. 430, p. 32) further states that, 'At a minimum, agreements covering co-designed services should extend for at [least] 5 years.' Providers concur, with WayAhead (sub. 310, p. 6) recommending that, 'across all governments, grants ... should be for a minimum of 5 years' and Aftercare (sub. 480, p. 11) recommending 'the development of longer-term funding investment models (5–10 years).' Some participants called for longer contract, of seven to ten years (ACOSS, sub. 1208, p. 9; cohealth, sub. 231, p. 28). Warwick Smith (sub. 937) suggested that all services should have ongoing funding with annual indexation.

Longer-term cycles may create risks to efficient use of taxpayer funds. Participants noted the 'need to balance ongoing certainty with evidence-based analysis' (ACT Government, sub. 1241, p. 21). The risk of poor provider performance could be reduced either before contracts are awarded (through more stringent requirements and assessment during the funding application process), or after contracts are delivered on (through rigorous reviews of service effectiveness) (PC 2017b). A shorter contract could be granted in exceptional circumstances, such as for pilot programs that have yet to be evaluated.

The Victorian Government (sub. 1228, p. 14) raised concerns over whether extending contract lengths would provide 'sufficient flexibility to introduce any potential changes to models for funding services providers.' The use of short contracts to give governments flexibility to alter funding priorities would be a lower priority were governments to recognise the long-term needs of people who require psychosocial supports. Short-term priorities can still be achieved in the context of long-term partnerships, with adequate performance management arrangements in place (chapters 23 and 24).

Although it is difficult to identify an ideal contract length, it is clear that, for many programs, the current length is far too short to provide effective and culturally capable support. Many in the sector call for a minimum five-year term.¹⁷⁵ The Productivity Commission suggests this could be adopted as a starting point, subject to evaluation in future. It is also important

¹⁷⁵ For example: ASU, sub. 791; CHF, sub. 646; Mental Health Australia, sub. 864; MHCC, sub. 920; NT Mental Health Coalition, sub. 430; QDN, sub. 662; WayAhead, sub. 704.

for providers to receive sufficient notice of the outcome of the subsequent funding cycle for the purposes of service planning and staff employment security (discussed further below).

ACTION 17.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS

Short funding cycles create uncertainty for providers of psychosocial supports, which can negatively affect consumers and support workers.

Start now

The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years, and ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle.

The Australian Government should require Primary Health Networks to enter into longer-term contracts when commissioning psychosocial services, in line with the longer funding cycles that have been introduced more generally for Primary Health Networks.

What the folding of psychosocial support funding into the NDIS has meant for people with mental illness

The gradual roll out of the NDIS is having a significant impact on the availability of psychosocial supports and has exacerbated existing challenges for consumers and providers of psychosocial supports. Funding for many Australian, State and Territory Government-funded supports has been, or is in the process of being, folded into the NDIS due to the close alignment of some program goals with the NDIS (Australian Government 2018a; Masters and Shelby-James 2017).

Of the 17 Australian Government programs that have been folded into the NDIS, four were designed to support people with mental illness:

- Partners in Recovery (PIR)
- Personal Helpers and Mentors (PHaMs)
- Support for Day to Day Living in the Community (D2DL)
- Mental Health Respite: Carer Support (MHR:CS).

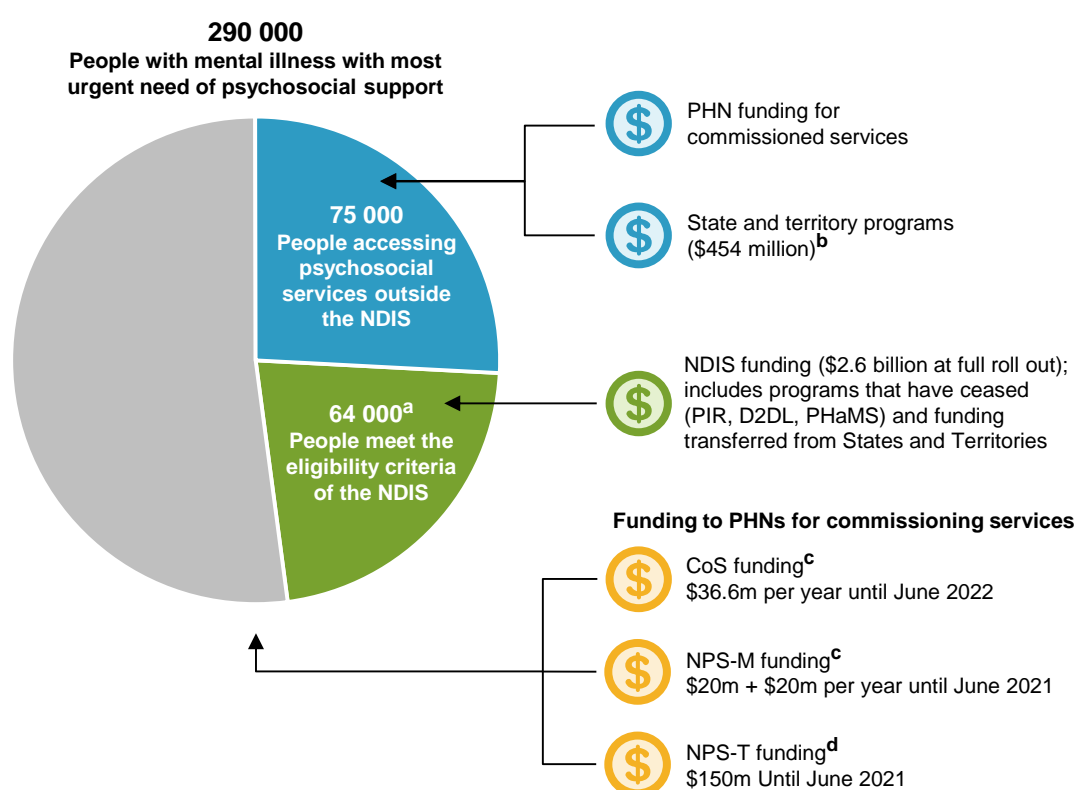
The first three were intended for people with severe mental illness impacting functioning, while the latter was for carers of people with severe mental illness. Approximately 30 100 people received support through PIR, PHaMs and D2DL in 2017-18 (unpublished data supplied by the Department of Social Services (DSS) and DoH)¹⁷⁶ and approximately 40 600 carers were supported by MHR:CS in 2014-15 (DSS 2016c). From 1 July 2019, no

¹⁷⁶ Derived from PIR and D2DL client numbers in the 2018 calendar year and PIR client numbers in the 2017-18 financial year.

new clients have been accepted into these programs in areas where the NDIS has been rolled out, though some stop-gap measures for previous users of PIR, PHaMs and D2DL have been introduced (discussed later).

However, not every person who has been accessing psychosocial support services is eligible for the NDIS. Of the estimated 290 000 Australians with severe and persistent mental illness who are most in need of psychosocial supports, only an estimated 75 000 people receive such supports from Australian, State and Territory Government-funded programs, and 64 000 people (with a primary psychosocial disability) are expected to access individualised supports under the NDIS once the scheme is fully rolled out (figure 17.4).

Figure 17.4 The level of need and funding for psychosocial support



^a This represents the number of people expected to access individualised supports under the NDIS once the scheme is fully rolled out. As at March 2020, 34 200 people with a psychosocial disability were receiving funding from the NDIS, therefore overall outlays were lower than those expected at full roll out. ^b State and Territory program funding is based on the latest available figures, from 2017-18, inflation adjusted to 2019-20 dollars. ^c Figures for CoS and NPS-M are inflation adjusted to 2019-20 dollars. ^d Based on an aggregation of the initial \$121.3 million for 2019-20 and additional \$28.3 million extension package for 2020-21.

Source: AIHW (2020c) DoH (2020e); Morrison, Payne and Ruston (2020); NDIA (pers. comm., 27 Mar 2020); NMHSPF estimates; adapted from Mental Illness Fellowship of Australia (sub. 343, p. 9).

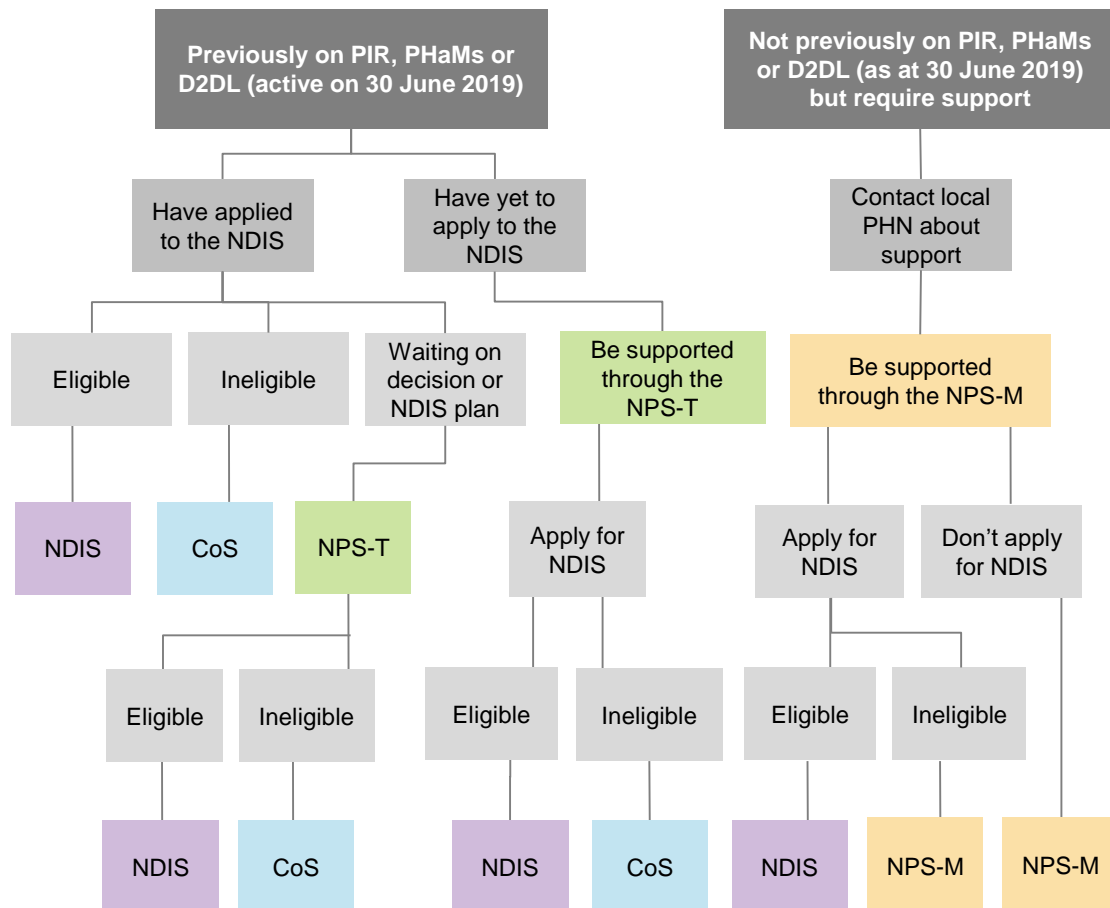
New measures introduced while the NDIS is being rolled out

There are three major sources of Australian Government funding to support people with psychosocial disability until the NDIS is fully rolled out:

- Continuity of Support (CoS)
- National Psychosocial Support Measure (NPS-M)
- National Psychosocial Support Transition (NPS-T)¹⁷⁷ (DoH 2020e).

The specific source of funding used in each individual case is dependent upon whether or not the person was previously in receipt of Australian Government-funded psychosocial support and in some cases, whether or not they have applied for the NDIS (figure 17.5).

Figure 17.5 How are people accessing psychosocial support during the NDIS rollout?^a



^a Acronyms: Partners in Recovery (PIR), Personal Helpers and Mentors (PHaMs), Support for Day to Day Living in the Community (D2DL), National Disability Insurance Scheme (NDIS), Primary Health Network (PHN), NPS-T (National Psychosocial Support Transition), NPS-M (National Psychosocial Support Measure), CoS (Continuity of Support).

Source: DoH (2019b); South Eastern Melbourne PHN (2019).

¹⁷⁷ Also sometimes referred to as the Transition Support Program or the Psychosocial Extension Program.

There is uncertainty around program eligibility and continuity

Governments committed to continue providing support to participants in programs that were rolled into the NDIS; however, decisions have been poorly communicated.

Just a few months prior to the announcement of extensions, many providers had little knowledge of what supports would be provided in place of the programs being folded into the NDIS, who would be eligible for them, and what the timeline for programs would look like (Anglicare Australia, sub. 376; ASU, sub. 177; NMHC, sub. 118). The announcement to extend funding (from the NPS-T) to previous providers of PIR, PHaMs and D2DL was made just three months prior to the date when all funding for the Australian Government programs was initially slated to cease.

The folding of programs into the NDIS and creation of stop-gap programs with little transparency has increased the funding and accessibility uncertainties already dominating the psychosocial support sector (Sjon Kraan, Perth transcript, pp. 29–30). Inquiry participants claimed that not all organisations received NPS-T funding to continue for 12 months, and some PHNs only gave three months of funding (CMHA, Sydney transcript, p. 105). There also remains considerable uncertainty as to the long-term arrangements for people accessing psychosocial supports outside of the NDIS. Currently, NPS-M and NPS-T are only funded until the end of June 2021 and CoS until the end of June 2022.

The fact that State and Territory funding is also being transferred (to varying extent) to the NDIS, while not all clients of State and Territory programs are receiving support from the NDIS, has raised concerns. Each State and Territory withdrew their funding to a different extent. For example, the Commission heard that South Australia saw a 25% cut to NGO-provided mental health services (ASU, sub. 791), while Victoria had transitioned its funding for psychosocial support (from the Mental Health Community Support Service) into the NDIS (Uniting Vic.Tas, sub. 95; Victorian Government 2019a). After committing the funds spent on existing psychosocial support for severe and permanent mental illness, it became apparent that some former clients were not eligible for the NDIS.

While some States have now reinvested some of these funds back into mainstream supports (for example, the Victorian Government's Early Intervention Psychosocial Support Response), the ad hoc transition process exacerbated the uncertainty in the sector.

The community mental health services, of course, have lost their funding in light of the NDIS transition. So they're often not able to help ... we're in that sort of no man's land in between. (Tandem, Melbourne transcript, p. 68).

Clinicians referring consumers to psychosocial support services also expressed confusion:

Understanding how and what support is available would be great. In my sector the NDIS has us baffled. The system changes and it can be very hard to learn how to navigate the new system and I don't have a mental health issue to make it harder. (ASMOF, sub. 233, p. 10)

An evaluation of NPS-M and CoS is expected to be completed in 2021, assessing the implementation process, outcomes, costs and program delivery (DoH 2020e). To afford some momentum and certainty around the psychosocial supports that are emerging in some States, the Australian Government, working with State and Territory Governments, should develop and make public long-term arrangements for people with mental illness who are not eligible for the NDIS. These arrangements must provide clarity for consumers, carers and providers as to what supports are available, who is eligible and how they can be accessed.

Psychosocial support services are experiencing staffing challenges

The uncertainty around programs being folded into the NDIS, stop-gap programs, and the NDIS rollout have all added to the staffing challenges faced by psychosocial support providers. By the time service providers had information on funding from the NPS-T, many workers had ‘moved on’ (ASU, Sydney transcript, p. 58) or were ‘already seeking employment elsewhere as organisations [were] unable to provide guarantees of employment after this date’ (One Door Mental Health, sub. 108, p. 11).

As a result, many skilled and experienced workers have left the mental health sector. Workers who have left are unlikely to return until employment opportunities in the sector stabilise, leading to lower skill levels across the psychosocial support workforce and lower quality care for consumers (ASU, sub. 177, sub. 791, Sydney transcript, pp. 55–60; CHA, sub. 463; CMHA, Sydney transcript, p. 105; EMHSCA, sub. 578; Jennie Fitzhardinge, Perth transcript, p. 120; Merri Health, sub. 120, sub. 855). Staff shortages may also increase waiting times for consumers to access services:

The NPS-M (National Psychosocial Support Measure) which was funded as a stop gap strategy because of the winding up of PIR and PHaMS has a fraction of the resources and is experiencing huge demand and long waiting lists. In Adelaide there is a current waiting list of 160 distressed people with a team of five workers. This will be replicated across the country. (ASU, sub. 791, p. 5).

Ensuring people can access required psychosocial supports

The Productivity Commission heard from Inquiry participants that previous clients of the Australian Government-funded psychosocial supports (PIR, PHaMs and D2DL) were being asked to test their eligibility for the NDIS — and have their application turned down — before they are given access to CoS (Anglicare Australia, sub. 376; EACH, sub. 227; MHCC, sub. 214; OTA, sub. 141; QAI, sub. 116).

Stakeholders noted that the requirement was in place regardless of the consumer’s likelihood of being eligible for the NDIS, resulting in many people needlessly being required to engage in a lengthy application process to access continued supports (CMHA and USYD 2019a; QAI, sub. 116, p. 14). Some former participants decided not to have their eligibility tested and disengaged from the system. Providers expressed concern that this risked their clients’ ability to access continuity of support measures, which would undermine progress towards their recovery (Anglicare Australia, sub. 376).

While this requirement is still in place, transition to the NDIS is progressing at a steady pace. Recently, the Australian Government announced a \$28.3 million in funding (as part of the Mental Health Support Package for people experiencing the impacts of the COVID-19 pandemic) and 12-month extension of the NPS-T deadline (DoH 2020d). This is likely to assist in the full transition to the NDIS before other supports run out.

Nonetheless, the current processes have led to poor consumer outcomes and uncertainty in the sector, even among professionals, and many consumers do not want to apply for the NDIS (Mission Australia, sub. 487). People who need psychosocial support should be able to obtain it without going through a long and difficult application process. Some assessment should be expected, to determine whether psychosocial support is appropriate and whether the need for it stems from mental ill-health, but access should not be dependent on previous use of psychosocial supports or require applications to other programs (NDIS) for which the individual has no need to apply. Such barriers cause people to disengage from the system or endure long processes that risk damaging their mental health.

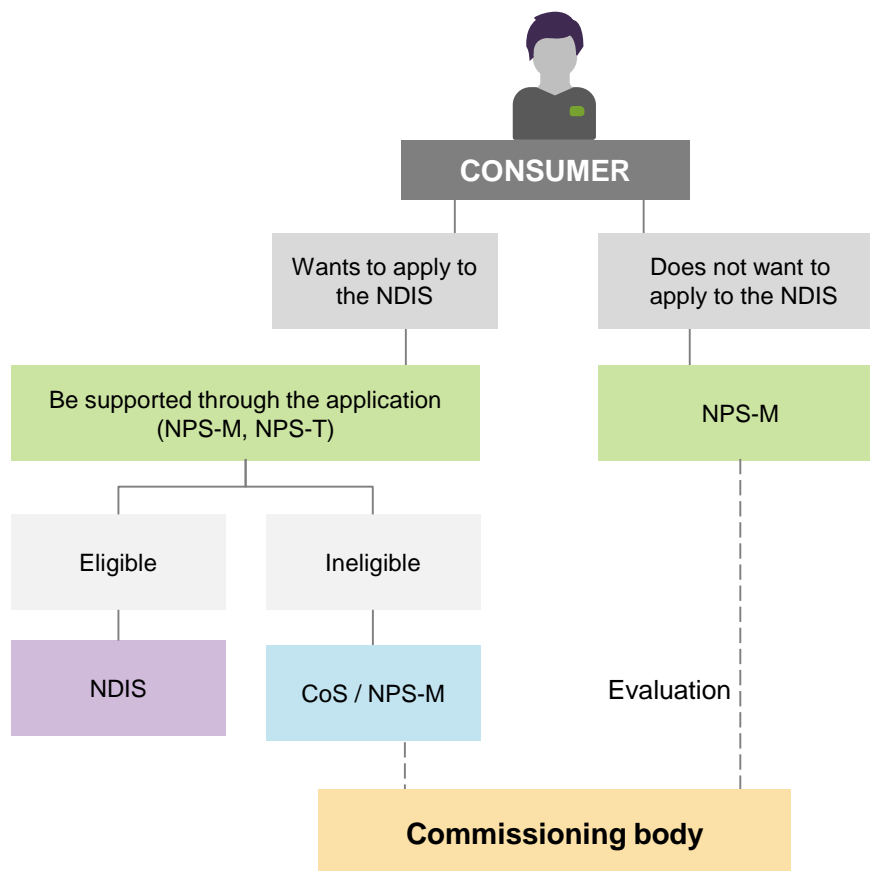
The decision to apply to the NDIS must be the consumer's, should they have the capacity to make such a decision (figure 17.6). People who require psychosocial supports with needs stemming from mental ill-health should be free to apply for the NDIS only if they wish to access the NDIS and not be motivated to do so only to pass a requirement to receive continuity of support. As such, the requirements for former participants to continue accessing supports should be altered to allow for this (Action 17.2).

Further, people should be supported throughout the transition to the NDIS. Stop-gap measures such as the NPS-M must run for a sufficient period, until States and Territories take on sole responsibility for psychosocial supports outside of the NDIS (chapter 23). (NDIA 2020f; Robert 2020b). By 2022, the Australian Government should evaluate the NPS-M to better understand why people who are potentially eligible for the NDIS are not applying. Following such an evaluation, there can be work to remove the barriers to applying for the relevant groups so that they may eventually access the NDIS. Those who remain ineligible for the NDIS would then be on programs commissioned by States and Territories. Inquiry participants strongly supported providing such continuity of support for consumers.¹⁷⁸

The principle of person-centred care extends beyond clinical services and should also apply to psychosocial support ... [Consumers Health Forum of Australia] calls for access to psychosocial support to be expanded to allow care to be provided while a person is applying for the NDIS or if a person chooses not to apply for the NDIS. Psychosocial support should be provided based on the person's need for it, not based on the category the system has placed that person in. This is also critical for continuity of care as we know that many people experience long waits while their NDIS application is being processed. (CHF, sub. 646, p. 13)

¹⁷⁸ For example: Carers NSW, sub. 808; Elucidate, sub. 755; Flourish, sub. 729; Lived Experience Australia, sub. 721; Mental Health Australia, sub. 864; MHCC, sub. 920; National Mental Health Commission, sub. 949; Royal Australian and New Zealand College of Psychiatrists, sub. 1200; SA Mental Health Commission, sub. 691, att. B; Victoria Legal Aid, sub. 818.

Figure 17.6 Recommended eligibility for psychosocial supports



ACTION 17.2 — GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS

People with mental illness who require psychosocial supports should be able to continue accessing them, regardless of changes to the source of funding for the service.

Start now

People who choose to apply for the National Disability Insurance Scheme (NDIS) should continue to be supported by their current service providers during the application process.

People who choose not to apply for the NDIS should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out.

Start later

The Australian Government should evaluate the National Psychosocial Support Measure. Evaluation outcomes should be used to remove barriers that people with mental illness face when applying to the NDIS. When the National Psychosocial Support Measure is phased out, participants should either access support through the NDIS, if appropriate, or access the replacement psychosocial support.

17.3 Improving the delivery of psychosocial supports in the NDIS

The application process and supports received from the NDIS may not always meet the objectives of people with psychosocial disability. The NDIS funds long-term disability care and support for people with severe or profound disabilities (box 17.4). The NDIS operates under the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act), and is administered by the National Disability Insurance Agency (NDIA). Funding for the NDIS is shared between the Australian and State and Territory Governments.

In 2011, the Productivity Commission recommended that people with psychosocial disability be supported through the NDIS on the basis of their support needs and care requirements (PC 2011).

Is the NDIS working well for people with psychosocial disabilities?

People with psychosocial disability have the potential to benefit substantially from the NDIS. It presents an opportunity for people with psychosocial disability to increase their social and economic participation through NDIS funded supports (NDIA 2019e). In addition, the NDIS gives people in the scheme choice and control over how their supports are provided (PC 2017c; Warr et al. 2017).

Box 17.4 **NDIS psychosocial disability requirements**

A prospective participant would meet the disability requirements if each of the following requirements in section 24 of the *National Disability Insurance Scheme Act 2013* (Cth) is met:

- the prospective participant has a disability that is attributable to ... one or more impairments attributable to a psychiatric condition (s. 24(1)(a))
- the prospective participant's impairment/s are, or are likely to be, permanent (s. 24(1)(b))
- the prospective participant's impairment/s result in substantially reduced functional capacity to undertake, or psychosocial functioning in undertaking, one or more of the following relevant activities: communication, social interaction, learning, mobility, self-care, self-management (s. 24(1)(c)).
- the prospective participant's impairment/s affect their capacity for social or economic participation (s. 24(1)(d))
- the prospective participant is likely to require support under the NDIS for their lifetime (s. 24(1)(e)).

Impairments that vary in intensity (for example, because the impairment is of a chronic episodic nature) may be permanent and a prospective participant may still require support under the NDIS for their lifetime despite the variation (s. 24(2)).

Fewer people are in the Scheme than expected

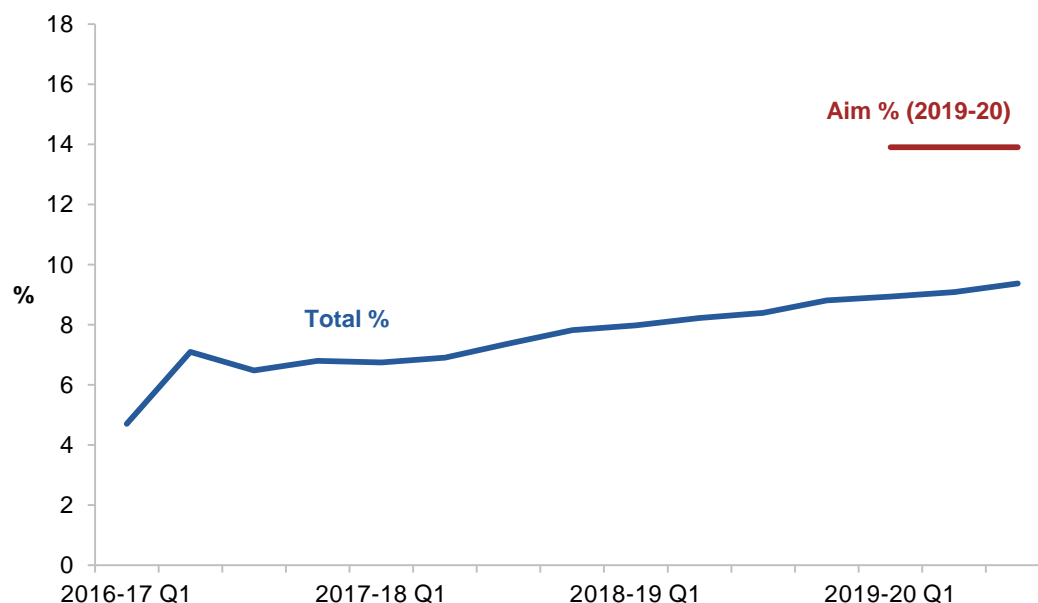
The NDIA estimated that by full rollout of the Scheme (2019-20), there would be 460 000 participants, with 13.9% (64 000 people) expected to have a primary psychosocial disability (NDIA 2017e). As of March 2020, the NDIS had 365 000 participants, and 9.4% (34 200 people) had a primary psychosocial disability (NDIA 2019b) (figure 17.7).

The proportion has been steadily rising over time, reflecting improvements in access to the Scheme for people with psychosocial disability. However, nationally it remains significantly below its target (NDIA 2020b). A lower number of people with psychosocial disability participating in the NDIS may place additional pressures on the mainstream mental health system outside of the NDIS (as discussed in section 17.2).

People with psychosocial disability can encounter several difficulties in the NDIS, including:

- the application process to gain access to the NDIS can be overwhelming
- comparatively poorer experiences upon entering the Scheme for some participants
- many choosing not to apply for the NDIS even though they would likely be eligible
- the unclear interface between the NDIS and mainstream services.

Figure 17.7 NDIS participants with a primary psychosocial disability^a



^a Prior to the 2018-19 financial year, the figures indicate the proportion of *active* participants, while afterwards the figures indicate the proportion of *all* participants.

Source: NDIA (2016a, 2016b, 2017c, 2017d, 2017a, 2017b, 2018c, 2018d, 2018a, 2018b, 2019c, 2019d, 2019b, 2019a, 2020b).

Application rates are lower than expected

The relatively low proportion of people with psychosocial disability in the Scheme arises from both low application rates and comparatively low rates of success for those who do apply.

Only 48% of participants across the major Australian Government-funded psychosocial support programs — PIR, PHaMs and D2DL — applied for the NDIS between August 2018 and June 2019.¹⁷⁹ The two most cited reasons for not applying were that the client was still collecting evidence for an application (22%) or that the client did not want or intend to apply (19%) (CMHA and USYD 2019a, p. 9). Anglicare Australia (sub. 376, p. 54) stated that clients are reluctant to apply for a range of reasons, including:

- not identifying as having a ‘permanent’ disability, as their illness is episodic,

¹⁷⁹ Community Mental Health Australia (CMHA) and The University of Sydney collected and analysed data available regarding the transition of clients from PIR, PHaMs and D2DL to the NDIS (CMHA and USYD 2018, 2019b, 2019a). Provider organisations from each of the three programs across each State and Territory provided non-identifiable data regarding clients who were transitioning or otherwise to the NDIS. Note that this time frame represents the 10-month lead-up to funding for PIR, PHaMs and D2DL being folded into the NDIS.

-
- not being at a point in their mental wellbeing where connecting with a formal application, assessment and planning process is possible for them to contemplate, and
 - a lack of understanding or scepticism about the benefits of an NDIS package.

A complex application process

Stakeholders contend that the high proportion of people who said they were still collecting evidence speaks to the complexity of the application criteria and the barriers that continue to exist for those with psychosocial disability. They have also suggested that consumers' unwillingness to apply for the NDIS highlights that there is ongoing work required to demystify the scheme and streamline the application process (CMHA and USYD 2019a; Mental Health Australia 2018b, 2018a; USYD and CMHA 2018). The NDIS application process can be time-consuming and especially daunting for people with psychosocial disability (Lorna MacKellar, sub. 406; MHCSA and LELAN, sub. 360). Providers of psychosocial supports outside of the NDIS trying to help their clients transition over have described some major challenges of collecting the evidence required by the NDIA, including:

- GPs or specialists lack an understanding of NDIS, the client or psychosocial disability
- limited or lack of evidence available due to limited service engagement
- clients' fluctuating mental health and ability to manage the application process
- the cost of gaining expert evidence
- barriers and time delays in accessing data from other services
- program staff have limited time to help collect evidence (CMHA and USYD 2018, 2019a, 2019b).

There is also concern over the costs associated with applying, with the Queensland Advocacy Incorporated (sub. 116, p. 14) stating that 'the cost to undertake assessments for reports can be crippling for many people, and that actually becomes a real gamble that for too many people doesn't pay off'.

People with severe and complex mental illness often struggle to advocate for their own support needs and hence find it especially difficult to engage in the NDIS application process (Anglicare Australia, sub. 376; Inner South Family and Friends, sub. 129). The Victorian Government (sub. 483, p. 13) suggested an 'uplift in funding for advocacy services for people living with mental illness who may not be well placed to self-advocate due to their condition'.

The introduction of a specialised psychosocial disability action plan demonstrates that the NDIA is aware of the unique needs and challenges of those with psychosocial disability and this is an area that may gradually improve (Fletcher and Henderson 2018; Mental Health Australia 2018a; Quinlan 2018). Details of the specialised action plan are discussed below.

Interpretation of eligibility requirements

There is significant confusion about the eligibility criteria with respect to demonstrating permanency for psychosocial impairments and whether diagnoses are sufficient evidence of functional impairment (Tune 2019). There are reports that many people with psychosocial disability are finding it difficult to prove their eligibility, contributing to lower participation rates.

Acceptance rates for people with psychosocial disability are lower than many other disability categories. Up to March 2020, cumulatively, only 70% of applicants to the NDIS with a primary psychosocial disability had their access approved, compared to 85% for all disabilities (NDIA 2020b). Some Inquiry participants believe that there have been many rejections even in cases where the applicant has a good claim to become a NDIS participant (Anne Mill, sub. 348; Peter Kent, sub. 352). Common reasons for ineligibility that the NDIA have given include insufficient evidence showing a functional impairment or disability; or insufficient evidence showing that the functional impairment or disability is lifelong; or that the impairment or disability could not be treated elsewhere (CMHA and USYD 2018, 2019a).

A recent review into the NDIS Act found that the assessment process can be inconsistent, resulting in people with similar clinical and psychosocial disability needs and circumstances receiving different outcomes. The review found that this inconsistency may be a result of insufficient guidance being provided about the form of evidence required and the lack of a working definition and no clear guidelines for assessing ‘permanency’ in the context of mental illness (Tune 2019, p. 73).

The review recommended that the NDIS Act and Rules be amended to provide clearer guidance in considering whether a psychosocial impairment is permanent, in terms of both the criteria and evidence that takes into account the episodic or fluctuating nature of some psychosocial impairments and also emphasises the language of empowerment, capacity building and recovery over that of disability, impairment and illness (Tune 2019). The Productivity Commission supports this recommendation.

Long wait for application outcomes

Most participants of PIR, PHaMs and D2DL wait between three and nine months after their NDIS application to receive their assessment outcome (CMHA and USYD 2018, 2019a, 2019b). As noted by the Mental Illness Fellowship of Australia (sub. 343, p. 14), ‘an emerging issue is the number of NDIS applications that are now stalling in the system, resulting in protracted decisions about the eligibility of participants’.

Inquiry participants have raised the concern that significant waiting times hamper a person’s recovery, as it can be emotionally exhausting and psychologically damaging (Lorna MacKellar, sub. 406). Such delays in access to support may lead to ‘increases [in the] risk of deterioration, relapse and results in discharge delays from bed-based mental health treatment services’ (Victorian Government, sub. 483, p. 12).

To reduce these risks, people with psychosocial disability are able to access supports before and while testing eligibility through the NPS-M (DoH 2019b). However, there may be a significant difference in the level of funding per person on the transition supports as opposed to PIR and PHaMs, with an even larger difference when contrasted with the NDIS.¹⁸⁰ Some providers reported the level of funding under the transition programs is inadequate (WAAMH, sub. 416).

It is important that people applying for the NDIS who require support are not disadvantaged by the application process and still receive the appropriate level of support they may require through non-NDIS services while they are waiting for a result (action 17.2).

What about those who get accepted into the NDIS?

Overall, participant satisfaction with the NDIS is high (75–79%, depending on which stage the participant reached) (NDIA 2019b). However, there is evidence that the experience of people with primary psychosocial disability accepted into the NDIS can be marred by inappropriate plans and difficulties finding services (USYD and CMHA 2018).

Unsuitable plans

Some stakeholders argued that people with psychosocial disability are receiving unsuitable plans under the NDIS. Issues include disproportionate funding packages, unskilled planners who lack understanding of psychosocial disability and its inherent episodic nature, as well as a lack of appropriate supports and coordination.

The funding allocated to NDIS participants can be greatly disproportionate to the level of need. Mind Australia (sub. 380, p. 44) noted a ‘lack of consistency between the [functionality or disability] scores and ultimate package size for those who have plans with Mind’. The Victorian Government (sub. 483, p. 12) stated that NDIS planners do not ‘adequately, or flexibly, [consider] the impacts of psychiatric crisis and [the] fluctuating needs of participants with a psychosocial disability’. Further, Anglicare Australia (sub. 376, p. 55) submitted that:

For people with psychosocial disability who have been successful in applying to the NDIS, there are still gaps in the service model. Poor assessment by the NDIA often results in no or low support available to people with psychosocial disability in their NDIS plans for daily living support.

Once a person has met the requirements for eligibility and received their plan, some experience difficulties in navigating the complex system. Anglicare Australia (sub. 376, p. 55) expressed concern that people with severe and complex mental illness are ‘unable themselves to navigate and use their NDIS funding’. The Victorian Government (sub. 483) stated that there is insufficient support coordination in NDIS plans, despite the major benefits

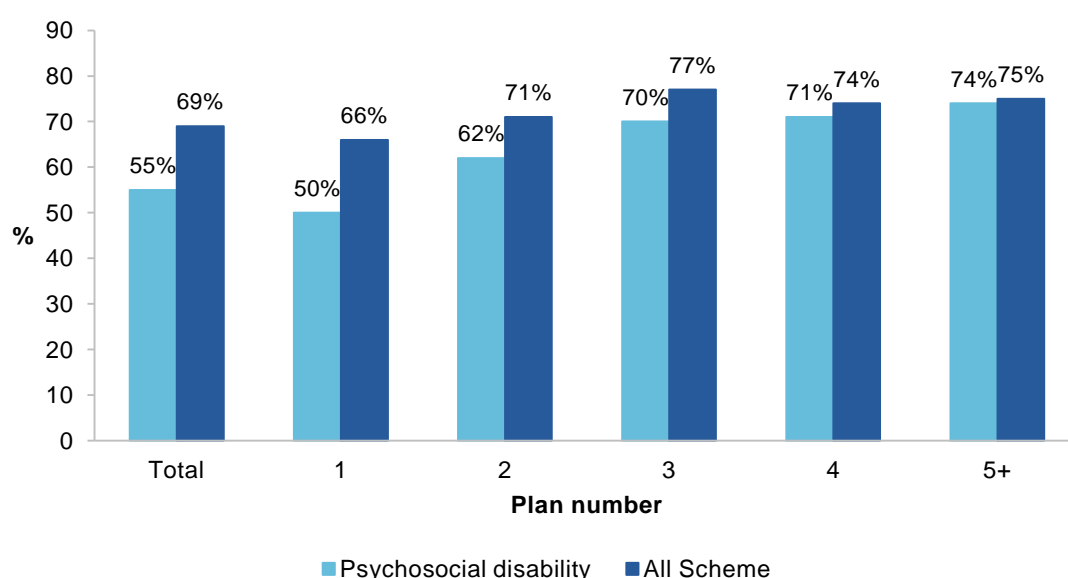
¹⁸⁰ According to Commission estimates, funding per client per year was roughly \$10–12 000 on PIR and \$6000–7000 on PHaMs. The NDIA places the average per participant expenditure for PIR, PHaMs and D2DL to be roughly \$6500 and under the Victorian MHCSS to be \$11 000. Through the NDIS, the average committed funding per active participant with psychosocial disability was \$38 900 (NDIA 2019f).

it would confer. The NDIS is introducing a new support item — ‘psychosocial recovery coaches’ — which may assist with coordination of supports (discussed further below).

That some participants’ plans may be unsuitable is reflected in the particularly low utilisation rates (the share of a participant’s budgeted supports that has been used) for those with psychosocial disabilities (figure 17.8). In a submission to the Productivity Commission’s 2017 study into NDIS Costs, the NDIA suggested that utilisation rates would reach a steady state of 80–95% (NDIA 2017f, p. 70). So far this is not the case, especially for participants with psychosocial disability, whose utilisation rates are lower than all other scheme rates. However, the utilisation rate gap between psychosocial disability participants’ plans and all scheme participants’ plans tends to decrease over time as plans are reviewed (figure 17.8).

Figure 17.8 Utilisation rate of committed supports increases over time

Utilisation rate of committed supports, by plan number, 1 April 2019 to 30 September 2019^{a,b}



^a Plan number refers to which plan a participant is on. For example, a new participant would be on plan number one. Following a plan review, they would move onto plan number two, and so on. Plans are generally for one year periods, but can vary according to individual circumstances. ^b ‘Total’ average utilisation rate includes participants who were partly through their first plan (those whose first plan approval date was between 1 April 2019 and 30 September 2019) and had substantially lower utilisation rates than other participants.

Source: Unpublished data provided by the NDIA (pers. comm., 4 May 2020).

Inquiry participants raised concerns that when the packages are not being used, package values can decrease at the next review. This is especially concerning when considered in light of the episodic nature of psychosocial disability (ACT Government, sub. 210; Victorian Government, sub. 483). Inherent to the episodic nature of psychosocial disability are fluctuations in the mental illness of the individual. It is important that a participant’s NDIS

plan is able to quickly respond to changes in their level of need, both during periods of health and illness. One Door Mental Health (sub. 856, p. 12) suggested a specialised response:

One Door supports a reform to the NDIS to let people with psychosocial disability come in and out of service as dictated by the nature of their recovery; with supports scaled up and down according to their need, and without penalty against their NDIS plan based on utilisation.

The COAG Disability Reform Council (DRC) Mental Health Senior Officers Working Group recently recommended enhancements to the NDIS planning and supports processes to increase responsiveness to the episodic nature of psychosocial disability. Work is underway by the NDIA — adapting current practices to quickly adjust plan budgets and supports to reduce waiting times for unscheduled reviews and increase planner discretion for top-up funding where increases in disability are associated with a deterioration in mental health (COAG DRC 2019c, 2019a). Improvement activities are planned to commence by mid-2020.

Difficulty obtaining required supports

Despite being successful in receiving an NDIS plan and funding for supports, participants sometimes find it difficult to purchase needed supports as they may not exist in their community or may be ill-suited to their needs (VCOSS, sub. 478; Carers NSW, sub. 808). This is especially the case in remote communities (CRRMH, sub. 465; NT Mental Health Coalition, sub. 430; RRMH, sub. 97; TeamHEALTH, sub. 756).

The issues surrounding acquisition of supports stem from two major reasons. The first is that the prices set by the NDIA for services may be too low. Inquiry participants raised concerns that providers are unable to meet the prices set by the NDIA (ACT Government, sub. 210; LELAN, sub. 771; MHACA, sub. 726; One Door Mental Health, sub. 856; VCOSS, sub. 478). Anglicare Australia (sub. 376, p. 55) expressed concern that ‘many organisations have discontinued providing such daily living support services as the price set by the NDIA is simply unfeasible’. The Australian Services Union (sub. 791, p. 8) noted that ‘some key NDIS supports ... do not include critical activities and overlook the diverse circumstances in which support is provided.’ In addition, many Inquiry participants have stated that the low pricing has led to workers leaving the sector or providers decreasing the quality of services (box 17.5).

The NDIS 2019-20 Price Guide included increases in price points that made the delivery of core supports more viable for psychosocial support providers. However, Inquiry participants noted that many providers may still struggle to deliver core supports without cross-subsidisation from other income sources (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212). The Victorian Government (sub. 483, p. 13) recommended that the Australian Government work collaboratively with the State and Territory Governments to ‘review current NDIS price settings as a pathway to independent price setting to ensure the sustainability of a specialist psychosocial disability workforce and quality and safety outcomes for participants with a primary psychosocial disability’. Chapter 16 discusses other challenges facing the community mental health sector workforce.

The other major reason for difficulty obtaining required supports is that there may be ‘thin’ markets, with a small number of people in a region needing psychosocial disability supports and few local providers. The NDIS market model does not work particularly well in thin markets and, as a result, many people are not able to access services and supports that they are funded to receive (NT Mental Health Coalition, sub. 430; TeamHEALTH, sub. 155; Victoria Legal Aid, sub. 500).

Box 17.5 Low NDIS prices are leading to workers leaving the sector

One Door Mental Health:

While the NDIS does not directly set the amount a service provider can pay an employee, the NDIS price for services are lower than what is needed to maintain the current skill of the workforce. Provisions for basic support items allow for the employment of only minimally qualified staff. The displacement of qualified staff to other sectors is currently impacting on the ability for providers to recruit good staff and is likely to have indications for the provision of quality community mental health programs. (sub. 108, p. 11)

The cost model for Disability Support Workers under the NDIS is insufficient. There is grossly inadequate funding provided for office costs, service quality, accreditation and genuine overheads. The community sector has been subsidising provision of NDIS service to the value of millions of dollars. The outcome of this insufficiency is that people eligible for the NDIS are not receiving the quality of support they need, and some service providers are ‘going under’. (sub. 856, pp. 11-12)

Mental Health Community Coalition of the ACT:

The downward pressure on wages in community mental health services since the introduction of the NDIS should not be underestimated ... we are seeing the emergence of a market where the least qualified and lower paid workers are employed in NDIS services, while more qualified and highly paid workers are employed in non NDIS services. This is concerning given that the NDIS is for people with the most severe and enduring disability. (sub. 517, p. 19)

Eastern Melbourne Mental Health Service Coordination Alliance:

The lower pricing for supports under NDIS have meant that pre-transition staff are leaving the sector and a new, less skilled and experienced workforce is emerging with limited capacity to attend care team and linkage meetings and capacity building activities such as cross-sector workshops (sub. 578, p. 10)

While some consumers are only able to use a portion of their package as there are not enough suitable services in their region, some NDIS providers are pulling out of unviable markets, leading to even fewer services for consumers to choose from. This issue is especially prevalent in rural and remote settings (SCARC 2018). There are concerns that where there are few psychosocial supports available in a community, people have to leave their communities to access supports, which can lead to social isolation and loss of connection to land and community supports (NT Mental Health Coalition, sub. 430). This inequitable access may disproportionately affect Aboriginal and Torres Strait Islander people in regional and remote areas, whose cultural needs may also not be met by mainstream services.

NDIA initiatives to improve consumer outcomes

The NDIA has acknowledged that changes are needed to improve outcomes for people with primary psychosocial disability and has introduced a number of initiatives to achieve this.

Initiatives to address thin markets

Where there is insufficient market supply or where providers have failed to provide care, responsibility to remedy the situation falls to the NDIA (NMHC 2018a, 2019b). Under Provider of Last Resort (POLR) arrangements, the NDIA will directly commission and procure disability supports for participants. As part of these arrangements, contingency funding should be available when crises arise for NDIS participants, and crisis and respite accommodation must be able to be secured at short notice (OPA Victoria 2018).

While the NDIA has yet to release a POLR framework, it has temporarily increased prices of some NDIS supports (NDIA 2020a).¹⁸¹ These price increases should be accompanied by the public release by NDIA of a POLR framework to help inform the appropriateness and effectiveness of market interventions where market development has not otherwise occurred.

The NDIA and the DSS commissioned the NDIS Thin Markets Project in 2019 to develop strategies to address supply gaps in thin markets in the NDIS. An output of the project is a roadmap for developing and delivering practical trial projects (DSS 2019l).

At the December 2019 meeting of the COAG DRC, the Council agreed to a more flexible approach to address market challenges in the NDIS, ‘recognising that one-size-fits-all approach to delivering the NDIS is not suitable to address market gaps faced by certain geographic locations, particular cohorts or disability support types’ (COAG DRC 2019b). The agreement was accompanied by a number of projects to address thin markets in all jurisdictions. Trial projects are being scoped and implemented in all jurisdictions in consultation with the DSS (NDIA, pers. comm., 27 March 2020). However, information on these projects is currently limited. A rollout plan is expected by December 2020 (NDIA, pers. comm., 4 May 2020).

Psychosocial disability action plan

The psychosocial disability action plan (termed the ‘psychosocial disability stream’ prior to October 2019) includes a variety of initiatives intended to improve the responsiveness of the NDIS to participants with primary psychosocial disability, their families and carers (NDIA 2019f). It has been in development since late 2018 (Fletcher and Henderson 2018). Improvements so far include:

- foundational psychosocial disability training for NDIA planners and Local Area Coordinator staff to better understand psychosocial disability. This training was completed in June 2019 and has also been incorporated into the standard induction training for all new staff
- the rollout of the Complex Support Needs Pathway, which commenced in March 2019, to provide specialised support for people who require additional support to access and engage with the NDIS, and have a greater need for coordination of multiple services

¹⁸¹ The loading begins at 7.5% in 2019–20 and will steadily reduce over five years (NDIA 2020a).

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- more consistent contact points, improvements in the consistency and robustness of functional assessments, the provision of customised support for people with psychosocial disability to better respond to specific disability requirements and the piloting of a new Typical Support Package for participants with a psychosocial disability (NDIA 2019f).

From 30 April 2019, streamlined access for people with psychosocial disability became available to prospective participants from State-based programs in all States and Territories. As part of the streamlined access process, prospective participants can:

- verbally begin their access request with a support worker or a trusted other person
- provide consent for their support worker or another trusted person to be the NDIA contact for the duration of the access process
- where required, re-test access to the NDIS with the support of a trusted person (NDIA 2019f).

Psychosocial recovery coach

In October 2019, the COAG DRC announced the creation of a new ‘psychosocial recovery coach’ support item, which will be included in the NDIS support catalogue and price guide in 2020-21 (COAG DRC 2019a; NDIA, pers. comm., 4 May 2020).

The recovery coach combines recovery and support coordination and is intended to fulfil a role that has been performed in the past by services outside of the NDIS (Skatssoon 2020). The recovery coach is intended to provide support to people with psychosocial disability to live a full and contributing life. They will work with participants to build their resilience, to develop their capabilities and to gradually take responsibility for their recovery and the ongoing management of psychosocial disability supports (NDIA 2019f). Participants who choose to have psychosocial recovery coaching will be able to select a coach with either lived experience or learnt experience competencies (NDIA, pers. comm., 4 May 2020).

Response to the COVID-19 pandemic

Given the face-to-face nature of a number of psychosocial supports, the provision of supports has been affected throughout the COVID-19 pandemic. Physical distancing requirements have created difficulties for service delivery. To maintain continuity of support, many providers have used telehealth to deliver some one-on-one outreach supports while group activities were cancelled. However, the Productivity Commission heard that many consumers are not able to access videoconferencing facilities due to a lack of access to suitable equipment, low technical literacy, inability to afford access to large data packages and unstable internet connection in some areas, especially in regional areas (Mind Australia, pers. comm., 7 May 2020).

A number of initiatives were announced to support NDIS participants.

- NDIS plans to be extended by up to 24 months, ensuring continuity of support and increasing capacity of NDIA staff to focus on urgent and required changes to plans (Robert 2020b).
- Face-to-face planning shifted to telephone meetings where possible (Robert 2020b).
- For five months, eligible participants able to flexibly use existing NDIS plan funding to purchase low-cost assistive technology, including smart devices, to enable continued access to disability supports through telehealth (Robert 2020a).
- Proactive outreach to high-risk participants and sharing of data with states and territories to ensure continuity of supports (Robert 2020b).
- Prioritising individuals whose disability and current health status places them at the greatest risk from COVID-19, including people who have complex supports needs, to undertake the activities of daily living (Hunt 2020).

Financial assistance was also offered to providers to help retain workers, including: one-month advance payments based on monthly average supports delivered in the previous quarter, a temporary 10% COVID-19 loading on some supports and increased flexibility to NDIA cancellation pricing policies (NDIA 2020f; Robert 2020b).

17.4 Improving access to, and delivery of, psychosocial supports

Addressing the shortfall in the provision of psychosocial support

Australia has long suffered a shortfall in the provision of psychosocial support. Only about 110 000 people¹⁸² were receiving psychosocial supports in 2019-20 (both within and outside of the NDIS), well short of the 290 000 people estimated by the NMHSPF to have severe and persistent mental illness who are most in need of psychosocial supports.

To address the gap in services, governments need to make the existing funding work more efficiently and increase funding overall.

To make existing funding work more efficiently, the Productivity Commission recommends that State and Territory Governments take on sole responsibility for the commissioning of psychosocial supports outside of the NDIS (chapter 23). This approach would assist in clarifying ambiguous governmental roles, reduce the number of separate funding streams, improve planning and accountability, and create opportunities for better links with the

¹⁸² This comprises 34 200 people with psychosocial disability participating in the NDIS, and approximately 75 000 people that the Commission estimates receive psychosocial support from Australian, State and Territory-funded programs outside of the NDIS (including transition and stop-gap measures).

clinical services required by consumers. This approach would also help in determining how much funding is required to address community needs.

While system changes can improve funding efficiency, the overall level of funding may need to increase as well. There is a large service gap and improvements in efficiency will only go so far to bridge the gap. Many Inquiry participants have argued for funding increases for psychosocial supports to meet demand (For example: Elucidate, sub. 755; Mental Health Victoria & Victorian Healthcare Association, sub. 1184; MHCC, sub. 920,).

Current funding levels have not been sufficient to meet demand ... [there is a] need for additional and growth funding to ensure the adequate provision of psychosocial supports into the future. (Merri Health, sub. 855, p. 2)

Gaps have been identified over and over ... we are seeing a reduction in funding to community managed organisations rather than the increases required. (Lived Experience Australia, sub. 721, p. 3)

Governments across Australia are increasingly transferring responsibility for service provision to the community sector, but without providing adequate indexation or growth funding. Services are seeing increased demand. And this is arising from a range of structural issues, such as lack of affordable housing, declining regional economies, slow wages growth. And yet services are expected to respond to this by stretching existing resources which are not sufficient to cover basic cost increases, let alone rising demand. (NCOSS, Sydney transcript, p. 83)

However, it is difficult to estimate the size of this gap due to the NDIS transition process and the lack of a national consistent dataset on community mental health services (Mental Health Australia, sub. 864). As a first step, each regional grouping of PHNs and their Local Hospital Networks should estimate the shortfall in the provision of psychosocial supports outside of the NDIS in their region, relative to NMHSPF benchmarks. This should be done as part of their broader joint regional planning processes, and repeated annually by regional commissioning bodies (chapters 23 and 24). If (and when) collection for a national NGO dataset is implemented, the Australian Institute of Health and Welfare should also perform State/Territory- and national-level gap analyses of psychosocial supports against NMHSPF benchmarks (chapter 24).

Once the level of need has been estimated, funding for psychosocial supports should be matched to the level of need across the jurisdiction. This should occur over time, and with support from the Australian Government. The Productivity Commission estimates that expanding the provision of psychosocial support to about 154 000 people who may currently miss out on services could cost approximately \$610 million (2019-20 dollars) per year and result in significant improvement in the quality of life of people accessing them (appendix K).¹⁸³

¹⁸³ The NMHSPF estimates the number of people with severe and persistent mental illness who are most in need of psychosocial services to be 290 000 people. Of these, 110 000 people receive support, leaving a gap of about 180 000 people. As the NDIS approaches full rollout, an additional 30 000 NDIS clients are estimated to be receiving support for a psychosocial disability and about 3000 people would transition from existing services to the NDIS. Therefore, the gap in psychosocial support services would be about 154 000, assuming the provision of supports remains similar outside of the NDIS.

The total costs were estimated using (1) the estimated number of people with unmet needs based on NMHSPF (2) approximate number of people currently receiving services, and (3) assumptions about

Access to psychosocial supports

Several Inquiry participants have expressed the importance of ensuring support can be provided in the absence of a clinical diagnosis (Anglicare Australia, sub. 376, sub. 1206; ASU, Sydney transcript, pp. 62-64; CMHA, sub. 449; SJGHC, sub. 77).

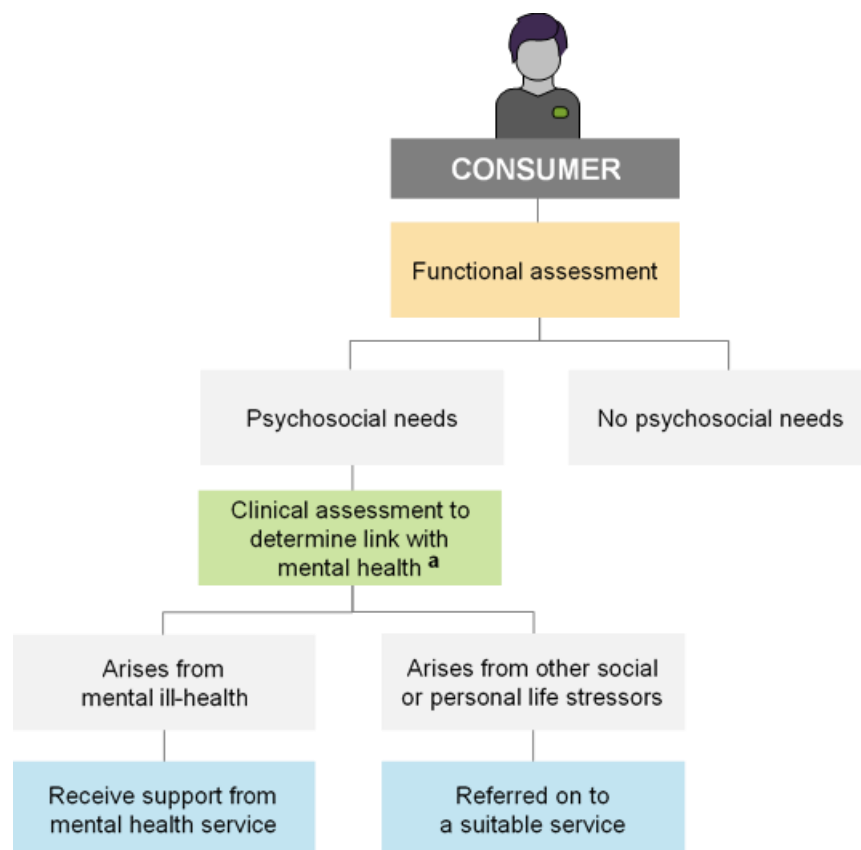
People with psychosocial needs arising from mental illness should be able to access supports if they require them and should not be deterred by the immediate need for a clinical diagnosis upon referral to a service (including self-referral). At entry to the service, potential participants should not be required to have a clinical diagnosis of mental illness. Rather, they should undergo an initial functional assessment that identifies their potential areas of functional limitation (similar to the PHaMs Eligibility Screening Tool)¹⁸⁴ and whether they have a psychosocial need (figure 17.9).

Some people may have a need for psychosocial supports that does not stem from mental ill-health and therefore a mental health psychosocial support service may not be the most appropriate service for them. Where the information provided by the consumer and the assessment indicate that the need for psychosocial support arises from mental illness, but there is no clinical diagnosis, the psychosocial support service should work with the consumer to facilitate their timely access to a clinical assessment (figure 17.9). As many people with mental illness may have had previous negative experiences with the clinical system, there must be a trusted non-clinical support worker, for example someone who is trained in a trauma-informed approach, to help guide the consumer through the process.

proportion of people and their severity of need using data from former Australian Government-funded psychosocial supports, PHaMs and D2DL, and the cost per client for these programs (from \$2400 to \$7000 per person, in 2018-19 dollars). PIR was excluded to avoid double counting as the additional cost of requiring coordination support is accounted for in chapter 10 estimates (appendixes I, K).

¹⁸⁴ The PHaMs Eligibility Screening Tool assigned a score to nine potential areas of functional limitations across personal capacity activities, community participation activities and independent living activities (AIHW 2019g). It is an example of a functional assessment tool, which is used to determine the impact of mental illness on a person's level of functioning, and distinguish it from impacts caused by environmental and social factors. It also considers the person's functioning in the context of the available supports, including their carer, family or mental health services (NADA 2013).

Figure 17.9 Reformed access criteria for psychosocial services



^a A trusted non-clinical psychosocial support worker should be available to support the consumer as required.

Interface with other services

To ensure that people receive the most appropriate supports for their needs, an important consideration is the boundaries, or the interface between the mainstream mental health system and the NDIS.

A seamless interface between the two systems is a particularly important nexus for enhancing the social and economic participation of people affected by mental illness. It is a legal requirement that the support received by an NDIS participant is most appropriately provided and funded by the Scheme and not by another service or system (NDIS Act s. 34(f)). The NDIS is not intended to replace mainstream psychosocial support services, but to work alongside them (ANMF, sub. 317). There should not be incentives for individuals or service providers to preference one system over another. Otherwise, there may be undue pressure on one system to provide for too many people or some may miss out.

Creating an effective interface between the NDIS and the rest of the mental health system has been difficult as inter-system policies and operational guidelines were not established prior to rollout (Summer Foundation 2018).

Despite the multitude of documents and legislation setting out boundaries,¹⁸⁵ Inquiry participants have stated that the interface remains underdeveloped, inhibiting agencies in reaching agreement on responsibility for service provision and clients missing out (CHA, sub. 463; NT Mental Health Coalition, sub. 430; Victoria Legal Aid, sub. 500). As acknowledged by the Victorian Government (sub. 483, p. 11), ‘unclear delineation between the NDIS and mental health system ... [has resulted] in scope creep, gaps in service provision and duplication of services’.

Previous reviews have noted similar issues. They found boundary issues, funding disputes and cost-shifting behaviour leading to service gaps, confusion for NDIS participants, poor quality planning and inconsistent decisions about when a support is reasonable and necessary (JSC 2018, 2019; PC 2017c, pp. 247–248, 2019b; Tune 2019). Recommendations from previous reviews include that the National Disability Agreement should set out the responsibilities of the Australian, State and Territory Governments to provide disability services outside the NDIS (PC 2019b) and that there should be work with the COAG DRC to address boundary and interface issues (JSC 2018, pp. xi–xii).

There is work underway to address a number of interface issues between the NDIS and the mental health system (NDIA 2019f). In October 2019, the COAG DRC Mental Health Senior Officers Working Group released an implementation plan for mental health and psychosocial disability interfaces, to ensure that the NDIS and the mental health system work closely together. This includes developing a nationally consistent approach to the coordination of roles and responsibilities of the NDIS and the mental health system in hospital and community-based settings (COAG DRC 2019c, 2019a).

In future, it is important that the Australian mental health system reaches a stage where regardless of their NDIS status, people are able to access the supports they need.

¹⁸⁵ Interactions between the NDIS and mainstream services are guided by the ‘Principles to Determine the Responsibilities of the NDIS vs Other Service Systems’ (COAG 2015). The principles outline many of the linkages with supports that lie outside of the NDIS. Examples of other documents include: NDIS (Supports for Participants) Rules; Mainstream Interface Working Arrangements (for each State and Territory); Bilateral agreements between NDIA and some governments; and Practice Guidelines (by NDIA and some States and Territories).

ACTION 17.3 — MEET UNMET DEMAND FOR PSYCHOSOCIAL SUPPORTS

All people who have psychosocial needs arising from mental ill-health should have access to adequate psychosocial support.

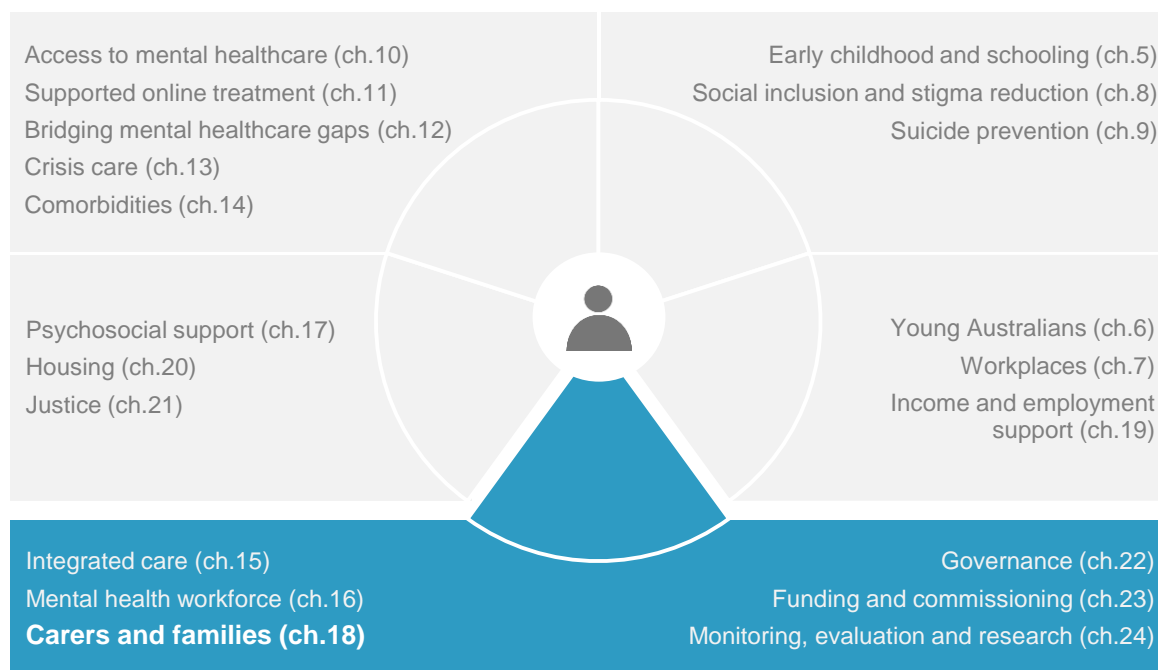
Start now

- Access criteria for psychosocial supports should be adjusted such that potential participants would not be required to have a diagnosis of mental illness before approaching a service. However, an initial functional assessment must be undertaken by the service to determine the individual's psychosocial needs and the level of support required.
 - Where the information provided by the participant and the functional assessment indicate that the need for psychosocial support arises from a mental illness, the provider should work with the participant to facilitate their timely access to a clinical assessment and any necessary clinical intervention.
- The shortfall in the provision of psychosocial supports outside of the National Disability Insurance Scheme should be estimated and published at both State and Territory and regional levels.
- State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the National Disability Insurance Scheme.

Start later

- State and Territory Governments, with support from the Australian Government, should, over time, increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall.
- The demand for psychosocial support services by people with mental illness in a region should be estimated as a component of integrated regional planning.
- Psychosocial support services should provide data to their regional commissioning body on the number and nature of functional assessments they have undertaken of individuals receiving their support services.

18 Carers and families



Support for carers and families matters because ...

- Almost 1 million carers provided regular assistance to a partner, family member or friend with mental illness in 2018.
- This caregiving role provides great value to people with mental illness, carers and the broader community.
- Carers could also be of great assistance to service providers, if service providers were more willing to draw on the understanding and insights of carers.
- Caring also has costs — it affects some people's mental and physical health, social participation, career trajectory, educational attainment and financial security.
- Carers are not the only ones affected by a family member's mental illness — children who have a parent or sibling with mental illness may particularly need support.

RECOMMENDATION 18 — SUPPORT FOR FAMILIES AND CARERS

Governments assist families and carers by funding support services and income support payments. There is scope to improve access to these supports and to improve how families and carers are included by mental health services.

As a priority:

- All mental health services should be required to consider family and carer needs, and their role in contributing to the recovery of individuals with mental illness. (Action 18.1)
 - State and Territory Governments should be collecting and reporting on the Carer Experience Survey to encourage carer-inclusive practice.
 - The Australian Government should amend the Medicare Benefits Schedule to provide rebates for family and carer consultations.
 - State and Territory Governments should ensure the workforce capacity exists in each region to implement family- and carer-inclusive practices within their mental healthcare services.

Additional reforms that should be considered:

- The recommended National Mental Health and Suicide Prevention Agreement (Action 23.3) should state that State and Territory Governments will be responsible for planning and funding carer support services related to the mental health caring role and family support services for families affected by mental illness. (Action 18.2)
- The Australian Government Department of Social Services should evaluate the outcomes achieved for mental health carers from its carer support program. (Action 18.2)
- The Australian Government should amend the eligibility criteria for the Carer Payment and Carer Allowance to reduce barriers to access for mental health carers. (Action 18.3)

Family members, partners and friends provide significant support to many people with mental illness, and this support can be critically important to their wellbeing and recovery. A caregiving role is often challenging, and mental health carers are more likely than other carers to report consequences for their own mental health and wellbeing. As Mental Health Carers Australia (sub. 489, p. 3) noted:

There are significant, well documented impacts on carers associated with the caring role, including but not limited to: emotional distress, depression, financial insecurity, employment insecurity and loss of connections with their own family, friends and community.

Governments assist carers by funding carer support services and income support payments. The Productivity Commission heard that there is scope to improve access to these supports for mental health carers. Inquiry participants also described how mental health professionals often fail to exchange information with carers that would contribute to their own wellbeing and the recovery of the person with mental illness.

Family and friends of people with mental illness who do not provide regular support and assistance may also be affected by the mental illness. Relationships within families and social networks can sometimes be strained as a result of the symptoms of mental illness, and children in families affected by mental illness may particularly need support.

This chapter examines reform options to improve supports for families and carers. Section 18.1 describes the experience of carers and family members of people with mental illness. Section 18.2 discusses how mental health services can better identify and support carers and family members of people with mental illness, and include carers as part of the care team. Section 18.3 proposes improvements to family and carer support services. Section 18.4 explores changes to income support payments for carers that would make them more accessible.

18.1 Mental health carers provide a valuable contribution to the community

A recovery approach with an emphasis on families and carers

In 2013, the Australian Health Ministers' Advisory Council endorsed a national framework for recovery-oriented mental health services as a result of a growing movement embracing the concept of personal recovery, rather than a narrow focus on clinical recovery (AHMAC 2013). The role of families and carers has always been recognised as an element of recovery-oriented practice, but the importance of considering a person within their social context — their family, carers, and community — in supporting recovery is now emphasised.

To this end, Inquiry participants promoted the idea of relational recovery.¹⁸⁶ With relational recovery, experiences such as hope, identity, meaningfulness and empowerment are inseparable from a person's social context and relationships (Price-Robertson, Obradovic and Morgan 2017). For mental health policymakers and service providers, this has implications for why and how they should consider families and carers as relevant to their work.

The wellbeing of consumers and their families is interdependent. Family and carers often hold a lifetime of information about the consumer, which service providers frequently overlook in forming a diagnosis and care plan for the consumer. This may be to the detriment of the service provider's capacity to help the individual in their recovery. An effective carer is one who feels informed and secure — a distressed or exhausted carer is not well-placed to support recovery. What must also be acknowledged, is that mental illness can affect the quality of relationships, which contributes to social isolation and impedes recovery.

At an interpersonal level, psychosocial supports build relationships with family and friends. These relationships are often fractured and people can become isolated. Without support from family and friends, clinical care often fails. (MIFA, Brisbane transcript, p. 19)

MHYF Vic is arguing for a mental health system that seeks solutions to mental health problems that might lie between people, rather than just within the body of a separated person. (MHYF Vic, sub. 628, p. 3)

Better outcomes can be achieved for people with mental illness when recovery is understood as a social process. For example, several participants urged this Inquiry to examine Open Dialogue, which is a model that views the consumer's support network as fundamentally involved in their recovery (GFCT, sub. 76; MHCC, sub. 920; MHCSA and LELAN, sub. 360; SleeplessNoMore, sub. 100) (box 18.1). The evidence supporting this recovery- and family-oriented approach is promising.

The benefits of the reforms recommended in this chapter are based on the robust evidence-base about the effectiveness of family interventions and demonstrate the value of working with families and carers to support recovery. The Productivity Commission has modelled the effects of support for families and carers on the mental health of carers, care recipients, children of parents with mental illness, and the cost-savings from reduced hospital admissions and visits to the emergency department (appendix I). The annual economic benefits (from increased income and cost savings) from actions 18.1 and 18.2 totalled \$164–\$318 million, and exceeded the estimated annual costs of implementing these reforms (\$160–\$189 million).

¹⁸⁶ Arafmi, Brisbane transcript, p. 94; BPD Community, Melbourne transcript, p. 121; MHCA, Canberra transcript, p. 20; MHFFTas, Launceston transcript, p. 77; Mind Australia, Melbourne transcript, p. 36; Tandem, Melbourne transcript, p. 67.

This chapter analyses the potential gains for consumers, carers, families and the broader community that could be achieved from a more family and carer-inclusive mental health system. Cultural change that places greater emphasis on support for families and carers will take time but services that ignore the value of this are not operating in consumers' long-term interests.

The Productivity Commission recommends several practical changes that will help move the mental health system in this direction. These include placing more people on the ground to promote family and carer work in mental health services, Medicare Benefits Schedule (MBS) rebates for consultations with carers and family, and improving transparency about the current state of family and carer work. The recommended reforms recognise that families and carers have needs of their own, and that meeting those needs would have broader benefits for consumers and the community.

Box 18.1 The Open Dialogue approach

The Open Dialogue approach was developed and implemented in the health district of Western Lapland, Finland in the 1980s. Early research focused on people experiencing first-episode psychosis but the model has been broadened. There are seven principles that define Open Dialogue, two of which are particularly relevant to family- and carer-inclusive practices: chosen members of the consumer's social network will be invited to the first treatment meeting and treatment meetings aim to promote an equal dialogue between the consumer, their social network and the treatment team.

... clinical expertise is seen as only one of the contributions to the dialogue. It is considered as equal to the ideas and opinions of all others in the network. (Ong et al. 2019, p. 419)

This can be a confronting shift in practice for clinicians and when first implemented, staff were offered extensive training in family therapy and other relevant methods.

A study that followed up on three different cohorts of consumers with first-episode psychosis who received treatment according to this approach found that the average number of meetings with family or network members was 33, compared to an average of 30 attended by the patient and treatment team only. Over half of these consumers required only one hospital admission or none at all. Compared with first-episode psychosis patients elsewhere in Finland, the Open Dialogue group spent significantly less time in hospital, and spent less time on disability-related income support. After two years, 84% of the Open Dialogue patients were in full-time employment or study.

It is not known the extent to which the principles promoting the active participation of the family in care contributed to these results compared to other elements of Open Dialogue, such as holding the first meeting within 24 hours of initial contact and maintaining continuity in the treatment team. As this approach is introduced in more countries, including Australia, more research is needed — particularly since a 2019 review concluded that the evidence base lacked methodological rigor.

Source: Bergstrom et al. (2017, 2018); Freeman et al. (2019); Ong et al. (2019).

According to the *Mental Health Statement of Rights and Responsibilities*, carers and support persons have the right to:

- comprehensive information, education, training and support to facilitate their caring role
- receive services that assist them to provide care and support
- receive support for their own difficulties that may be generated as a result of caring
- participate in treatment decisions, and seek and receive additional information about the mental health consumer's support, care, treatment, rehabilitation and recovery (with the consent of the mental health consumer) (Standing Council on Health 2012).

Other commitments to support carers exist outside of mental health policy. The Australian Government and most State and Territory Governments, except Tasmania and the ACT have introduced legislation to recognise the contribution and role of carers. For example, the *Carer Recognition Act 2010* (Cth) states that all carers should have the same rights, choices and opportunities as other Australians.

These stated objectives provide a good basis for assessing: how mental health services draw on and support families, and partner with carers (section 18.2), the effectiveness of support services for families and carers (section 18.3), and income support services for carers (section 18.4).

Who are mental health carers?

There were 2.65 million family and friend carers in Australia in 2018 — more than one in ten people (ABS 2019b). Approximately 971 000 (37%) people were caring for someone who had mental illness (Productivity Commission estimates using ABS 2020b) (figure 18.1).¹⁸⁷ For 414 000 (43%) of these mental health carers, mental illness was the *main* condition of their main care recipient, but for the majority of mental health carers, mental illness was a comorbid secondary illness.¹⁸⁸

The Carer Recognition Act defines a carer as someone who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition, mental illness or are frail and aged. They are typically relatives, partners or friends of the person who needs support, although they may not identify as carers themselves. Carers are also known as informal carers because the assistance they provide is unpaid, in contrast to paid carers who are part of the formal mental health workforce.

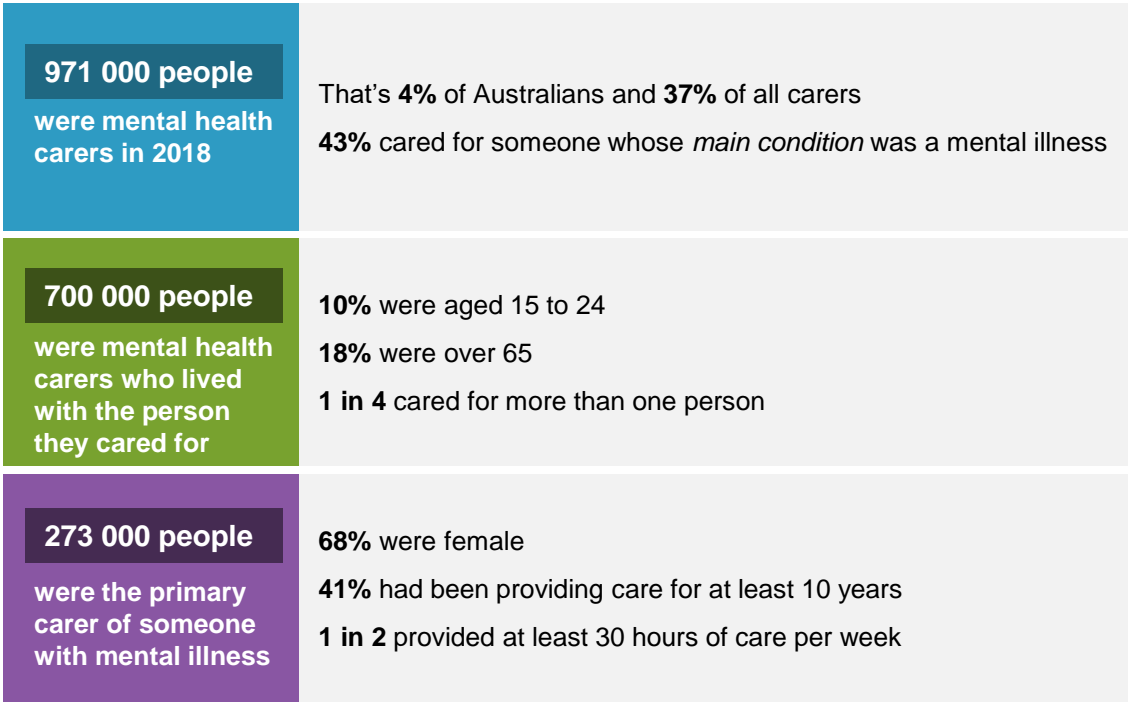
¹⁸⁷ Of the 1.9 million carers who lived with their care recipient, 700 000 were caring for a person with mental illness. Due to data limitations, the Productivity Commission estimated how many of the 718 000 carers who did not live with their care recipient were mental health carers. This was based on the proportion of people who did not live with their carer that had mental illness (38%).

¹⁸⁸ Using an earlier version of the same survey, Diminic et al. (2017) found there were 240 000 carers of people whose main condition was mental illness. Their methodology differed from the Productivity Commission's in that they excluded carers of people with substance use disorder or under the age of 16 years.

A carer providing the most assistance to a person is called the primary carer. We know most about primary carers relative to other carers because they are a focus of the ABS Survey of Disability, Ageing and Carers. There were approximately 273 000 people acting as primary mental health carers in Australia in 2018 — 96 000 (35%) were primary carers to someone whose *main* illness was mental illness (ABS 2020b).¹⁸⁹ But this understates the number of primary mental health carers because it excludes primary carers who do not reside with their care recipient.

Carers can be any age (figure 18.1). Carers over the age of 65 years may find it difficult to maintain a caring role as their own health needs increase. Young carers are those less than 25 years old. Hamilton and Redmond (2019) reported that 5% of children aged 9 to 14 years old in 2014 provided care to a family member who had mental illness or who were using alcohol or other drugs.

Figure 18.1 **Who are Australia’s mental health carers?**



Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).

How are mental health carers different from other carers?

All carers typically provide support with practical tasks. For mental health carers, this often includes navigating the complex mental health system and advocating for their care recipient to receive the services they need (Name withheld, sub. 104).

¹⁸⁹ All references to ABS (2020b) throughout this chapter are Productivity Commission estimates.

As these parents described it:

I am my daughter's advocate ... My daughter constantly has stated ... Nothing is working. Nobody is helping me. (Name withheld, sub. 392, pp. 1, 9)

Over her 3 years in Perth, one of us typically visited [our daughter] weekly to assist with cleaning, shopping, getting to class, Centrelink, Drs or psych appointments, general mood lifting and problem solving etc, and our other daughters provided 'respite' & 'crisis' accommodation when required ... we saw how easily she would have slipped into homelessness without our support. Due to the BPD [borderline personality disorder], the challenge of dealing with these issues on her own was overwhelming and she would just avoid them. (Robert Davis, sub. 133, p. 11)

Mental health carers have different needs and experiences compared with other carers due to characteristics associated with mental illness.

First, compared with carers of people with a physical health condition as their main condition, mental health carers are more likely to provide emotional and psychosocial support and less likely to assist with activities of daily living, such as washing, dressing, or eating (Diminic et al. 2017). Emotional and psychosocial support does not just encompass providing encouragement, reassurance and managing behaviours; for mental health carers, this often includes the difficult tasks of guarding against self-harm and managing crises (Carers Victoria 2013). For some parents, caring can include an extremely challenging role, reflected for example, in the vigilance needed to prevent their children from attempting suicide (Name withheld, sub. 392; Robert Davis, sub. 133).

Second, the symptoms of mental illness can sometimes strain relationships, and this can make providing support more difficult and stressful.

People with BPD [borderline personality disorder] experience relational dysregulation. This means that those who are closest to them are often subjected to the more extreme behavioural and emotional dysregulation. This is a burden that affects the mental health of these loved ones. (BPD Community, sub. 74, p. 3)

Third, the episodic nature of mental illness has implications for the caring role. Fluctuations in the duration and intensity of needs can make the caring role more unpredictable (Carers NSW, sub. 183; MHFFTas, sub. 391; MIFA, sub. 343). In 2018, about one quarter of primary mental health carers only needed to provide care during periods or episodes when the care recipient's condition deteriorated (ABS 2020b). Even for those providing care, hours of care provided can increase significantly during an episode or crisis (Carers Victoria 2013). When they are not actively providing care, mental health carers often remain on-call, in case support is required (Diminic et al. 2017).

Intensive and episodic care responsibilities can affect a carer's ability to juggle caring with employment and education (Mind Australia, sub. 380). Carers Australia (sub. 372, p. 7) described how:

... structuring flexibility into jobs works best when carers are caring for people who, except in relatively unusual circumstances, have predictable care needs. Carers of people with unpredictable episodic conditions, especially when these episodes are frequent, may find it harder to plan their working responsibilities around their caring role.

Fourth, mental illness typically has an earlier age of onset than many physical health conditions (MHCN, sub. 245; Tandem, sub. 502). The toll on a mental health carer's life can be significant given that many are in this role for many years and often from a relatively young age.

Finally, stigma associated with mental illness can further complicate the role (Carers NSW, sub. 183; MHFFTas, sub. 391). It contributes to isolation, a lack of understanding and reduced support from service providers and the broader community, compared with what might be experienced by other types of carers.

Many families, including carers within those families, find it hard to tell other people that they have a family member with a mental illness. They may feel that to do so would be a form of betrayal of that person. This is especially the case for carers in some culturally and linguistically diverse communities where, for cultural reasons, the level of stigma is very high. (Carers Australia, sub. 372, p. 7)

Carers are still suffering isolation and poor health ... Small town syndrome (stigma) for carers who live in rural towns is very real; they suffer in silence and eventually become a shadow in their own community. (LMMHCN, sub. 52, p. 2)

[I]t is the stigmatisation and discrimination in the services that are supposed to be a support that hurts the most. From psychiatrists to nurses, to admin staff, help line personnel and social workers, discrimination is a unifying feature of the experience of all carers and people with BPD [borderline personality disorder]. (BPD Community, sub. 74, att. 1, p. 1)

Differences in the roles and challenges faced by mental health carers compared with other carers translate into differences in the types of support they need from government, employers and the broader community.

The 'hidden carers'

Hidden carers — people who do not identify as carers or who are not recognised as carers by service providers — often do not know that carer support services exist or how to access them.

Mental health carers often do not identify as carers, at least initially. People may associate the word 'caring' with the tasks related to assistance with daily living rather than the emotional and practical support that is commonly provided by mental health carers. Also, care recipients may not realise their family member or friend is providing informal care.

Certain types of carers are more likely to be hidden from services systems and miss out on support. Aboriginal and Torres Strait Islander carers and culturally and linguistically diverse carers may not access services because of a lack of culturally capable services or awareness of services (DSS 2016c; Hill et al. 2016). In these communities, the caring role may be shared with many in the community and this makes it difficult to identify who is a carer (Mind Australia et al. 2016; Northern Territory Mental Health Coalition, sub. 741). Cultural norms about family responsibilities and stigma about mental illness also contributes to lower rates of service use among people from culturally diverse backgrounds (Carers Victoria 2013; Diminic et al. 2017; MHFFTas, sub. 391). Carers Victoria (sub. 664) stated

that LGBTIQ carers can experience additional difficulties in the healthcare system if staff do not recognise or support their relationship.

Young carers are another group who are more likely to be hidden from support and services, and often have unmet needs (Tandem, sub. 502). They may not identify as carers, or conceal their caring role because they:

- do not realise that what they do is different to what occurs in other families
- are not taken seriously by service providers because of their age
- fear stigma and bullying
- are concerned about intervention from child protection services (Carers NSW 2020; Cass et al. 2009; Hamilton and Redmond 2019; HelpingMinds, Geraldton transcript, p. 12).

Many carers see themselves as a mother or daughter or husband rather than as a carer. However, when they are not also recognised as a carer, they can miss out on support that would benefit them. For example, Mental Health Carers NSW (sub. 245, p. 18) described carers who ‘prior to their contact with our organisation, did not know that they were eligible for income support based on their caring role, some of whom, had undertaken substantial caring responsibilities at significant personal cost for extended periods of time.’ People not recognised as carers also miss out on being included by service providers in ways that would enhance the care recipient’s recovery.

To what extent is caring a choice?

Many carers value their caring role. Most have chosen to take on this role because they want to provide support to a loved one and because it is the best choice available for their family. The majority of primary mental health carers assumed a caring role out of a sense of family responsibility — 26% stated they had no other choice (ABS 2020b).

The decision to provide informal care, and the hours provided, depend on a range of factors, including: the person’s preferences, their own situation (such as what type of job they have and whether they have child raising responsibilities), the needs of the person with mental illness, and the availability and quality of appropriate formal care for that person.

A *primary* caring role is typically equivalent to a full-time job. The average number of caring hours provided by all mental health carers (including primary carers) was 11 hours per week, whereas it was 40 hours per week for primary mental health carers (Diminic et al. 2017, p. 138). Time spent caring significantly reduces the time available for the carer to participate and thrive in the community, through employment, education and social interactions.

Some carers prefer to provide a significant level of care themselves regardless of services available or used by the consumer. Others would like to provide fewer hours if suitable service options were available. Several Inquiry participants described how there was a lack of appropriate services available to meet the needs of their care recipient (LMMHCN,

sub. 52; Mental Health Carers ARAFMI Illawarra, sub. 161; Name withheld, sub. 66; Name withheld, sub. 104; Name withheld, sub. 392).

Tandem (sub. 502, p. 2) stated that mental health carers often have no option but to ‘provide extensive social and practical support in the absence of support services’. When Diminic et al. (2017, pp. 89, 91) surveyed mental health carers, they heard that ‘there is nowhere near enough support for mental health carers’ and that carers were ‘tired of filling ... the shortfall in services’.

SANE Australia (sub. 130) and Mind Australia (sub. 380) observed that while the shift from institutional care to community-based care over recent decades is a positive change for the community overall, it has resulted in an increased reliance on informal care provided by family. The transition to the National Disability Insurance Scheme (NDIS) has reduced access to psychosocial supports for people not eligible for that program (chapter 17), and may be contributing to increased demand for informal care.

For young carers it is less clear that providing significant hours of care is their choice to make. The Productivity Commission heard from several Inquiry participants about young people taking on a caring role (AIFS, sub. 753; HelpingMinds, sub. 470; One Door Mental Health, sub. 108). Carers Australia (sub. 372, p. 9) provided extracts from applications for the Young Carer Bursary program, which it administers, including this story from a 14 year old boy:

It is just Mum, me and my brothers living at home. I have been caring for my family since I was 8 years old. Mum suffers from drug addiction and mental illness. Because Mum is sick, it is up to me to get my brothers up and ready for school, including making lunches, breakfast, getting them ready and getting them to school. I also have to take them to appointments, clean the house, make dinner. I also care for Mum which includes personal care, and providing heaps of emotional support. I get worried about keeping everyone safe and sometimes I can't sleep from worry and being scared.

Support services targeted to young carers are important. However, if the mental health system framed young carers differently, as being part of a family affected by mental illness, this may lead to more whole-of-family support. The best thing for many young carers may be to reduce the intensity of care they need to provide by increasing the psychosocial supports provided to the care recipient. The risks to their education and work outcomes, and wellbeing over their lifetime are significant. This increases the importance of governments taking a prevention and early intervention approach to supporting young carers, rather than taking actions to mitigate against poor outcomes later.

Although the Productivity Commission is recommending changes to policies that directly affect carers in this chapter, carers will also benefit from reforms recommended elsewhere in this report that aim to improve access to the right mental health services, at the right time and place. A more effective service system for mental health consumers would give carers more choice in how much care they provide and reduce the stressors related to caregiving.

... the best outcomes are achieved when caring is a choice, rather than a sacrifice made in the absence of any other satisfactory alternative to ensure that a loved one receives support. (MHCN, sub. 245, p. 3)

The effects of caregiving

Benefits of caregiving

The value to the community of the informal care provided by mental health carers is immense. Carers provided over 200 million hours of care in 2015, which would have cost taxpayers \$13.2 billion (2015 dollars) to replace with formal support services that were fully-funded by government (Diminic et al. 2017).

One parent described how their support contributed to the recovery of their child:

My child (I believe) is one of the lucky ones. I have been the one to pick her up after suicide attempts, I have been the one to get her back after running away from a health practitioner session, I have been the one staying home making sure she ate, keeping the family together, dealing with outbursts and all the ups and downs that comes with it! I have been the one to research, fight and demand assistance for my child, to get people to listen. (Name withheld, sub. 66, p. 3)

For some people with mental illness, the support they receive from family and friends is irreplaceable. Tandem (sub. 502, p. 3) noted that if ‘a carer is no longer able to provide ongoing support, the person with mental illness can become more at risk of hospitalisation, homelessness and suicide’. Johnson and Chamberlain (2011) found that the ongoing support from family was an important factor in preventing young people with mental ill-health from becoming homeless.

The benefits of caring described above — reduced expenditure on government-funded services and reduced homelessness — are tangible and measureable. Other benefits for both carers and consumers, although very real, are more difficult to measure:

The sense of personal connection and belonging generated by positive informal support networks is critical to the recovery process ... Some carers report that caring can be a rewarding experience and many derive a sense of pride and accomplishment from their caring role. In some circumstances, relationships between family members can be strengthened when they are able to cooperate to overcome difficult circumstances. (MHCN, sub. 245, pp. 3, 8)

Costs borne by carers

Time and effort spent providing informal care imposes costs on some carers — including costs to their health and financial security. Mental Health Families and Friends Tasmania (sub. 391, p. 3) stated that the ‘practical, physical, economic and emotional demands of supporting a loved one with a mental illness can be enormous’. While not all carers are negatively affected by their caregiving role, those who provide care to someone with severe disability, or who work full-time and provide a high level of care, are more likely to face significant costs (Diminic, Hielscher and Harris 2018; Kenny, King and Hall 2014).

Carers are facing greater challenges since the COVID-19 pandemic. A survey by Caring Fairly found that as a result of the COVID-19 pandemic, many carers have experienced increased stress from their caring role and experienced a deterioration in their own mental

health (Mind Australia, pers. comm., 7 May 2020). Some carers reported working fewer hours due to their caring responsibilities. Mind Australia (pers. comm., 7 May 2020) noted that when formal supports were not accessible, it is carers who are left to replace the support not being provided. Carers were affected by worsening mental health of their care recipients, who were unable to leave the home for respite.

The physical, emotional and mental costs of caregiving

Stress associated with caring can take its toll. One study found that carers experienced clinical levels of depression at a rate 1.8 times higher than the general population (Productivity Commission estimate based on Edwards et al. 2008). Being a carer of a person with mental illness can be particularly stressful and have a larger effect on mental wellbeing (table 18.1).

Table 18.1 The emotional and mental effects of caregiving

<i>Primary carers of people with^{a,c}</i>						
	<i>mental illness (main condition)</i>	<i>mental illness (secondary condition)</i>	<i>other behavioural or cognitive conditions</i>	<i>physical conditions</i>	<i>All carers^b</i>	<i>Not a carer^b</i>
	%	%	%	%	%	%
Kessler 10 indicator of psychological distress:						
Low distress level	32	38	46	54	53	60
Moderate distress level	25	29	29	26	23	21
High distress level	24	18	16	14	13	12
Very high distress level	19	14	9	7	10	7
Effects explicitly attributed to caring by carers:						
Had a stress-related illness	20	17	12	8	..	..
Feels weary or lacks energy	53	43	47	31	..	..
Feels worried or depressed	43	37	33	22	..	..

^a 2018. ^b 2017. ^c Throughout this chapter, mental illness includes: depression and mood affective disorders; schizophrenia and other psychoses; phobic and anxiety disorders, obsessive-compulsive disorder, and other neurotic, stress-related and somatoform disorders; aggression; mental disorders due to alcohol and other psychoactive substance use; eating disorders; adult personality and behavioural disorders; attention deficit disorder/hyperactivity; speech impediment; insomnia; and other mental and behavioural disorders. Other behavioural and cognitive conditions includes: dementia; intellectual disability, autism, developmental learning disorders, coordination disorder, and other intellectual and developmental disorders; dyslexia; dyslalia; memory loss and problems; agitation or confusion; and acquired brain injury. Physical conditions included all other conditions. .. not applicable.

Source: Productivity Commission estimates using ABS (*Microdata: Disability, Ageing and Carers, Australia, 2018*, Cat. no. 4430.0.30.002) and wave 17 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey.

The challenges faced by mental health carers were evident in the stories they shared with the Productivity Commission:

My husband and I have had many sleepless nights, whether because we are worried about what she might do to herself while we are asleep, or waking to hear her distraught hysterical crying. (Anonymous Parent, sub. 399, p. 3).

In the past 18 months I've observed my daughter's decline. It's a nightmare that evolves and it's getting more frightening ... I'm already stretching my emotional and mental limitations. (Name withheld, sub. 392, pp. 24, 29)

Carers are more likely than their peers to have physical health problems. Kenny, King and Hall (2014) found that females providing 20 or more hours of care per week had poorer physical functioning after two years as a carer, relative to non-carers in an otherwise similar life situation. Edwards et al. (2008) found that 29% of carers were in poor health compared with 17% of the general population.

Lower labour force participation and productivity

Time spent caring means less time available for employment. The Productivity Commission has analysed the effect of caring on the likelihood of being employed for the Australian population between 2001 and 2018 (table 18.2). About 70% of carers were in employment the year before becoming a carer but providing more than 10 hours of care significantly reduced their likelihood of being in employment. The effect was largest for carers providing over 30 hours of care per week; their likelihood of employment was 14.8 percentage points lower than if they were not providing care. The negative effect of caring on employment remained after people ceased providing care.

Not only does providing care reduce the probability of employment it also reduces the hours of work undertaken by carers who remain employed (table 18.2). For example, employed carers who provide care for 30 or more hours per week worked 3.2 fewer hours on average than if they were not providing care.

There was little difference in the rate of employment for working-age primary mental health carers (51%) compared to other primary carers (52%) in 2018 (ABS 2020b). Some mental health carers would like a job or to work more hours (figure 18.2). There are a range of reasons why carers were not in work or were working part-time, including raising children and retirement. However, over one third of mental health carers who were not employed stated that the main reason they stopped work was due to their caring role (figure 18.2).

Table 18.2 The effect of caring on employment^a

Regression results using HILDA waves 1–18

<i>Carer status (variables of interest)</i>	<i>Employment (regression coefficient)</i>	<i>Hours of work per week (regression coefficient)^b</i>
0–9 hours of care provided each week	0.008	***-0.654
10–19 hours of care provided each week	***-0.060	***-1.677
20–29 hours of care provided each week	***-0.084	***-2.775
30+ hours of care provided each week	***-0.148	***-3.225
Ex-carer (was a carer in the previous 3 years)	***-0.063	***-1.163
<i>Model statistics</i>		
Observations (total)	139 493	98 478
Observations (persons)	20 462	16 560
Number of carers in the sample	4 890	3 331
R squared	0.68	0.71

^a For people aged 25–64 years old, a linear fixed effects model was estimated: $\text{Employment}_{i,t} = \beta \times \text{Carer_status}_{i,t} + X'\beta + \text{Individual}_i + \text{Time}_t + \varepsilon_{i,t}$, where Individual_i and Time_t are individual and year fixed effects and $X'\beta$ is a vector of covariates (age quadratic, marital status, education level, number of children), consistent with Leigh (2010). A person is considered an ex-carer if they are not providing care but provided 10 or more hours of care in any of the previous three years. The comparison group for carer status is 'not a carer'. Robust standard errors, clustered at the person level. *** denotes statistical significance at the 1% level. Cross sectional weights were applied. ^b The sample for hours of work includes those employed only.

Source: Productivity Commission estimates using the Household, Income and Labour Dynamics in Australia (HILDA) Survey.

Figure 18.2 Carers' labour market transitions and aspirations

Working-age co-resident primary carers of people with mental illness



Source: ABS (Microdata: Disability, Ageing and Carers, Australia, 2018, Cat. no. 4430.0.30.002).

Lower labour force participation has flow-on effects. At the community level, it reduces economic growth and tax revenue, and can raise government expenditure on income support. On a personal level, it not only affects income, but also precludes other benefits of employment, such as the social connection and feelings of empowerment and achievement that employment can provide.

Employment and education can provide an opportunity for carers to spend time away from the caring role and to focus on other aspects of their identity and wellbeing. (MHCN, sub. 245, p. 21)

For carers, work can be the best form of respite from caring. It is well established that carers can become very socially isolated. Work can provide them with the opportunity to socialise with other people and to have an identity and a focus beyond their caring role. (Carers Australia, sub. 372, p. 6)

Carers experience significant barriers to employment. The intensity of the caring role and lack of alternative formal services are two such barriers, but there are others (MHCA, sub. 489; Tandem, sub. 502). Many years spent caring can reduce confidence to re-enter the labour force and leave carers without the skills and work experience of their peers (MHFFTas, sub. 391, Mind Australia, sub. 380). Carers may not be attractive as potential employees if employers make assumptions based on their time out of the workforce (cohealth, sub. 231). Carers may also have difficulties finding a job that offers work arrangements with the level of flexibility needed to accommodate caring responsibilities (Caring Fairly, sub. 427).

Lower workplace productivity and educational attainment is also associated with caring. Mental health carers were more likely to be in low-skilled occupations than other types of carers and non-carers in 2015 (Diminic, Hielscher and Harris 2018). A survey undertaken by Carers Victoria (2013) found that the caring role affected some mental health carers' performance at work and led others to switch to a lower paying job.

Carers may need time off from work due to their caring responsibilities. For employed working-aged primary mental health carers in 2018:

- 14% had to leave work for at least 3 months to provide care
- 23% needed time off work at least once a week because of care responsibilities
- 25% needed time off work because of caring but not as often as once a week (ABS 2020b).

One carer described their experience juggling caring and work responsibilities:

I have had to take significant time off work (have utilised a large portion of my accrued sick leave) and my wife has taken a year's leave without pay, so as we can afford our daughter every opportunity to support/care, manage flare ups, attend to appointments/meetings and reintegrate back into mainstream society (school, home, community). (Name withheld, sub. 392, p. 2)

Reduced engagement in education and work for young carers

Disruptions to education and employment due to caregiving responsibilities are particularly consequential for young carers. For young people in general, not being in education and/or work at such an important time of transition and skill development is associated with increased vulnerability to their career and broader wellbeing throughout their life (chapter 6).

Several studies have found that young carers generally are at risk of poorer educational outcomes than their non-carer peers. Warren and Edwards (2016) found that the difference in Year 9 NAPLAN results between young carers with significant responsibilities and other children was equivalent to more than one year of schooling. Cass et al. (2011) reported that young carers (and potential young carers who did not identify as carers in the 2006 census) were less likely than their peers to be participating in either education or employment.

Outcomes are even worse for young mental health carers. Hamilton and Redmond (2019) found that children aged 9 to 14 years old who were caring for someone with mental illness were less engaged in school than non-carers and carers of people with a physical disability or chronic illness. The rate of participation in either work or education was lower for young mental health carers aged 15 to 24 years compared with other carers and non-carers in 2015 (Diminic, Hielscher and Harris 2018, table 3.2).

Poorer educational outcomes for young carers may reflect lack of time to do their homework; being late to, or missing, school more often; worrying about their care recipient while at school; and low participation in extra-curricular activities (Hamilton and Redmond 2019).

The effects of being a young carer are often compounded by other risk factors for poor educational attainment. The young carers surveyed by Hamilton and Redmond (2019) were more likely to have a disability or live in a materially disadvantaged household. Some of these risk factors for school engagement apply to children and young people without caring responsibilities in families affected by mental illness (discussed below).

Despite its challenges, Caring Fairly (sub. 765) noted that caregiving can help some young people to have an increased: emotional maturity level, ability to relate to adults better, problem-solving skills, and ability to work well independently.

Effects on income and financial hardship

Less time in formal employment affects carers' incomes and savings and can contribute to financial hardship (Carers Victoria, sub. 461; MHCA, sub. 489; MHFFTas, sub. 391; Mind Australia, sub. 380; Tandem, sub. 502). In 2018, 41% of primary carers of people with mental illness reported difficulty meeting everyday living costs as a result of caring (compared with 30% for other primary carers) (ABS 2020b). Women's Health Victoria (sub. 773) and Caring Fairly (sub. 765) noted that reduced workforce participation caused by caring responsibilities results in less superannuation accumulation and retirement income, and that women are disproportionately affected because more women are carers.

Carers also tend to incur expenses associated with their caring role that are over and above what can be covered by the income of the person they are caring for (Carers Victoria 2013). Costs include those related to healthcare for the person they are caring for, the cost of travelling to appointments, and property damage and debts associated with symptoms of mental illness (BPD Community, sub. 74; Carers Victoria, sub. 461; LMMHCN, sub. 52; Montelukast (Singulair) Side Effects Support and Discussion Group, sub. 197; Name withheld, sub. 104; Robert Davis, sub. 133).

I was hit with the harsh fact I had to quit my job to nurse my child around the clock, while accumulating regular considerable medical expenses, losses, and property damage repairs. (Carers NSW, sub. 183, p. 5)

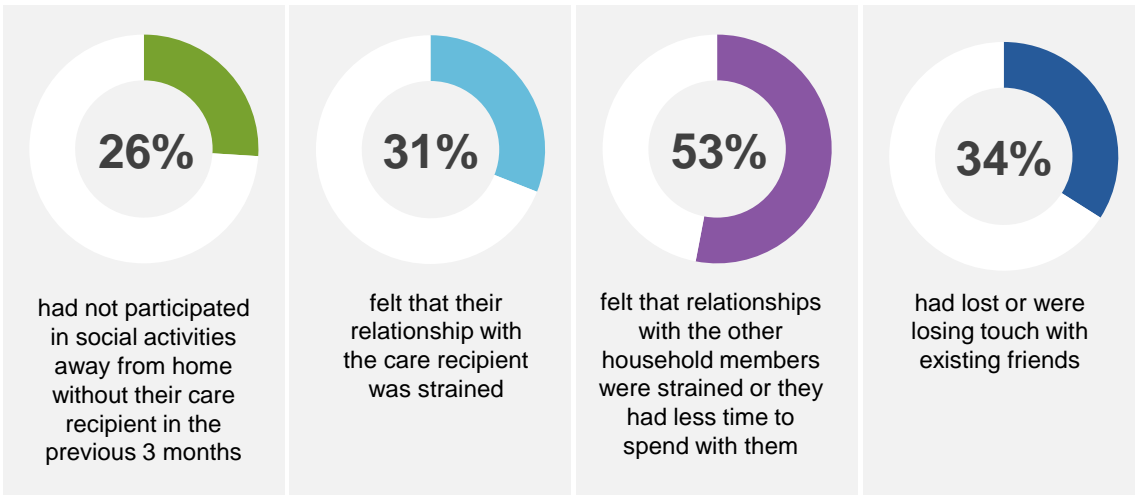
The whole process is time consuming and costs me a great deal of time off work, and with ongoing expenses out of my pocket that are not covered for mental health services, no one can afford these on a disability pension. If I was not able to assist my child with these expenses, they would be unable to attend! (Name withheld, sub. 66, p. 2)

Reduced social participation

Less time in work, more time spent in the home providing informal care and increased stress, can reduce social participation, strain relationships of the carer with their family and friends, or lead to social isolation (figure 18.3).

The costs associated with carers experiencing stress, poor health or financial hardship extend to carers’ families and the broader community. Carers who do not receive support when they need it may come to need mental health services for themselves. Moreover, if burnt-out carers become unable to continue their caring role, this would lead to greater demand for formal mental health services for the person receiving care.

Figure 18.3 Social costs of caregiving
Primary mental health carers who co-reside with their care recipient



Source: ABS (*Microdata: Disability, Ageing and Carers, Australia, 2018*, Cat. no. 4430.0.30.002).

Costs to families affected by mental illness

When a family member has mental illness, this affects not just their carer but the entire family. Children and young people may face risks to their education due to the stressors related to growing up with a sibling with mental illness (Siblings Australia, sub. 124). And stigma associated with mental illness can affect any family member, not just carers.

It's a very traumatic experience for a family to have the police or something come on in, and sometimes literally drag your care recipient out, and the damage that does both to the person and the other person, is ginormous to me. (CMHA, Sydney transcript, p. 108)

Having a family member with mental illness can affect family relationships and dynamics (Robinson, Rodgers and Butterworth 2008). Parents described how their child's illness affected the household's relationships and functioning:

It was an incredibly stressful period without any path forward that pushed both myself and my husband close to breaking point. It increased the arguments between us as we couldn't agree on how to solve the issue ... Frequently when my husband got home from work he would just go straight to bed, without even eating dinner. Basic life tasks broke down — the housework piling up, eating takeaway and fast food rather than healthy home cooked meals, sometimes not leaving the house at all. (Anonymous Parent, sub. 399, p. 3)

Throughout my child's struggle, I have found little understanding and support for myself and my other children — who have also suffered through this time. (Name withheld, sub. 66, p. 2)

One of the most vulnerable groups are dependent children of a parent with severe mental illness. As many as 44% of children and adolescents aged 4 to 17 years old in 2013-14 lived with a parent (primary or secondary carer) who had ever been diagnosed with mental illness (including alcohol or drug dependence) (Productivity Commission estimate based on table 1 of Johnson et al. 2018). Prevalence is considerably lower for children of parents with severe mental illness — 11.4% of children and adolescents aged 4 to 17 years old had a primary carer who reported high or very high psychological distress in the previous four weeks and 4.6% reported that mental health problems had interfered with daily activities most or all of the time since the child was born (Johnson et al. 2019). The symptoms of, and treatment for, mental illness can affect parenting and disrupt a family's daily life. Environmental factors associated with mental illness — such as financial hardship or lack of social support — can also contribute to adverse outcomes for children (Campbell et al. 2020; Goodyear et al. 2015; Reupert, Maybery and Kowalenko 2012; Riebschleger et al. 2017).

Inquiry participants described some of the intergenerational effects of mental illness. For example, the mental health of children of refugees has been linked to the mental ill-health associated with trauma and grief experienced by their parents (AIFS, sub. 753). Traumatic experiences in childhood (such as parental mental illness, substance use or parental separation) increase the risk of suicide, substance use, mental illness and comorbid physical illness for those children in their adulthood (Emerging Minds, sub. 455).

Adolescents aged 10 to 14 years in New South Wales whose parents had used specialised mental healthcare services were: more likely to enter out of home care, more likely to interact with the justice system, less likely to finish high school and more likely to have an alcohol and other drugs-related hospital admission in the future (Taylor Fry 2018).

18.2 Family- and carer-inclusive practices

Family- and carer-inclusive practices in mental health services acknowledge the importance of family and friends, and ask clinicians to identify and support the consumers' families and carers, and consider how best to include carers as part of the care team.

Considering a consumer's social context as part of their care does not equate to always including family and carers in treatment.

For some, recovery may necessitate disconnecting from certain relationships and establishing firmer boundaries. From the perspective of relational recovery, however, even these assertions of autonomy and boundary-setting are seen as interpersonal acts; acts that only have meaning within the context of relationships ... (Price-Robertson, Obradovic and Morgan 2017, p. 116)

... when we look at family engagement it's not about necessarily involving the family completely, it's about navigating ethically when ... to involve the family and how to respond to the family in a way that is supportive of what the consumer wants as well. (MHCN, Sydney transcript, p. 101)

Families and carers should be included and supported in a way that upholds the rights of consumers and protects the safety of all involved. Consumers should be in a position to give informed consent to include their family or carer in their treatment. The National Standards for Mental Health Services stated that mental health services must uphold the rights of consumers to nominate if they wish to have or not have others involved in their care (to the extent that it does not impose serious risks) (Australian Government 2010).

A partnership model between carers and mental health services

Carer-inclusive practice is a way of working that treats carers as partners in care. HelpingMinds (Geraldton transcript, p. 7) described the 'triangle of care' — communication and partnership between the consumer, the clinicians and the carer. For example, when a person is discharged from hospital and their care is placed in the hands of a carer, they should be supported with the information and skills they need to execute this role safely and effectively. And as partners in care, the direction of information should be two-way — carers often have insights on how best to support the recovery and wellbeing of their care recipient and mental health services may be disadvantaging consumers by not recognising this.

Inquiry participants raised concerns that their role, views and needs as carers are not being recognised and respected by mental health services (box 18.2). Frequently, the reason given for not engaging with carers is to protect the privacy of the consumer (ACT Government, sub. 210; Carers NSW, sub. 808; Name withheld, sub. 32; Name withheld, sub. 63). However, there is a lot that service providers can and should do to support carers without breaching confidentiality (box 18.3). For example, protecting privacy is not a valid reason for not listening to the views of carers or for not providing carers with general information (Mind Australia et al. 2016).

[T]here's sometimes some confusion about what it is that families want to know and it often is not the content of the conversation between the consumer and the clinician. They really want to know is everything going to be okay. Is everything all right? Or, "Because I'm the carer at home, is there something that I need to know to look out for?". (MHFFTas, Launceston transcript, p. 79)

Box 18.2 The scope to improve carer-inclusive practice

Inquiry participants shared the experiences of some carers, including that:

- carers were not being given sufficient information about diagnosis, treatment or the mental health system
- carers' views about the consumer's history and care needs were not sought or were disregarded
- carers were excluded from care and marginalised in decision-making processes
- carers were not given enough information or support when the consumer was discharged from inpatient care
- carers were not given information about prescriptions, even though they may be assisting the consumer with taking medication
- mental health professionals blamed carers and assume that carers were a cause of the consumer's problems
- carers own needs were not considered or supported.

Source: ACT Government, sub. 210; Carers NSW, sub. 183; Carers Victoria, sub. 461; HelpingMinds, sub. 470; Mental Health Carers ARAFMI Illawarra, sub. 161; Mental Health Complaints Commissioner, sub. 916; MHC of NSW, sub. 948.; MHCA, sub. 489; MHFFTas, sub. 648; Name withheld, sub. 392; Name withheld, sub. 66; Name withheld, sub. 8; Northern Territory Mental Health Coalition, sub. 430; Private Mental Health Consumer Carer Network (Australia), sub. 547; Robert Davis, sub. 133; Sarah Sutton, sub. 508; Tandem, sub. 502.

Box 18.3 **National Standards for Mental Health Services: Standard 7**

The National Standards for Mental Health Services, which were agreed to by all Health Ministers, includes Standard 7, which relates to carers. Some of the criteria within this standard that mental health services should meet include:

- having clear policies and protocols:
 - to enable staff to effectively identify carers as soon as possible in all episodes of care, and this is recorded and prominently displayed within the consumer's health record.
 - to address the issue of sharing confidential information with carers in accordance with privacy legislation and guidelines
- in circumstances where a consumer refuses to nominate a carer, the service reviews this status at regular intervals during the episode of care
- providing carers with a clear written statement and verbal explanation of their rights and responsibilities
- providing non-personal information about the consumer's mental health condition, treatment and ongoing care
- actively seeking information from carers in relation to the consumer's condition during assessment, treatment and ongoing care and recording that information in the consumer's health record
- engaging carers in discharge planning prior to discharge from all episodes of care.

Source: Australian Government (2010).

Mental health services can enable and promote carer-inclusive practice by providing training to their staff and through organisational policies and procedures. This includes processes for identifying a consumer's carers and documenting whether consent to share information has been granted to them by the consumer.

Mental health professionals should possess the attitude and skill to understand and be responsive to carers' rights specified under each State's and Territory's mental health legislation. In certain circumstances, mental health professionals are obliged to share information with carers. For example, the *Mental Health Act 2014* (Vic) includes specific obligations for service providers to consult with and inform carers when a consumer is subject to compulsory treatment. The *Mental Health Act 2007* (NSW) enables consumers to nominate up to two 'designated carers' and gives these carers rights. If no carer is nominated by the consumer, then the designated carer can be assumed in some cases (such as spouses of consumers).

Several State and Territory Governments have prepared guidelines to describe mental health services' responsibilities to families and carers under mental health legislation, and to assist them to put it into practice. Examples include: the Victorian Chief Psychiatrist (2018) guideline for working with families and carers; Queensland Health's (nd, ndb) fact sheets on information sharing and rights of family under the *Mental Health Act 2016* (Qld); and the South Australian Office of the Chief Psychiatrist's (2017) plain language guide to the *Mental Health Act 2009* (SA).

In addition to technical knowledge, mental health professionals also need to develop ways of working effectively with carers and consumers to enable carers to be included and supported. Inquiry participants commented on the scope to improve the skills and confidence of clinicians to engage with carers (ADACAS, Canberra transcript, p. 63; Arafmi, Brisbane transcript, p. 96).

Many participants promoted the use of *A Practical Guide for Working with Carers of People with a Mental Illness* (Arafmi, Brisbane transcript, p. 94; Carers Tasmania, sub. 660; HelpingMinds, sub. 470; MHCA, sub. 898; MHFFTas, sub. 648; Mind Australia, Melbourne transcript, p. 36; Private Mental Health Consumer Carer Network (Australia), sub. 550). This guide provided examples of strategies that staff might use to help identify carers and share information with them:

Asking “who are your carers?” rarely receives a positive outcome. ... If you work in an acute inpatient unit, you might say “Your husband/wife/partner brought you to hospital today. They seem very concerned about you. Would it be okay to nominate them as your primary carer? We will agree what information you feel comfortable sharing with them. It seems like they will be important to have involved in any plans we make.” (Mind Australia et al. 2016, p. 19)

This guidance is accompanied by free online training modules and a mobile application to help individuals and organisations to improve their skills and complete the self-assessment against the guide’s Partnership Standards, and to allow organisations to access reports that describe how well it is implementing the standards (Private Mental Health Consumer Carer Network, sub. 550).

It is important to make sure that consumer preferences about information sharing with carers are both actively sought, documented, and acted upon. There are many options available and each service will need to have its own policies and procedures for this. One option is attaching a carer nomination form to admission forms, such as the one included in the appendix of *A Practical Guide for Working with Carers of People with a Mental Illness* (Mind Australia et al. 2016). Alternatively, if the service is using electronic medical records, equivalent fields for nominating carers and sharing information could be added to this system.

The best option may depend on the relevant provisions in state and territory mental health legislation. For example, the Queensland Mental Health Act requires the chief psychiatrist to maintain electronic records of advance health directives and appointments of nominated support persons. Some other State and Territory Governments, including New South Wales, Victoria and South Australia, have prepared forms that enable carers to be nominated in line with their legislation (NSW Health nd; SA Health 2017; Victorian Government 2014).

Each mental health service’s procedures should also cater to cases where consumers have nominated their carer in advance. ACT Disability, Aged and Carer Advocacy Service (Canberra transcript, p. 61) stated that supported decision making is a good frame through which to improve information sharing with carers. Mental Health Carers NSW (sub. 1231, p. 9) noted that for ‘individuals with fluctuating decision-making capacity due to mental ill-health, services should support them to prepare an advance care directive which outlines their wishes regarding how personal information should be shared when they are very

unwell'. Arafmi (Brisbane transcript, p. 96) and Alicia Boyd (Sydney transcript, p. 182), a carer, also considered advance directives would be a useful tool to enable information sharing with carers.

Legal documents for supported decision making are called different things in different States and Territories — including Advance Care Plans, Advance Statements, and Advance Health Directives. Consumers who go to the effort of preparing these legal documents should be able to expect that clinicians will at least attempt to abide by them. The Mental Health Legal Centre (Melbourne transcript, pp. 169, 172) described how it supports people to create concise Advance Statements and works with mental health services to encourage their use. Advance care plans can also be uploaded to a person's My Health Record (ADHA 2019).

The Productivity Commission is proposing ways to improve the take-up and use of advance directives, statements or agreements, including more help with creating these documents, formal recognition of them in mental health legislation and making them more easily accessible by any mental health service (action 21.10).

Greater use of care coordination services and adoption of single care plans for people with severe mental illness may also help with identifying carers and keeping track of requests and decisions related to consent to share information (recommendation 15).

Encouraging change by improving transparency about service quality

Several Inquiry participants suggested that there should be stronger regulatory requirements to mandate carer-inclusive practice (Carers Tasmania, sub. 660; HelpingMinds, Geraldton transcript, p. 7; MHCN, sub. 1231; MHFF Tas, sub. 648; MHV, sub. 580, att. 1; Mind Australia et al., sub. 1212).

... we're told time and time again, "We'd love to do it, but we're just too busy." (MHCA, Canberra transcript, p. 25)

Many mental health services are already subject to quality standards related to carer-inclusive practice, either under Standard 7 of the National Standards for Mental Health Services (NSMHS) (box 18.3) or the National Safety and Quality Health Service (NSQHS) Standards (ACSQHC 2018b; COAG Health Council 2017a). Although the NSQHS Standards are less explicit about facilitating information sharing with carers than the NSMHS, several of the actions in the Partnering with Consumers and Comprehensive Care Standards include carers (ACSQHC 2017b).

Despite this, the experiences reported by carers (box 18.2) suggest that some services are not meeting these standards. The Productivity Commission has considered what else can be done to encourage improvements and is recommending greater monitoring and reporting of how well services are providing carer-inclusive practice. Fortunately, the first steps have already been taken to enable this. Under action 23 of the Fifth National Mental Health and Suicide Prevention Plan, State and Territory Governments agreed to implement surveys for monitoring consumer and carer experiences of care by 2021 (COAG Health Council 2017b).

These surveys have been developed by the Australian Mental Health Outcomes and Classification Network and are known as the Your Experience of Service (YES) survey for consumers and the Carer Experience Survey (CES) (AMHOCN 2019c).

The CES survey was designed for inpatient and community state and territory mental healthcare services. The survey includes questions to carers about whether they were identified as a carer and ‘given opportunities to discuss the care, treatment and recovery of your family member, partner or friend (even, if for reasons of confidentiality, you could not be told specific information)’ (AMHOCN 2016, p. 1). Inquiry participants supported the national implementation of the CES (Carers Victoria, sub. 664; Mental Health Complaints Commissioner, sub. 916; NMHC, sub. 949; St Vincent’s Mental Health Family and Carer Reference Committee, sub. 1193).

Collecting surveys from carers is not new — the Australian Institute of Health and Welfare reported that carer satisfaction surveys were used in 67% of specialised mental health service organisations in 2017-18 (AIHW 2020h, table FAC.10). However, the design of the CES built upon previous surveys. It was co-designed with carers, consumers and clinicians nationally; trialled, tested and improved upon; and found to be highly regarded by carers and to perform well and reliably (AMHOCN 2017). Moreover, carer experience survey collection and use has not been systematic in the past. What is missing is widespread collection of a nationally consistent survey, transparent reporting and benchmarking of results to encourage behaviour and culture change in services.

Except for Queensland and New South Wales, most State and Territory Governments were not yet collecting responses to this survey from carers as of April 2020 (Queensland Health 2019b). The Australian Mental Health Outcomes and Classification Network, which is working on the development of a range of resources to support implementation and the use of results, stated that all jurisdictional representatives expressed an ongoing commitment to measuring and reporting the CES (AMHOCN 2019a).

The New South Wales Government implemented the paper-based version of the survey in its services in 2018 and released an online version in 2019, which is available in 26 languages (Mental Health Carers NSW 2018; NSW Government 2020). A range of reports have been developed to enable team managers and directors within the Local Health Districts to assess their performance against the survey results over time and compared to other services (when and where the number of surveys collected is sufficient) (NSW Ministry of Health, pers. comm., 24 February 2020).

The CES should be collected routinely by services and results should be used to drive continuous improvement in carer-inclusive practice. Greater use of and reporting against the CES would improve incentives for staff to identify carers and work in partnership with them. This is consistent with action 24.5 where the Productivity Commission is proposing that the Australian Institute of Health and Welfare provides more of its reporting at the regional level. In addition, reports describing detailed results should be developed for service managers to enable them to monitor and improve practices over time.

Services with good practices in place would have this reflected in their CES results and this can count towards their next NSQHS or NSMHS assessment. It is possible that the CES results may identify shortcomings in carer-inclusive practice that relate to a service's culture rather than the absence of procedures and training opportunities. Promoting a carer-inclusive culture may take time but increasing transparency about the status of services is a first step to encourage change and improve outcomes for consumers and carers.

How services improve their practices in response to below average results should be determined in consultation with carers, as per Standard 3 of the NSMHS, which relates to consumer and carer participation.

Family-inclusive practice

Family-inclusive practice requires mental health services to consider the needs of family members and the role of a person's family in their recovery. People who may need support include spouses, siblings or parents. Two elements of a more family-focused mental health system are discussed below — support for families where a parent has mental illness and family interventions.

Families where a parent has mental illness

Inquiry participants described the importance of mental health services identifying consumers who are parents with dependent children, and taking this into account in supporting recovery and the family's wellbeing.

In terms of prevention ... the importance of family recovery and supporting parents who are living with mental health issues to ensure that the family can stay well and people can stay living with their families ... (WAAMH, Perth transcript, p. 86)

We should have a system ... that there's active outreach and engagement with parents and not a presumption that we don't want these services for our children. ... there are discrimination issues about parents with serious mental illness lacking the insight to want better for their children ... (Helena Willan, Brisbane transcript, p. 14)

To improve the wellbeing of the whole family, mental health professionals may need certain skills to work sensitively with their clients who are parents. For example, parents may anticipate stigma associated with being a parent with mental illness or fear intervention by child protection departments (Cuff 2019). Maybery et al. (2014) found that skills, knowledge and confidence to provide family-inclusive practice when treating a parent with mental illness varied between psychiatric nurses, social workers and psychologists.

As with carer-inclusive practice, guidance and training to improve practice in this area exists for those who seek it out, but a focus on family is not embedded in all mental health services.

The Australian Government funded Emerging Minds to implement the Children of Parents with a Mental Illness initiative from 2001 to 2017 (Emerging Minds, sub. 944). This work

produced evidence-based resources and guidance that aimed to improve outcomes for children of parents with mental illness. The Children of Parents with a Mental Illness website has information and resources, which are targeted separately to parents, children and young people, family and friends, and professionals (Emerging Minds 2016). Emerging Minds continues to produce resources to assist health professionals with family-inclusive practice as part of its broader work program (for example, Emerging Minds 2019).

In addition, policy and procedures are needed at the organisational level. Emerging Minds (sub. 944) suggested a need for clear pathways of support between adult mental health services and relevant child health, mental health, and parent support services. Reupert et al. (2012, p. 9) stated that it:

... is imperative that there are procedures to identify the parenting status of patients, to screen for competence in various domains (parenting, child wellbeing and family dynamics) and, at a minimum, to refer parents and/or children to appropriate services if required.

Progress in supporting families where a parent has mental illness in mental health services is evident in some States and Territories (box 18.4).

Box 18.4 Examples of efforts to improve family-inclusive practice

The Victorian Government commenced the Families where A Parent has a Mental Illness (FAPMI) strategy in 2007 to reduce the effects of parental mental illness on all family members, particularly dependent children. The strategy includes employing local FAPMI coordinators in each catchment area. FAPMI coordinator tasks include 'building capacity of the mental health workforce and partner agencies through education and training, referral pathways and procedure development to improve identification and support for parents and their children' (Falkov et al. 2016, p. 183). The FAPMI strategy has been statewide since 2016.

The *New South Wales Children of Parents with a Mental Illness (COPMI) Framework* sets directions for its mental health services, such as the provision of services for families, strengthening the capacity of interagency partners and supporting the workforce to provide family-inclusive practice (NSW Health 2010). It provides detailed instructions on ways to achieve the directions, including the use of COPMI coordinators. The NSW COPMI initiative has since been renamed Family Focused Recovery (NSW Government, sub. 551).

The Queensland Government has also produced a guideline for working with parents with mental illness and the ACT Government has a COPMI families policy (ACT Health 2013; Queensland Health 2010).

A targeted preliminary evaluation of the Victorian Government's Families where A Parent has a Mental Illness (FAPMI) strategy was completed in 2012. It compared two catchment areas with a FAPMI coordinator with two catchment areas without a FAPMI coordinator (Maybery et al. 2012). The evaluation found that adult mental health clinicians in the catchment areas with a FAPMI coordinator provided more family-inclusive practice. These clinicians had greater skills and knowledge regarding the effects of parental mental illness on children and were better able to provide referrals to family support services. In catchments

with a FAPMI coordinator, the staff of mental health services and family support services had greater access to secondary consultations, resources and training related to FAPMI.

The Victorian Government also funded a trial and research project for the ‘Let’s Talk about Children’ program. The program is an evidenced-based 2 to 3 session, psycho-educational intervention designed for parents with mental illness, where mental health professionals are trained to have conversations that empower consumers as parents and support their families (Allchin et al. 2020; Solantaus et al. 2010). It was trialled at 11 mental health and family support services in Victoria and is being rolled out elsewhere in the State (Monash University 2016; The Bouverie Centre 2019).

Beyond clinical services, psychosocial support services may be in a good position to assess family context and needs:

... every time a [psychosocial support] team member is going ... to do an intake process we identify who is around — you know, are there young children in the house, are other people, family members within the house, and look at [what] are the needs ... (HelpingMinds, Geraldton transcript, p. 12)

The Productivity Commission has identified a need for clearer policy responsibilities and better service planning for psychosocial supports at the State and Territory Government level (chapter 17). The role of family assessments and family support for people with psychosocial disability could be considered as part of this.

Family interventions and inclusion in care discussions

The process of identifying families and carers, and assessing their needs, is the minimum level of care that should be offered to all families and carers of people accessing mental health services but some families will have greater needs (Mottaghipour and Bickerton 2005). Family interventions may be needed, including psycho-education, carer or family consultations, family or relationship counselling, or family therapy. Psycho-education aims to provide carers with problem solving and coping strategies to help them be effective in their caring role or improve family functioning. Psycho-education may be provided to a carer by the care recipient’s clinician but is often delivered as part of a structured program, and as such, is discussed in section 18.3. This section focuses on consultations, counselling and family therapy.

Family interventions have been shown to be an effective way to improve outcomes for many consumers, carers and families affected by mental illness. For example:

- the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia note that the evidence base for family interventions for schizophrenia is strong (Galletly et al. 2016)
- behavioural family therapy programs for schizophrenia reduce carer burden and improve consumer mental health (Macleod, Elliott and Brown 2011)

-
- a systematic review of family interventions as an adjunct to treatment for bipolar disorder was found to be effective for patients and carers (Reinares et al. 2016)
 - results from two randomised control trials showed that family therapy as part of treatment for anorexia nervosa may be more effective than individual treatment in the short term at least (Fisher, Hetrick and Rushford 2010)
 - family-based models of care are among the most effective approaches for treating both adults and adolescents with drug problems (Rowe 2012).

For children and adolescents, family interventions are effective for a range of mental health problems (Carr 2018). The Centre for Excellence in Child and Family Welfare (sub. 211) stated that the best interventions for children with emotional and behavioural needs are holistic, family-centred supports.

The National Mental Health Service Planning Framework (NMHSPF) provides a benchmark of community need for mental health services across Australia.¹⁹⁰ This model makes provision for \$185 million worth of structured psychological therapies (such as psycho-education counselling and family therapy) for carers and other family members of people with mental illness in 2019-20 nationally.

The aim of family interventions varies but is typically to meet the needs of the consumer or the carer, or to improve family functioning and relationships. For example, support for families to work through family conflict and strengthen relationships can help with a consumer's recovery.

... social inclusion is trying to reconnect with family members that have been disengaged because of the illness and try and connect with those support networks and mediate those support networks ... (Anglicare Central Queensland, Rockhampton transcript, p. 43)

Without peoples' links to culture and community, and without positive connections with family and friends, people's self-esteem, resilience and sense of individual and collective identity may suffer, to the detriment of their mental health and wellbeing. (Victorian Government 2019a, p. 23)

Given that family relationships are an important determinant of health for Aboriginal and Torres Strait Islander people, this type of support may be particularly important for Aboriginal and Torres Strait Islander people's social and emotional wellbeing. To be effective, services also need to be culturally capable. For example, the Bouverie Centre (sub. 719) developed a family therapy service tailored to the needs of Aboriginal families in Victoria and provides postgraduate training in family therapy for Aboriginal and/or Torres Strait Islander Workers.

¹⁹⁰ The NMHSPF was initially developed by the NSW and Queensland Governments and is being revised by the University of Queensland, with funding from the Australian, State and Territory Governments, to quantify the level and mix of mental health services needed to meet the needs of Australia's population. NMHSPF national estimates of services costs are indicative only, and require adjustments to wages by the jurisdiction or service using the planning support tool.

Family therapy, when delivered by a specially qualified family therapist, is on the higher end of the family intervention spectrum in terms of complexity of needs and intensity of the intervention (Mottaghipour and Bickerton 2005). In addition to highly qualified practitioners, family therapy often requires a significant commitment and motivation from the participants due to the number of sessions and long-term nature of the intervention.

Several Inquiry participants discussed the benefits of family and carer consultations, provided as a brief intervention. The Bouverie Centre (sub. 719) promoted the use of Single Session Family Consultation and noted that is relatively straightforward model for private practitioners with little training in family work. Some of the settings where this model has been used include some Child and Adolescent Mental Health Services in Victoria, Tasmania and the ACT, and a trial within headspace centres (Fry 2012). An evaluation of the headspace trial described positive reports from clinicians, consumers and families (Poon et al. 2019). headspace Geraldton (sub. 617) stated that Single Session Family Consultation sessions can often be a fast way to address some issues in families and bring about positive change.

Inquiry participants described the importance of meetings between clinicians and carers, to share their views and ask questions.

It's the lack of 'me' time that is concerning ... you must afford 'me' the time to validate and clarify any embellishments or skewed reality that my daughter articulates. It also gives me the opportunity to discuss my feelings, views and understanding with respect to treatment, progress and prognosis. (Name withheld, sub. 392, p. 22)

[There is] limited scope for case management meetings ... GP's, Psychologists and Psychiatrists should be provided with Medicare codes to undertake case management meetings, more extensive communications with other professionals, and patient 'decision making' meetings (with their Advocates). (Robert Davis, sub. 133, pp. 8, 19)

However, Inquiry participants also described the barriers to accessing family interventions. Relationships Australia (sub. 103) stated that there is under-recognition of the value of family therapies. Limited funding was also a concern. Orygen and headspace (sub. 204, p. 36) stated that 'support of families is critical in young people's treatment, yet there is no funding stream to support their involvement in treatment'. And Mental Health Australia (sub. 864) stated that funding models tend to focus on individual interventions. The other main barrier is skills; professionals have low confidence or reluctance in delivering family interventions due to lack of training (Emerging Minds, sub. 944; The Bouverie Centre, sub. 719).

Family-based intervention is more difficult than intervention with individuals, because there is more complexity in the transactions ... Family therapy has long demonstrated its capacity to find workable problem solutions in less time. But there needs to be a change in practitioner mind set ... Most post-graduate courses do not provide adequate training in family-based responding and intervening. (MHYF Vic, sub. 628, p. 6)

Increasing access to funding for family interventions

For services reliant on MBS rebates, there is need to amend the MBS to better accommodate work with families and carers. The Australian Government should provide MBS rebates for family interventions, both with and without the presence of the family member receiving treatment for mental ill-health.

The MBS has items that support consultations between psychiatrists and carers without care recipients present, but there is no equivalent for psychologists.¹⁹¹ Claims for these items have increased significantly over the past 10 years (unpublished MBS data and RANZCP 2018). Psychiatrists claimed each of these items for between 15 500 and 25 000 people in 2018-19 and total benefits paid was \$10.6 million (unpublished MBS data). Nearly 40% of these consultations related to patients under the age of 25 years (RANZCP 2018).

The Bouverie Centre (sub. 719, p. 2) stated that funding for relevant non-patients would provide ‘access to much needed support for families in circumstances where the care recipient may not be agreeable to family participation in sessions’. Melbourne Children’s Campus (sub. 927, p. 21) noted that this is ‘particularly pertinent for young children with mental health problems where the most effective approaches are through moderating the parenting styles which necessarily requires one on one work with parents, not the child’.

The MBS Review Mental Health Reference Group (2018) stated that sessions for carers were a fundamental element of evidence-based best practice and that they would enhance collaboration and recognition of carers. Their draft report recommended that a new family and carer MBS item should be created for psychologists and allied mental health professionals, with a four-session limit per year. The Queensland Mental Health Commission (sub. 228) supported this recommendation by the Mental Health Reference Group and the Australian Psychological Society made the same recommendation (APS 2019).

The Productivity Commission agrees. A limit of four sessions per 12 month period is proposed due to the precedent set by the existing MBS items for psychiatrists. However, the next time there is an MBS review, the limit should be aligned with the latest evidence about what works to improve outcomes for consumers, families and carers. The average number of consultations per patient in 2018-19 was fewer than two for the existing MBS items (unpublished MBS data). However, a four session limit may be insufficient for some clients:

Working in this collaborative manner with carers has been stipulated as a basic requirement, particularly in the field of child and adolescent psychiatry, and intellectual and developmental disability psychiatry and geriatric psychiatry, and usually requires separate interview time at each substantial consultation. (RANZCP 2018, pp. 11–12)

¹⁹¹ MBS item numbers 348, 350 and 352 allow psychiatrists to consult with non-patients (including carers and multidisciplinary clinicians) (DoH 2020b). Rebated sessions are unlimited if undertaken in the course of initial diagnostic evaluation (first month) and limited to four sessions per year thereafter.

The second change the Productivity Commission is proposing is to expand access to family interventions under the MBS when both the consumer and their family are present. MBS-rebated sessions with the consumer and family present can be provided by medical practitioners and clinical psychologists.¹⁹² However, registered psychologists and other allied mental health professionals may only provide family interventions that align with the list of acceptable psychological strategies approved for MBS rebates, such as psycho-education or parent management training (DoH 2019d).¹⁹³ Orygen (sub. 1110) suggested a need for a dedicated MBS item for single-session family consultations. The MBS Review Mental Health Reference Group (2018) recommended adding family interventions to the list of approved interventions that can be delivered by allied health professionals. The Productivity Commission agrees with this recommendation.

Workforce capacity for family- and carer-inclusive practices

For state and territory specialised mental health services, funding should be available in each region to ensure that dedicated staff have the time and resources to develop family- and carer-inclusive practices. These staff would balance dual roles; building greater capacity within services and supporting families and carers directly where needed. They would promote training opportunities for family- and carer-inclusive practices as well as advising managers about organisational changes, such as the introduction of carer nomination forms. Each State and Territory Government should determine whether staff are based in hospital or community settings, or within a regional commissioning body.

Although all mental health services should have this capacity, the proposed action focuses on supporting improvements in the same community and inpatient services required to collect the Carer Experience Survey. As results from the CES provide greater transparency about areas for improvement, these staff will promote improved practices on the ground.

Given the evidence of improved family-inclusive practice in Victoria, services should have identified people with responsibility for coordinating support and training to staff working with families where a parent has mental illness. This view was supported by the Victorian Mental Health Complaints Commissioner (sub. 916). These coordinators would: work with mental health professionals who seek advice about how best to support the families of their patients; assist with service referral; and improve networks with other relevant agencies.

Some services already adopt elements of the proposed approach. In New South Wales, \$2.3 million was provided to Local Health Districts in 2018-19 to improve family- and carer-inclusive practices as part of its Family and Carer Mental Health Program (NSW Ministry of Health, pers. comm., 22 July 2019). How this funding is spent is determined by

¹⁹² Medical practitioners may provide family therapy under items 170, 171, 172, 342, 344 and 346. Clinical psychologists providing psychological therapy under items 80000 to 80021 may use any clinically relevant evidenced-based therapies (DoH 2019d, p. 42).

¹⁹³ The range of acceptable strategies are: psycho-education; cognitive-behavioural therapy; relaxation strategies; skills training, including parent management training; interpersonal therapy; and narrative therapy (DoH 2019d, p. 49).

each Local Health District, but some services have used it to employ staff to support the skills and knowledge of other mental health professionals. Mental Health Carers NSW (Sydney transcript, p. 101; sub. 1231) stated that the use of family and carer workers has driven quality improvement related to family and carer engagement within those districts.

South Australia has carer consultants supporting carers in its public mental health services. Sarah Sutton (sub. 737), a carer of two brothers with schizophrenia, stated that carer consultants provide support with navigation, information about their rights and emotional support, and are particularly important for those who are new to a service. She emphasised the importance of lived experience for people in these roles and would like carer consultants employed in all mental health services.

Carer peer workers should be considered to fill dedicated roles when services have opportunities to recruit new staff. Carer peer workers use their experience of caring for someone with mental illness in providing support to other carers. The use of carer peer workers in specialised mental healthcare services is highly variable within and across States and Territories (table 18.3). Victoria and Queensland more commonly employ carer peer workers in specialised mental health facilities, but a number of other States also employ carer peer workers. Several Inquiry participants supported the use of carer peer workers in mental health services to promote carer-inclusive practice (Anne Barbara, sub. 910; Mind Australia, Melbourne transcript, p. 35; MHCN, Sydney transcript, p. 97; St Vincent's Mental Health Family and Carer Reference Committee, sub. 1193).

A carer peer workforce harnesses and validates the lived experience of carers, and uses their unique skill set ... to complement the clinical staff skill set, allowing for a stronger caring team (MHFFtas, sub. 648, p. 6)

Table 18.3 Carer peer workers employed in state and territory specialised mental healthcare facilities, 2017-18^a

<i>State or Territory</i>	<i>Count of FTE carer peer workers</i>	<i>FTE carer peer workers per 100 000 people in the population</i>	<i>% of specialised mental health service organisations employing at least one mental health carer</i>
New South Wales	3	—	11
Victoria	35	0.6	55
Queensland	24	0.5	45
South Australia	5	0.3	57
Western Australia	1	—	3
Tasmania	1	0.1	27
Northern Territory	0	0.0	0
ACT	0	0.0	0
Australia	69	0.3	27

^a Carer peer workers are defined as persons employed specifically for their expertise developed from their lived experience as a mental health carer. Carer peer workers employed in the community managed sector are not included. — rounded to zero.

Source: AIHW (2020h, tables FAC.34, FAC.36 and FAC.5).

Chapter 16 describes ways to support the effectiveness and growth of the peer workforce, including by improving their access to professional development, and professional supervision and support.

The costs and benefits of reform

The cost of the recommended reforms to improve family- and carer-inclusive practices is estimated to be \$74 million to \$102 million in the first year and \$73 million to \$101 million per year thereafter. This was estimated based on:

- approximately \$900 000 for one FTE senior project officer for one year to support the implementation of the Carer Experience Survey in each State and Territory, except New South Wales
- \$10–\$23 million per year for MBS-rebated family and carer consultations without the care recipient present
- \$4–\$10 million per year for MBS-rebated family and carer consultations provided by registered psychologists and other allied health professionals to provide family and carer consultations with the care recipient present
- \$60–\$68 million per year for family and carer workers based in each region, comprising:
 - \$26–\$29 million per year for additional peer workers
 - \$20–\$24 million per year for manager-level staff
 - \$14–\$16 million per year for coordinators for families where a parent has mental illness (except in Victoria, which already has them).

Assumptions behind these calculations are described in appendixes I and K. The combined benefits of reform were calculated once for both actions 18.1 and 18.2. These actions are expected to improve the mental health of carers, care recipients and children of parents with mental illness, and are likely to provide net benefits to the community (through increased incomes and cost-savings). For example, the modelling results show that family interventions provided as part of treatment for people with schizophrenia and other psychoses would reduce government expenditure by \$40–\$73 million per year as a result of reduced hospital admissions and emergency department presentations (appendix K).

ACTION 18.1 — FAMILY- AND CARER-INCLUSIVE PRACTICES

Family- and carer-inclusive practices require mental health services to consider family members' and carers' needs, and their role in contributing to the recovery of individuals with mental illness. This includes children in families affected by mental illness.

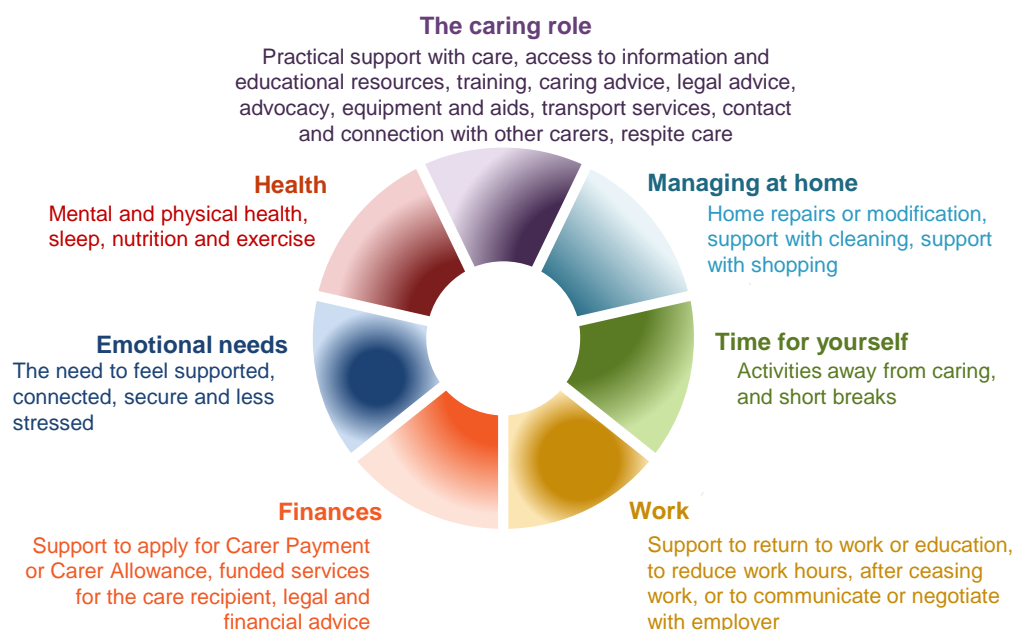
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- Where this is not already occurring, state and territory community and inpatient mental healthcare services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient to enable benchmarking and to provide services with evidence of their compliance against the related sections of the National Standards for Mental Health Services and the National Safety and Quality Health Service Standards.
- The Australian Institute of Health and Welfare should use the data to report annually on survey collection rates and carer experiences at the regional level.
- The Australian Government should amend the Medicare Benefits Schedule so that family interventions provided by psychologists and other allied mental health professionals are rebated.
 - Family and carer consultations with the consumer present should count towards session limits for psychological therapy.
 - Family and carer consultations without the consumer present should be limited to four per 12 month period.
- State and Territory Governments should, over time, work towards ensuring the workforce capacity exists in each region to implement family- and carer-inclusive practices within State and Territory community and inpatient mental healthcare services. These services should identify people with responsibility for:
 - supporting family and carer participation in co-design and service improvement processes
 - providing and supervising carer peer work within mental healthcare services
 - providing advice to clinicians and managers about how to improve family- and carer-inclusive practices
 - facilitating training opportunities to improve family- and carer-inclusive practices
 - promoting the use of effective family interventions.

18.3 Family and carer support services

Given the challenges faced by some carers (section 18.1), carers may need support services to help them achieve their goals and meet their needs. The Australian Government Department of Social Services (DSS) has classified a range of carer needs according to the areas of life in which carers most typically need support (figure 18.4).

Figure 18.4 Carers have a range of support needs



Source: based on DSS (2018g).

Services for carers are provided by non-government organisations (NGOs), for-profit providers and state and territory specialised mental health services. Some NGOs are carer-specific service providers and others are providers of psychosocial supports. Services are mostly government funded, but some are also funded from private donations and consumer charges (MHCN, sub. 245). Funding for carer support services has long been provided by both the Australian Government and State and Territory Governments.

Inquiry participants described how carer support services are valued by those who use them.

I have found [organisations like ACT Carers] to be the most useful source of information and support, especially the educational workshops, access to counselling and respite care they provide to carers of loved ones with mental health issues. (Name withheld, sub. 104, p. 2)

Since Oct 2015, BPD Community has had a Family & Friend's Group meeting monthly. ... The quarterly report for 2019 indicates a usefulness of the sessions at 90%, 98% indicated they felt more confident, 99% felt supported and 78% reported an improvement in their relationship with their loved one with BPD [borderline personality disorder]. (BPD Community, sub. 74, p. 6)

It wasn't long before my health was affected. After several biopsies, I am a survivor, building up resilience thanks to the carer support connection, education and respite I used to benefit tremendously from, leading to my now volunteer advocacy position. (MHCN, sub. 245, p. 9)

There is good evidence that demonstrates the effectiveness of specific interventions for families and carers, particularly psycho-education (box 18.5). However, there are few publicly available evaluations of the programs run in Australia. Therefore, it is not clear the extent to which the mix of services available here is effective and aligns with best practice.

Box 18.5 Evidence of the effectiveness of carer support services

A review of the evidence base for psycho-education concluded that multifamily psycho-education groups were 'associated with significantly improved problem-solving ability and a reduced burden on families, compared with control groups, among other strong outcome effects' (Lyman et al. 2014, p. 416).

A randomised control trial of a structured group psycho-education and skill development program for carers of people with borderline personality disorder demonstrated that this intervention improved family relationships and carer empowerment (Grenyer et al. 2019). The program participants valued the peer support they gained by meeting and interacting with other carers. The mental health of participants in the intervention improved in the 12 months that followed.

A randomised control trial evaluated the efficacy of a brief version of an existing psycho-education program for carers of people with an eating disorder, and found that it reduced carer burden, and improved self-efficacy, skills and knowledge (McEvoy et al. 2019).

Young people aged 13 to 17 years who nominated caring adults to support them following suicidal ideation or attempt as part of the Youth-Nominated Support Team program were significantly less likely to die in the 14 years that followed, compared with a control group (King et al. 2019). Nominated carers were provided with psycho-education and weekly support by telephone.

A review of what works for mental health nurses in supporting carers of people with schizophrenia found that supportive family education reduced carer burden and that there was some evidence that peer support groups reduced burden and improved coping (Macleod, Elliott and Brown 2011).

A carer peer worker-led group psycho-education and skills-building program in the United Kingdom resulted in statistically significant improvements in carer mental wellbeing, carer burden and family empowerment based on surveys of the 60 carers who completed the program (Chiocchi et al. 2019).

A meta-analysis of various interventions for carers of people with eating disorders reported that most interventions reduced carer distress and burden (Hibbs et al. 2015).

Australian Government funded services

Carer support services funded by DSS are in transition. Six programs providing carer support services have ceased and been replaced with the new Integrated Carer Support Service (ICSS) and funding from another two programs has been redirected into the NDIS (DSS 2018n, 2019j).¹⁹⁴ Once transition is complete, total funding of the ICSS is expected to be \$134 million in 2020-21 and then increase to \$143 million in 2021-22 (DSS 2019d, p. 3).

¹⁹⁴ Funding from an additional program, the Young Carers Respite and Information Services program, is transitioning in part to the ICSS and in part to the NDIS.

All services funded under the ICSS are delivered through the Carer Gateway. The Carer Gateway website and phone line provides a service entry point, as well as digital services such as information about caring, phone counselling, self-guided coaching and online skills courses. For face-to-face services, a lead Carer Gateway provider has been selected for 16 regions that span the country. Ten lead organisations and their consortium partners commenced delivery of these services in April 2020, including carer support planning; tailored support packages; in-person counselling, peer support and coaching; and emergency respite care (Ruston 2019).

The ICSS was designed through consultation with carers, and has an outcomes-based needs assessment, and monitoring and evaluation framework (DSS 2018g, 2018j). Each carer seeking assistance will work with a Carer Gateway provider to record a snapshot of their goals and needs, using a tool developed in the United Kingdom called the Carers Star that covers the areas of life described in figure 18.4. This then informs service planning — the carer's Action Plan might include a mix of Carer Gateway services and other services that the support worker helps to coordinate. Service providers are required to collect data on the wellbeing of carers before and after they receive support, and this enables monitoring and evaluation of the outcomes achieved for carers over time (DSS 2019f).

Although Inquiry participants see the ICSS as a promising development, some were tentative about what the ICSS and NDIS transition means for mental health carers.

... a lot of work went into creating that and a lot of consultation with carers and it's probably going to work quite well ... (Sjon Kraan, Perth transcript, p. 30)

The Department of Social Services has undertaken one of the most extensive consultation processes in its history to co-design the Integrated Carer Support Service (ICSS), which will trade as the Carer Gateway. ... for the first time, unpaid, informal carers will access supports through a single front door, namely a single 1800 number and website. (Carers Tasmania, sub. 660, p. 11)

The integrated carer support service ... is a good concept, however, ... our financial modelling shows the amount of services available through the allocated funding will not provide sufficient services to mental health carers ... (HelpingMinds, Geraldton transcript, p. 7)

One of the programs that is being wound up due to the transition to the ICSS and NDIS — the Mental Health Respite: Carer Support — was just for mental health carers, whereas most of the other programs were for a broader range of carers or young carers. The Mental Health Respite: Carer Support program provided mental health carers with relief from caring through in-home or out-of-home respite or social and recreational activities, counselling, practical assistance, case management, education and information (DSS 2019f). Approximately 41 000 carers were supported by the program in 2014-15 and \$64 million was allocated to the program in 2015-16 (DSS 2016c). Funding reduced each year thereafter as it was progressively transitioned over five years to the NDIS (DSS 2018f).

Having one comprehensive program for all carers, rather than many targeted programs, is likely to give service providers more flexibility to be responsive to carers' individual needs and prioritise carers most in need. However, the Mental Illness Fellowship of Australia (sub. 343) expressed concern about the Mental Health Respite: Carer Support program ceasing and submitted that funding specifically for mental health carers should continue.

Some of the services that were available under the Mental Health Respite: Carer Support program will be available under the NDIS, for those people who qualify for the NDIS and choose supports for their carer as part of their plan. Supports funded under the NDIS that may give carers a break from caring include short-term accommodation, personal care supports provided in the home and community-based activities (DSS 2018k). The NDIS also funds services that can build a carer's skills related to caring. The NDIS provided \$1.2 million in 2018-19 to train carers and parents of people with primary psychosocial disability, predominately for training in behaviour management strategies (National Disability Insurance Agency, pers. comm., 8 August 2019).

However, Inquiry participants reported that the number of services providing support for mental health carers has reduced and that the types of services provided has changed (Anglicare Sydney, sub. 190; cohealth, sub. 231; LMMHCN, sub. 52; Mind Australia, sub. 380; One Door Mental Health, sub. 108; Tandem, sub. 502). Further, some State and Territory Government funding decisions relating to carer support services have been altered as a result of the transition to the NDIS. For example, the Queensland Department of Communities, Disability Services and Seniors transferred some of its funding for carer support services to the NDIS from 1 July 2019 (State and Territory Governments Survey).

Inquiry participants were also concerned that the NDIS' focus on the choice and control of individuals with disability, rather than carers, would result in unmet needs for carers (MHCA, sub. 489; MHFFTas, sub. 391; Mind Australia, sub. 380; One Door Mental Health, sub. 108). Support for carers is included within NDIS guidelines, but there is no formal assessment of carers' needs undertaken as part of the assessment process (PC 2017c).

In response to feedback for Mental Health Carers Australia and others, the National Disability Insurance Agency is working to introduce the psychosocial stream pathway to better support with people with psychosocial disability and their carers (chapter 17).

State and Territory Government funded services

State and Territory Governments fund services that support carers of people with mental illness. State and Territory Government expenditure on mental health family and carer support services delivered by NGOs totalled \$20.3 million in 2017-18 (a 17% decrease on the previous year in 2018 dollars) (Productivity Commission estimate based on AIHW 2020c, table EXP.16).

This figure underestimates total State and Territory funding for mental health carer support services for two reasons. First, as this measure only includes NGOs; it would not include services delivered by state and territory government mental health services or for-profit providers. Second, this amount does not include programs funded for a broader range of carers (not just mental health carers). For example the Victorian Government has committed approximately \$12 million per year for four years from 2019-20 for additional respite services (Andrews 2018; Carers Victoria 2019). The Productivity Commission was not able to determine the share of funding for mental health carers from these sorts of programs.

In addition to estimating community need for carer support services, the NMHSPF also estimates the amount of family support services needed in the community for families affected by mental illness. In scope within this planning framework are:

- support services for children in families affected by mental illness
- other family support services, such as family mediation and family-oriented counselling.

The NMHSPF estimates that only 43% of the funding for these services comes from mental health budgets (this is the component used to estimate the costs and benefits of reform below).

There are some family support services funded by State and Territory Governments. For example, the Western Australian Mental Health Commission funds Wanslea Family Services (2020) to provide support services to children affected by parental mental illness, including counselling and social recreational activities. Eastern Health (2020) in Victoria provides peer support services for children and young people with a parent with mental illness. An evaluation of one of these programs (called CHAMPS) found that the intervention resulted in significant improvements in self-esteem, coping and connections within the family, and reductions in relationship problems (Goodyear et al. 2009).

Sjon Kraan described the importance of support services for children and parents:

... children of parents who experience long-term mental health conditions should have access to a program which provides education on mental health conditions, ... social inclusion and wellbeing activities in order to reduce isolation and disadvantage experienced by these young people ... parents who experience a persistent mental health condition should be given access to peer and psychosocial support that enables them to retain their role as a parent or preserve their family functioning. Parents at risk of or demonstrating reduced parental capacity should have resources directed towards a family inclusive support plan to safe-guard the wellbeing of the family and avoid children leaving the parent's care. (Perth transcript, p. 31)

However, EACH (sub. 875) stated that the needs of children and young people who have a parent with mental illness are often overlooked until such time as they also need mental health support.

Unmet need for carer support services

Inquiry participants' views, survey data and the poor wellbeing outcomes of mental health carers described in section 18.1 indicate that many carers are unable to access the support they need. Over half of primary carers of people whose main condition was mental illness needed additional support in 2018 (table 18.4). The most common unmet supports needed were emotional support and support for the carer's own health. And considering the cost of replacing the care they provide with formal services (\$13.2 billion in 2015), it is in the interest of governments to identify how the needs of mental health carers can be better met (Diminic et al. 2017).

Participants stated that there are barriers to accessing carer support services, for reasons including: poorly coordinated services and fragmented funding, difficulties navigating service access, and insufficient funding and services available (LMMHCN, sub. 52; MHCN, sub. 245; MHFFTas, sub. 391; Northern Territory Mental Health Coalition, sub. 430).

Table 18.4 The level and nature of unmet carer needs, 2018

Co-residing primary carers of people whose main condition is mental illness

<i>Unmet sources of support for carers^a</i>	<i>Number of carers</i>	<i>% of carers</i>
Receives assistance and needs further assistance	17 500	18
Does not receive assistance and needs assistance	12 100	13
Dissatisfied with range of organised services available to primary carers	16 400	17
Would like more respite care	17 800	19
Would like more emotional support	32 800	34
Would like more support to improve carer's own health	27 600	29
Would like more courses on how to care for persons with particular disabilities	24 500	25
Carers who fell into any of the above categories	54 900	57
All co-residing primary carers of people whose main condition is mental illness	96 300	100

^a Multiple responses possible.

Source: ABS (*Microdata: Disability, Ageing and Carers, Australia, 2018*, Cat. no. 4430.0.30.002).

Employment support services for carers

One area that Inquiry participants suggested has scope for policy improvement was support to help carers achieve their employment goals (Carers Australia, sub. 372; Caring Fairly, sub. 427; MHFFTas, sub. 391; Mind Australia; sub. 380).

Over half of all working-aged primary mental health carers have a possible need for more employment-related support to maintain, improve or enter employment (Diminic, Hielscher and Harris 2018). For employed carers this included those providing over 40 hours of care per week, those who had reduced working hours to commence caring, those wanting to work more hours and those who wanted to make more use of special working arrangements (such

as leave and flexible hours). Also included were carers not in employment who had left employment due to their caring role and those who reported wanting to work.

The Australian Government funds employment support for job seekers. The jobactive program provides employment support nationally, but most clients are referred to this program as a result of receiving the JobSeeker Payment (chapter 19). Other programs funded by the Department of Education, Skills and Employment provide more tailored support to specific cohorts, including the Career Transition Assistance program and the Transition to Work program (DESE 2020b, 2020a). A Senate Committee examination of the jobactive program concluded that the Australian Government should examine the merits of providing more tailored career counselling and support services for carers (EERC 2019).

Employment support services that are designed with mental health carers' circumstances and needs in mind should be available to carers and ex-carers who would benefit from them. To this end, supporting the employment goals of carers is within the scope of services provided as part of the ICSS (DSS 2018g).

Tailored employment support for mental health carers was trialled through DSS' Carers and Work Program between 2015-16 and 2018-19. DSS provided about \$1.5 million annually to trial the program within four services (two in Victoria, and one each in Queensland and New South Wales) (DSS 2017). Unfortunately, the trial finished without DSS undertaking a formal evaluation. DSS should nevertheless proactively incorporate lessons learned about what works in delivering employment support to mental health carers, to maximise the potential for Carer Gateway services to be an effective replacement in this area.

The effectiveness of the Carer Gateway's employment support should be evaluated within five years of the services commencing in 2020. If the evaluation finds that the program is not helping carers to achieve their goals, then a new approach may be needed. One option is to improve the capacity to support carers within the programs funded by the Department of Education, Skills and Employment. The national reach of these programs could help with scaling up employment supports to mental health carers. Another option would be a greater policy focus on supporting workplaces to be more carer-inclusive, as proposed by Caring Fairly (sub. 427), Carers Victoria (sub. 664) and Carers NSW (sub. 808).

Clarifying responsibilities for carer support services

Clearer policy responsibilities are needed to improve the commissioning of carer support services for mental health carers. Currently, both Australian and State and Territory Governments partially fund carer support services, but neither is accountable for ensuring that services are effective and meet community needs. The Productivity Commission noted this lack of clarity in policy responsibility for carer support services in its review of the National Disability Agreement (PC 2019b). Mental Health Carers NSW (sub. 245, p. 3) described how having both levels of government and multiple departments funding carer support services results in fragmented services and 'creates the potential for gaps in service provision to go unnoticed as well as for services to be duplicated needlessly'.

In the draft report, the Productivity Commission proposed that the responsibility for all carer support services for mental health carers should sit with one level of government. The State and Territory Governments were seen as a preferable option because of the specialised supports they could fund through the mental health system. For example, Tandem (Melbourne transcript, p. 69) stated that respite for mental health carers is not a generic service; staff need mental health skills to provide it effectively for people with mental illness. In practice, giving States and Territory Governments sole responsibility for carer supports would mean excluding mental health carers from Carer Gateway services and providing State and Territory Governments with additional funding to assess and meet the full range of carer needs.

Inquiry participants suggested this was not a feasible approach (Carers Tasmania, sub. 660). Excluding mental health carers from Carer Gateway services could lead to more fragmentation of services (Carers NSW, sub. 808). Mental health carers cannot be classified into a discrete category that separates them from other carers (Carers Australia, sub. 911). One quarter of mental health carers care for more than one person and many care for people with comorbidities (figure 18.1). Care recipients over 65 years of age could be interacting with both the aged care system and the mental health system. There would be significant duplication in policy development, infrastructure and administration.

Therefore, rather than assigning the responsibility for all carer supports to one level of government, the Productivity Commission is recommending a clearer division of roles for each level of government. Carer supports related to the mental health caring role should be planned for and funded by State and Territory Governments. State and Territory Governments, which are responsible for commissioning specialised mental health services, would be better placed to consult on and determine the sorts of mental health specific carer supports needed in each region. Moreover, they have greater incentive to continuously improve these services as consumers too would benefit from supports that improve carers' capabilities. The Australian Government's role would not change. Many mental health carers would still interact with the Carer Gateway because it considers their broader support needs and its services aim to meet goals related to other aspects of their lives (such as health, work, or financial advice).

This responsibility should be defined and supported under the recommended National Mental Health and Suicide Prevention Agreement (chapter 23). To improve accountability of State and Territory Governments for family support services for families affected by mental illness, this responsibility too should be included within the recommended agreement. Funding levels should be based on a transparent evidence-based planning framework, such as the NMHSPF. Planning processes should take into account the supports for mental health carers funded through the NDIS, although this is unlikely to represent a large share of carers' needs.

This delineation clarifies the objectives of each level of government but there would still be some duplication in the services they fund. Psycho-education is clearly related to the mental health caring role so would be funded by State and Territory Governments; whereas peer support may be funded by both levels of government, depending on its context. This system would also rely on effective coordination and referral between the two systems. A carer trying to achieve their employment goals may need regular respite in the form of

psychosocial services funded by State and Territory Governments, while a peer worker counselling a carer at a mental health service may refer them to the Carer Gateway to receive advice about accessing Carer Payment. Protocols to enable information sharing between service providers may assist with service coordination, and reduce the burden on carers to tell their story multiple times.

With both levels of government continuing to fund services for mental health carers, monitoring and evaluation will be key to keeping governments accountable for their respective roles and preventing people from falling through policy cracks. For State and Territory Governments, the focus should be on monitoring outcomes related to the caring role and family wellbeing; and there are well established indicators in the literature related to carer mastery, carer burden, family and carer mental distress, family functioning and relationships, and recovery for consumers that can be incorporated into program design.

For Australian Government services, it will be relevant to know whether mental health carers as a group are achieving similar outcomes as other types of carers participating in the ICSS program. The effectiveness of referral pathways between Carer Gateway services and State and Territory Government carer supports should also be evaluated once both of these systems are established.

The broad scope and scale of the Carer Gateway may assist in meeting the needs of different parts of the community compared with programs just for mental health carers. Young carers, Aboriginal and Torres Strait Islander carers, and culturally and linguistically diverse carers face barriers to accessing appropriate supports (section 18.1). The effectiveness of services for these groups should also be actively monitored. The Northern Territory Mental Health Coalition (sub. 430) stated that further research is needed into the appropriateness and uptake of existing resources for Aboriginal people in caring roles.

Monitoring of outcomes for mental health carers should also exist at a system level to further encourage continuous improvement. The Productivity Commission is recommending the National Mental Health Commission report on outcomes derived from the Contributing Life Framework for people with mental illness and their carers (action 24.9). Chapter 24 suggests some relevant outcomes for carers, including the proportion of mental health carers: who feel weary, angry, worried or depressed due to caring role; who have unmet need for support; and who are not working, but would like to (all of which can be estimated using the Survey of Disability, Ageing and Carers undertaken every three years).

ACTION 18.2 — FAMILY AND CARER SUPPORT SERVICES

Government responsibilities for family and carer support services should be clarified.

Start now

The recommended National Mental Health and Suicide Prevention Agreement (action 23.3) should state that State and Territory Governments would be responsible for planning and funding:

- carer support services related to the mental health caring role
- family support services for families affected by mental illness.

Start later

The Australian Government Department of Social Services should use data it collects on changes in carer outcomes to evaluate and report publicly on:

- how well the Carer Gateway meets the needs of mental health carers relative to other types of carers
- how well the Carer Gateway meets the needs of young carers, Aboriginal and Torres Strait Islander carers and culturally and linguistically diverse carers
- the effectiveness of Carer Gateway services in achieving carers' employment goals.

The evaluation should also assess the effectiveness of referral pathways between the Carer Gateway and mental health carer support services funded by State and Territory Governments.

The costs and benefits of reform

The NMHSPF (described in section 18.2) estimates that in 2019-20 it would cost \$153 million to provide family and carer support services that meet the needs of the community. This includes:

- \$17.0 million for individual and group based carer peer work delivered by specialised mental health community support services
- \$101.6 million for day and flexible respite, and residential crisis and respite services
- \$10.1 million for other carer support services
- \$24.4 million for family support services funded by the mental health system.

The Productivity Commission used data about primary carers — collected as part of the 2018 Survey of Disability, Ageing and Carers — to identify the proportion of carers with unmet needs. Of the 96 300 co-residing primary carers of people whose main condition is mental illness, 57% recorded one of the measures of unmet need in table 18.4. Assuming this is proportional to the amount of services required, approximately \$87.3 million per year in additional funding is needed to meet the unmet needs of mental health families and carers.

The benefits of action 18.2 were modelled together with the benefits from action 18.1 (appendices K and I). These reforms are expected to improve the mental health and health-related quality of life of carers, care recipients and children of parents with mental illness. The improvements in mental health from these actions would result in economic benefits (from increased income and cost-savings) worth \$164-\$318 million per year, which exceeds the combined annual costs of implementing these actions (\$160-\$189 million).

18.4 Income support payments for carers

Which income support payments are relevant to mental health carers?

In 2018, 69% of primary mental health carers reported receiving a government pension, allowance or benefit, the most common being the Carer Payment and Carer Allowance (ABS 2020b). Some carers receive the Age Pension, JobSeeker Payment¹⁹⁵ or Youth Allowance instead of Carer Payment. Carers who receive JobSeeker Payment may be exempted from mutual obligation requirements that typically apply to this payment because of their caring role (DSS 2019a). Some carers may be eligible for the Health Care Card if they care for someone under the age of 16 years (DSS 2018m).

Some State and Territory Governments also provide financial support to carers. For example, the Victorian Government funds Tandem, a mental health carers peak body, to administer the Mental Health Carer Support Fund, which provides financial assistance for costs associated with caring (Tandem 2018). Carers in Victoria also receive benefits associated with the Carer Card (Carers Victoria, sub. 461).

Carer Payment and Carer Allowance

Carer Payment and Carer Allowance are fortnightly income support payments for carers of a person with a severe disability or medical condition or who is frail due to old age. Close to one third of all Carer Payment and Carer Allowance recipients cared for someone with a psychological or psychiatric condition as their main condition (table 18.5).

Expenditure on mental health carers was approximately \$1.5 billion on Carer Payment and \$733 million on Carer Allowance in 2018-19. As at the end of June 2019, 200 500 carers of a person whose main condition was a psychological or psychiatric condition received *either* Carer Payment or Carer Allowance and 70 400 of these carers received *both* payments (DSS, pers. comm., 22 April 2020).

¹⁹⁵ The JobSeeker Payment replaced the Newstart Allowance in March 2020.

Table 18.5 Receipt and funding of income support for carers

	<i>Care recipients of carers receiving a payment, as at June 2019</i>		<i>Expenditure, 2018-19</i>	
	<i>Any medical condition</i>	<i>Main condition is psychological or psychiatric condition^a</i>	<i>Any medical condition</i>	<i>Main condition is psychological or psychiatric condition^c</i>
	persons	persons	\$ million	\$ million
Carer Payment	280 999	75 851 (27%)	5 590 ^b	1 509
Carer Allowance	673 564	214 981 (32%)	2 297	733
Carer Supplement	na	na	585	174
Total	..	..	8 472	2 417

^a Based on the first listed medical condition. ^b Includes Commonwealth Rent Assistance ^c Estimates based on the proportion of care recipients who have a psychological or psychiatric illness (27% and 32%). **na** not available; .. not applicable.

Source: Productivity Commission estimates using DSS (2019e, table 2.1.15) and DSS (2019k).

Both payments have two streams: one for carers of adults and one for carers of children below 16 years. Although rates of payment are the same, different rules and eligibility exist for the adult and child streams. For example, a carer who qualifies for Carer Payment (child) automatically receives Carer Allowance for that child but the same rule does not apply for Carer Payment (adult). This rule was implemented after a review of the child streams of carer payments in 2007 (Carers Victoria 2013). However, unlike the child payments, the design of the adult versions of Carer Payment and Carer Allowance have not been comprehensively reviewed since 1999 (Campbell 2018).

The objective of the Carer Payment is to provide income support for people who are unable to support themselves through substantial paid employment due to the demands of their caring role (DSS 2020a). Carer Payment is classified as a pension and paid at the same rate as the Age Pension and the Disability Support Pension. As at 20 March 2020, the maximum rate was \$944.30 for a single person per fortnight and \$711.80 for a person in a couple (DSS 2020d).

Carer Allowance is an income supplement — currently \$131.90 per fortnight (DSS 2020c). The purpose of Carer Allowance is to ‘recognises the care provided to a person with disability or medical condition in a private home’ (DSS 2018a). This leaves room for interpretation and the Productivity Commission has interpreted this to mean that the purpose of Carer Allowance is to offset some of the costs associated with caring. Anyone who receives Carer Payment or Carer Allowance automatically receives a third type of payment, the Carer Supplement — an annual lump sum payment of \$600 for each eligible payment to assist with the costs of caring (DSS 2020b).

Eligibility for Carer Payment and Carer Allowance is prescribed in the *Social Security Act 1991* (Cth). Table 18.7 summarises the eligibility rules relevant to the discussion below. Other details can be found in the Act, such as the eligibility for carers who have more than one care recipient.

Carer Payment is means tested — income and asset tests apply to both the carer and their care recipient. Taper rates apply so that the payment level reduces as fortnightly income earned increases. Over a fortnight, a single carer's payment is reduced by 50 cents for every dollar earned over \$174. For couples, every dollar earned over \$308 will reduce the Carer Payment in the same way (Services Australia 2020d).

Mental health carers are disadvantaged in accessing Carer Payment and Allowance

Inquiry participants raised three main shortcomings about Carer Payment and Carer Allowance. First, the eligibility criteria disadvantages mental health carers, relative to carers of people with a physical disability (for example, Private Mental Health Consumer Carer Network (Australia), sub. 49; Carers Australia, sub. 372). Second, some were concerned about how the eligibility criteria affects carers' ability to work and study. Third, others considered the level of payment to be insufficient, especially to enable carers to save (BrainStorm Mid North Coast, sub. 309; Caring Fairly, sub. 427; Eating Disorders Victoria, sub. 892; NMHCCF, sub. 708).

A high-level analysis of access to Carer Payment and Carer Allowance provides some evidence to support claims that mental health carers are less likely to receive these payments than carers of people with a physical condition (table 18.6). For example, of those carers potentially eligible to receive Carer Payment, 53% of carers of people with mental illness received the payment compared with 61% of carers of people with physical conditions. Moreover, those carers providing continuous care were more likely to be on either payment than those providing episodic care (table 18.6).

Table 18.6 Receipt of Carer Payment and Carer Allowance, 2018

For a potentially eligible subset of carers^a

<i>Carers by main illness of care recipient</i>				
	<i>Mental illness</i>	<i>Other cognitive or behavioural condition</i>	<i>Physical condition</i>	<i>All conditions (total)</i>
Carers on Carer Payment (n = 382)				
Number	16 800	24 200	62 500	103 500
%	53%	52%	61%	57%
Carers on Carer Allowance (n = 1 174)				
Number	24 100	65 500	140 700	230 300
%	34%	49%	44%	44%

<i>Carers of people over 16 years old, by main illness of care recipient</i>				
	<i>Mental illness</i>	<i>Other cognitive or behavioural condition</i>	<i>Physical condition</i>	<i>All conditions (total)</i>
Carers on Carer Payment (n = 270)				
Number	14 200	13 400	57 100	84 800
%	65%	59%	63%	63%
Carers on Carer Allowance (n = 941)				
Number	20 800	38 100	131 800	190 700
%	39%	50%	44%	45%

<i>Carers by care recipient's care needs</i>		
	<i>Continuous care</i>	<i>Episodic care</i>
Carers on Carer Payment (n = 382)		
Number	98 700	4 900
%	58%	45%
Carers on Carer Allowance (n = 1 174)		
Number	213 700	16 600
%	47%	23%

^a For Carer Payment, this estimate is based on an analysis of primary carers who: provided care for at least 20 hours per week; were under 65 years old; did not receive the Age Pension or Disability Support Pension; resided with their care recipient; were not studying full time; were not working more than 25 hours; and either earned below average income (as an income unit, not personal income), had difficulty meeting everyday costs or reported financial support as their main source of unmet need. For Carer Allowance, this estimate was based on all primary carers who reside with their care recipient, provide more than 9 hours of care per week and earn less than the top income decile (as an income unit, not personal income). n is the survey sample size, estimates are the weighted population estimates. The numerator of the percentage calculations are included but the denominator is excluded to save space.

Source: ABS (*Microdata: Disability, Ageing and Carers, Australia, 2018*, Cat. no. 4430.0.30.002).

The Adult Disability Assessment Tool

One of the main eligibility tools for the adult stream of the Carer Payment and Carer Allowance is the Adult Disability Assessment Tool (ADAT). The ADAT contains two questionnaires, one to be completed by the carer and another by a health professional treating the care recipient. Each multiple choice response in the questionnaires is given a score and the scores are summed to measure the amount of help the care recipient needs to undertake daily activities. The questions and scores are set by the Adult Disability Assessment Tool Determination 2018.¹⁹⁶

The two ADAT questionnaires each have three sections intended to capture the types and intensity of care that a carer provides. The first section assesses activities of daily living (including washing, dressing, or eating), the second relates to cognitive function and the third records behaviours and symptoms related to mental illness. Inquiry participants were critical of the ADAT's focus on activities of daily living relative to care tasks commonly performed by mental health carers (Brian Shevlane, sub. 147; Carers NSW, sub. 183; Carers Victoria, sub. 461; Peter Heggie; sub. 72). Carers Australia (sub. 911, p. 4) stated that it 'is very hard to get a sufficiently high score for a qualifying ADAT' based on the behaviour and mental health section alone.

The weightings allocated to the questions are not the only problem. The questions themselves do not adequately capture the care provided by mental health carers.

The first section focuses on basic self-care but has no questions about support required to organise and attend appointments or need for assistance with household chores. Since the ADAT was developed in 1999, the importance of psychosocial support for people with disability or severe illness has received greater attention. For example, in 2001 the World Health Organisation released the first iteration of the International Classification of Functioning, Disability and Health which included domestic responsibilities and a person's ability to participate in the community as relevant to their overall functioning (WHO 2013a).

A Carers Victoria (2013) review found that the second section on cognitive functioning in the health professional's questionnaire is skewed towards symptoms of dementia, but does not ask questions about symptoms of psychosis, such as hallucinations or delusions.

Mental Health Carers NSW (sub. 245, p. 19) stated that the questions in the third section on behaviour in the carer questionnaire 'describe a small set of very specific symptoms which relate to some mental health conditions'. Moreover, in contrast to the questions on activities of daily living, which ask about the level of support required to support the care recipient, the questions in the third section on behaviour ask how often certain behaviours occur. This makes it harder for some mental health carers to reach the required score because the time they spend maintaining vigilance and supervision to *prevent* certain behaviours, such as self-harm, is not counted.

¹⁹⁶ The children's equivalent of the ADAT is the Disability Care Load Assessment (Child) Determination 2010. Inquiry participants did not raise specific concerns about this form.

Finally, the health professional's report portion of the ADAT can be completed by a medical practitioner, registered nurse, physiotherapist, occupational therapist, member of an Aged Care Assessment Team or an Aboriginal health worker in a geographically remote area (DHS 2018b). Psychologists are not on this list but are listed on the equivalent form for care recipients under the age of 16 years (DHS 2018a).

Restrictions on location of care

Regarding location of care, the rationale for the requirement that care must be provided *in the home of the care recipient* to be eligible is unclear. For Carer Allowance this goes further — for carers who do not reside with their care recipient to be eligible for this payment, they must be providing care that relates to the care recipient's bodily functions or to sustaining their life.¹⁹⁷ These restrictions are poorly aligned with the care tasks of mental health carers.

Care activities that may be provided outside of the care recipient's home may include emotional support provided by telephone, time spent out of the home attending appointments, and time spent preparing meals. Almost half (45%) of the people who participated in a national survey of people with psychosis did not reside with their carers but had frequent contact with them (Poon et al. 2017).

The eligibility restriction related to location of care that has clearer policy intent, is the requirement that the care recipient resides in a private home. The care recipient is considered to reside in a private home if they carry out their main domestic functions there and there are no commercial care arrangements in place for the provision of personal care (DSS 2016b). This excludes supported housing such as a residential aged care facilities. There is scope to simplify the eligibility rules to better reflect this intent.

Restrictions on frequency of care

Carer Payment eligibility allows recipients to cease care to work, study or volunteer for up to 25 hours a week (including travel time). This is called the '25 hour rule'. In addition, temporary cessation of care provisions allow carers to take 63 full days off from constant care for any purpose throughout each calendar year. Eligibility restrictions on frequency of care have been relaxed significantly since the payments were first introduced. For example, rules were relaxed in 1993 to allow carers to work or study for 10 hours per week, increasing to 20 hours in 1997 and then to the current limit of 25 hours in 2005 (Edwards et al. 2008).

Despite flexibility to allow part-time work or study and to take days off from caring each year, the requirement that carers are otherwise providing 'constant care' restricts eligibility beyond the stated policy intent of Carer Payment. Constant care is expected to be 'at least the equivalent of a normal working day', including active care, supervision and monitoring (DSS 2015a). This is a high bar. People working full time generally work approximately

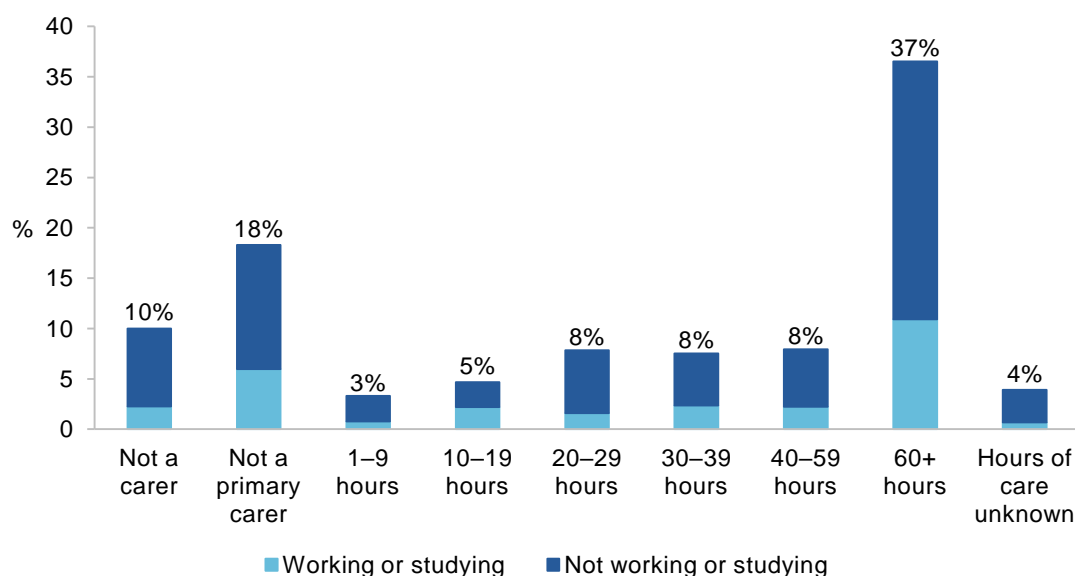
¹⁹⁷ *Social Security Act 1991*, s. 954A.

40 hours a week over five days, equivalent to 104 days off per year. Yet, carers on Carer Payment cannot take more than 63 full days off from caring per year. The Productivity Commission's analysis of the effect of caring on employment (table 18.2) found that providing as few as 10 to 19 hours or care per week reduced the likelihood of employment.

The requirement to provide constant care is even more challenging for carers of people with episodic care needs. In this case, the consistency in the level of care provided is not the choice of the carer. Indeed, having unpredictable hours of care likely weakens a carer's ability to sustain substantial employment (NMHCCF, sub. 708). Given that Carer Payment is means tested and the intensity of care provided is assessed by the ADAT, the requirement to provide constant care may be an unnecessary barrier to Carer Payment, especially for carers of people with episodic illness. Victoria Legal Aid (sub. 818) supported the use of 'regular care' instead of 'constant care' to better reflect the realities of care provision.

A substantial proportion of carers already receiving Carer Payment in 2018 reported providing less than constant care, and some may no longer be primary carers at all (figure 18.5).¹⁹⁸ This suggests that the requirement to provide constant care to access the payment is either not tested effectively initially or is not monitored sufficiently over time as carers' circumstances change.

Figure 18.5 Hours of care provided by carers on Carer Payment, 2018



Source: ABS (*Microdata: Disability, Ageing and Carers, Australia, 2018*, Cat. no. 4430.0.30.002).

¹⁹⁸ Given constant care is expected to be 'at least the equivalent of a normal working day' and 63 days off from care per year is approximately one day off per week, the Productivity Commission interpreted constant care as 42 hours of care per week for carers not in employment or study and a minimum of 18 hours per week for those working or studying 25 hours per week.

Similarly, carers must provide ‘care and attention on a daily basis’ to be eligible to receive Carer Allowance. This means that except when carers are using their 63 temporary cessation of care days, they must provide care every day. However, costs associated with care are not limited to those who provide care every day.

Restrictions on work and study

Inquiry participants objected to the 25 hour rule for several reasons, some of which apply to mental health carers more than other carers. The general criticism was that the restriction on hours of work, volunteering and education was a perceived disincentive for carers looking to enter the workforce or develop their career prospects (MHCN, sub. 245). Although the 63 temporary cessation of care days can be used to prevent carers from exceeding the 25 hour rule and having their payment cancelled, this may not be clear to carers considering a temporary increase in their hours of work or study (DSS 2019b). Moreover, with opportunities for online education and working from home now more prevalent, there may be periods where carers can be on call to respond to their care recipient while working, studying or volunteering more than 25 hours per week.

Caring Fairly (sub. 427), Mental Health Carers Australia (sub. 489) and Tandem (sub. 502) expressed concern about the effect this rule has on carers of people with episodic conditions. Some of these carers would be willing and able to work more than 25 hours a week when their care recipient is well, but experience unpredictable periods where caring responsibilities intensify and financial support consistent with a pension is needed.

Although Carers Victoria (sub. 664) has long advocated for the removal of the 25 hour rule, they stated that greater flexibility in the rule would be a welcome step. They suggested the rule should be expanded to allow carers to work for 300 hours over a 13 week period, with carers advising that a three month block would allow them to pick up additional work while their care recipient had a period of improved health.

The effect of the 25 hour rule on young carers is particularly problematic (Mind Australia, sub. 380; One Door Mental Health, sub. 108). The rule may require young carers from low-income families to choose between pursuing full-time education or receiving less income support for their family.

Reform options

The ADAT is clearly in need of reform. It is not appropriate for mental health carers for the reasons outlined above. DSS commenced a review of the ADAT and started field testing new questions in September 2016 (DSS 2018h). Field testing of questions with carers and health professionals continued into 2018 (DSS 2019i). Although the review was not specific to mental health carers, Mental Health Carers NSW (sub. 245) reported that the revised ADAT questions that were field tested are better suited to assess the care responsibilities of mental health carers. However, as of May 2020, DSS’ analysis of the ADAT field tests was

ongoing and next steps for the review had not been announced (DSS, pers. comm., 8 May 2020). Once new questions are finalised, new weightings will also be required and these should be developed in consultation with carers and health professionals.

As part of the review, DSS should also update the list of professionals allowed to complete the health professionals report to include others of relevance to mental illness, such as psychologists and accredited mental health social workers. A broad list of professionals is preferable because this improves the likelihood that the carer can bring the form to someone who has a good understanding of the carers' role and who has the skills to seek consent from the care recipient to share their personal information with the carer and Centrelink. It should not be assumed that these skills exist in all health professionals (section 18.2).

Beyond the ADAT review, additional changes to the eligibility of Carer Payment and Carer Allowance are also warranted in order to improve access to these payments for mental health carers. Recommended changes are summarised in table 18.7.

The Productivity Commission is recommending that the eligibility changes apply at this time to mental health carers only, given that the focus of this Inquiry is on those affected by mental illness, but there are clearly issues of broader application. Some of the recommended changes seek to better accommodate the often episodic nature of mental illness, and as Carers Australia (sub. 911, p. 10) noted, this is relevant to other carers too:

Multiple Sclerosis is also episodic, as is Parkinson's Disease, rheumatoid arthritis, muscular dystrophy — the list is not exhaustive.

The 25 hour rule should not continue in its current form. The costs of preventing a mental health carer willing and able to invest in their education are difficult to justify. Similarly, volunteering can be an important stepping stone to employment. Maintaining a restriction on work hours only may assist with managing risks to the integrity of Carer Payment. However, there is need to allow more flexibility for people providing episodic care. A change to the time period over which work is assessed would achieve this — that is, a change from 25 hours per week to 100 hours per month.

A broader review of income support for carers could result in a system that is more coherent and flexibly meets the needs of carers. But as any such reforms would affect all carers, not just mental health carers, they are considered beyond the scope of this Inquiry. That said, the Productivity Commission has suggested principles that should be considered if there was a broader review.

McClure, Aird and Sinclair (2015, p. 9) found that changes to the social support service system over time had led to 'complexities, inconsistencies and incoherencies'. Carers Victoria (2013, p. 10) noted that 'complexity can bring its own barriers because it provides greater opportunity for misunderstandings and divergent interpretations of the legislation and its guidelines'. To improve the simplicity of the system, carers might be better served by one payment that is designed to meet the objectives of all three payments (Carer Payment, Carer Allowance and Carer Supplement).

Mental Health Carers Australia (sub. 489) and Tandem (sub. 502) called for a review of the payments to understand the effect that their design has on participation in work and education. The need for a more flexible safety-net for carers may become more important if the NDIS and future mental health reforms provide carers with greater opportunities to balance both a caring role and employment. If pursued, a review of Carer Payment should give consideration to the following elements proposed by McClure, Aird and Sinclair (2015) for the design of a new system of payments:

- clear and personalised information about how changes in earned income affect receipt of income support payments
- periodic discussions between carers and qualified staff about their goals for economic and social participation.

There are some good measures in place that support carers whose circumstances change over time. For example, when a person's Carer Payment is cancelled because they are no longer eligible, carers may be able to re-apply for the payment through an abridged application process (if the health professional's report for the ADAT is less than two years old) (DSS, pers. comm., 8 May 2020). It is important that these sorts of measures are advertised to carers, especially those caring for someone with episodic care needs.

FINDING 18.1 — INCOME SUPPORT FOR CARERS IS UNNECESSARILY COMPLEX

The existence of a Carer Payment, Carer Allowance and Carer Supplement that all achieve similar objectives, but have some arbitrary differences in eligibility, contributes to an income support system that is complex and not well understood by carers.

ACTION 18.3 — REDUCE BARRIERS TO ACCESSING INCOME SUPPORT FOR MENTAL HEALTH CARERS

Eligibility requirements for income support payments should change to better address the needs of mental health carers.

Start now

The Australian Government Department of Social Services (DSS) should complete its review of the Adult Disability Assessment Tool used to assess eligibility for Carer Payment and Carer Allowance. DSS should:

- publish its findings from the review and field testing process
- consult with carers and health professionals before setting revised weightings for the new questions and the minimum score required to be eligible for each payment
- expand the list of persons who can complete the health professional questionnaire to include psychologists and accredited mental health social workers.

Start later

The Australian Government should amend the eligibility criteria for Carer Payment and Carer Allowance for mental health carers, and consider adopting these changes for other carers. Amendments for mental health carers should include:

- for both payments, replacing the requirement that care must be provided in a private residence that is the home of the care recipient with a requirement that the care recipient must reside in a private residence
- for Carer Payment, replacing the requirement to provide 'constant care' with the requirement to provide 'care on a regular basis every week'
- for Carer Payment, replacing the 25 hour per week restriction on work, study and volunteering with a 100 hour per month restriction on work only
- for Carer Allowance, replacing the requirement to provide 'care and attention on a daily basis' with the requirement to provide 'care on a regular basis every week'
- for Carer Allowance, removing the requirements for the carer to either live with the care recipient or to provide care that relates to the care recipient's bodily functions or to sustaining their life and for more than 20 hours per week.

Table 18.7 Current and recommended eligibility criteria for Carer Payment and Carer Allowance

For carers of an adult with severe illness or disability

Criteria	Current		Recommended	
	Carer Payment	Carer Allowance	Carer Payment	Carer Allowance
Intensity and types of care	Minimum ADAT ^a score of 25 points, including 10 from the health professional's report.	Minimum ADAT ^a score of 30 points, including 12 from the health professional's report.	Minimum ADAT ^a score to be determined following review.	Minimum ADAT ^a score to be determined following review.
Frequency of care ^b	Constant care. Work, study and volunteering cannot exceed 25 hours per week.	Care and attention on a daily basis.	For mental health carers: Care on a regular basis every week'. Work cannot exceed 100 hours per month.	For mental health carers: Care on a regular basis every week'.
Expected duration of illness	Condition is expected to continue for at least 6 months or the illness is terminal.	Condition is expected to continue for at least 12 months or the illness is terminal.	No changes recommended.	No changes recommended.
Place of provision of care ^b	In a private residence that is the home of the care recipient.	In a private home that is the residence of the carer and care recipient or if the care recipient and carer do not co-reside, then the care must be in the care recipient's home and must: relate to the care recipient's bodily functions or to sustaining their life, be provided for at least 20 hours a week and be received in a private home.	The care recipient lives in a private residence (for mental health carers only).	The care recipient lives in a private residence (for mental health carers only).
Income test	Equal to that for Age Pension ^c . Another test applies to care recipient's income.	Threshold is \$250 000 in annual family income.	No changes recommended.	No changes recommended.
Assets test	For carer: same annual thresholds as Age Pension ^d . Care recipient: \$716 750 (principal home excluded)	None applies.	No changes recommended.	No changes recommended.

^a The ADAT is the Adult Disability Assessment Tool. ^b Carers are exempt from these criteria for up to 63 full days per year. ^c Payment ceases for before-tax income earned over the fortnight above \$2062.60 for a single person or \$3155.20 for couples. ^d Single homeowner: \$263 250; single non-homeowner: \$473 750; couple & homeowner \$394 500; couple & non-homeowner: \$605 000.

Source: Social Security Act 1991 (Cth); DSS (2015b); Services Australia (2020a, 2020d, 2020c).

The costs and benefits of reform

An increase in the number of people receiving Carer Payment and Carer Allowance does not impose a net cost on the community as a whole — rather it is a transfer in income from one part of the community to another. That said, increasing the total taxpayer funds allocated to income support payments is a cost to the Australian Government because it prevents it from using the funds to achieve other policy objectives.

The costs of the recommended changes to the eligibility criteria for Carer Payment and Carer Allowance are based on the Productivity Commission's estimate of the additional carers that would receive these payments. If the review of the ADAT closed the gap between the rates of mental health carers and other carers on Carer Payment and Carer Allowance (table 18.6), then we would expect 3000 additional carers on Carer Allowance, at a cost of \$10.3 million per year.

Relaxing the 25 hour rule may allow approximately 464 additional mental health carers to access Carer Payment, at a cost of \$5.8 million per year. Approximately 880 mental health carers were working part time more than 25 hours per week, but otherwise might meet the criteria for Carer Payment (Productivity Commission estimate using ABS 2016b, 2020b). If the same proportion of these carers were on Carer Payment as those in table 18.6 (53%), then 464 additional mental health carers might receive Carer Payment. Mental health carers studying full time were not less likely to receive the payment than other carers that might meet the criteria for Carer Payment, so this change has not contributed to the estimated cost of the reform (Productivity Commission estimate using ABS 2016b, 2020b).

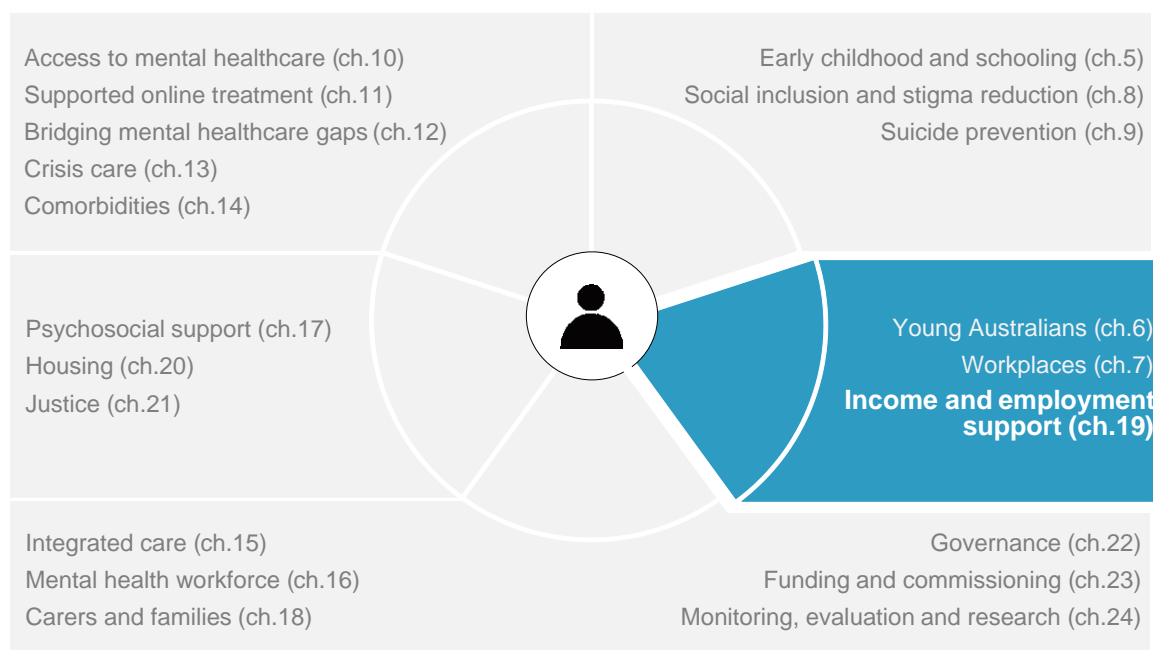
Primary carers that broadly met the eligibility criteria for Carer Payment were less likely to be receiving Carer Payment if they did not reside with their care recipient (48% compared with 67%) (Productivity Commission estimates using HILDA, wave 18).¹⁹⁹ However, the Productivity Commission could not use this data to estimate how many additional carers would receive Carer Payment if the rules related to location of care were relaxed because it is unknown how many of the care recipients were not living in a private residence. These carers would remain ineligible for Carer Payment under the recommended reforms.

The Productivity Commission was also unable to estimate the cost of relaxing the requirements related to 'constant care' and 'care and attention on a daily basis' because it is unknown how many mental health carers would meet all the other eligibility criteria except for this one and how many would apply for income support.

The benefits of this reform were not able to be estimated but it is expected to improve the mental wellbeing of carers and their families who are able to receive Carer Payment or Carer Allowance as a result of the recommended changes. Mental wellbeing would improve as a result of reduced financial hardship. This a common issue among primary mental health carers — 41% of whom reported difficulties meeting everyday living costs in 2018 (section 18.1).

¹⁹⁹ Potentially eligible primary carers defined as those: providing at least 20 hours of care; under the age of 65 years, not on the Age Pension or Disability Support Pension; earned below the maximum income thresholds reported in table 18.7; were not working more than 25 hours per week and were not studying full time.

19 Income and employment support



Changes to income and employment support programs matter because ...

- Employment can be important for maintaining good mental health for people with mental illness and for the broader population.
- People with mental illness are under-represented in the workforce and face barriers to employment.
- The Individual Placement and Support model of employment support, while still subject to further review, has resulted in increased numbers of people with severe mental illness finding and remaining in employment, compared with other programs.
- For people with mild to moderate mental illness, the upcoming shift toward online employment support programs offers scope for support that better meets their needs — however, further policy development is required for participants to be able to take advantage of this.
- Income support is an important safety net but there is scope to improve the incentives for Disability Support Pension recipients to return to work.

RECOMMENDATION 19 — TAILOR INCOME AND EMPLOYMENT SUPPORTS

Employment can be important for maintaining good mental health for people. There is considerable scope to reduce barriers to employment faced by people with mental illness and increase their workforce participation.

As a priority:

- All governments should act to extend the Individual Placement and Support (IPS) model of employment support beyond its current limited application through a staged rollout to community ambulatory mental healthcare services. (Action 19.4)
 - The rollout should be staged to allow Governments to thoroughly test and review how to tailor the IPS program in a cost effective manner to particular demographic groups and for people with different types of mental illness.
 - The program should initially be open to all non-employed working age consumers of community ambulatory mental healthcare services who express a desire to participate. Participation in the program should be considered to fulfil any mutual obligation requirements for income support recipients.
 - At each stage of the rollout, data should be shared between IPS sites, with a mechanism put in place to share lessons and best practice between programs on what works for particular targeted groups of participants. If the net benefits of the program apparent on a small scale to date are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.

Additional reforms that should be considered:

- Processes for streaming of participants into employment support programs via improved employment support assessment tools should be tailored to people with mental illness by relevant governments. (Action 19.1)
- The Department of Education, Skills and Employment should ensure that the New Employment Services program includes design features that explicitly consider the needs of participants with mental illness as it is developed and later rolled out as a national program. (Action 19.2)
- For job seekers with complex needs, employment support providers should be required to assist with personalised Job Plans that go beyond meeting compliance obligations. (Action 19.3)
- Over time, the Australian Government should improve the work incentives for Disability Support Pension recipients and recipients should be well informed of their entitlement to work for a period without losing access to the Disability Support Pension by Services Australia. (Action 19.5)

The bulk of Australians with mental illness manage their lives without a negative impact on their employment (Orygen Youth Health Research Centre 2014). However, people with mental illness are under-represented in the workforce. In 2017-18, 55% of working age Australians with mental illness were employed, compared with 64% of the wider Australian workforce (ABS 2019c). Most people with mental illness would like to work (Consortium of Australian Psychiatrists and Psychologists, sub. 260; Merri Health, sub. 120; NSW Government, sub. 551; RANZCP, sub. 385) and avoid joblessness, which lowers psychological wellbeing and increases poverty (Murali and Oyeboode 2004; Wilkinson and Marmot 2003).

The Australian Government provides employment support to assist people with and without mental illness to find and keep jobs. It also provides income support to alleviate the impacts of joblessness on household incomes. Given their distinctive barriers to employment, the design of employment and income support measures can affect labour market and wellbeing outcomes of many people with mental illness in different ways, compared with other jobless people. Australia achieves relatively poor labour market outcomes for people with mental illness compared with OECD leaders such as Switzerland and the Netherlands (OECD 2015). This suggests potentially significant payoffs from improved policy for employment support participants with mental illness — the prime focus of this chapter.²⁰⁰

19.1 The importance of income and employment support for people with mental ill-health

Employment is beneficial to mental health

Employment is beneficial to mental health. Llana-Nozal (2009) examined data from Australia, Canada, Switzerland and the United Kingdom and found that psychological distress levels fell (representing an improvement in mental health) after people moved into employment and rose after people moved into unemployment. Further, unemployment has been found to have a significant negative effect on mental health (in Australia, Germany, the United Kingdom and the United States), regardless of the duration of time spent unemployed (Cygan-Rehm, Kuehnle and Oberfichtner 2017).

There are a range of specific mechanisms through which employment can improve mental health.

- Employment (and re-employment) can act as a restorative psychological process (McClure, Aird and Sinclair 2015; OECD 2012).
- Working gives people a sense of identity, structures routines, increases social interaction, and provides regular communication and shared experiences with people outside the individual's nuclear family, all of which are beneficial to mental health (Goodwin and Kennedy 2005; OECD 2012; Waghorn and Lloyd 2005; Wise Employment, sub. 186).

²⁰⁰ Income support for carers of people with mental illness is discussed in chapter 18.

-
- The collective effort and purpose of work provides a sense of personal achievement (FCDC 2012; OECD 2012; Waghorn and Lloyd 2005).
 - Increased employment of people with mental illness reduces the stigma of mental illness throughout the workforce, thereby benefiting more than these newly employed individuals (OECD 2012; Waghorn and Lloyd 2005).
 - Entering work can address key stressors impacting people with mental illness — unemployment, loneliness and lack of income (WISE Employment, sub. 186).

A range of other studies have established a positive association between employment and mental health, but not a causal relationship. Examples include Clark (2003), Michon et al. (2014), Modini et al. (2016), Stafford, Jackson and Banks (1980), Woodside, Schell and Allison-Hedges (2006).²⁰¹ Likewise, suicide rates are higher for people unemployed than for people employed (Milner, Morrell and LaMontagne 2014; Rinaldi et al. 2008), and people receiving unemployment benefits are more than three times as likely to have depression or anxiety as wage earners (Collie, Sheehan and Mcallister 2019).

But not all jobs are created equal. Jobs with good working conditions where workers receive appropriate supervision, stress management and social and emotional support, and jobs with high job satisfaction are more beneficial to mental health than others (Faragher, Cass and Cooper 2005; Modini et al. 2016). Jobs with detrimental psychosocial environments (poor security, control and support) can adversely affect worker mental health (PHAA, sub. 272; as discussed in chapter 7).

For improved mental health, the number of hours worked does not have to be large. A recent United Kingdom study found that only 1–8 hours of work per week is required to gain the psychological benefits of employment (Kamerade et al. 2019). Indeed, working excessive hours may reduce mental health (Afonso, Fonseca and Pires 2017). The negative effects of unemployment may also depend on whether or not unemployment is ‘common’ in society. If unemployment is widespread (such as during a recession or in societies with entrenched unemployment), moving into unemployment can have a reduced (negative) impact on a person’s mental health (Clark 2003; Thill, Houssemand and Pignault 2019).

People with mental illness face barriers to employment

Most people who experience mild to moderate mental illness are able to manage their illness and mitigate its effect on their employment. But for some, especially those with more severe illnesses, there are barriers to employment at the individual and community levels.

At an individual level, a person’s mental illness can inhibit their ability to work. It can affect their interpersonal, perceptual, affective and cognitive abilities, thereby limiting potential employment options and the number of hours they are able to work (FCDC 2012). For

²⁰¹ Without causal analysis, the apparent benefit of employment on mental health can be conflated with the adverse impact of an existing mental health condition on employment probability.

example, schizophrenia may affect concentration and memory (FCDC 2012), while depression may reduce motivation levels and decision-making capacities (Peter Viney, sub. 149). For severe episodic mental illnesses, feelings of frustration and helplessness about relapses can undermine work performance (Rutman 1994). The side effects of new medication or dosage changes — such as blurred vision, light-headedness or tremors — can also negatively affect employment outcomes (Rutman 1994). People with mental illness also typically attain lower education levels, which can further reduce employment opportunities (Cook 2006; Orygen Youth Health Research Centre 2014; Waghorn et al. 2007).

At a community level, misconceptions and negative perceptions of people with mental illness pose barriers. While for some people, mental illness affects work performance, this is not true for every individual nor every mental illness. Employers can sometimes use the existence of mental illness as a crude and inaccurate indicator of employment or promotion potential. Moreover, they may generally discriminate against people with mental illness out of fear or prejudice, without an objective assessment of work capabilities (Cook 2006; Peter Viney, sub. 149). Even fear of this discrimination may prevent people with mental illness from entering the workforce (Orygen Youth Health Research Centre 2014).

Once in employment, some people with psychosocial disability fear they cannot disclose their mental illness without it limiting future opportunities (AHRC 2016). As a consequence, they may not seek treatment or request changes to workplaces that might improve their performance, such as alternative hours or tasks. This leaves them more vulnerable to dismissal or poor career prospects. More generally, low community expectations of the work capacity of people with mental illness may be self-fulfilling — leading to poorer employer training and encouragement, weaker ambitions and lower self-esteem — which, in turn, lowers job performance (Westcott et al. 2015).

Employment support can help overcome these barriers

The Australian Government's main employment support programs are privately provided, with providers competing for participants and receiving additional remuneration if their enrolled participants find and stay in work.

People with mental illness may face additional barriers to employment, compared with other job applicants, and may require additional support to find a job. In a buoyant labour market, a job-ready unemployed person would usually have the option of choosing between many jobs and many employers. In a less buoyant labour market, and for those people with mental illness (particularly severe mental illness), job search outcomes are more sensitive to employer attitudes and the type of job in which the person can succeed. This additional complexity should be reflected in the design of employment support.

Clinicians could also improve employment outcomes by moving beyond a focus on good clinical outcomes (relief from symptoms) to also consider good functional outcomes from treatment (re-engaging people with their workplace and/or community) (Westcott et al. 2015). Some clinicians do not encourage consumers to find work, believing that it could

be harmful (FCDC 2012), or that it is ‘incidental’ to the recovery process (Crawley, Fitzgerald and Graham 2007). This is not to suggest that remunerated employment is appropriate for all people with mental illness, but clinicians should acknowledge and support employment aspirations where the consumer considers that this is an important part of their recovery. Effective employment support has the potential to generate better health outcomes and lower health costs, as well as benefits from higher personal incomes, lower welfare dependence and a more productive economy.

The key qualifier above is the imperative for effectiveness. Policy decisions about the form, funding and targeting of employment support depend on the net payoffs associated with variants of such services. Such a cost-benefit approach weighs the beneficial impact of such programs on employment (and its duration), wage income, healthcare savings and non-pecuniary gains (including the gains to consumers’ mental health), against the program costs. This framework is particularly useful for deciding how far to move toward more intensive and targeted forms of employment support (section 19.4).

Income support is an important safety net

Many people with mental illness who are outside the workforce or unemployed receive government-funded income support and access to concessions (such as lower cost access to pharmaceuticals or more general benefits from having a concession card). Australia has a well-developed social security system that is largely blind to the types of disadvantages that prompt disengagement from the labour market, but does take into account the permanence and severity of those disadvantages. For example, access to the Disability Support Pension (DSP) is not determined by the cause of disability (with some medical exceptions), but by its expected duration and impact on work capacity.

An ideal income support system would distinguish between people whose detachment from work does not reflect barriers to employment and those for whom it does, potentially due to mental illness. This report considers the latter, which comprises a group of people with a varying range of illnesses.

- People with permanent psychological or psychiatric disability whose likelihood of working consistently is low. The relevant income support for this group is the DSP.
- People with severe but episodic mental illness, for whom transition in and out of work is desirable, accompanied by the certainty of adequate income support where employment is not realistic. The appropriate form of support would be more complex than for others and could vary between individuals.
- People with less severe or temporary severe mental illness, which constrains employability but to a lesser extent than for those with severe and enduring conditions. Such people would typically receive the JobSeeker Payment or Youth Allowance.

Whether payments are at a level that represents an adequate safety net is contentious (particularly in relation to the JobSeeker Payment), but as noted in section 19.5, that concern is outside the scope of this Inquiry as it is not specific to people with mental illness.

However, the mental health benefits of employment are grounds to reassess the arrangements for accessing various income support measures and for (re)entering employment. Questions such as ‘I have an episodic mental illness. Am I eligible for the DSP? How can I show that? Can I get work when I am well?’ may identify various shortcomings. Of course, reforms in response to these concerns should consider the effects on people with other disabilities before implementing any policy change. These issues are the subject of section 19.5.

19.2 Current income and employment support payments and programs

The four major income support payments of relevance to working age people with mental illness are the:

- JobSeeker Payment, the main income support payment for all working age people. It replaced the Newstart Allowance and several other payments in March 2020. Recipients must be looking for work unless they are unable to do so due to sickness or injury
- Youth Allowance (job seeker), an unemployment benefit paid to job searchers aged under 22 years
- Youth Allowance (student and apprentice), a payment for full-time students or apprentices aged under 24 years
- DSP, a payment for people with enduring disabilities and a low probability of employment. Usually, the DSP is paid at a higher rate than the JobSeeker Payment and Youth Allowance (appendix C; table 19.1).²⁰²

While data for the JobSeeker Payment are not yet available, at June 2019 there were more recipients of the DSP with severe mental illness than recipients of the Newstart or Youth Allowances who reported a mental illness combined (table 19.1), potentially due to the often enduring nature of DSP recipients’ disabilities. In this respect, it is notable that the most common reason for exit from the DSP is the transition to the Age Pension.

People with mental illness who are not working may also receive financial support through income protection payments or life insurance claims (chapter 8; Life Insurance Industry, sub. 821).

The majority of JobSeeker Payment and Youth Allowance (job seeker) recipients, and some DSP recipients aged under 35 years, are required to participate in employment support programs (appendix C; figure 19.1; table 19.1). Key programs are:

- jobactive, a program for a wide cohort of job seekers looking for full-time employment

²⁰² Recipients of the JobSeeker Payment and Youth Allowance are eligible for the temporary Coronavirus Supplement, meaning that – in effect – the JobSeeker Payment and Youth Allowance are currently paid at a higher rate than the DSP (appendix C).

- Disability Employment Services (DES), a program for jobless people whose main barrier to employment is a disability
- the Community Development Program (CDP), a program for job seekers in remote Australia.

In addition, some people with mental illness may receive employment support from other providers outside of jobactive, DES or the CDP, such as clubhouses (Stepping Stone Clubhouse Inc, sub. 647) or social enterprises (chapter 8).

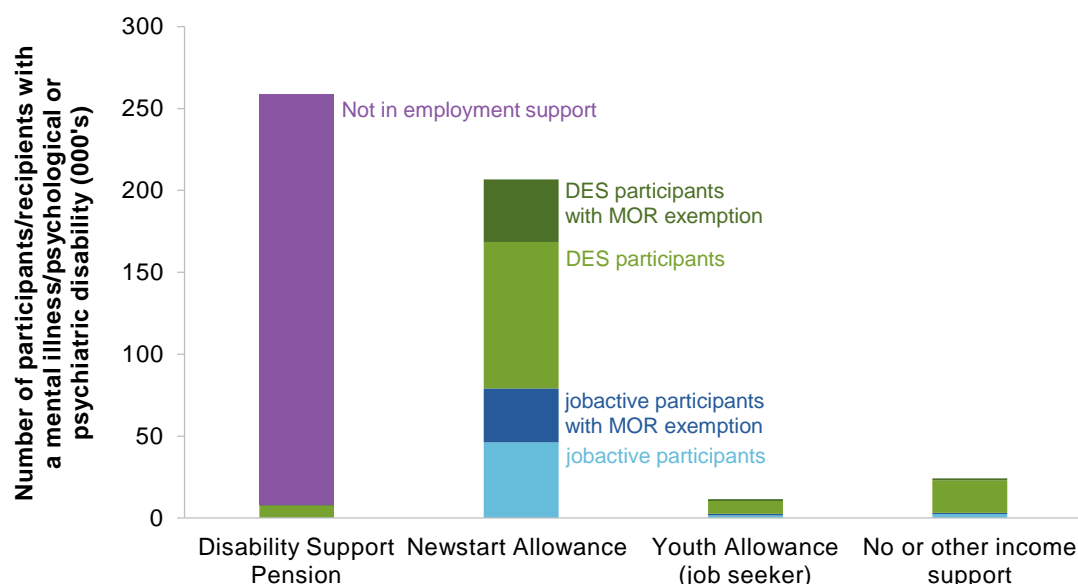
Table 19.1 How many people with mental illness receive income or employment support?^a

<i>Payment or program</i>	<i>Number of people</i>	<i>Estimated cost of payments or programs for people with mental illness (2018-19)^b</i>
<i>Income support payments</i>		
Newstart Allowance ^c	181 700 deemed to have a mental illness	\$2 578 million
Youth Allowance (job seeker)	9 200 deemed to have a mental illness	\$98 million
Disability Support Pension	258 600 with a primary psychological or psychiatric disability	\$5 774 million
<i>Employment support programs</i>		
jobactive	85 100 deemed to have a mental illness	\$139 million ^d
Disability Employment Services ^e	95 700 with a primary psychiatric disability	\$328 million
Community Development Program ^f	3 800 deemed to have a mental illness	\$53 million

^a The number of payment recipients in 2019-20 is likely to be significantly higher as the COVID-19 pandemic continues to affect unemployment rates and the broader economy. ^b Estimate is the product of the total program cost (as provided in the Department of Social Services (DSS) and Department of Jobs and Small Business Portfolio Budget Statements for 2019-20) and the proportion of recipients/participants with mental illness, psychiatric disability, or psychological or psychiatric disability. ^c The JobSeeker Payment replaced the Newstart Allowance and some other payments in March 2020. ^d This estimate was supplied by the Department of Education, Skills and Employment and is equivalent to the value of payments supplied to jobactive providers supporting job seekers deemed to have a mental illness. ^e May include other non-DES disability employment support (approximately \$35 million in 2018-19). ^f Cost estimate uses 2017-18 data.

Source: Productivity Commission estimates using ANAO (2017a); DJSB (2019); DSS (2019h, 2019k); unpublished data from Department of Social Services; Department of Education, Skills and Employment, and National Indigenous Australians Agency.

Figure 19.1 Most income support recipients are split between jobactive and Disability Employment Services programs^{a,b,c,d}
Income support recipients deemed to have a mental illness or related disability by employment program, June 2019



^a Reported jobactive, Newstart Allowance and Youth Allowance participants/recipients are those with a mental illness as reported via the Job Seeker Classification Index and/or Employment Services Assessment assessments and may not be directly comparable. Reported Disability Employment Services participants receiving the Disability Support Pension are those with a primary psychiatric disability, while other reported Disability Employment Services participants are those with mental illness reported via the Job Seeker Classification Index and/or Employment Services Assessment assessments. Reported Disability Support Pension recipients are those determined to have a primary psychological or psychiatric disability based on the Disability Support Pension assessment process. ^b The number of jobactive and Disability Employment Support participants receiving the Newstart Allowance and Youth Allowance (job seeker) does not sum to the total number of Newstart Allowance recipients presented in table 19.1 due to reporting differences. ^c Participants with MOR (mutual obligation requirement) exemptions do not need to complete employment support activity requirements. ^d The JobSeeker Payment replaced the Newstart Allowance and some other payments in March 2020.

Source: Unpublished data from the Department of Social Services and the Department of Education, Skills and Employment.

19.3 Improvements to the employment support system

Effectiveness of employment support for people with mental ill-health

Some service providers, service users and advocacy groups have argued that standard jobactive and DES supports are inadequate for people with mental illness and can exacerbate their illness, in part due the high ratio of participants to caseworkers (box 19.1, box 19.2).

Box 19.1 Stakeholder views about jobactive effectiveness

Advanced Personnel Management, a jobactive provider, told a recent Senate inquiry that mental health issues 'are not currently being serviced appropriately' under jobactive (EERC 2019, p. 73).

yourtown (sub. 511, p. 8), a jobactive provider, contended that:

[G]iven the structure and high case load of jobactive, it is extremely difficult to meet the mental health needs of young people who present with them through the program due to the lack of funding to support psychological and/or psychiatric interventions.

The National Social Security Rights Network (sub. 283, pp. 4–5), a peak community organisation in the area of income support law, policy and administration submitted that:

Job providers can assist people to actively engage and participate in the labour workforce. However, to do this effectively in the case of people living with mental illness, it is critical that the job provider have the expertise and capacity to understand their particular needs. In our members' experience, job providers which are not specialist Disability Employment Service Providers often do not have this capacity or expertise ... For example, it is common for job providers to offer a person living with mental illness employment that is incompatible with their condition and negatively impacts on their mental health.

Users of jobactive have criticised jobactive providers as being unhelpful to their job search or indicated that jobactive participation negatively affected their mental health:

They seem to be stretched so thin, I'm sure that individually they're fine at their jobs but due to the sheer volume of people they need to deal with, you'd never know. (ACOSS 2018, p. 57)

My new job plan now states I must 'take responsibility' for finding my own work and to report (online) my attendances at all required activities. This begs the question. 'What is the provider being paid to do?'. (EERC 2019, p. 61)

Employment agency and Centrelink requirements continue to be the number one reason in forcing me to stop work/study/volunteer work. (CHF, sub. 496, p. 41)

Sometimes it has made me feel suicidal. I feel depersonalised and a failure in general. That I don't have the same rights as an employed person. (ACOSS 2018, p. 13)

In 6 years being registered with many different agencies, I have not been sent to one, not one job interview from an agency. Every fortnight, by compliance with the threat of Newstart Allowance suspension/cancellation if I miss it, I must attend these useless appointments ... In the long term this is psychological torture and it affects me greatly where I once had a panic attack in the office and walked out halfway through the appointment and got a suspension. I felt useless and just a unit for the agency to make money off and felt degraded and dehumanised by the constant nothingness in a system that does nothing to help me gain employment. (Ewen Kloas, sub. 567, p. 1)

Outcomes for jobactive participants with mental illness are worse than for others. Between July 2015 and June 2019, people who reported a mental illness comprised 12% of the jobactive cohort, but only 7% of job placements (although participants with and without mental illness keep the jobs they are placed in at comparable rates)²⁰³ (unpublished data from the Department of Education, Skills and Employment). And at December 2018, 82% of jobactive participants who reported a mental illness spent more than 12 months in employment support, compared to 64% of the wider jobactive population (unpublished data from Department of Employment, Skills, Small and Family Business).

²⁰³ From July 2015 to June 2019, 63% of job placements among participants with mental illness resulted in the participant remaining in work for at least four weeks, compared with 64% of placements among people without mental illness. The equivalent statistics for 12 and 26 weeks were 54% vs. 56% and 33% vs 41%, respectively (unpublished data from the Department of Education, Skills and Employment).

Likewise, outcomes for DES participants with a primary psychiatric disability are worse than those for participants with other disabilities. People with a primary psychiatric disability comprised 41% of the DES cohort in January 2020, but accounted for only 21% of total employment outcomes in that month (LMIP 2020).

Box 19.2 Stakeholder views about Disability Employment Services effectiveness

Submitters to this Inquiry critiqued the effectiveness of Disability Employment Services.

Disability Employment Services [is] uneconomic, inefficient and ineffective ... The Australian Government's Disability Employment Services are ineffective at supporting those with a mental health diagnosis as they lack the understanding of lived experience. There is a lack of connection between the DES and Centrelink to provide wrap around support which is what an individual needs to support their healing and recovery. (David Clark, sub. 205, pp. 5, 28)

I applied for and was granted the disability support pension (DSP) in 2012. I then sought support from disability employment services (DES) because I desperately wanted to, in time, be back in employment and off the DSP. My experiences with the two DES providers I saw were not only unhelpful but highly distressing. This greatly exacerbated my mental health issues. I found that the DES staff I engaged with, lacked knowledge and expertise in working with people with mental health issues. (Name withheld, sub. 67, p. 3)

DES could be and should be more effective, particularly for people living with mental health issues ... The significant majority of people who commence with an employment service should expect an employment outcome. (CMHA, sub. 449, pp. 11–12)

Disability Employment Services (DES) has great potential to improve lives however currently predisposes people with a mental illness to failure. People with a mental illness have the lowest success rates within DES and part of this is due to the one size fits all nature of the DES Performance and Funding Models. Providers are under resourced to give the support that is needed and as a result people with a mental illness fail to achieve employment outcomes. (Worklink Group Ltd, sub. 611, p. 1)

Further, a review of the Employment Services Assessment found anecdotal evidence that DES providers 'seldom' considered the barriers to employment and the recommended interventions detailed in a participant's Employment Services Assessment report (EY 2019).

However, such figures are misleading indicators of program effectiveness. People with mental illness face significant barriers to employment and, as such, it is somewhat inevitable that they would achieve fewer employment outcomes when compared to participants without such illness.

And there are examples of DES and jobactive providers developing or funding additional (and successful) supports for participants with mental illness to improve employment outcomes (box 19.3). These show that the employment support system is potentially capable of addressing the employment support needs of people with mental illness.

That said, there are some clear ways to improve the employment support that people with mental illness receive.

- Assessment and streaming processes could be adjusted to more reliably detect mental illness in participants at the intake stage.

- New Employment Services (currently in development) could introduce complementary services like online peer support groups, and ensure participants with mental illness have access to face-to-face support if they need it.
- Compliance frameworks for mutual obligation requirements (MORs) could be applied more flexibly for people with mental illness.
- People with severe mental illness could receive more tailored support integrated with their clinical care via an Individual Placement and Support (IPS) program.

Box 19.3 Provider innovations for participants with mental illness

Psychosocial interventions

A Job Services Australia (the program that preceded jobactive) provider established psychosocial intervention workshops that aimed to increase employment outcomes by improving participant resilience, wellbeing and self-efficacy. The workshops increased overall job placements by 71%, with the sharpest improvements coming from participants deemed to be the least job-ready (Coppin et al. 2019).

your job, your way

yourtown, a national charity for children and young Australians and a jobactive provider, is piloting a new service for participants aged 16 to 21 years who have been unemployed for more than 52 weeks. Participants are provided a case manager and employment mentor who both have completed mental health training, and caseloads are small (approximately 25 participants). The results of the pilot have yet to be finalised (yourtown, sub. 511).

Mental Health Consultancy

EPIC Assist, a Disability Employment Services provider, supplements the work of its usual caseworkers with a trained psychologist in the role of 'mental health consultant'. Disability Employment Services caseworkers can refer participants to this consultant, who then assists the caseworker with job searching and also provides services such as counselling and therapeutic support, referral to bulk-billing psychologists, help to navigate government services, and ongoing support after employment. During a 14 month pilot, 61% of referred participants achieved an employment outcome (Anglicare Australia, sub. 376).

Assessment and streaming process

The Job Seeker Classification Index (JSCI) and the Employment Services Assessment (ESAt) (appendix C) are used to stream jobless people into the different variants of employment support. But too often, these tools misclassify people with mental illness. Placing participants with severe mental illness into low support programs decreases the likelihood of them gaining employment and unnecessarily extends time spent unemployed. Conversely, placing job-ready participants into expensive, high support programs needlessly increases program costs. Even though the CDP does not have formal streams, improvements

to the JCSI and ESAt would also benefit CDP participants by better informing providers of participants' vulnerabilities (including mental illness), which determine their MORs.

The Job Seeker Classification Instrument

The JSCI is a brief assessment, usually conducted over the phone in less than five minutes by an assessor from Services Australia (EERC 2019). This questionnaire relies on participants disclosing information about their employment barriers, including mental illness and its impact on their work capacity (the type of work they can complete and the number of hours they can work). Reliance on disclosure raises a significant concern that respondents who are unwilling to disclose a mental illness or who are unsure how it impacts their work capacity may be inappropriately placed in a lower support stream than necessary.

Two aspects of the questionnaire accentuate the risk of non-disclosure. First, participants are told that answering medical questions is voluntary. Second, the JSCI does not ask any specific question concerning mental illness, but instead two broad questions relating to any disabilities or medical conditions that affect working hours or job type (Australian Government 2018c). Without more specific guidance about what comprises an illness, people who do not have a formal diagnosis or do not see their problem through a medical or disability lens may not self-report an illness. As such, yourtown (sub. 511, p. 8) submitted that:

[The JSCI] has been found to not accurately stream clients, and as a result many clients with complex issues such as mental health, homelessness or post detention find themselves placed into Stream A, which is designed to assist participants with a high level of independence.

We know that many people do not disclose a mental illness during the JSCI questionnaire. The 2014-15 National Health Survey estimated that 42% of Newstart and 29% of Youth Allowance recipients had a mental illness (ABS 2015), but only 16% of Newstart and 7% of Youth Allowance recipients at June 2015 self-reported a mental illness when they completed the JSCI (Australian Government 2018b; unpublished data from Department of Social Services).²⁰⁴

In principle, the accuracy and precision of the JSCI in detecting mental illness that affects work capability could be enhanced by adding more specific guidance to JSCI respondents about the kinds of disabilities or medical conditions that are relevant to the assessment. For example, specifically asking about the presence of anxiety or depression could trigger respondents to disclose their condition. If there is capacity to further expand the JSCI, a short tool assessing psychological distress or functional capacity should be added to better determine the presence of disabilities or medical conditions, as suggested by the OECD (2015). Crude estimates of the aggregate costs of adding a short tool (of, say, 10 questions) to the JSCI suggest it is not significant when compared to other administrative costs of employment support programs, and the personal and other costs of streaming people into the wrong level of support, but care should be taken to not overload the JSCI in its

²⁰⁴ These data are not exactly comparable, as the JSCI is completed on entry into the payment (except where there is a reassessment) and the National Health Survey captures the mental health of recipients at a common point in time.

current form. Adding more detail on mental illness may set a precedent for other refinements, such as other medical conditions or factors impeding employment.

Offering online completion of the JSCI would substantially lower the incremental costs of additional questions, and allow for more specific guidance about, and examples of, what comprises an illness that negatively affects work capacity. Online completion of the JSCI has also been found in a recent trial to be slightly more accurate than assessments completed over the phone (Department of Education, Skills and Employment, pers. comm., 24 January 2020). And it could give respondents more time to fully consider their answers and de-stigmatise the process. Hence, while it is beyond the scope of this Inquiry to recommend that the JSCI be available online, if such a shift is made it should be accompanied by more substantial changes, such as the addition of a diagnostic tool and more specific guidance to respondents, to increase disclosure of mental illness.

The Employment Services Assessment

If the JSCI identifies sufficient barriers to employment, participants are referred to a more thorough assessment process — the ESAt. This is undertaken by an allied health professional and in a face-to-face setting in about 80% of cases (SSCEEWR 2013). However, there are concerns that it is too generic and not adequately geared toward the needs of people with mental illness.

Waghorn and Hielscher (2014, p. 3) proposed enhancing the ESAt by including specific measures tailored to participants reporting a mental health-related illness or disability:

[T]he DES eligibility classification system could be enhanced by providing assessors with specialised training in mental health, particularly psychosis. This could include developing a new assessment tool to classify the overall employment related severity of psychiatric disability. Promising components of such a tool include the Personal and Social Performance (PSP) Scale, as well as measures of duration of illness and course pattern of illness. The last two in particular are brief and can be assessed from treatment history, and all three are correlated with employment status in the second national survey of psychosis. Such a tool could be developed by policy makers. If found reliable and valid, it could prevent much of the misclassification of people with psychiatric disorders that is so often reported by those involved with job capacity assessments.

Before adding instruments to the ESAt, consideration of context, training and costs is necessary. The Personal and Social Performance scale may be a viable option based on positive reviews of its reliability (Burgess et al. 2016) and ability to predict employment outcomes (Waghorn and Hielscher 2014). However, further investigation should consider other equally suitable instruments before changes to the ESAt are implemented.

Workforce shortages in regional areas appear to hinder the use of ESAts, leading to inappropriate streaming toward lower levels of support and higher MORs (NSSRN, sub. 283). Increased provision of the ESAt over the phone may help relieve these shortages with no loss of quality. A recent review found that ESAts conducted over the phone and in-person produce comparable streaming outcomes (EY 2019).

Leveraging the new mental health assessment and referral tool

A further step would be to enhance the JSCI and ESAt with data collected elsewhere about participants' mental health. This could allow for more accurate sorting at minimal additional administrative cost and prevent participants from having to tell and re-tell their stories.

The Productivity Commission has recommended the development of a mental health assessment and referral tool, which would include details of a consumer's mental health treatment plan and functional capacity (action 10.4). Once this has been developed, the Department of Education, Skills and Employment should work with the Department of Health to allow employment support participants who have a mental health assessment generated by the new assessment tool to be able to share parts of it with Services Australia (for the purposes of streaming) and/or their employment support provider.

Participant choice and consent is vital. Participants should be able to choose which (if any) information is shared with Services Australia and/or their employment support provider.

ACTION 19.1 — EMPLOYMENT SUPPORT ASSESSMENT TOOLS

Assessment tools that stream participants into different levels of employment support programs should be made more relevant to people with mental illness.

Start now

- The Department of Education, Skills and Employment should increase the Job Seeker Classification Instrument's relevance for participants with mental illness by:
 - providing more specific guidance to job seekers about the types of impacts on their functionality resulting from illness or disability that are relevant to their employability and work capacity
 - adding a short form mental health assessment tool to the Job Seeker Classification Instrument.
- The Department of Social Services should supplement the Employment Services Assessment with the Personal and Social Performance Scale or similar instrument to more accurately assess the employability of participants with mental illness.
- Once the new mental health assessment tool is developed and in common use (action 10.4), participants should be given a choice to share the information contained in their clinical assessment when completing their employment assessment under the Job Seeker Classification Index or the Employment Services Assessment. Any sharing of information should require the participant's explicit consent.

Future of the jobactive program

The anticipated Australia-wide extension of the current trial of online provision of jobactive services (appendix C) would, on face value, have benefits for participants, including those with mental illness. The new system offers the scope for more flexible activities to meet MORs. This is likely to benefit those with mental illness, as those who fail to meet requirements can face punitive measures of payment cuts and suspensions. In addition, participants would avoid travel costs for currently obligatory face-to-face meetings with service providers.

Moreover, Digital First is also open to all Australians, which may improve job accessibility for people with mental illness who are not on income support. And real-time data from a digital service also has the potential for more sophisticated matching of participants to jobs. This is likely to be of greatest benefit for those where matching is currently crude, including those with mental illness.

While not planned as a feature of the system, a digital approach to services also offers the scope for the low cost introduction of complementary services. Online peer support groups, for example, could add value. A recent German study found that participants using an online peer support group experienced higher self-efficacy (belief in capacity to job search and find employment) and were more likely to acquire skills relevant to employment (Felgenhauer et al. 2019). While this study focused on participants with a range of barriers to employment (physical and mental illness, ex-prisoners, single parents, people with low education levels, and others with high risk of long-term unemployment), the positive outcomes of emotional support from peers and reduced social isolation are likely to significantly benefit participants with mental illness. These are similar to benefits from social connection provided by generic online forums (Smith-Merry et al. 2019). The advantage of digital platforms is that the largest cost of any change is borne during the development phase, with the incremental costs close to zero for a developed service.

However, the new model does bring possible risks. Digital First targets people who are job ready and digitally literate, but many people with mental illness may be allocated to this stream despite being ill-suited to it. As noted above, many people with mental illness are not identified using the JSCI and will be expected to access employment support autonomously using Digital First. This suggests that where a participant provides additional evidence of illness (or signs of illness evident from a person's patterns of use of the service), it should be straightforward to shift them from Digital First (no human support) to Digital Plus or Enhanced Services (where face-to-face assistance is available). This issue further reinforces the case for improving the capacity of the JSCI to determine the presence of mental illness in participants.

The scale of this risk could be significant as 16% of jobactive participants who self-reported a mental illness in February 2019 were allocated to Stream A jobactive services (DJSB, sub. 302). While this is the lowest level of support, face-to-face interactions still occur, which may reveal more serious obstacles to employment than suggested by the JSCI alone. Were this group to be enrolled in Digital First, then there would be no watchful human eye on each person's vulnerabilities, and the cost of misclassification for the person and society could be significant.

It may be prudent not to allocate anyone disclosing a mental disorder to Digital First without first offering them the choice of a higher support stream or making further assessment of their capacity to seek a job unaided by any service provider. Further, Digital First participants who have not been able to find employment after an extended period of time could be referred to higher levels of support. Under a separate (ongoing) trial of online employment support, participants receive in person support if they do not find a job within six months (DESSFB 2019). Learnings from this trial should inform the development of New Employment Services.

A further concern is that some participants may struggle with using the technology, reducing their capacity to search for and find employment and placing them at higher risk of inadvertently breaching compliance requirements. Not everyone has reliable access to a computer or the internet, and some people struggle with language barriers or poor digital literacy (Citizens Advice Bureau New Zealand 2020). Clearly, no penalties should be imposed when online services are unavailable due to technical issues. Feedback to the New Employment Services trial suggested that payment suspensions or cancellations imposed for apparent non-compliance for someone using a purely digital system should be followed up in-person before they are applied (NESA 2018a; Nous Group 2018a). This would give providers the opportunity to review a participant's capacity to meet their MORs and ensure they do not face unduly severe financial penalties, which would likely to contribute to a relapse in their mental illness. Participants moving between penalty zones under the new compliance framework should have their activity requirements reviewed (DSS 2018I), which should take this into account.

ACTION 19.2 — TAILOR ONLINE EMPLOYMENT SUPPORT

Ongoing development of the New Employment Services should explicitly consider the needs of participants with mental illness.

Start now

As part of the national rollout of New Employment Services, and drawing on evidence of the trial underway from 2019 to 2022, the Department of Education, Skills and Employment should:

- ensure participants with inadequate digital literacy and/or mental illness are able to choose to maintain access to face-to-face services
- not allocate any participants who have reported a mental illness to Digital First unless they have chosen this stream or been determined to not be at high risk of long-term unemployment (potentially through an in-person assessment by the Job Seeker Classification Instrument or Employment Services Assessment)
- assess the potential for online peer group support for participants with mental illness as part of the Digital First software
- ensure scope for participants to inform service providers of a relapse in mental illness in a timely manner.

Mutual obligation requirements may impact participant mental health

MORs are regular activities almost all employment support participants must complete that aim to encourage participants to actively search for employment, improve their employment prospects or contribute to their community (appendix C). For the majority of participants, completion of these activities will be linked to their receipt of income support payments (figure 19.1).

Some Inquiry participants and advocacy groups viewed the existing MORs as excessive or overly punitive (appendix C). Whether or not MORs are reasonable should be determined by balancing their effectiveness in encouraging job search, achieving job outcomes, their cost and their incidental effects on the wellbeing of participants subject to them. Notably, weakening of MORs must, to some extent, reduce the quantity of job searches participants complete and potentially the quality of participation in employment support programs. While it is likely that more stringent MORs also impose stress on participants, little is known about the degree to which different intensities of MORs could precipitate clinically defined mental illness in previously well participants.

Given this, and the broad labour market impacts of changes to MORs for all participants, this report considers MORs from a narrower perspective. There are good grounds to be much more cautious from a policy perspective in implementing stringent MORs for people with pre-existing mental illness, as sound reasons and plausible evidence suggest this could aggravate their illness and increase distress (ADACAS, sub. 493; AMA, sub. 387; cohealth, sub. 231).

Existing policy settings already recognise that a participant's illness or disability should be taken into account when setting MORs (box 19.4). The issue is whether these settings are reasonable for people with mental illness.

While, in principle, social security regulations provide many avenues for people with mental illness to avoid inappropriate sanctions, these avenues rely on being able to identify people experiencing mental illness. As noted earlier, the JSCI may not detect mental illness and this lack of detection may not be corrected quickly through subsequent re-assessment. Consequently, people with mental illness may too often be allocated to the less supportive streams of assistance and exposed to the risk of sanctions when they fail to achieve unrealistic MORs. For example, a person with significant depression may not be able to attend a job appointment or notify their jobactive provider that they have failed to do so. As a result, they would acquire demerit points, which can lead to payment suspensions, placing them at risk of worsening mental health. Surveys of jobactive participants suggest that improperly tailored Job Plans with copious MORs can adversely affect the mental health of income support recipients with pre-existing mental illness (ACOSS, sub. 270; CHF, sub. 496; JA, sub. 398).

This highlights the importance of refining the assessment processes for determining participants' obstacles to work to avoid misclassification errors — as recommended above. Some have argued the Targeted Compliance Framework (used to impose penalties on jobactive and DES participants) should also be changed given its adverse impacts on some clients (EERC 2019). Similar criticisms have been made of the Job Seeker Compliance Framework, which is used for the CDP (Fowkes 2019). There are provisions to ensure participants with mental illness are not disproportionately affected by either compliance framework (box 19.4) and the first step should be to ensure these provisions are used as needed. The question of whether the compliance frameworks themselves should be less strict (for example, by requiring participants to accrue more demerits before receiving a financial penalty) on the grounds that they cause mental illness among participants without a pre-existing mental illness or exacerbate existing mental illness is more complex. There may be grounds for this, but the evidence is, so far, anecdotal. Ongoing assessment of any such causal links would be worthwhile.

Jobs Australia (sub. 398, p. 8) suggested greater flexibility for participants with mental illness:

[There is] value of providing greater flexibility in the application of the Targeted Compliance Framework (TCF) for jobseekers experiencing mental health concerns, with members indicating that the TCF can engender a greater level of stress for these jobseekers, detracting from their wellbeing and stability, generating barriers to employment. The utilisation of flexibility in how appointments are conducted (for instance, via phone or at a time when the office is less busy) can generate a more therapeutic environment.

Increased flexibility from providers in the application of compliance frameworks is likely to be beneficial to all participants, not just those with mental illness and could come in the form of improved Job Plans (as below), broadening the scope of activities that count toward MORs and increasing participants' choice about the activities they undertake. In this last respect, Inquiry participants suggested activities that foster improved mental health and reduce social isolation could be counted as MORs for some participants with mental illness (NDS, sub. 777).

Box 19.4 Reduced mutual obligation requirements for people with disability and illness

Several measures aim to assist participants with limited capacity to meet mutual obligation requirements (MORs), and thereby avoid unduly punitive financial penalties under compliance frameworks. In particular, providers across all employment support programs are instructed to consider a participant's mental illness when determining whether they have a reasonable excuse for not completing MORs outlined in their Job Plan (DSS 2018b; Fowkes 2019). This applies to the removal of demerit points and the reinstatement of payments if a mutual obligation failure has occurred. Under the Job Seeker Compliance Framework, Community Development Program participants must have the opportunity to complete a Comprehensive Compliance Assessment before extended financial penalties (withdrawal of payments for eight weeks) can be imposed. While not specific to people with mental illness, the outcome of these assessments can be a referral to mental healthcare or other specialist services (Australian Government 2017b).

Participants with a worsening illness who are unable to complete MORs for an extended period can apply for a 'temporary incapacity' exemption. Applicants must provide a medical certificate (detailing a diagnosis and prognosis) and be unable to work or complete another work-like activity for more than eight hours per week due to their medical condition (DSS 2018d). At June 2018, 17% of Newstart Allowance recipients with a self-reported mental illness held an exemption on this ground (20 100 recipients) (unpublished data from Department of Social Services). Centrelink grants this exemption, which lasts for 13 weeks, and may extend it up to 52 weeks in total without the provision of additional medical certificates, depending on the length of illness listed in original medical certificates (DSS 2018d). Subsequent extensions require an additional medical certificate. Long-term exemptions can be extended to 52 weeks (and sometimes by a further 6 months) if a participant has a serious illness and is receiving treatment in a mental health institution (DSS 2018d). A person with a severe and permanent (as defined by eligibility criteria) mental illness can apply for the Disability Support Pension at any time.

More generally, participants should have a Job Plan that is tailored (if needed) to their individual characteristics, including any barriers to employment and work capacity. The expected level of mutual obligation varies with a person's assessed capacity. For instance, a participant with a partial capacity to work between 0–14 hours a week may be able to meet their MORs by attending a quarterly interview with Services Australia to discuss their participation and meeting the terms of their Job Plan. Such participants can volunteer to accept a referral to a suitable program of assistance recommended by medical assessments, but cannot be penalised for not accepting a referral (DSS 2018c). And some participants can meet their MORs by participating in mental health support, drug and alcohol rehabilitation or other non-vocational activities that aim to increase community participation (Australian Government 2019a).

Improving Job Plans

Where a participant needs little support to find suitable employment, the quality of their interactions with employment support providers and of the associated Job Plans are unlikely to have a substantial impact on their employment outcomes. Hence, most Job Plans *should* be similar (containing the standard number of required job searches and face-to-face provider meetings, among other requirements). However, for many people with mental illness — often comorbid with other obstacles to work — more personalised Job Plans are almost certainly needed. Many such participants will not have an illness serious enough to be covered by a scaled-up IPS program (section 19.4), increasing the grounds for ensuring Job Plans are customised.

However, Job Plans reflect mixed motivations. On the one hand, plans are effectively a social security compliance document. They are the primary means of recording the specific and quantifiable requirements expected of participants to retain benefits (such as number of job applications, enrolments in particular courses, specified voluntary work) (DSS 2015c). Those obligations may be reduced based on a participant's circumstances, such as a limited capacity to work due to mental illness — again consistent with being a compliance instrument. On the other hand, plans must also take into account participants' 'personal needs' and be focused on achieving sustainable employment — both more positive goals.

Participants and some providers of employment support programs largely view plans as compliance documents. A survey undertaken for the Department of Jobs and Small Business (Thinkplace 2018, p. 73) found that participants strongly perceived plans to be 'a standard compliance activity more than anything else', rating 4.2 out of scale from 0 (no agreement) to 5 (full agreement). In contrast, jobactive participants only weakly agree a Job Plan 'considers my needs and requirements' (2.6 out of 5), or 'considers my ability to find work' (2.7). These perceptions echoed the National Employment Services Association's (2018b, p. 19) judgment that the plans have evolved to be a 'purely ... administrative function'. yourtown, a jobactive provider, stated that Job Plans are highly prescriptive and 'do not give clients and employment consultants much room for personalisation' (sub. 917, p. 15). However, this is based on a small non-representative sample of participants, which is insufficient to conclude that the quality of Job Plans is poor for people with complex needs.

One way of ensuring that such plans are meaningful for this group is to monitor the adequacy of plans as part of the quality assurance processes used by Department of Education, Skills and Employment. Though these processes are generally good (ANAO 2017b), data analytics could systematically check the degree to which Job Plans reflect the needs of those with more complex obstacles to employment (as revealed by the JSCI and ESAt). This could then inform feedback to providers about lifting their performance.

Another (and potentially complementary) way is to extend the time that participants with complex needs have to consider the terms of their Job Plan. Currently, participants have up to two business days of 'think time' to consider their plan and consult with a third party if they wish (although there is some anecdotal evidence this does not always occur

(EERC 2019)). Extending this period to one week (five business days) would allow, at least in principle, greater scope for participants to discuss their plans with a clinician or carer, and propose amendments. Increased ownership of Job Plans by participants could help promote participation in preparing and searching for employment. This flexibility could be reserved for participants identified as likely to require more intensive support (potentially 85 100 jobactive participants with a recorded mental illness or 181 700 Newstart Allowance recipients with a recorded mental illness as at June 2019 (unpublished data from Department of Education, Skills and Employment and Department of Social Services)).

ACTION 19.3 — MUTUAL OBLIGATION REQUIREMENTS

Mutual obligation requirements need to be adjusted so that they better assist job seekers with complex mental health needs to find employment.

Start now

The Departments of Human Services; Social Services; and Education, Skills and Employment should:

- provide greater flexibility in the application of the Targeted Compliance Framework and Job Seeker Compliance Framework for job seekers experiencing mental illness
- assess systematically whether employment support providers are meeting their obligations to provide personalised Job Plans that go beyond compliance, targeted at job seekers with complex needs
- extend to five business days the period of time that job seekers with both mental illness and complex needs have to consider and propose changes to their Job Plan.

19.4 Toward an Individual Placement and Support model of employment support

People whose complex, enduring or severe mental illness is their main barrier to employment require more intensive support than is usually provided via DES. An emerging model that integrates employment with on-the-job training and clinical supports is the Individual Placement and Support (IPS) program. The IPS model involves a rapid job search followed by on-the-job training (known as a ‘place-train’ focus), ongoing support from caseworkers after employment and tight integration between employment and clinical support (appendix C). This program holds promise for both existing employment support participants with severe mental illness and DSP recipients who access community ambulatory mental healthcare services but are not engaged in employment support

(chapter 12). The provision of IPS to jobless adults with severe and persistent mental illness is supported by numerous participants in this Inquiry.²⁰⁵

At present, the IPS model operates in two forms in Australia.

- *Direct employment*, where mental healthcare services directly employ IPS specialists to work alongside clinical teams. Orygen Youth Mental Health employs 4 full-time equivalent IPS specialists and 14 headspace centres employ 31 full-time equivalent IPS specialists (Waghorn et al. 2019). The headspace IPS trial, which targets younger people whose symptoms of mental illness are relatively less acute, is discussed in chapter 6.
- *DES partnerships*, where a specialised DES provider partners with a mental healthcare service (in practice, a community ambulatory mental healthcare service) to offer an IPS program. The IPS specialists are employed by the DES provider, but seconded to the community ambulatory mental healthcare service. In 2018, 53 full-time equivalent IPS specialists were employed in this capacity (Waghorn et al. 2019).

However, participant take up across either format is low. At mid-2018, about 1800 people accessed an IPS service (including the headspace trial) (Productivity Commission estimate using Waghorn et al. 2019), whereas there were more than 193 000 DES participants at that time (LMIP 2018).

Evidence underpinning the Individual Placement and Support model

Individual trials and meta-analyses in Australia and abroad have shown that the IPS model outperforms conventional approaches, with superior vocational outcomes (greater employment of participants) and non-vocational results (improved mental health leading to reduced need for healthcare). The effects are often large — sometimes with employment rates of the order of 40 percentage points greater than conventional programs (table 19.2). This evidence also points to community ambulatory mental healthcare services as the logical clinical setting from which to base IPS services, as the evidence base mostly derives from studies of IPS in community ambulatory mental healthcare setting or international equivalents.

²⁰⁵ For example, Aftercare, sub. 480; Allianz Australia, sub. 213; Australian Clinical Psychology Association, sub. 359; Black Dog Institute, sub. 306; Consortium of Australian Psychiatrist-Psychologists, sub. 260; Consumer Mental Health Australia, sub. 449; Jobs Australia, sub. 398; Mental Health Coordinating Council, sub. 214; Mental Health Victoria, sub. 580; NT Mental Health Coalition Inc, sub. 430; Olav Nielssen, sub. 37; Private Mental Health Consumer Carer Network, sub. 49; Public Health Association of Australia, sub. 272; Royal Australian and New Zealand College of Psychiatrists, sub. 385; Rehabilitation Counselling Association of Australasia, sub. 732; Robert Parker, sub. 12; Roger Gurr, sub. 40; Tim Heffernan, sub. 552; Victorian Government, sub. 483; and WAAMH, sub. 1112.

Table 19.2 Individual Placement and Support trial results

From Australian trials and international meta-analyses

<i>Reference</i>	<i>Location</i>	<i>Time frame</i>	<i>No. of participants</i>	<i>Findings</i>
Parletta and Waghorn (2016)	Australia	18 months	68 IPS, 107 control	<ul style="list-style-type: none"> • More IPS participants achieved a job commencement than the control group (68% vs 56%) • IPS programs generated more net revenue for employment providers than the control group.
Killackey et al. (2008)	Australia	6 months	20 IPS, 21 control	<ul style="list-style-type: none"> • 36% more IPS participants found employment, compared with the control group • 25% less of the IPS group's primary source of income was welfare (control group experienced no change) • IPS group worked more weeks, more hours and earned more income over the course of the trial
Waghorn et al. (2014)	Australia	12 months	106 IPS, 102 control	<ul style="list-style-type: none"> • IPS participants were more likely to commence employment (43% of IPS group employed at 12 months, compared with 24% of control group)
Marshall et al. (2014)	Meta-analysis (international)	6 months – 12 years	Varies (17 studies considered)	<ul style="list-style-type: none"> • IPS consistently demonstrated higher rates of competitive employment, fewer days until first competitive job, worked more hours over more weeks and earned higher wages
Kinoshita et al. (2013)	Cochrane review (Australia and international)	6–24 months	Varies (14 studies considered)	<ul style="list-style-type: none"> • IPS participants spent more time in competitive employment and in paid employment than control groups
Suijkerbuijk et al. (2017)	Cochrane review (Australia and international)	3 months – 5 years	Varies (48 studies considered)	<ul style="list-style-type: none"> • IPS and augmented IPS programs were the most effective interventions for people with severe mental illness to obtain and maintain employment (regardless of the trial duration) • IPS participants had better mental health than the control group in the long term (> 12 months) • IPS participants had better quality of life compared with participants who only received psychiatric care in the long term.

Notwithstanding that the IPS model leads to better employment outcomes and reduced healthcare costs when compared with conventional employment support models (usually due to a reduction in the number of days participants spend hospitalised) (Heslin et al. 2011; Hoffman et al. 2014; Knapp et al. 2013), its more labour-intensive nature means that it costs significantly more to administer, raising the issue of cost effectiveness.

The Productivity Commission has estimated that providing IPS employment supports to a cohort of 40 000 participants (box 19.5) for one year would cost \$108–286 million, but would:

- increase participants' income from additional employment by \$42–90 million
- result in savings to the healthcare system (mostly from reduced hospital admissions) of \$137–575 million and savings to DES of about \$49 million (as participation in IPS would substitute for participation in conventional DES programs for some participants)
- increase participants' quality of life by 238–434 quality-adjusted life years (appendix K).

Why hasn't the Individual Placement and Support model been used more widely in Australia?

Given the relatively strong case for greater take-up of IPS employment supports within community ambulatory mental healthcare services, why has take-up been so low? The Productivity Commission estimates that, in 2017–18, roughly 40 000 consumers of community ambulatory mental healthcare services could have benefited from participation in an IPS program (box 19.5), yet only an estimated 1800 did so at mid-2018 (Productivity Commission estimate using Waghorn et al. 2019).

Funding barriers and unclear roles appear to be the dominant constraints to the diffusion of the IPS model, though each plays out in different ways for the two forms of IPS delivery.

State and Territory Governments could fund community ambulatory mental healthcare services to directly employ IPS specialists or these services could do so from their own budgets. However, despite the acknowledged importance of the recovery of people within their community, these services may not consider vocational rehabilitation as part of their core business (Waghorn and Hielscher 2014). Moreover, some State and Territory Governments may regard employment support to be an Australian Government responsibility.

Greater take-up by DES providers of IPS services in partnership with community ambulatory mental healthcare services looks ostensibly achievable and, at present, is more common than the direct employment form of IPS. The DES model gives considerable flexibility in how providers deliver employment support, with this applicable to all DES providers across Australia. However, an open question is whether the blended volume- and outcomes-based payments for DES providers are sufficient to fund the IPS model. Notwithstanding the views of DES providers, one assessment found that it was financially viable to adopt an IPS model within the 2010–2018 DES payment model, particularly when adopted for participants with more severe disabilities (Parletta and Waghorn 2016). But this study did not consider the transition costs that conventional DES providers would bear in making such a switch (such as additional staff training and the need to co-locate with a community mental health service). It is not clear whether the higher outcome payments for the most hard-to-place job seekers announced as part of the DES Reform in 2018 would be sufficient to fund these transitional costs, but the lack of a rapid take-up of IPS by DES providers since 2018

suggests not. The lack of widespread formation of new IPS partnerships post-2018 suggests that more active policy settings are needed to drive expansion of the model.

Box 19.5 IPS target cohort for a new national program

A new national Individual Placement and Support (IPS) program should target jobless consumers of community ambulatory mental healthcare services with a severe mental illness who express a desire for employment. This would include consumers who would otherwise:

- participate in other employment support programs — participation in the IPS program would fulfil any mutual obligation requirements and negate their need to participate in these programs
- not participate in employment support programs — because they do not receive income support or receive the Disability Support Pension.

In a 2014 IPS trial run out of a community ambulatory mental healthcare service, 68% of the participants were DSP recipients and 74% had not received assistance with job seeking in the past year (Waghorn et al. 2014).

How many participants nationally would this suggest? A rough estimate follows. In 2017-18 there were approximately 212 900 community ambulatory mental healthcare service consumers aged 18–44 years (AIHW 2019k). Not all of these consumers would be out of work. In 2010, the employment rate of Australians with psychosis was 22% (similar to an employment rate of 28% for people with schizophrenia in Victoria in 2006) (FCDC 2012; Morgan et al. 2012). If the former value were used as a rough estimate for all types of severe illness, then it would imply a population of about 166 100 jobless consumers. Not all consumers would need the IPS program (over other employment support options) because IPS is intended for consumers with the most severe illness (those receiving medium- to long-term treatment). This is approximately 41% of all consumers, leaving about 68 100 potential IPS participants (AIHW 2019k). Around 60% of surveyed people with schizophrenia want to work, leaving slightly more than 40 000 people (Waghorn and Hielscher 2014). These estimates are conjectural. Successful programs may attract additional participants, but may also reduce the longer-term need for the program as existing demand is met.

The route to broader adoption of the Individual Placement and Support model

These obstacles do not preclude the wider adoption of the IPS model. Cultural shifts could be achieved through transparent demonstrations of program achievements and purposeful diffusion among those not yet familiar with the model. And the benefits are sufficiently large as to be an attractive investment for either the Australian or State and Territory Governments.

Aside from its strong evidence base, three aspects favour the new model. There is good evidence of efficacy, the nature of the intervention has been very clearly defined (appendix C) so that governments know what to implement with some precision, and the target group for the intervention is established (box 19.5). Remaining questions about delivery, funding and implementation are discussed next.

Who should deliver Individual Placement and Support services?

The draft report sought feedback on two options for expanding IPS: direct employment of IPS specialists by community ambulatory mental healthcare services or a partnership approach (similar to DES, but with new funding arrangements that mandate that the contract holder deliver an IPS service and fee-for-service remuneration).

Inquiry participants generally favoured the direct employment option on the grounds that it is likely to encourage better integration between IPS specialists and clinical teams (Elucidate, sub. 755; Mind; Neami National; Wellways and Sane Australia, sub. 1212; Mitchell Institute, sub. 744; RANZCP, sub. 1200). The Productivity Commission agrees with this judgement. Better integration drives fidelity to the IPS model, which is linked to higher employment outcomes for participants (Bond et al. 2012) and can promote better communication between teams (Geoffrey Waghorn, Brisbane transcript, p. 30).

That said, wholesale adoption of the direct employment approach would disrupt established IPS programs based on DES partnerships (Consortium of Psychiatrists and Psychologists, sub. 882). While there are few of these partnerships in place, disbanding those that do exist in a dogmatic pursuit of national consistency has little merit and should be avoided. Any rollout of IPS should seek to preserve the existing programs in place.

How should Individual Placement and Support services be funded?

During the initial rollout and testing stages of the IPS program, a simple block funding approach is likely to be most appropriate. This would ensure adequate funding to get the program off the ground, when demand is likely to be uncertain and there are larger priorities than incentivising efficiency. As the program becomes more established, a transition to fee-for-service funding would be desirable so as to incentivise greater efficiency (with requirements to maintain fidelity to the IPS model). This funding model could involve loadings for participant complexity and other refinements so as to minimise any perverse incentives for community ambulatory mental healthcare services.

A further progression would be to add outcomes-based payments to the funding model (as suggested by the Consortium of Psychiatrists and Psychologists (sub. 882) and Geoffrey Waghorn (Brisbane transcript, p. 30)). This is a critical aspect of the jobactive and DES funding models, as these providers are given significant latitude to choose the ways they support participants into employment and need some incentive to run effective programs. But the need would be less critical for the IPS program as community ambulatory mental healthcare services would be required to follow evidence-based program guidelines and be subjected to fidelity reviews. Moreover, outcomes-based funding mechanisms are relatively complex to design and create financial risks for providers. So, while we are not opposed to including outcomes-based payments in the funding model, it should be less of a priority than other aspects of the rollout.

A related issue is which level of government should fund IPS services. Both levels of government would benefit from the national rollout of the IPS program. The Australian Government would save on DES program costs (as participation in the program would substitute for participation in DES for some participants) and both levels of government (although mostly State and Territory Governments) would save on healthcare costs. This suggests a cooperative funding model for IPS services could be established — potentially through a national partnership.

How should a rollout occur?

It would be impractical to immediately implement a full-scale rollout of the IPS program. Among other things, a workforce of IPS specialists needs to be created with coordination between clinical and employment support staff. About two years' experience is usually required to develop an IPS skillset (Geoffrey Waghorn, Brisbane transcript, p. 29).

Further, adaptations to the model will likely be needed as it is implemented for different groups or as the empirical evidence grows. While the IPS model is the most evidence-based approach to providing employment support for people with severe mental illness (as noted by Waghorn et al. 2019), the existing evidence principally relates to people with psychosis and may not generalise to all conditions. There is also some weak evidence that so-called 'augmented' versions of the IPS model — which include IPS with other interventions such as cognitive skills training — may further improve outcomes (Suijkerbuijk et al. 2017). Other potentially valuable additions include using peer workers, engaging participants' families or carers (Wellways Australia, sub. 396), focusing on education outcomes of young participants (Killackey, McGorry and Jackson 2008) and using cognitive skills training to improve participant psychosocial functioning (Warwick Smith, sub. 937).

Moreover, while there are many instances where the IPS model has been trialled, most have involved small numbers of participants. For example, of the 48 randomised controlled trials underpinning the Cochrane systematic review (Suijkerbuijk et al. 2017), the average number of participants per trial was 182 (of whom, roughly half received the usual employment support program as a control group, while the other half received IPS style services). It has generally been hard to replicate the outcomes of small scale social programs when delivered to large populations. For instance, while it is possible to build up the workforce of IPS specialists, it is difficult to ensure a uniform level of skill and erosion in fidelity of the model is a risk (Bond et al. 2016). Assessing fidelity with routine audits against established scales (appendix C) can reduce this risk. Additional ongoing monitoring of outcomes and periodic evaluation would be required to test that effectiveness is being maintained with program expansion and to identify potentially underperforming services.

And, while the numerous assessments of the IPS model have covered diverse populations (veterans, ex-prisoners, people from culturally and linguistically diverse backgrounds, younger and older people), the small scale of each program has not been sufficient to test differences in the effectiveness of the model across different types of people and different conditions. Effectiveness for different types of people and illness severities (and in different

locations and economic conditions) should be subject to testing as the model is expanded, and may lead to variations in eligibility conditions.

Bearing the above in mind, rollout of the IPS program should start with a review of a limited number of sites. Geoffrey Waghorn (Brisbane transcript, p. 34) suggested that 10-20 sites would be suitable. These sites — which should be reviewed through a randomised controlled trial format — should aim to uncover more information about the population groups for whom the IPS model is most effective and how the viability of the local economy impacts on its success. These sites should also collect data on participants' healthcare utilisation, as studies from abroad have indicated savings to the healthcare budget to be a significant (and often largest) source of benefit from IPS, but Australian trials have yet to study this (Burns et al. 2007; Heslin et al. 2011; Hoffman et al. 2014; Shi 2011; van Stolk et al. 2014).

There are also learnings from the headspace IPS trial (chapter 6) that should be taken into account. This trial suggests there is value in developing forums for IPS specialists to share knowledge across sites and streamlining data collection processes so that data for evaluation and fidelity reviews can be collected together at minimal administrative cost (KPMG 2019). This could be achieved by establishing a central technical support team to collect this data and manage coordination (Geoffrey Waghorn, Brisbane transcript, p. 34). There may also be merit in considering how to develop career paths for IPS specialists to reduce turnover rates.

The rollout should follow a realistic timetable. A lesson from the rollout of the National Disability Insurance Scheme was that its implementation timetable was far too ambitious, placing pressures on quality and giving false hope to people about the likely access to services (PC 2017c). While the desired timetable for a rollout should be subject to critical assessment, five years may be enough. However, there should be explicit recognition that timetables may need to be extended, if ongoing monitoring and evaluation suggests it is unattainable.

Systematic learning over time and 'comfort for funders'

The concept of fidelity with the original IPS model is an important mechanism for avoiding the erosion of service quality by particular providers as the program is scaled up. However, it could slow innovation and learning if it precludes any changes to the overall model in the long-run, and is not a guarantee of good outcomes (Geoffrey Waghorn, Brisbane transcript, p. 34). As noted earlier, there may be a role for augmentations of the IPS model. This suggests a flexible approach is needed in conducting fidelity reviews and interpreting results to promote best practice and allow for changes to the model.

Moreover, while requirements for providers to not exclude participants that meet the basic eligibility criteria help to avoid some providers prioritising some types of clients over others, this should not stop adjustments to eligibility criteria for the model as a whole, as learnings about effectiveness for different sub-groups becomes apparent. For instance, this may involve people with different severities of illness (widening eligibility) or excluding across all sites categories of people where the benefits of interventions are likely to be significantly exceeded

by the costs. Or there may be merit in placing a time cap on participation for individuals who are unable to obtain any employment outcome after an extended period of high-level support.

As discussed above, the IPS model should be well-evaluated with systematic data collection and periodic nationwide evaluations. Formal channels should be put in place to share data between jurisdictions to promote best practice throughout Australia (for example, all evaluations should be made publicly available to share evidence on what works well). The institutions and processes for achieving this learning should be specified at the outset.

A monitoring and evaluation approach of this kind should provide comfort to funders that the program could be scaled up while maintaining the net benefits of the trials. If this is not apparent, there should be a re-think of the design of the scheme.

ACTION 19.4 — STAGED ROLLOUT OF THE INDIVIDUAL PLACEMENT AND SUPPORT PROGRAM

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all relevant State and Territory Government community ambulatory mental healthcare services.

Start now

- Governments should roll out and review the IPS program to better establish the factors that influence its cost-effectiveness to different demographic groups.
- The program should initially be open to all non-employed consumers of community ambulatory mental healthcare services who express a desire to participate. Participation in the program should fulfil any mutual obligation requirements for income support recipients.
- IPS specialists should be directly employed by community ambulatory mental healthcare services.

Start later

- The IPS program rollout should be accompanied by information sharing between IPS sites to allow dissemination of best practice. If a site does not demonstrate similar net benefits to the original IPS sites, the program's design for that site (and if necessary, its desirability) should be re-appraised.
- Over the longer term, Governments should fund the IPS program on a fee-for-service basis, and require fidelity to the IPS model as a condition of this funding.

19.5 Income support benefits and incentives

This section focuses on how the current suite of income support payments can better meet the needs of people with mental illness, provided that some access issues and incentives are addressed. Because of their temporary nature, this section does not discuss changes to payments in light of the COVID-19 pandemic or relevant economic stimulus payments (outlined in appendix C).

As noted earlier, those with mental illness who are not eligible for the DSP, but remain in need of income support, may receive either the JobSeeker Payment or Youth Allowance. Submitters to this Inquiry raised concerns regarding the adequacy of the JobSeeker Payment (known as the Newstart Allowance at the time of submission),²⁰⁶ which have been further amplified through recent tightening of DSP eligibility criteria (box 19.6). For example:

I am receiving Newstart, but it is not enough to live on. ... I'm struggling to pay my rent, I have to choose between food, medicine and paying my bills. ... Living like this, without enough money or support: it is unspeakably awful: it makes you feel like no one cares, like you don't matter. I want to see my psychologist but I can't even afford to do that. I'm in a dark place. (Service consumer, ADACAS, sub. 493, p. 16)

I have severe anxiety and OCD. My main struggles have been finding help and having enough money to live ... I'm on Newstart while my DSP application is assessed. I cannot afford a rental anywhere in Vic. I am 32 and I have been forced to move home, putting more financial strain on my mum, who already supports me a lot. Anyone without my level of family support would be homeless. (comment no. 34, consumers)

It was not until I finally got victims compensation and the DSP nearly six years after the rape that led to my PTSD diagnosis that I was able to do anything more than crisis management in therapy. All nine of my suicide attempts and all of my involuntary hospitalisations occurred during this period of insecurity and debt. I urge the Commission to recommend raising Newstart and the DSP ... (Scarlett Franks, Sydney transcript, p. 162)

The rates of Newstart are so low that they make living with a mental illness a constant struggle. Accessing treatment, maintaining social connections, eating healthy food and engaging in exercise all support a person's recovery. However, many people on Newstart have very little money to pay for such things after their housing costs are accounted for. (MHLC, sub. 1222, p. 6)

[T]he extreme level of poverty experienced by people reliant on income support payments, particularly Newstart Allowance, is a serious concern for mental wellbeing. This payment is now so far below all poverty benchmarks that it works against the ability of people to seek work and contributes to social isolation and marginalisation ... (cohealth, sub. 231, p. 10)

²⁰⁶ These included Anglicare Australia, sub. 376; ACOSS, sub. 270 and 1208; cohealth, sub. 231; Consumers Health Forum of Australia, sub. 404; Ewen Kloas, sub. 567; JA, sub. 398; Jesuit Social Services, sub. 1186; Joe Calleja, sub. 422; Karen Donnelly, sub. 90; KLC, sub. 469; MHCT, sub. 314; MHLC, sub. 1222; Name withheld, sub. 136; NSSRN, sub. 283; CCL, sub. 484; Mission Australia, sub. 487; Piers Gooding and Yvette Maker, sub. 933; QAI, sub. 116; St Vincent de Paul Society National Council of Australia, sub. 1216; Uniting VIC-Tas, sub. 95 and 931; VLA, sub. 500; VCOSS, sub. 478, and Ian Webster, sub. 626.

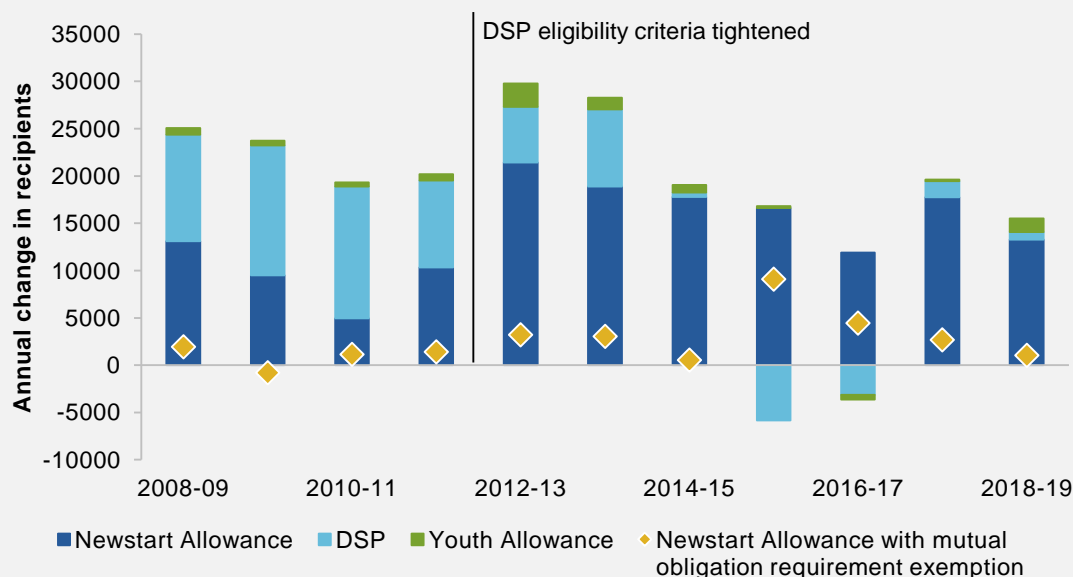
Box 19.6 Impacts of changes to Disability Support Pension eligibility criteria

The number of successful Disability Support Pension (DSP) applicants and the number of applicants with a primary psychological or psychiatric disability fell following a tightening of the DSP eligibility criteria in 2012-13. The number of new recipients with a primary or psychiatric disability fell by 37% over three years, although the share of new applicants with primary psychological or psychiatric disability remained relatively high (DSS 2016d).

The tightening of the criteria corresponded with a sharp increase in the number of Newstart and Youth Allowance recipients who reported a mental illness (figure below), and an increase in the number of medical exemptions from mutual obligation requirements for people receiving the Newstart Allowance who reported a mental illness.

Trends in income support reciprocity

Newstart Allowance or Youth Allowance recipients who reported a mental illness and DSP recipients with a primary psychological or psychiatric disability, 2008-09 to 2018-19



Source: Unpublished data from the Department of Social Services.

There are also concerns about the adequacy of the DSP (ACT Mental Health Consumer Network, sub. 297; Mission Australia, sub. 487). In 2015-16, a substantial proportion (36%) of the total DSP cohort were living below the poverty line — a weekly income less than \$433 (VCOSS, sub. 478). Although the DSP is paid at a higher rate than non-pension payments, there are concerns this does not adequately take into account the higher cost of living faced by people with a disability, which is generally driven by healthcare costs (Piers Gooding and Yvette Maker, sub. 933).

Relatedly, some participants raised concerns about the out-of-pocket cost of accessing mental healthcare (AMA, sub. 633; Balancing of Life, sub. 582; CHF, sub. 645), especially for income support recipients (ACOSS, sub. 1208). While acute mental healthcare is provided

free-of-charge in the public system, primary mental healthcare is subsidised (via Medicare Benefits Schedule (MBS) rebates) and clinicians may still charge consumers out-of-pocket.

While out-of-pocket costs are undoubtedly a barrier to care for some, income support recipients typically access lower cost primary mental healthcare than people not on income support.²⁰⁷ In 2016:

- 76% of Newstart Allowance recipients and 81% of Youth Allowance recipients who accessed MBS-rebated mental healthcare paid nothing out-of-pocket, compared with 58% of recipients of MBS-rebated mental healthcare who did not receive income support (figure 19.2), despite each of these groups receiving similar amounts of care (figure 19.3).
- 68% of DSP recipients who accessed MBS-rebated mental healthcare care paid nothing out-of-pocket (figure 19.2), and DSP recipients who accessed MBS-rebated mental healthcare received twice as many sessions of care as people who did not receive income support (driven mostly by higher utilisation of MBS-rebated psychiatry) (figure 19.3).

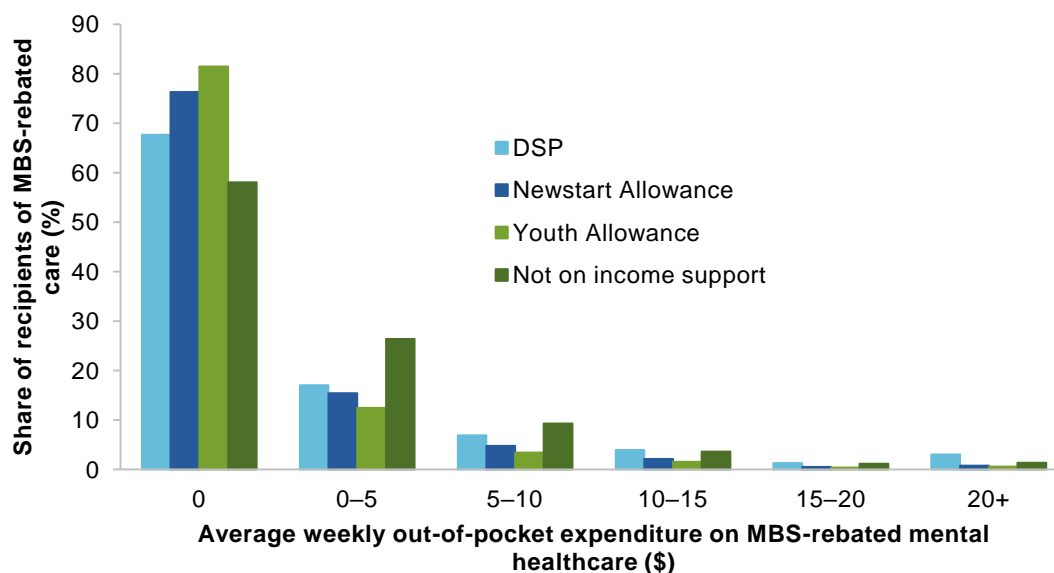
The issue of adequacy of these payments relates to all recipients, not just people with mental illness, and is beyond the scope of an inquiry focused on mental health. Also of relevance in determining the extent to which the income support system is meeting the needs of those with mental illness is whether:

- participants with mental illness on income support payments receive appropriate employment support, and whether mutual obligation requirements are moderated (or not applied) where they aggravate illness or are unlikely to improve work incentives
- the eligibility criteria for the DSP are reasonably robust in that recipients of the JobSeeker Payment or Youth Allowance genuinely have better longer-term employment prospects than DSP recipients (box 19.6)
- DSP recipients who are able to return to work are not unduly disincentivised from doing so.

²⁰⁷ Some clinicians charge lower out-of-pocket costs to income support recipients than to people not on income support. In some circumstances, GPs receive incentive payments (\$12.75 per session) if they provide mental healthcare at no out-of-pocket cost to concession card holders, including holders of Pensioner Concession Cards (DSP recipients) and holders of Health Care Cards (Jobseeker Payment (formerly Newstart Allowance) and Youth Allowance recipients) (DoH 2020a; Services Australia 2020b). These incentive payments reduce out-of-pocket costs for concession card holders (Wong et al. 2017). Many clinicians that do not receive incentive payments also charge lower out-of-pocket costs to concession card holders. A non-random survey of clinical psychologists found that 72% routinely reduced their out-of-pocket costs for some consumers, with the presentation of a concession card a common reason for doing so, and a non-random survey of registered psychologists found that 38% charged lower out-of-pocket costs to people on low incomes (again, with presentation of a concession card a determinant) (Harris et al. 2010).

Figure 19.2 Distribution of out-of-pocket costs for Medicare-rebated mental healthcare

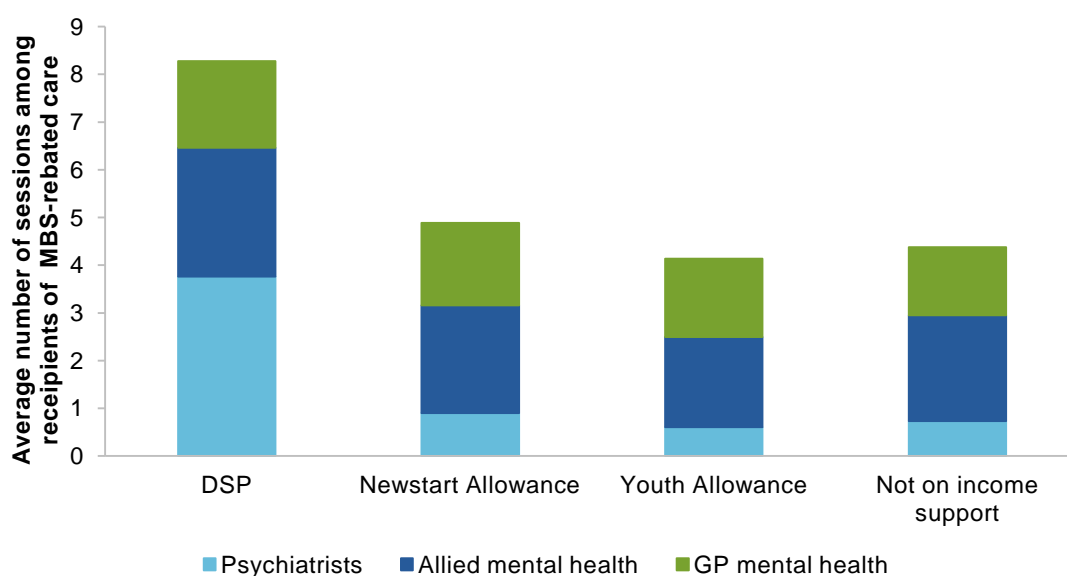
By type of income support payment, 2016



Source: Productivity Commission estimates using ABS (*Microdata: Multi-Agency Data Integration Project, Australia*, Cat. no. 1700.0).

Figure 19.3 Access to Medicare-rebated mental healthcare

By type of income support payment, 2016



Source: Productivity Commission estimates using ABS (*Microdata: Multi-Agency Data Integration Project, Australia*, Cat. no. 1700.0).

The Productivity Commission's actions above about streaming tools, New Employment Services and MORs should address the first of these. The remainder of this section addresses the latter two points.

Eligibility criteria for the Disability Support Pension

In considering eligibility criteria for the DSP, an important point is that people without a primary psychological or psychiatric disability comprise two-thirds of DSP recipients. This means that any changes to the design of the payment on behalf of those with primary psychological or psychiatric disability must consider the implications for the broader population and for overall payment costs. Nonetheless, considering the implications of mental illness is important, given that estimates suggest more than half of the DSP cohort have some mental illness (ABS 2015).

Access to the DSP is a multi-stage process requiring independent clinical evidence and assessment of job capacity (appendix C). The most prominent misgiving about DSP eligibility criteria relates to the desirability of the requirement to prove that an illness or disability is 'fully diagnosed, treated and stabilised', and more likely than not to persist for more than two years (deemed a 'permanent' disability). Between 2012 and 2014, almost 43% of all claims were rejected on failing these criteria (DSS 2016d), although participants rejected on this basis may have otherwise been rejected on other grounds.

Read literally, the eligibility criteria seem to leave significant scope for people with severe mental illness to be denied the DSP. For instance, some Inquiry participants were concerned that the 'fully stabilised' criterion would exclude people with severe but episodic mental illness, such as bipolar disorder.²⁰⁸ However, as the term is applied for the DSP, such concerns should be unfounded. A stabilised condition 'has a specific meaning and does not mean stable in the usual sense of the word' (DSS 2015d). It is one where there are weak prospects that further treatment would significantly reduce the impact of an applicant's disability on their functional capacity, which does not rule out episodic illnesses (DSS 2016a). Indeed, job capacity assessors are explicitly instructed to consider 'the severity, duration and frequency of the episodes or fluctuations' (DSS 2015d) when determining the functional impact of an episodic condition.

Some Inquiry participants also argued that the requirement to be 'fully diagnosed and treated' denies people access to the DSP because obtaining sufficient medical treatment and evidence can be challenging for people with mental illness (JA, sub. 398; KLC, sub. 469). However, the criterion does not, on face value, appear unreasonable. The formal requirement is that corroborating evidence shows the applicant has a diagnosed mental illness, and records of past and continuing treatment, or a treatment plan for the following two years (DSS 2016a). The absence of such a requirement would leave the DSP open to people with

²⁰⁸ For example, David Guthrey, sub. 902; Jobs Australia, sub. 398; Kingsford Legal Centre, sub. 469; and the National Mental Health Commission, sub. 118.

conditions that would improve with proper treatment or where the diagnosis was unclear or not verified, which would be inconsistent with proper risk management.

Nonetheless, there are cases where people find it hard to demonstrate they have been fully diagnosed and treated. The reforms suggested in this report for improved access and quality of mental healthcare services should partly address this concern. The ANAO (2018) has also made various recommendations in relation to improving DSP-specific assessments (the Job Capacity Assessment and disability medical assessment), and these have largely been acted upon. Finally, the various review processes already in place go some way to being a safety valve for addressing errors (ANAO 2018). However, there remains space to improve DSP eligibility assessments by increasing their test-retest reliability (whether an applicant's outcome is the same after re-testing) and inter-rater reliability (whether different assessors reach the same outcome). This could be facilitated through ongoing monitoring of the decisions of those determining access to the DSP and the distribution of outcomes for Centrelink offices to ensure assessors are not overly harsh or generous in their assessments (PC 2011).

Some applicants with mental illness struggle to manage the bureaucratic requirements of the DSP application process, especially those with trauma experience (Mental Health Commission of NSW, sub. 486; MHLC, sub. 1222). While some applicants may be assisted by a carer, friend or family member, this is not an option for all applicants. Care coordinators are well-placed to assist in the DSP application process, as they already work with a number of service providers to assist consumers with complex needs. Improved access to care coordinators (as discussed in chapter 15), as well as coordinators taking on the burden of payment application for consumers, could reduce the bureaucratic burden for applicants and carers and help ensure equitable access to the DSP.

There may be some scope to improve incentives for Disability Support Pension recipients to work

Although DSP recipients with psychological or psychiatric disabilities may work while continuing to receive a proportion of their payment, few do.

- Only about 3% of recipients (with any type of disability) left the DSP to enter the workforce between 2001-02 and 2016-17 (PBO 2018), and less than 4% of DSP recipients with a primary psychological or psychiatric disability reported labour income of more than \$50 per fortnight in June 2019 (unpublished data from the Department of Social Services).
- Less than 4% of DSP recipients with a primary psychological or psychiatric disability were engaged with DES or jobactive in June 2019 (figure 19.1).
- The Department of Social Services (2019g) estimates that, of the DSP recipient cohort aged 18 to 40 years and with a primary psychological or psychiatric disability (as at 30 June 2017), only 15% will have transitioned off the payment after 10 years (with one third of 'transitions' due to the death of the recipient).

This largely reflects that, given the eligibility criteria, DSP recipients have a limited capacity to work. Nevertheless, the design of the DSP provides incentives for recipients to work at least some hours if they can:

- A DSP recipient who works and earns less than the income threshold of \$174 per fortnight (about 8.9 hours of work per fortnight at the minimum wage rate) keeps their payment in full. They may also receive the DSP if their earnings are more than this, but each dollar of additional earnings leads to a 50 cent reduction in the DSP payment, meaning that their income increases by 50 cents for each additional dollar earned. DSP recipients earning over \$18 200 per annum (\$700 per fortnight) will also pay income tax of 18 cents for each dollar they earn over \$18 200, meaning that their total income increases by 32 cents with each additional dollar earned.²⁰⁹
- A DSP recipient who works less than 30 hours per week but with earnings above the threshold for a DSP payment can still receive certain supplementary benefits and have their payment resumed if, within 2 years, their hours worked falls below the weekly threshold.

Accordingly, the DSP maintains some significant incentives for recipients to engage in *some* work. Possible caveats to this are if:

- DSP recipients fear that they will lose access to the payment if they work at all (Jobs Australia, sub. 398; Mental Health Commission of New South Wales, sub. 486), which could occur through ad hoc eligibility reviews (as provided for in the 2014-15 and 2016-17 Budgets (ANAO 2018))
- a recipient is dissuaded from working because a prospective job requires them to work to a point where their income support payments are reduced, or because the prospect of earning less than \$174 per fortnight does not justify the upfront effort of finding and commencing work.

A more significant concern is that the design of the DSP may discourage recipients from earning at levels that are subject to the 50% taper rate (Mind Australia Ltd; Neami National; Wellways and SANE Australia, sub. 1212). In other words, people may choose to work for fewer hours than they could, choose jobs with a set number of hours or avoid jobs that pay higher wage rates — none of which are desirable outcomes. For these reasons, several participants supported increasing the DSP threshold and/or reducing the taper rate (Anglicare Australia, sub. 1206; Brainstorm Mid North Coast, sub. 803; Independent Private Psychiatrists Group, sub. 742).

²⁰⁹ This assumes the recipient works for less than 30 hours per week. If a DSP recipient works for more than 30 hours per week on an ongoing basis their payment is suspended for up to two years. Temporarily working for more than 30 hours per week — for example, over the Christmas period — does not result in payment suspension (DSS 2018e).

However, evidence of the impact of the 50% taper rate is scant. The distribution of DSP recipient earnings shows some clustering around the threshold (figure 19.4), but not to a large degree. More importantly, the available data give no direct indication of how earnings would differ under a counterfactual (lower) taper rate or (higher) threshold, so it is not possible to confidently draw any conclusions. As such, the Productivity Commission does not see a strong argument for changes to the DSP taper rate or threshold.

Figure 19.4 Earnings of working Disability Support Pension recipients^a

Distribution of the ratio of working DSP recipients' fortnightly employment earnings to the income threshold at which the DSP begins to taper off, 2001–2018



^a The threshold for the imposition of taper rates for the DSP changes annually, and increased from \$112 in 2001 to \$172 in 2018.

Source: Productivity Commission estimates using DSS (2019c) and Household, Income and Labour Dynamics in Australia (waves 1–18).

A related issue is that a recipient would lose eligibility for the DSP after a sustained period of employment of more than 30 hours per week. This requirement is separate to the entry requirement to the DSP as it only applies to recipients. The rule means there is a substantial net cost for recipients when deciding whether or not to complete their 31st hour of work. The gain of an extra hour's wages could be as low as \$19.49 (the minimum wage), but the loss would be the remainder of the fortnightly payment (about \$345 after means testing with the current taper), as well as any additional concessions for which the individual was eligible.

This provides a strong rationale for increasing the 30-hour rule to the ordinary hours of work in the National Employment Standards (38 hours), but maintaining the condition that working more than 30 hours a week for two years would result in cancellation of DSP eligibility. Anglicare Australia (sub. 1206) supported such a change.

More broadly, DSP recipients should be aware that they are able to work while receiving the payment and would likely benefit from additional communication or welfare counselling (where payment recipients receive personalised information on the impact of a change in employment or other income on their payment rate and eligibility). These tools may alleviate fears that a small amount of work or volunteering, or increasing employment hours, will lead to a DSP recipient losing eligibility for the payment. For some DSP recipients, welfare counselling will be provided through the IPS employment program, but for the majority of recipients, additional support will be required.

ACTION 19.5 — WORK INCENTIVES FOR DSP RECIPIENTS

Disability Support Pension (DSP) recipients with a capacity to work should have improved incentives to find employment.

Start now

The Australian Government should increase the weekly hour limit above which no DSP is payable from 30 to 38 ordinary full time hours of work. The requirement that a person would lose eligibility for the DSP if they work for more than 30 hours per week for more than two years should be retained.

Services Australia should ensure DSP recipients are well informed of their entitlement to work for a period without losing access to the DSP.

Access to payments for part-time students

Mental illness is relatively commonplace among university and vocational education and training students, and can adversely affect educational attendance and outcomes, with lifetime impacts (chapters 2 and 6). If a student has, or acquires a mental illness, they may not be able to study full-time, which can affect their income support eligibility. As a default, student payments (Youth Allowance, Austudy and ABSTUDY) require students to undertake at least 75% of their course's full-time study load (Services Australia 2020e). However, this can, on a sustained basis, be beyond the capacity of some students with mental illness (Michelle Smith, sub. 126; Name withheld, sub. 122). That said, if a full-time student receiving the Youth Allowance temporarily cuts back their study to less than 75% of their course's full-time load due to illness, they will remain eligible for the Youth Allowance, provided they have an intention to return to full-time study and remain enrolled in their course (DSS 2018d).

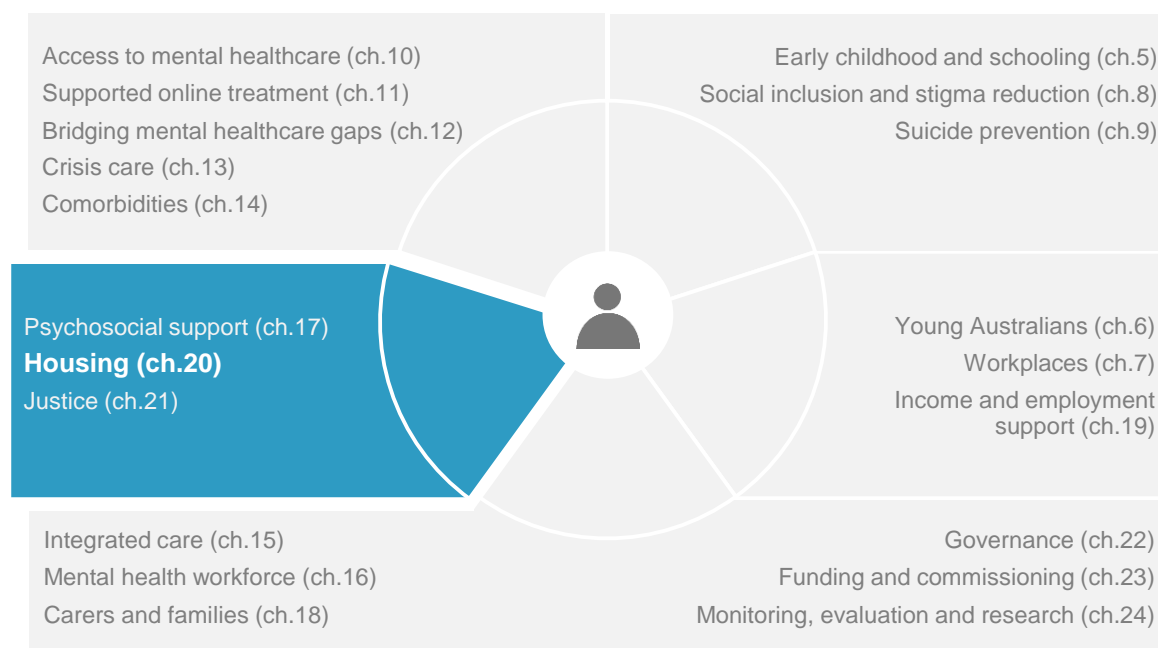
However, students with mental illness who are not working or looking for work, and who intend to study part-time on an ongoing basis are not covered by student or job seeker payments (barring those with an illness severe enough to qualify for the DSP).

The following points should be considered when determining whether this cohort should qualify for income support.

- Extending income support to part-time students with mental illness could allow people who would not otherwise study to do so on a part-time basis. This could raise their employment prospects (potentially working to close financial resource gaps between people with mental illness and the wider population, as well as ensuring part-time students with mental illness and limited financial resources are able to choose between work and tertiary education).
- In some instances, it would be undesirable for a student to continue a prolonged period of training on a part-time basis if this results in poor quality qualifications or a high likelihood of subsequently dropping out. Part-time students face a high risk of not completing university studies — 40% of all part-time students will not complete their course within 8 years (Norton and Cherastidham 2018). Either a job (that takes into account potentially limited work capacity) or a shorter vocational course may be a better option until recovery, and a student headed down this path would be eligible for either the JobSeeker Payment or the Youth Allowance (job seeker).
- There would be a need to develop adequate eligibility requirements to ensure this arrangement was only available to people genuinely unable to participate in full-time study or work due to illness. Stricter requirements (for example, involving independent medical assessments) would reduce the risk of gaming, but could be expensive to administer. It would also be challenging to assess whether the number of people receiving the payment aligns with expectations, as there is no obvious way in existing data collections to identify the cohort to whom it should apply.

On balance, the Productivity Commission does not currently see a compelling argument for extending income support eligibility requirements beyond the current arrangements for students who intend to study part-time on an ongoing basis due to a mental illness who are not working or looking for work.

20 Housing and homelessness



Housing and homelessness services matter because ...

- Housing is a key protective factor against mental ill-health and promotes recovery for people with mental illness.
- Many people with mental illness live in unsuitable housing situations that negatively affect multiple aspects of their lives, including the recovery and management of their mental illness.
- Some people with mental illness require support to find and maintain stable housing in the community.
- In some regions, there is a chronic shortage of short- and long-term supported housing for people with moderate and severe mental illness.

RECOMMENDATION 20 — SUPPORTIVE HOUSING AND HOMELESSNESS SERVICES

Housing and homelessness services help prevent people with mental illness from experiencing housing issues and support people with mental illness to find and maintain housing in the community. But their current capacity falls well short of need.

As a priority:

- State and Territory Governments should, with support from the Australian Government, commit to a nationally consistent policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and correctional facilities. (Action 20.2)
 - People with mental illness who exit hospitals, correctional facilities or institutional care should receive a comprehensive mental health discharge plan and have ready access to transitional housing.

Additional reforms that should be considered:

- State and Territory Governments should provide mental health training and resources to social housing workers, and work with the relevant bodies, including the real estate institutes, to assist them in organising training and resources on mental health for private sector real estate agents. (Action 20.1)
- State and Territory Governments should review housing policies to better consider the needs of people with mental illness. This should include information sharing between housing authorities, acute mental healthcare facilities and correctional facilities. (Action 20.1)
- Tenants with mental illness who live in the private housing market should be provided the same ready access to tenancy support services as those in social housing. (Action 20.1)
- The effects of forthcoming reforms to residential tenancy legislation, including 'no grounds' evictions, should be assessed by State and Territory Governments to better understand the implications for people with mental illness. (Action 20.1)
- With support from the Australian Government, State and Territory Governments should address the shortfall in the number of supported housing places and the gap in homelessness services for people with severe mental illness. (Action 20.3)
- The National Disability Insurance Agency should continue to amend its Specialist Disability Accommodation strategy and policies to encourage development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness. (Action 20.3)
- As part of the next negotiation of the National Housing and Homelessness Agreement, there would be benefit from governments increasing the quantum of funding for housing and homelessness services, including for the expanded provision of services for people with mental illness. (Action 20.3)

Housing plays a key part in preventing mental ill-health and promoting recovery for people with mental illness. This chapter discusses the close relationship between housing and mental health (section 20.1), and examines ways to improve housing and homeless supports for people with mental illness based on the severity of mental illness and housing needs (figure 20.1).

Figure 20.1 Framework: housing supports according to level of need

Section 20.2 <i>Lower need</i>	Section 20.3 <i>Higher need</i>	Section 20.4 <i>Homelessness</i>
Preventing people from losing their housing, by improving: <ul style="list-style-type: none"> • tenancy support • training for housing workers • laws and policies. 	Support for people with mental illness to find and maintain housing through: <ul style="list-style-type: none"> • integrated supported housing • improved transition out of institutional care (such as hospital or correctional facilities) • long-term supported accommodation with 24/7 support. 	Support for people with mental illness who are homeless to find and maintain housing through: <ul style="list-style-type: none"> • homelessness services • 'housing first'.

In this chapter, the Productivity Commission has recommended reforms to deliver a range of housing and related mental health supports to better meet the needs of people with mental illness in Australia. Not all recommendations were able to be costed (appendix I). However, if implemented, the costed recommendations would require Australian, State and Territory Governments to increase estimated expenditure, in aggregate, by \$740 million to \$940 million each year. This would, in turn, be expected to improve the mental health, quality of life and economic participation of the relevant recipients of the housing supports. However, the *net* cost is estimated to be far lower as improved housing is likely to lead to reductions in the use over time of other government services, such as healthcare and the justice system (associated with estimated cost savings of \$450 million to \$790 million). There may also be additional, unquantified, spillover benefits from the recommended housing reforms, as improving an individual's housing situation can facilitate workforce participation and also improve the wellbeing of the individual's family.

20.1 Housing and mental health are closely linked

Suitable and secure housing is important for all Australians and is closely linked to good mental health. As a key protective factor against mental ill-health, suitable housing can be a first step in promoting long-term recovery for people with mental illness (Giuntoli et al. 2018), and an enabler for the delivery of other services and supports to an individual.

Until the need for suitable shelter is met people cannot begin to think of employment, participation in their community or health. (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 1)

It's very difficult for people to start their recovery journey if they don't have a stable, secure and affordable place to live. (Launch Housing, Melbourne transcript, p. 49)

Mental health contributes to poor housing outcomes

Mental illness can affect a person's ability to sustain their existing housing, including their capacity to independently manage housing tasks, such as budgeting, paying rent or utility bills on time, opening mail or maintaining a property. Symptoms of mental illness can also lead to unsociable behaviour (such as aggression) that causes disturbances or conflicts with family, flatmates, neighbours, landlords and employers (Jones et al. 2014; MHCA 2009; Patterson et al. 2008).

Many of our clients experience paranoia making it very difficult to sustain accommodation [which] often [leads to them] leaving due to a perceived fear of being unsafe from others ... some have been known to be evicted due to disconnecting lights, appliances and smoke detectors due to the belief they are monitoring devices, some clients can become hostile believing they need to defend themselves from others which also leads to eviction. (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 2)

Box 20.1 Case study: Threat of eviction for hoarding behaviours

Lydia is 53-year old woman living in a property managed by a social housing provider in Melbourne. Lydia has had some involvement with the criminal justice system and has spent some time in prison. She has been a victim of severe family violence.

Lydia has been affected by complex trauma and this manifests in hoarding behaviours. This has caused issues throughout her 12-year tenancy. Her relationships with some of the other occupants of the apartment building have broken down and they complain frequently to the housing provider about Lydia's hoarding. The housing provider has issued Lydia with numerous breach of duty notices over the years, and has applied to Victorian Civil and Administrative Tribunal for possession of the property on multiple occasions.

Lydia's case highlights how community and public housing providers can resort to eviction as the mechanism for managing tenants with complex behaviours directly linked to their mental health.

Source: adapted from VLA (sub. 500, pp. 16–17).

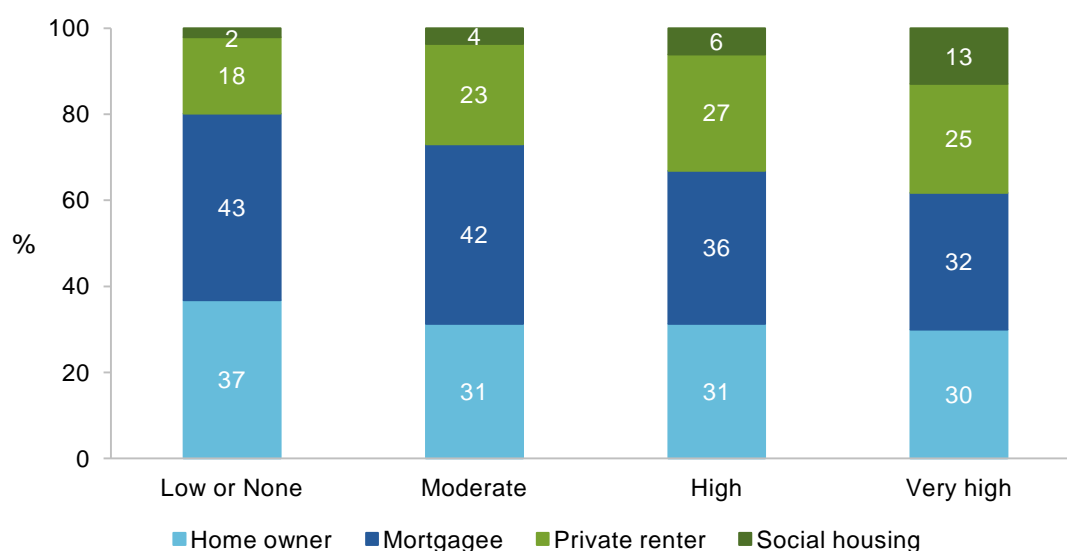
People living in less secure housing (such as renters and social housing tenants) also disproportionately experience higher levels of physiological distress (figure 20.2).

In some cases, people experiencing acute episodes of severe mental illness risk eviction, especially while temporarily incapacitated in hospitals or other institutions (MHCA 2009; MHLC, sub. 315, p. 3; SCMH 2006).

... due to the often episodic nature of mental illness, people hospitalised for acute care risk loss of housing or job because they have been unable to pay their rent or attend work. This further exacerbates stress and impacts people's mental health. There is a call for more support to ensure that eviction or loss of job does not occur in these circumstances. (SAMHC, sub. 477, p. 17)

Figure 20.2 Renters and people in social housing tend to experience higher levels of psychological distress^{a,b}

Proportion of Australian population by level of psychological distress, 2017-18



^a Psychological distress is measured using the K10 scale. ^b As K10 data is not available for people who are homeless, psychological distress levels for people who are homeless have been omitted from this chart.

Source: ABS (National Health Survey, 2017-18, Cat. no. 4324.0.55.001).

Mental illness can also affect a person's ability to find new housing. People with mental illness often face discrimination in the private rental market as many consider they are relatively difficult tenants and/or have reduced income stability (CLBB, sub. 146, p. 5; KLC, sub. 469, p. 9; MHV, sub. 580, att. 1, p. 29). In one survey, 90% of people with mental illness believed they had been discriminated against at some time, particularly in the private rental market, forcing them to accept unsafe or substandard housing (SANE Australia 2008).

Discrimination can take many forms. Prospective renters who disclose or reveal their mental illness tend to be less likely to: receive a response to their rental inquiries; be told that an advertised unit is available; be invited to inspect an available unit (Hammel et al. 2017); or be able to secure a private rental without first producing significant guarantees of support or references (Bleasdale 2007). As a result, some individuals and their carers may avoid telling agents about their mental illness (Browne and Hemsley 2010).

Mental illness can also affect an individual's housing situation indirectly. For example, insecure housing can make it more difficult to find and maintain employment (chapters 7 and 19), thereby reducing the individual's income and subsequent ability to afford and maintain adequate housing.

Housing difficulties contribute to mental ill-health

Not only can mental illness reduce a person's ability to find and maintain housing, this relationship can also run in the opposite direction. Housing issues — such as accommodation that is of low quality, unhygienic, unsafe, of poor design, affected by noise and pollution, provides insecure tenure and affordability pressures — can contribute to mental ill-health and inhibit recovery from mental illness (Bonney 2007; Evans, Wells and Moch 2003; Guite, Clark and Ackrill 2006; Pevalin et al. 2017; Singh et al. 2019). For example, overcrowding is an environmental stressor that is particularly detrimental to mental health — poor housing conditions can cause individuals to socially withdraw, which may lead to increased psychological distress (Wells and Harris 2007). An ABS survey found that 14% of Aboriginal and Torres Strait Islander people in remote areas cited overcrowding at home as a significant environmental stressor that could lower their mental health (ABS 2013).

Not surprisingly, homelessness can also exacerbate, or contribute to the onset of, mental ill-health (Brackertz, Davison and Wilkinson 2019; Scutella et al. 2014; Sullivan, Burnam and Koegel 2000). For example, Johnson and Chamberlain (2011) found that 16% of a sample of 4291 homeless people developed mental ill-health after they became homeless. Research tends to show elevated levels of psychosis, anxiety, depression, post-traumatic stress disorder and substance use disorder among people who are homeless (Muir et al. 2018). Losing the psychological support associated with adequate housing can be detrimental to an individual's sense of order, trust, continuity and security (Hulse and Saugeres 2008; Muir et al. 2018). A lack of safety, privacy, sense of belonging or social connectedness can lead to feelings of social isolation, anxiety and stress, affecting mental health. People who are homeless are also likely to have higher rates of interaction with the health and justice systems, and tend to have poorer education and employment outcomes.

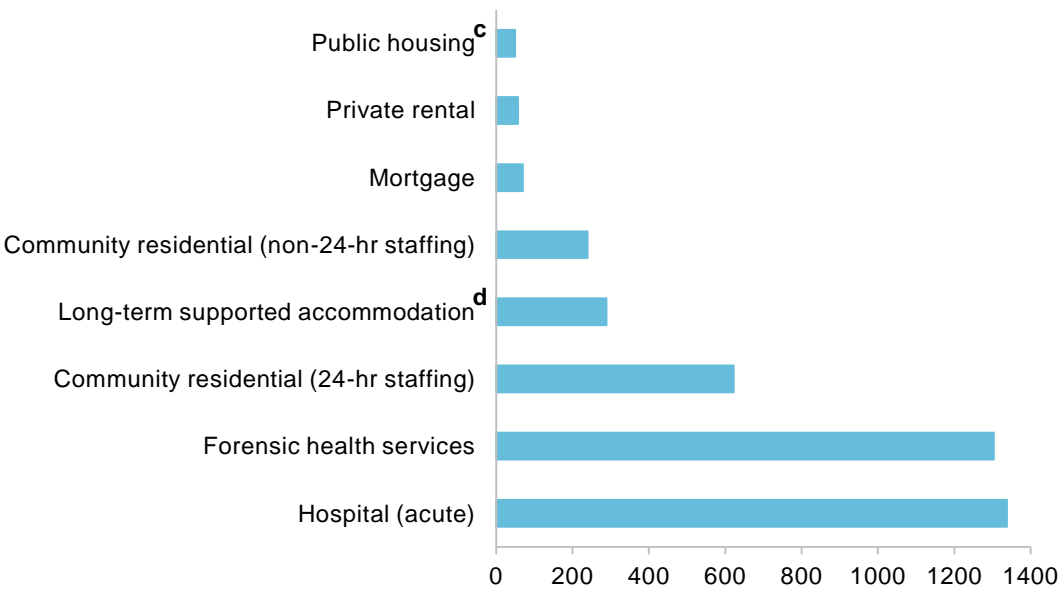
Keeping people in the community

People with mental illness often express that one of their goals is to live independently and participate in the community (Richter and Hoffman 2017; Vallesi et al. 2018). However,

many people with a diagnosed mental illness (about 16%) in 2016-17 were living in ‘unsuitable’ accommodation (AMHOCN 2019b). Common experiences included overcrowding, substandard facilities, unhygienic conditions, risk of eviction, homelessness or other housing problems that make it unsuitable or unsafe for someone with mental ill-health (Allan Fels, sub. 303, p. 4; Anglicare Sydney, sub. 190, p. 15; Eastern Health – Murnong Adult Mental Health, sub. 187, p. 2; MHLC, sub. 315, p. 2).

In some cases, this lack of suitable housing results in people being stuck in institutional care, which tends to be far more expensive for society. About 30% of mental health hospital inpatients — over 2000 people — could potentially be discharged if appropriate clinical and accommodation services were available in the community (chapter 13). The average ongoing cost of housing someone in the community, such as in a private rental or in social housing, is significantly lower than the cost of having someone either in hospital or in a residential mental healthcare facility (figure 20.3).

Figure 20.3 Cost of alternative housing options for an individual
Average daily ongoing cost, 2018-19 dollars^{a,b}



^a For public housing, private rental, mortgage and long-term support accommodation costs inflated using rent price index, other costs inflated using health wages index. ^b We take account of the fact that community ambulatory services often provide reach-in services for acute and community residential care. Based on information provided by States and Territories, it is estimated that reach-in services increases the cost of both acute inpatient care and community residential care by about 5%, and decreases the cost of community ambulatory care by about 5% (Productivity Commission estimate based on AIHW pers. comm., 17 March 2020). ^c Includes recurrent government expenditure plus rent collected. ^d 24-hour supported living arrangements. Estimated costs based on the annual cost of support in the Haven model (section 20.3).

Source: Productivity Commission estimates using ABS (*Consumer Price Index, Australia, Jun 2019*, Cat. no. 6401.0; *Housing Occupancy and Costs, 2017-18*, Cat. no. 4130.0), AIHW (2019f), Mind Australia Limited (sub. 380, p. 40) and SCRGSP (2020b, 2020c, unpublished data).

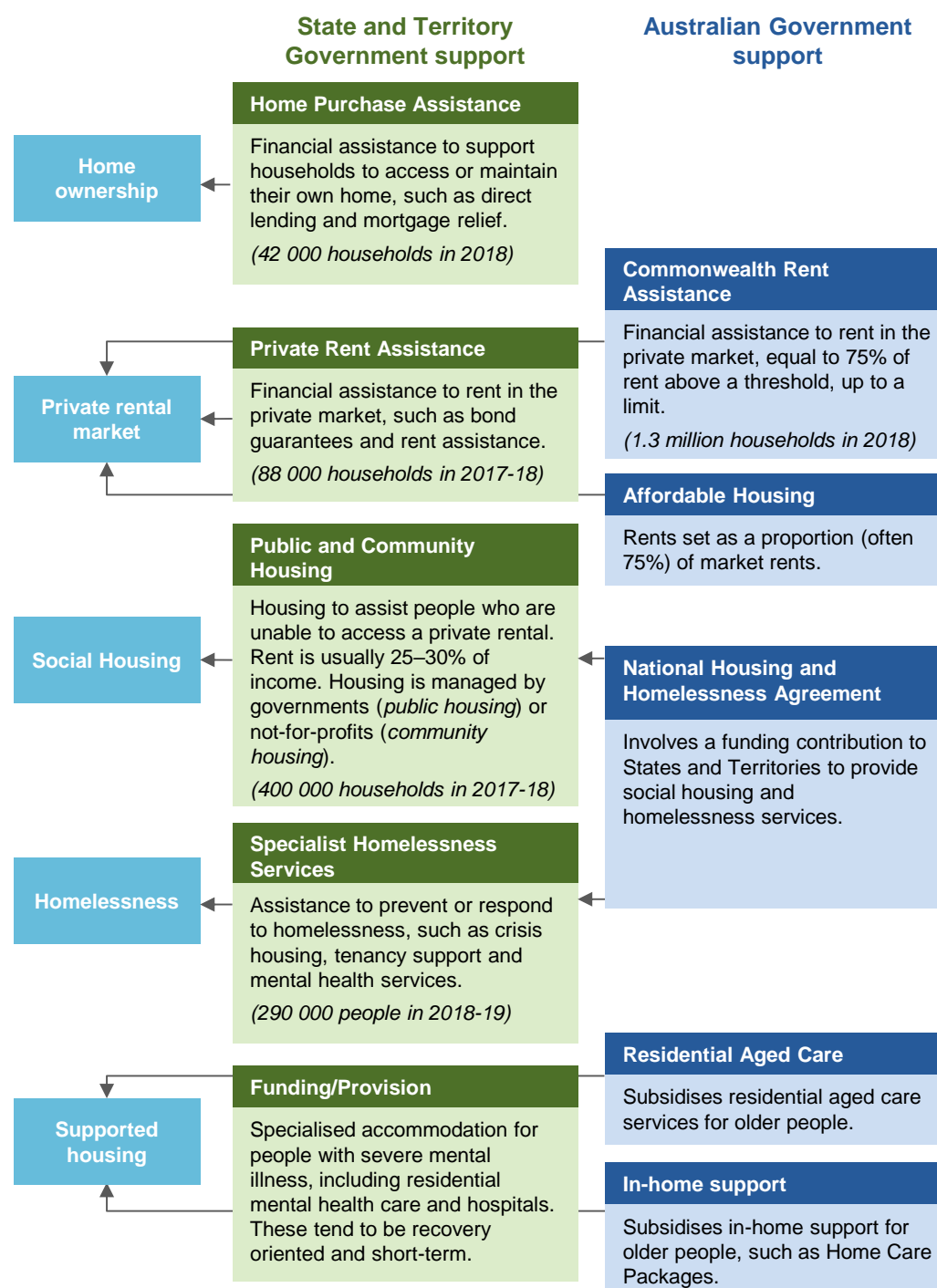
Improvements in mental health associated with improvements in housing supports can lead to subsequent potential savings in other areas of expenditure for government, with reductions in the use of other government services (such as healthcare or the justice system) and improved employment prospects. However, while such links are clear, there are a range of hurdles that need to be overcome when meeting housing needs for people with mental ill-health. These are discussed below.

There is no one-size-fits-all housing solution

There are a number of housing supports available to Australians, such as financial assistance to access the rental market, social housing and other supports to find and maintain housing, and homelessness services (figure 20.4). For some people (typically those with severe mental illness and a complex mix of clinical and social needs), governments also provide specialised supported housing, such as residential mental healthcare, to support individual's recovery and facilitate their inclusion in the community. The forms of housing that work for a person at one stage in their life will inevitably change as the person ages and their life circumstances and health change.

Under the National Housing and Homelessness Agreement (NHHA), State and Territory Governments have primary responsibility for funding and delivering housing supports, with some funding and responsibilities shared by the Australian Government. State and Territory Governments are generally responsible for providing social housing and homelessness services, land use planning and development policy, and tenancy legislation and regulation. The Australian Government contributes some funding to State and Territory Governments for housing and homelessness services, and provides income support, Commonwealth Rent Assistance and some Australian Government housing and homelessness programs and services. Both levels of government also fund the National Disability Insurance Scheme (NDIS) which, in some limited cases, may contribute to the cost of accommodation for participants in need of specialised housing due to their disability.

Figure 20.4 Main housing supports in Australia^{a,b}



^a The Australian Government also provides some supports for home ownership, such as the First Home Loan Deposit Scheme (NHFIC 2020). ^b Supported housing, including Specialist Disability Accommodation, is also funded through the NDIS.

Source: AIHW (2019d, 2019p).

20.2 Preventing housing issues arising

A range of supports already exist to assist people to remain in their home in the community. Many Australians currently receive financial assistance from governments to remain in private housing (figure 20.4). And if a household struggles with their mortgage repayments as a result of mental illness, they can generally ask their lender for a hardship variation to make the loan more manageable, such as extending the loan period or temporarily postponing repayments (ASIC 2019). Temporary supports were also introduced by governments to assist people to maintain housing during the recent COVID-19 pandemic (for example, NSW DCJ 2020a). Further, many other existing instruments are designed to protect people's financial security, such as general income and employment support (chapter 19) and workers compensation (chapter 7).

However, more can be done to deal with the specific issues faced by people with mental illness. Housing workers can often lack the understanding and knowledge to respond to housing issues experienced by people with mental illness and social housing policies often do not adequately take into account the needs of people with mental illness. Renters in the private market also often have limited access to tenancy support services to prevent housing instability.

Mental health training for front-line housing workers

Social housing workers and real estate agents play an important role on the ground to support people to maintain their tenancies. These frontline housing workers are often the first to identify vulnerable tenants and can then link tenants with supports.

However, in many cases, there is a lack of understanding and knowledge within these roles to identify, monitor and respond to housing issues among people with mental illness.

Early intervention is limited to giving tenants a short 'Help is Available' brochure that lists tenant support services at the start of each tenancy. Tenant support is typically not offered until disruptive behaviour incidents are reported. We found strikes were issued against tenants with complex mental health illness, family violence or inter-generational dysfunction. The Department [of Communities] does not direct resources towards early intervention for these tenants, instead following standard procedures to manage all disruptive behaviour. (OAGWA 2018, p. 8)

We need steps to provide each party with the necessary skills to construct positive relationships, to identify early signs and to refer to the appropriate service for the issue at hand in a timely fashion. Identifying vulnerable tenants for example is a skill and using eviction alone without offering other pathways should always be only a last resort. (Almondale, sub. 735, p. 14)

This lack of awareness extends to the private rental market, where it can lead to discrimination against prospective tenants with mental illness, potentially preventable evictions and, in some cases, blacklisting from future rental properties.

Real estate agents and landlords in this sector may have far less training or understanding of the multiple challenges faced by their tenants and fewer resources to handle difficult situations, and thus see eviction as a solution rather than a last resort. (Anglicare Australia, sub. 376, p. 31)

Further, some people might not tell their landlord or real estate agent that they are experiencing mental ill-health for fear they will be evicted from their home.

No-cause evictions are a tool that has been used to remove people from tenancies. This creates a substantial imbalance of power and a fear in tenants that prevents them from making complaints, requesting repairs and notifying landlords of hardship. (NT Shelter, sub. 333, p. 8)

Inquiry participants supported more mental health training for frontline housing workers.²¹⁰ As NT Shelter (sub. 879, p. 3) stated, ‘mental health training and resources for social housing workers must be offered and encouraged’.

Training should incorporate awareness about how to identify early warning signs of mental ill-health (ACT Government, sub. 1241, p. 22; NT Shelter, sub. 879, p. 3; One Door Mental Health, sub. 856, p. 15). It should also communicate the benefits of early intervention, such as avoiding the costs associated with deterioration of housing issues or potential eviction. For example, a pilot program involving training for social housing workers in Queensland showed that with increased awareness and understanding of mental health and suicide among workers, there were fewer incidences of tenancy problems, decreased use of emergency departments and improved mental health outcomes (Walter, Parsell and Cheshire 2017). In many circumstances, building trust and a greater awareness of a tenant’s mental ill-health can support a more understanding relationship.

Training should also advise on effective ways to intervene and to refer tenants to appropriate supports (SAMHC, sub. 691, att. B, p. 4). This need not be costly or onerous, and can be as straightforward as connecting vulnerable tenants to existing tenancy support, mental health or suicide prevention services. For example, housing workers could use dedicated information portals to determine where best to direct tenants for support, or connect with the tenant’s care coordinator (chapter 15).

While some social housing workers are already offered some mental health first aid training (for example, ACT Government, sub. 1241, p. 22), there is scope for improvement in resources, uptake across front-line housing workers, and links into mental health services.

State and Territory Governments should ensure mental health training and resources are provided to all social housing workers (action 20.1). The average total cost of providing mental health first aid training to the 17 400 workers in non-aged residential care services is estimated to be \$4.5 million (appendix K). This is likely to be an overestimation, as it is

²¹⁰ Anglicare Australia, sub. 1206, p. 16; breakthru, sub. 112, p. 11; Carers NSW, sub. 808, p. 12; Leonie Segal and Jackie Amos, sub. 468, p. 18; Uniting Vic.Tas, sub. 95, p. 8.

likely that only client-facing staff and managers would require such training. This would be a once-off cost to educate all current employees who require it, with lower ongoing costs for refresher courses and to educate new entrants into the industry.

Inquiry participants also argued that training and resources should be made available to private sector real estate agents (Almondale, sub. 735, p. 14; NMHC, sub. 118, p. 11). Mind Australia Limited, Neami National, Wellways and SANE Australia (sub. 1212, p. 35) stated:

It is the experience of many of the people who use our services that stigma and discrimination towards those experiencing mental ill-health on the part of landlords and real estate agents is a very significant issue.

The Sector Partners would advocate that each State and Territory Government, with support of the Australian Government engage with their relevant Real Estate Institute to commission community organisations to deliver mental health training to real estate agents ...

Anglicare Australia (sub. 376, p. 31) also said that providing training, resources and establishing support networks for real estate agents can be a cost-effective way to help sustain complex tenancies. They also provided an example of a program of workshops run by the Northern NSW Health Service, which have shown positive results, and a similar program that was to be undertaken by Anglicare Southern Queensland in 2019.

The State and Territory Governments should work with the relevant bodies, including the real estate institutes, to help them organise training and resources on mental ill-health for private sector real estate agents as part of their professional development.

Social housing policies that recognise the realities of mental illness

Policies governing anti-social behaviour management and temporary absences can often be insensitive to the needs of people with mental illness. As such, there is scope to improve social housing policies to better protect the housing of people with mental illness and reduce the likelihood of housing instability and eviction.

Anti-social behaviour

Policies that govern how social housing providers manage anti-social behaviour of tenants aim to provide a safe and positive living environment for all tenants. However, these policies often negatively affect people with mental illness (Brackertz, Wilkinson and Davison 2018; Jones et al. 2014). If these policies do not adequately consider the circumstances of tenants with mental illness, tenants who exhibit episodes of unsociable behaviour as a symptom of mental illness may be issued with eviction warnings and potentially be evicted (CLBB, sub. 146, p. 5; Uniting Vic.Tas, sub. 95, p. 6). Eviction will necessarily remain the ultimate threat to induce compliancy with tenancy conditions, but its success as a means of inducing compliance of those with some forms of mental illness is questionable. Most people evicted would experience stress; but the eviction of someone who already has a mental illness could exacerbate that illness and inhibit their recovery.

In some cases, social housing policies may be adequate, but poor implementation can cause unnecessary stress to tenants. Even if an eviction is ultimately overturned and the housing loss avoided, there remains an unnecessary cost of the process to government.

Our review of 5 applications for termination where mental health concerns were involved found the Court did not agree to terminate the tenancies. The eviction process can cause unnecessary stress for tenants and support workers and unsuccessful eviction processes may be an inefficient use of Court and Departmental resources. (OAGWA 2018, p. 20)

There is scope to review and improve existing state and territory policies governing how social housing providers manage anti-social behaviour. For example, many state and territory policies have provisions relating to ‘mitigating circumstances’ (for example, SA Housing Authority 2020). However, they do not have explicit provisions relating to mental illness. This may be a potential area for review and improvement, noting that better mental health training would assist in this (action 20.1).

Additionally, some States and Territories have stricter policies than others. For example, in South Australia, tenants who directly contribute to serious or moderate anti-social behaviour are excluded from being able to live in social housing for 12 months (SA Housing Authority 2020). This can be inconsistent with the episodic nature of mental illness, as the person may recover but then become unable to access housing again for a long time. It may be appropriate to consider a provision that allows a person to register to be re-housed, with approval from a mental health professional, once they have recovered.

Some jurisdictions have policies in place to help tenants who exhibit anti-social behaviour to maintain their tenancy. For example in Queensland, actions may be taken to help the tenant address their behaviour and maintain their tenancy, such as referral to a support worker or agency. Upon eviction from public housing, assistance may also be offered to find alternative housing in the private market through bond loan or referrals (Queensland Government 2016).

It may also be necessary to consider protections for carers of people with mental illness. As noted by Carers NSW (sub. 808, p. 12), about 70% of mental health carers live with their care recipients and may also face the risk of eviction due to their care recipient’s behaviour.

However, any review of the policies and their implementation would need to ensure a fair balance between the rights of the other tenants sharing the housing facility — to a safe, clean and peaceful environment — and the needs of the tenant with mental illness to experience as little unnecessary distress as possible (action 20.1).

Temporary absences

Temporary absence policies restrict the time that people are allowed to be absent from their tenanted dwelling. This can help to make sure the housing stock is being used efficiently and fairly, especially as there are often long waitlists for housing. However, these policies can also increase the risk of eviction for people with mental illness.

For example, people experiencing acute episodes of severe mental illness may need to temporarily reside in a mental health facility, such as a hospital or community residential facility (chapter 13). But if the housing policy does not allow longer absences, these tenants may be evicted while temporarily absent, causing additional stress and making it more difficult to find them a home when they recover (QAI, sub. 116). Clinical treatment teams can lose contact with consumers after they are discharged from hospital, increasing the risk of relapse and readmission to hospital.

The NSW Council of Social Services (sub. 659, p. 8) described the experience of one of their clients:

During his time in custody, John's social housing was relinquished on his behalf without his knowledge or consent. After he was released, the police told him to return to his place of residence but John came home to find his house boarded up and belongings thrown away due to his absence. When John tried to gain access to his home again, the police were called and found him to have breached his Intensive Correction Order. John was taken back into custody for a further 8 months.

Upon release from custody, John's house was no longer available to him and he had to seek emergency housing. This causes significant problems in satisfying his probation requirements as he does not have a fixed address. At no point during both periods of release was he given any care coordination or aftercare from government agencies to support his transition back into the community and help him find stable housing.

The length of absence and conditions for temporary absences varies in each State and Territory (table 20.1). The length of time people are able to be absent from their homes, for reasons such as hospitalisation or institutional care, can range from one month (in Western Australia and the Northern Territory) up to six months (in New South Wales). However, the tenant often must make arrangements to continue to pay their rent and water usage, and satisfy the social housing provider that the property will be adequately cared for while they are away, for example by an agent or house sitter (for example, NSW DCJ 2020b; Queensland Government 2019). These can be quite reasonable requirements, but accomplishing each of these tasks may be near impossible for a tenant experiencing an episode of mental illness.

Wei was a long-term social housing resident with significant psychiatric illness. He lived alone with assistance from community-based mental health services. During his tenancy he was hospitalised for a period of almost 6 months. The social housing provider sent Wei an eviction notice for not occupying his premises in breach of their "allowable absences" policy. This was despite the hospital nursing staff telling the housing provider that more time was required, and that eviction would have a very serious negative impact on Wei's health.

The eviction notice was not withdrawn until Kingsford Legal Centre assisted Wei to make a discrimination complaint, which was eventually resolved through conciliation. (KLC, sub. 469, p. 10)

Table 20.1 Temporary absence policies in each State and Territory

<i>State</i>	<i>Maximum length (without notification)</i>	<i>Maximum length (with notification or approval)</i>	<i>Conditions</i>
NSW	na	Six months	<ul style="list-style-type: none"> Reasons for which approval can be granted to be away from a property include, for example, to care for sick or frail family members, hospitalisation or admission to institutional care, or entering a correctional facility.
Vic	Six weeks	Six months	<ul style="list-style-type: none"> Tenant must provide written notification if they are going to be away for longer than six weeks. Discretion can be provided for periods longer than six months. Reasons include receiving psychiatric care.
Qld	Eight weeks	Five months in a 12 month period	<ul style="list-style-type: none"> Reasons approval can be granted include: hospitalisation, rehabilitation and carer responsibilities.
SA	na	Three or six months	<ul style="list-style-type: none"> Tenants can be absent for up to three months with Housing SA's approval. This can extend for further three months for circumstances such as hospitalisation, rehabilitation and carer responsibilities.
WA	One month or any periods that combined exceed three months in a 12 month period in total	na	<ul style="list-style-type: none"> Must obtain written consent from the Housing Authority if absence is going to exceed one month or any periods that combined exceed three months in a 12 month period in total.
Tas	Eight weeks	na	<ul style="list-style-type: none"> Required to appoint an agent if away for more than a few days. Must apply for absence if away for more than eight weeks for reasons including medical treatment and prison.
NT	30 days	na	<ul style="list-style-type: none"> Required to seek permission from the Department of Housing if going to be absent for longer than 30 days.
ACT	Three months	na	<ul style="list-style-type: none"> Required to seek approval to be absent for more than three months, but managers can exercise discretion based on the circumstances of the case. Where there is concern about a tenant's ability to maintain the property, properties can be voluntarily surrendered with the understanding that they will be supported to access priority housing when they exit institutional care. Tenants can pay maximum of \$5 per week rent when they are not in receipt of income or are accessing residential rehabilitation services.

na Not available.

Source: ACT Government (sub. 1241, p. 22); HousingVic (2018); NSW FACS (2020b); NT DHCD (nd); Queensland Government (2019); South Australian Government (2020, sub. 692, p. 7); TAS DoC (nd); VIC DHHS (2018b); WA Housing Authority (2019).

In some cases, eviction due to a temporary absence may be a result of a lack of information sharing between mental health services and social housing authorities (or rental agents). Improving information sharing between these agencies (with agreement of the consumer) can reduce the likelihood of eviction. This is particularly important upon admittance to an inpatient psychiatric facility and again prior to discharge. The Productivity Commission has

recommended ways to improve coordination across services through formal information sharing arrangements in single care plans and using care coordinators (chapter 15).

It is important that people experiencing acute episodes of mental illness do not lose their accommodation while requiring treatment in a mental health facility. State and territory social housing authorities should review their policies relating to temporary absences to provide greater consideration for people with mental illness to reduce the likelihood of housing instability and eviction (action 20.1). Any review of the policies will have the difficult task of balancing the housing needs of people with mental illness with the needs of other vulnerable people who may be on waiting lists for social housing properties.

Expand tenancy support services for private housing

Tenancy support services help people access housing, or intervene early to stabilise their tenancy and prevent them from becoming homeless. These services are often provided to people in social housing and, in limited circumstances, to people in private housing. Tenancy support services do not specifically target people with mental ill-health, but mental ill-health is a common reason for seeking support. Services can range from general housing advice to more intensive supports, including:

- help maintaining a tenancy — such as help with budgeting, support to access existing financial assistance, income support, tenancy advice, debt counselling, financial management and resolving rent arrears
- assistance to improve a tenant's economic participation, such as help to find employment
- linking tenants with broader support services, such as mental health services (Costello, Thomson and Jones 2013; PC 2017b).

In general, tenancy support services can be very effective at stabilising housing. An evaluation of several tenancy support programs across Australia found that, as a result of support, 81% to 92% of people maintained their existing tenancy, 8% to 17% of people moved home (for a variety of reasons) and less than 4% of people were evicted (Zaretsky and Flatau 2015). The vast majority of tenancies were sustained for 12 months or longer. This was considerably fewer evictions compared with public housing tenants who do not receive tenancy support services (over 16%).

Tenancy support services can also be cost effective for governments when they prevent eviction, homelessness or a deterioration in mental health. For example, Zaretsky and Flatau (2015) estimated the average cost of assisting someone to maintain or access a tenancy was about \$5400 per presenting unit head²¹¹ (2019-20 dollars) compared with about \$11 100 per eviction event.²¹² In particular, preventing people from losing an existing home costs

²¹¹ All costs from Zaretsky and Flatau (2015) are per 'presenting unit head', which is a group of people who present together for support. It is used as a proxy for a household.

²¹² Inflated using the ABS Producer Price Index for real estate services (number 672) (ABS 2020c).

significantly less than general support to access or maintain housing (\$1800 compared with \$8000). Further, it has been estimated that supporting evicted tenants through homelessness services in Victoria cost upwards of \$50 000 per year (2019-20 dollars) (VIC DHS 2011).

However, there is unmet demand for tenancy support services (NT Shelter, sub. 879, p. 3). In 2018-19, about 15% of people who tried to access services to assist them to maintain their housing had their need unmet (AIHW 2019n). About 5500 people in this group experienced mental ill-health (AIHW Specialist Homelessness Services Collection, unpublished data). It is unclear how many of these people were living in social or private rental housing. The total cost of providing additional tenancy support services to meet demand across Australia for clients with mental ill-health was estimated to be \$10 million to \$44 million each year (appendix K).

While tenancy support services are generally associated with the social housing system, limited support services are also sometimes available for people in the private rental market — often called ‘private rental brokerage services’ (PC 2017b). Services may be funded and provided by governments, such as Housing Connect in Tasmania and Supportive Tenancy Service in the ACT, or through NGOs, such as the Private Rental Access Program (Launch Housing 2020; Tually et al. 2016; Woden Community Service nd). Services can include providing information, advice, referrals, advocacy and support to help people with complex needs — such as mental illness — to find and maintain housing.

Some Inquiry participants suggested there was a need to increase the availability of these services to people in private housing as well as social housing (Australian Red Cross Society, sub. 490, pp. 16–17; CHP, sub. 145, p. 7; MHV, sub. 580, att. 1, p. 32). As most people with mental illness reside in private rental housing, expanding services to this market has the potential to benefit large numbers of people with mental illness. There is limited accessibility of private rental brokerage services and the Productivity Commission has previously discussed the importance of State and Territory Governments ensure that people renting in the private market have the same access to tenancy support services as those in social housing (PC 2017b, p. 231).

It is also necessary to consider the carers of people with mental illness when expanding tenancy support services. As discussed above, approximately 70% of mental health carers live with the care recipient and in many cases their housing outcomes are intrinsically linked with the lease held by either the carer, the care recipient, or both (Carers NSW, sub. 808, p. 12). A potential consideration is to allow carers to also access tenancy support programs in both social housing and private housing.

Improve private rental tenancy laws

In the private rental market, there is scope to reduce the risk of eviction and its associated stresses for people with mental illness.

Laws that allow ‘no grounds’ evictions permit landlords to evict tenants without having to identify a particular reason, either at the end of a fixed term lease, or at any time during a periodic lease. Several submissions expressed concern that no grounds evictions create a substantial imbalance of power and can impose significant stress on renters (Anglicare, sub. 376, p. 9; NT Shelter, sub. 333, p. 2).

The constant threat of ‘no grounds’ evictions also remains a source of real stress for renters. A 2019 survey by Tenants’ Union NSW and Marrickville Legal Centre found over 60% of NSW renters report the possibility of a ‘no grounds’ eviction is a significant source of anxiety, and 90% report they would experience significant financial costs, emotional toll, anxiety and stress if forced to move. (NCOSS, sub. 143, p. 15)

Further, the legal minimum notice periods for rental terminations vary across Australia, but tend to be shorter than those internationally (PC 2019c, pp. 121–122). While notice periods are intended to give the party receiving the notice time to plan their future activities and save for the costs of moving, shorter notice periods increase the difficulty of securing alternative housing that meets their needs (such as proximity to support). This can be particularly stressful for people with mental illness.

The Productivity Commission has found in past research that reforms to prohibit no grounds evictions and extend notice periods for landlord initiated evictions would improve the welfare of vulnerable private renters by increasing their certainty of tenure and providing more time to make alternative arrangements (PC 2019c, p. 123).

However, an important consideration is that tenancy laws that limit landlords’ options may translate into higher rents over time, to cover an increase in risk to landlords associated with leasing activity (PC 2019c, p. 123). Additionally, it could also exacerbate discrimination by landlords and real estate agents against renters who have a mental illness.

Recent reforms in Victoria and New South Wales have sought to rebalance the interests of tenants and landlords within residential tenancy legislation (Consumer Affairs Victoria 2020; NSW Fair Trading 2020; PC 2019c, p. 118). However, reforms have not yet fully commenced, making it difficult to determine the likely effects of these changes on the private rental market.²¹³ State and Territory Governments should monitor the effect of these forthcoming reforms to assess the potential benefits for people with mental illness to rent in the private market, including whether or not the reforms change the willingness of private landlords to rent to people with mental illness.

²¹³ These reforms are being staged over time. In New South Wales, changes to the residential tenancy legislation started on 23 March 2020 (NSW Fair Trading 2020). In Victoria, changes are scheduled to be implemented by 1 July 2020 (Consumer Affairs Victoria 2020).

ACTION 20.1 — HOUSING SECURITY FOR PEOPLE WITH MENTAL ILLNESS

Housing services should increase their capacity to reduce the risk of people with mental illness experiencing housing issues (such as housing that is of low quality or of insecure tenure) or losing their home.

Start now

- Each State and Territory Government should provide mental health training and resources to social housing workers. Training should incorporate awareness about how to identify early warning signs of mental illness and the benefits of early intervention. It should also provide advice on appropriate interventions to stabilise existing tenancies for people with mental illness, such as connecting tenants to mental health services.
- State and Territory Governments should work with the relevant bodies, including the real estate institutes, to help organise training and resources on mental health for private sector real estate agents as part of their professional development.
- State and territory social housing authorities should review their policies relating to anti-social behaviour, temporary absences and information sharing between institutional care facilities and housing authorities to provide consideration for people with mental illness, to reduce the risk of eviction.
 - The review of anti-social behaviour policies should take into account the episodic nature of mental illness and ensure a fair balance between the needs of the tenant experiencing mental illness and the needs of other tenants sharing a housing facility.
- Each State and Territory Government, with support from the Australian Government, should ensure that tenants with mental illness who live in the private housing market have the same ready access to tenancy support services as those in social housing by meeting the unmet demand for these services.

Start later

- State and Territory Governments should monitor the effects of forthcoming reforms to residential tenancy legislation, including no-grounds evictions, and assess the potential effects for people with mental illness who rent in the private market.

20.3 Support for people with complex needs to find and maintain housing

Many people with severe mental illness, and complex needs arising from their mental illness, find it difficult to locate or maintain suitable long-term housing in the community. While in some cases better integrated supports and financial assistance may be effective in helping people to live successfully in the community (section 20.2), in others, more intensive support may be needed. And in circumstances where people transition out of institutional care (such as hospitals or correctional facilities), support to find and maintain housing can reduce the risk of future housing problems.

Supported housing: integrated housing and mental health services

Integrated housing and mental health services (hereon described as ‘supported housing’) can be an effective way of providing support for people with severe mental illness. Supported housing programs integrate access to housing, tenancy (or psychosocial) support services and mental health services. These programs can help people to find and maintain a home, prevent homelessness, aid recovery and be more cost-effective than spending time in more acute clinical settings, such as hospitals (ACT Government, sub. 210, p. 16; Mind Australia Limited, sub. 380; TeamHEALTH, sub. 756). Supported housing can be achieved in either social housing, the private rental market or a hybrid of the two (such as headleasing).

Most states and territories have trialled (or are trialling) supported housing for people with mental illness in a social housing setting (box 20.2). These programs generally involve a close partnership between social housing, tenancy support services and mental health services. Where evaluations exist, results tend to show improved housing and mental health outcomes for participants. And in many cases, the cost of running the program is offset to some extent as participants reduce their use of other relatively high cost services, such as hospitals. The Housing and Accommodation Support Initiative (HASI) is a key example (box 20.2). The Mental Health Coordinating Council (sub. 214, p. 16) stated that ‘investment in additional HASI type services will return \$1.20 per every dollar invested in the short term’.

Many submissions were supportive of HASI and similar initiatives.²¹⁴

HASI support helps people to achieve their own, unique goals. The types of support people receive depends on their individual needs and what they want to achieve ... Findings from an evaluation conducted by the University of New South Wales in 2012 demonstrate that HASI has provided significant benefits for those who have received support from the program as well as the broader NSW community. (MHCC, sub. 920, p. 19)

²¹⁴ Beyond Blue, sub. 275, p. 29; EMHS, sub. 152, p. 3; FOCP, sub. 198, p. 4, sub. 758, p. 4; Mental Health Commission of New South Wales, sub. 486, p. 31; MHCC, sub. 214; MHV, sub. 479, p. 14; Mission Australia, sub. 487, pp. 15–16; NCOSS, sub. 143, p. 16; Northern Territory Mental Health Coalition, sub. 430, p. 24; One Door Mental Health, sub. 108, p. 14; RANZCP, sub. 385, p. 31; VCOSS, sub. 478, p. 37; WayAhead Mental Health Association NSW Ltd, sub. 310, p. 3.

Box 20.2 Integrated supported housing programs across Australia

Several states and territories have trialled supported housing programs for people with severe mental illness. Only some of these programs have been evaluated, with results showing that participants generally sustain housing, their mental health improves or remains stable, hospital usage falls and employment or training somewhat improves.

Results from integrated supported social housing programs around Australia

State	Program	Sustained housing	Mental health	Hospital usage	Employment and training
NSW	Housing and Accommodation Support Initiative	90%	↑	↓	—
Qld	Housing and Support Program	83%	—	↓	↑
SA	Housing and Accommodation Support Partnership Program	93%	↑	↓	↑
WA	Individualised Community Living Initiative	na	↑	↓	na

na Not available.

Source: Bruce et al. (2012); Meehan et al. (2010); SA DoH (2013a); Smith (2015).

An example of a supported housing program is the Housing and Accommodation Support Initiative (HASI), a partnership between NSW Health, Housing NSW, community housing providers and providers of tenancy support (Bruce et al. 2012). The scheme aims to provide stable housing integrated with clinical and psychosocial rehabilitation services to people with mental illness. Tenants receive:

- tenancy support services and rehabilitation services from non-government organisations
- clinical care services from specialist mental health services
- housing from social housing providers (HASI services are also available for private renters).

An evaluation of the HASI in 2012 found:

- about 90% of participants successfully maintained their tenancy; of the remaining 10% who ended their tenancies, most left for planned reasons, such as moving to other housing
- a 59% decrease in the average number of days each year in a mental health inpatient hospital
- an improvement in life skills, and community participation and a reduction in behavioural issues.

The average (non-accommodation) costs of HASI was about \$46 000 per person annually (2019-20 dollars), depending on the level of support needed (not including the cost of clinical mental health services). However, this was largely offset by an estimated \$43 000 reduction in costs as a result of reduced use of mental health inpatient hospitalisations.²¹⁵

Given these positive experiences, both the Northern Territory and Tasmania have begun piloting programs based on HASI (NT Shelter, sub. 333, pp. 6–7; Tasmanian Government, sub. 498, pp. 15–16, sub. 1242, p. 3). In its early stages, as at August 2019, each of the 50 people who have received services from Northern Territory HASI had maintained their tenancy (Northern Territory Government, pers. comm., 21 August 2019).

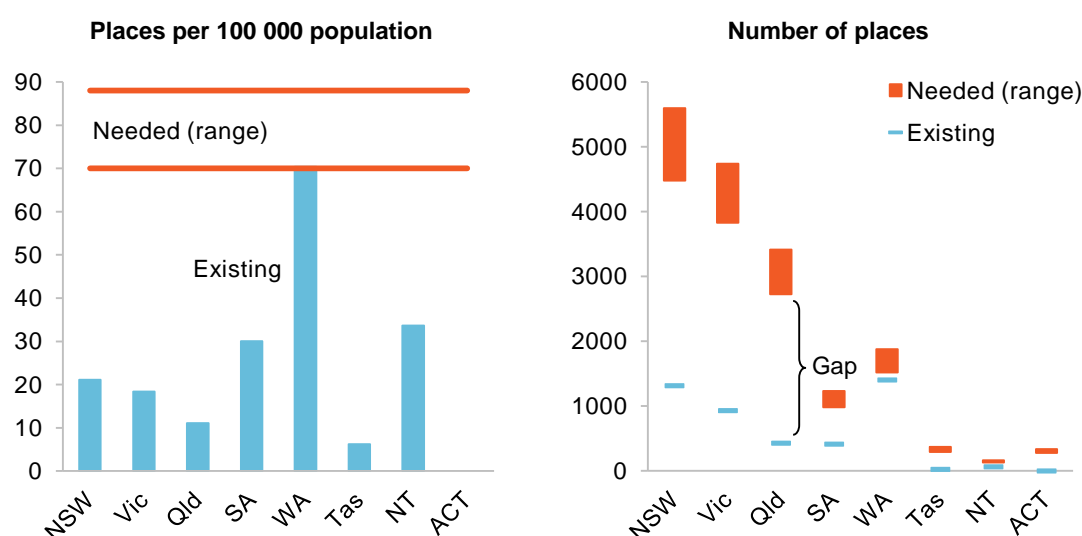
²¹⁵ Costs inflated to 2019-20 dollars using CPI numbers for Health, weighted average of eight capital cities (ABS 2020a).

However, there is significant unmet demand for supported housing places in Australia (Brackertz et al. 2020; figure 20.5). In 2017-18, there were about 4600 supported housing places across Australia (AIHW 2020h).²¹⁶ Yet, about 14 000 to 17 000 places were estimated to be needed across Australia. This is a gap of about 9000 to 12 500 places (figure 20.5). While these are estimates rather than exact figures, they are consistent with a broader understanding in the community that more supported housing places are needed.

There are a number of mental health supported accommodation packages via [Housing and Support Packages (HASP)] but not currently enough to meet demand. [The Office of The Public Advocate] understands that South Australia has 36 HASP packages. There is sufficient demand to increase the number of HASP packages available. (OPA South Australia 2017, p. 4)

But the level of housing supply needs to increase substantially. Estimates made for inner Melbourne by Launch Housing suggest that 500 people would benefit from some form of Housing First or permanent supportive housing each year. (Launch Housing, sub. 764, p. 3)

Figure 20.5 Gap in supported housing places across Australia^{a,b}
As at 30 June 2018



^a The needed range was estimated using assumptions in Siskind et al. (2012) that the optimal number of supported housing places lies between 70 to 88 places per 100 000 population. Existing places are reported by the Australian Institute of Health and Welfare (AIHW 2020h). The gap in the number of supported housing places is the difference between the existing number of places and the estimated number of places needed (using population estimates for people aged 18 years and over). ^b The ACT reporting having zero supported housing places in 2017-18. In 2016-17, the ACT reporting having 11.8 places per 100 000 population.

Source: Productivity Commission estimates using ABS (*Australian Demographic Statistics, Sep 2019, Cat. no. 3101.0*); AIHW (2020h); Siskind et al. (2012).

²¹⁶ While this is the most consistent source of data available to measure the existing number of supported housing places, it is not necessarily an accurate reflection of a jurisdiction's mental health housing supports because not all schemes are in scope for this data collection.

Unless more supported housing places are developed, this gap can be expected to increase as the population grows. Currently, Western Australia is the only state or territory that reaches the estimated range of supported housing places needed, despite reporting a significant gap in community mental health services more broadly (WAMHC 2019).

Supported housing programs are generally provided through social housing (box 20.3). However, there are examples of supported housing being provided through the private market and through headleasing arrangements.

A key barrier to meeting the demand for supported housing places is a significant shortage of social and affordable housing. Across Australia, almost 190 000 people were on social housing waitlists as at 30 June 2017 — although this is likely to be an overestimate as some applicants may be on more than one waiting list (AIHW 2018a). While many on this list can access housing within three months, wait times of two years or more are not uncommon. Submissions noted that time spent on waitlists exceed 10 years in some areas (Eastern Health – Murnong Adult Mental Health, sub. 187, p. 1; Shelter WA, sub. 200, att. 1, p. 7). Supply constraints mean that, in all jurisdictions, most entries into social housing come from the priority list.

As a result, many submissions recommended an increase the social housing stock.²¹⁷ However, fixing the broader social housing system is beyond the scope of this Inquiry. The Productivity Commission has recognised in a previous inquiry that the social housing system is ‘broken’ and recommended a single system of financial assistance across both social housing and private housing (among other recommendations) to address the underlying problems (box 20.4). However, to date, no state or territory has adopted this approach.

Inquiry participants were also supportive of expanding supported housing places.²¹⁸ The South Australian Mental Health Commission (sub. 691, att. A, p. 2) stated:

An increase in [supported housing] would provide a safe place for people experiencing mental health issues to go, and for those also experiencing housing distress, it would also provide more options for hospitals to discharge people into, increasing the availability of acute mental health bed[s] in hospitals for those in crisis.

Further to this, the Commission has also heard that an increase in supported housing options would provide much needed support to people who experience chronic conditions and complex circumstances, where general housing options may not be appropriate.

²¹⁷ ACP, sub. 522, p. 25; Anglicare Australia, sub. 376, p. 32; APS, sub. 543, p. 7; cohealth, sub. 231, p. 13; Jesuit Social Services, sub. 441, p. 5; KLC, sub. 469, p. 17; Launch Housing, Melbourne transcript, p. 49; Mind Australia, sub. 380, p. 37; Uniting Vic.Tas, sub. 95, p. 8; VCOSS, sub. 478, p. 36.

²¹⁸ AHURI, sub. 885, pp. 23; Almondale, sub. 735, p. 14; CHF, sub. 646, p. 17; FOCP, sub. 758, p. 4; Jesuit Social Services, sub. 1186, p. 1; Mental Health Australia, sub. 864, p. 16; NT Shelter, sub. 879, p. 5; UnitingSA, sub. 807, p. 10; Uniting Vic.Tas, sub. 931, pp. 16–17.

Box 20.3 **Different options to deliver supported housing**

Social housing

Most supported housing is provided through social housing. A key benefit of using social housing is tenants have access to all the supports available in social housing. However, people with mental illness do face barriers to accessing social housing. In addition to the significant wait many people face to access social housing, when they do finally access housing they have little choice over the home in which they live (PC 2017b), and could end up far away from support services. In addition, navigating the administrative procedures for social housing can be particularly difficult for people with mental illness (APS, sub. 543, p. 32; MHCA 2009). In a survey of people with mental illness, 90% of respondents reported complexity in applying for public housing that created difficulties for them (SANE Australia 2008). Once people are in social housing, some may struggle to understand their tenancy obligations and what constitutes a breach (QMHC 2015).

Private rental

Supported housing in private rentals can provide significant benefits. It opens up a much larger pool of housing stock, which can provide greater choice and opportunity for people to find housing that meets their needs and preferences, such as proximity to support services. It can also provide an alternative to social housing, freeing up social housing places. Supported housing can help to overcome many of the barriers people with mental illness may face in accessing the private rental market, such as discrimination, difficulties managing housing tasks and unsociable behaviour (section 20.1). Coordination with the private rental sector would facilitate access to an immediate and greater supply of homes (NMHC, sub. 118, p. 10).

However, there are some barriers to providing supported housing through the private rental market. Tenancy support services are either lacking or not well integrated with other housing and non-housing supports. And vulnerable tenants, such as those with mental illness, face rental affordability issues (PC 2019c). Also, people with severe mental illness can find it difficult to secure private rental housing, even with a supported housing program, due to anxiety concerning lease length, stigma, absence of rental history, poor work history, making a poor first impression, poor literacy skills or reliance on financial assistance.

Doorway

An example of a supported housing program implemented through the private rental market is Doorway. Doorway is a housing and recovery support program funded by the Victorian Government and designed to improve the capacity of individuals with severe and persistent mental illness who are homeless or at risk of homelessness to live independently in the private rental market (Nous Group 2014). The program provides client support services (such as tenancy support) and a housing supplement to subsidise rent where required. This housing payment supplements Commonwealth Rent Assistance.

An evaluation of Doorway estimated the cost of the housing supplement at \$10 136, the cost of client support at \$7937 and operational costs of \$1228 per person each year. About 85% of participants remained housed at the end of the evaluation period. Participants also showed improvements in mental health outcomes and greater interaction with others. Participants significantly reduced their use of health services, particularly bed-based mental health services, ambulatory care, emergency department presentations and hospital admissions. This led to an estimated \$11 050 reduction in health service costs per person each year (Nous Group 2014).

(continued next page)

Box 20.3 (continued)

Headleasing

A headleased property is one that is owned by private individuals or corporations and leased to another party, such as government social housing providers who then enter into a separate sub-lease arrangement with a tenant. The private landlord is generally responsible for routine property maintenance, and the social housing provider is responsible for tenancy management (such as collecting the rent and passing on any maintenance requests). The social housing provider is usually liable (up to a cap) for any property damage after the application of the tenant bond and any insurance proceeds. These arrangements already exist for some community housing and Defence housing in Australia. About 20% (12 500 properties) of all community housing properties are headleased from the private market (PC 2017b).

Headleasing is a useful tool that State and Territory Governments can use more broadly to give social housing tenants a wider choice of home (PC 2017b). This option provides more long-term flexibility over property type and location than building new public housing, providing more choice to tenants.

Box 20.4 Previous recommendations to reform social housing

The Productivity Commission's (PC 2017b) inquiry into Reforms to Human Services found that social housing in Australia is broken. Below are two of its key recommendations for improvement.

One system of financial assistance

The Productivity Commission recommended implementing a single system of financial assistance for tenants social and private housing, who currently can receive vastly different rates of financial assistance. Tenants would receive a single package of assistance that is portable between private and social housing. At its base, all eligible households in both markets would receive Commonwealth Rent Assistance (CRA). Some households would also receive income support payments or National Disability Insurance Scheme funding that are currently used to contribute to housing costs. Where these programs and CRA are not sufficient to meet a household's rental payments, State and Territory Governments could pay a housing supplement to that household. This would bridge the gap between CRA, tenant contributions and market rent.

Choice-based letting

The Productivity Commission recommended that State and Territory Governments introduce choice-based letting for tenants in social housing. Choice-based letting involves ranking social housing applicants against selection criteria (such as waiting time, age and need) and offering the highest ranked applicant the property. This changes the allocation process from one driven by the housing provider to one driven by the preferences of the households. Choice-based letting has been implemented elsewhere, including the United Kingdom and the Netherlands.

While some governments are looking at implementing this reform, none have done so to date.

State and Territory Governments should develop or scale up existing supported housing programs that integrate housing, tenancy support and mental health services. A mix of supported housing options are likely needed to meet a variety of needs and preferences, including social and private housing, and headleasing arrangements.

The total expenditure required to meet the gap for supported housing places across Australia is estimated to be \$230 million to \$807 million each year (appendix K). Less than half of this cost is attributable to accommodation — about \$108 million to \$226 million each year.²¹⁹ However, to the extent that supported housing avoids costs to other government services, the net cost to government is likely to be lower in the long term. For example, both the Doorway (about \$16 300 per person each year) and HASI (\$43 100) programs estimated significant reductions in average health service usage. This suggests the net cost to government is likely to be closer to \$83 million to \$267 million each year (appendix K).

Funding for this increased investment should be included in the renegotiation of the NHHa (section 20.5). State and Territory Governments should report annually to the National Mental Health Commission on their progress in meeting the gap in supported housing places in their jurisdiction (chapter 24).

Long-term supported accommodation for people with severe and persistent mental illness

Some Australians with severe and persistent mental illness and resulting psychiatric disability may lack the necessary social supports or financial capacity to access longer-term accommodation that provides the support they need to live in the community. As a result, they can end up effectively stuck in specialist mental healthcare facilities or hospital-like environments that are intended for short- to medium-term stays (chapters 12 and 13). Meanwhile, some others may cycle in and out of hospitals or homelessness if they cannot access support.

‘Long-term supported accommodation’ can give them the best opportunity to live a contributing life. It is a specific form of supported housing for people with severe and persistent mental illness who require mental healthcare, tenancy support services and daily living support to be available on site 24 hours a day, 7 days a week. Specialist housing may involve individual or congregated living arrangements in purpose-built units or houses that provide space for on-site support.

... in Australia and overseas there are models of housing that feature more flexible combinations of private and shared space, individual bedrooms with shared kitchen and living areas. Purpose built facilities have the advantage that they can also contain co-located health [and] employment support services and social participation opportunities to provide the supports that many people require to live independently and in communal settings. (AASW, sub. 432, p. 8)

²¹⁹ Productivity Commission estimates using Nous et al. (2014). The non-accommodation costs component primarily consists of costs incurred providing psychosocial supports such as helping people take part in social and community activities, improving relationships and building confidence in day-to-day tasks (Nous Group 2014).

Some State and Territory Governments are developing long-term supported accommodation (for example, ACT Government, sub. 210, p. 16; Tasmanian Government, sub. 498, p. 14). NGOs (with government assistance) have also entered this space. For example, the Haven Foundation model has led to improved outcomes for many of its participants (box 20.5).

Box 20.5 The Haven model of long-term supported accommodation

The Haven provides long-term supported accommodation to people with severe mental illness (Mind Australia Limited, sub. 380, p. 32). Residents live in their own self-contained apartment, with independent kitchen and bathroom facilities, within a block of units that also has some shared communal areas to encourage social interaction. The program provides 24/7 on-site psychosocial support staff to help residents to live successfully in the community.

Residents must meet strict eligibility criteria to live in the Haven. They must be diagnosed with a severe and persistent mental illness, receive a Disability Support Pension and be eligible for the National Disability Insurance Scheme (The Haven Foundation, pers. comm., 13 February 2019).

Residents enter into an open-ended lease with The Haven Foundation. They pay 25% of the Disability Support Pension and 100% of rental assistance to cover the cost of maintenance and repairs. Residents are responsible for paying their own utilities, such as electricity and water. Funding received under the National Disability Insurance Scheme covers the cost of on-site psychosocial and tenancy support (The Haven Foundation, pers. comm., 13 February 2019).

An evaluation of the pilot Haven model in South Yarra found that tenants have experienced:

... the reduced need for acute psychiatry or residential rehabilitation service care, has enhanced participation in vocational or educational opportunities, has strengthened the link with carers and family members, and has assisted in establishing new connections with members of the broader community. (Lee et al. 2013, p. 15)

The Haven is estimated to cost about \$100 000 per person each year (Mind Australia Limited, sub. 380, p. 40). This does not include an annualised cost of capital to fund the development of these units.

The first Haven site in South Yarra, Melbourne has 14 units. The model has subsequently been established in Frankston (18 units), with more sites in Geelong (16 units) and Laverton (16 units) and Whittlesea in the pipeline (Mind Australia, sub. 380, p. 40).

Many Inquiry participants were supportive of greater development of long-term supported accommodation for people with severe mental illness.²²⁰ Launch Housing (Melbourne transcript, p. 53) said that it was:

... very keen for the Commission to consider permanent supportive housing options as recommendations in regards to longer-term housing options, because permanent supportive housing offers 24-hour supportive ... trauma informed care to people. It's secure, it's safe, it's affordable, and it can be done in scattered sites.

²²⁰ For example, ACT Mental Health Consumer Network, sub. 297, p. 10; CHF, sub. 646, p. 17; Ian Webster, sub. 626, p. 5; KLC, sub. 469, p. 18; Launch Housing, sub. 764, p. 2; Mind Australia, sub. 380, Melbourne transcript, p. 36; Olav Nielssen, sub. 37, p. 1; SAMHC, sub. 477, p. 16, sub. 691, att. B, p. 9.

Long-term supported accommodation can also be more cost effective than residential mental healthcare and hospitals. The estimated recurrent (non-capital) cost of housing someone in the Haven is about \$100 000 per year (Mind Australia, sub. 380, p. 40). This is significantly cheaper than the average annual recurrent cost of 24-hour staffed residential mental healthcare (about \$210 000) and hospitals (\$510 000) in 2018-19 (SCRGSP 2020b).²²¹

The Productivity Commission estimates that about 3000 people could be living in non-acute 24-hour staffed accommodation across Australia in 2019-20, were sufficient places available.²²² However, we acknowledge the insufficient availability of long-term supported accommodation. For example, during 2017-18, 135 people had been living in residential mental healthcare for more than one year (AIHW 2019h). The South Australian Government (2018) estimated that 82 older adults with enduring mental illness would require this type of housing by 2021, and that 36 long-term accommodation places would be needed to help fill the gap in existing services.

Making use of the NDIS to encourage accommodation support

Many people with severe and persistent mental illness who require 24/7 mental health and housing support are likely to be eligible for disability funding under the NDIS (chapter 17). There are two streams of funding that can be used to help people find and maintain housing.

- Supported Independent Living (SIL) supports involve a person assisting with daily tasks to help people live as independently as possible, such as help cooking and budgeting (NDIA 2020e).
- Specialist Disability Accommodation (SDA) involves specialist housing solutions for people with very high support needs. This may involve developing new accommodation or retrofitting existing dwellings to satisfy particular support needs (NDIA 2020d).

SIL supports can help people with mental illness to manage their housing tasks. People who receive SIL supports may live in accommodation funded under SDA, or they may live in their own home, a private rental or social housing. The supports can be provided in a shared or individual arrangement. However, unlike SDA, funding for SIL cannot be used to pay for the cost of housing, such as rent. Further, Queensland Advocacy Incorporated (sub. 889, p. 13) noted that SIL can be unnecessarily restrictive on people's choices.

SDA funding can be used to encourage development of long-term supported accommodation for people with severe and persistent mental illness with very high support needs (box 20.6). The National Disability Insurance Agency (NDIA) projects about 6% of NDIS recipients are intended to receive SDA funding, which should accommodate the estimated 3000 people in need of this type of housing (provided all 3000 people qualify for the NDIS).

²²¹ The average cost of residential care may be higher than this estimate as it does not fully account for reach-in services from state and territory providers.

²²² Productivity Commission estimates using the National Mental Health Service Planning Framework. This projection is based on all other services being available.

Box 20.6 **Specialist Disability Accommodation**

Specialist Disability Accommodation (SDA) refers to accommodation for eligible participants of the National Disability Insurance Scheme who need specialist housing solutions to help cater for their significant functional impairment or very high support needs (NDIA 2018e). SDA is intended to ensure that participants do not pay more for housing because of their disability.

SDA funding provides a return to investors to develop SDA to meet demand. Eligible participants receive ongoing payments to live in eligible SDA (in practice, SDA funding is paid to the SDA provider on behalf of the participant). Residents in SDA are still required to pay a reasonable rent contribution, limited to 25% of their Disability Support Pension plus applicable Commonwealth Rent Assistance (Beer et al. 2019). Some people may decide to develop their own SDA.

As at 31 March 2020, 13 944 participants were in receipt of SDA funding, at a cost of about \$156 million, and 4123 SDA dwellings were enrolled (NDIA 2020b). When the scheme is fully rolled out, about 28 000 households (6% of National Disability Insurance Scheme recipients) are expected to receive SDA funding. Funding is expected to reach about \$700 million each year and is intended to attract an additional \$5 billion in investment from the market to develop more than 12 000 purpose-designed dwellings (NDIA 2018e; PwC and Summer Foundation 2017).

However, this housing solution is still in its infancy. As at 31 December 2019, 468 participants with primary psychosocial disability received SDA funding, though this is likely an underestimate (NDIA, pers. comm., 4 May 2020). This is just 1.6% of current NDIS participants with primary psychosocial disability — far from the 6% target and significantly lower than the almost 4000 people projected. Ongoing funding for SDA is already budgeted (box 20.6), but SDA growth remains slow.

Growth in SDA may be slow for people with psychosocial disability for several reasons. First, barriers to accessing the NDIS has led to fewer people with psychosocial disability entering the scheme than expected (chapter 17). Second, according to *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016*, SDA is generally restricted to housing five or fewer residents and is intended to reduce clustering of people with long-term psychosocial disability. This criteria potentially restricts the development of some successful congregated site models, such as the Haven model. Third, there is a requirement for participants to exhaust all other options before they can access SDA funding (COAG DRC 2019d). Finally, there may be a perception in the community that SDA funding is only available for NDIS participants with physical disability (Mind Australia, sub. 380, pp. 36–37).

In October 2019, the NDIA published the SDA Limited Cost Assumptions Review (NDIA 2019b, 2020c). The review recommended a number of price limit increases for some design categories and locations to encourage investment in SDA and improve the choice of living options for participants eligible for SDA. The NDIA has also introduced the SDA Design Standard to provide clarity for housing design requirements to encourage growth in the construction and development of SDA (NDIA 2019g).

However, there are several potential ways the NDIA can further encourage development of SDA, especially for people with mental illness. The NDIA can lift restrictions on the number

of people who can share SDA in a congregated living environment. Beer et al. (2019) suggested several other ways the NDIA could encourage SDA development, including:

- support to increase investor certainty by building systems to estimate the number of people expected to be eligible to access SDA and where they live
- providing resources to assess and approve participants
- developing SDA policy about clients with complex, challenging or aggressive behaviours that may lead to significant property damage — these clients may not be an attractive investment proposition to SDA providers, but have some of the greatest needs.

The NDIA should amend its SDA strategy and policies so that they encourage the use of SDA funding to develop long-term supported accommodation for people with severe and persistent mental illness (action 20.3). As part of this, the NDIA should:

- lift restrictions on the number of people who can reside in newly developed SDA
- develop and report estimates of the number of people with psychosocial disability who are expected to be eligible to receive SDA funding, and where they live
- provide clarity about how the NDIA will deal with problems of liability concerning property damage for this cohort.

Improving transitions out of hospitals and correctional facilities

People with severe mental illness may require time in hospital or a specialised mental health facility to support their recovery (chapters 12 and 13). However, many of these people find it difficult to transition back into the community and find adequate housing, and either remain in care or are discharged into homelessness.

As noted in section 20.1, over 2000 mental health hospital inpatients could potentially be discharged if appropriate clinical and accommodation services were available (chapter 13). As well, nearly half of people leaving prison are expected to spend at least their first night in short-term or emergency accommodation (Baker 2014). In addition, the Council to Homeless Persons (sub. 145, p. 5) stated that:

Acute mental health services report that approximately 25 per cent of patients are homeless prior to admission, and most are discharged back into homelessness because of a lack of suitable accommodation options.

There are several reasons why people may be discharged from acute mental healthcare into unstable housing or homelessness or have to remain in care.

- Difficulty identifying people who are homeless or at risk of homelessness.
- Constraints on hospital capacity and non-acute bed-based services (chapter 13), and time pressures, can affect discharge assessments and lead to people being discharged too quickly.

-
- Delays or lack of follow up after discharge. While follow up with a hospital liaison officer is common practice in Australia, there can be significant delays. Follow up care and support are only possible if the individual has been discharged to a stable address.
 - Difficulty accessing housing and community mental health services after discharge (Brackertz, Wilkinson and Davison 2018; NSW Ombudsman 2012).

Many Inquiry participants recognised the importance of improving transition out of institutional settings to prevent people being discharged into homelessness or eventually readmitted into these facilities.²²³

... we see the impact of housing instability and homelessness on people's mental health treatment and recovery. This includes people being discharged from hospital into rooming houses or onto the streets, and the risk of readmission into hospital that this presents. (VLA, sub. 500, p. 17)

Clients who are mentally unwell and prematurely discharged from acute care facilities into inappropriate accommodation represent a risk for completed suicide or multiple presentations to ED ... (ACP, sub. 522, p. 24)

Failed discharges increase the likelihood that people will end up back in hospital or other treatment settings. (MHV, sub. 580, att. 1, p. 31)

There are several examples of hospitals that have implemented programs that successfully avoid discharging people into homelessness (box 20.7). Some programs (such as Queensland's Transitional Housing Teams) provide time-limited housing and thus are more costly, compared with other programs (such as the Royal Perth Hospital Homeless Team) that provide discharge planning and other supports. Successful programs tend have three key elements, including:

- staff are trained to identify at-risk patients
- care coordinators (such as case managers) make thorough discharge assessments, well ahead of discharge, and provide timely and assertive follow up after discharge
- people have ready access to transitional housing that meets their long-term recovery needs.

While jurisdictions have formal policies or guidelines that dictate discharge and transfer of care from hospitals and correctional facilities, many jurisdictions do not have a clear and explicit reference to prevent discharge into homelessness. For example, some jurisdictions told us that they have informal policies that no person should be discharged into homelessness, or that mental health inpatients who are discharged with no fixed address are offered basic hotel accommodation for three nights (State and Territory Governments Survey). Protocols and planning for people exiting hospital care are also often underdeveloped (Brackertz et al. 2020).

²²³ ADACAS, sub. 493, p. 15; APS, sub. 543, p. 40; Beyond Blue, sub. 275, p. 31; breakthru, sub. 112, pp. 10–11; CHF, sub. 646, p. 17; CHP, sub. 145; FARE, sub. 269, p. 20; FOCP, sub. 198, p. 4; Mental Health Commission of New South Wales, sub. 486, p. 23; MHCT, sub. 314, p. 39; Mission Australia, sub. 684, p. 3; NMHC, sub. 118, p. 10; Northern Territory Mental Health Coalition, sub. 430, p. 29; PPIMS, sub. 179, p. 9; VCOSS, sub. 478, pp. 37–38.

Box 20.7 **Programs preventing discharge into homelessness²²⁴**

Transitional Housing Teams

In 2005, Queensland established a Transitional Housing Team to provide time limited social housing and intensive support to clinically case managed patients with mental illness (Siskind et al. 2014). Participants entered the program upon discharge from an acute psychiatric inpatient unit or from the community. Staff trained the participants in living skills, such as cooking and shopping, provided crisis management and coordinated with other services.

Evaluation results showed that participants experienced significantly fewer inpatient bed days and improved living conditions. This reduced the average cost of health service use by about \$38 600 per participant, and completely offset the \$31 200 per participant cost of the program. As such, the program provided an estimated return on investment of about \$1.24 per dollar invested (Siskind et al. 2014).

Royal Perth Hospital Homeless Team

The Royal Perth Hospital Homeless Team provides GP care, care coordination and discharge planning for patients who are homeless. The team is made up of a clinical lead, administration assistants, GPs, nurses and a caseworker.

An evaluation showed that contact with the team reduced emergency department presentations and mental health inpatient care (Gazey et al. 2019). Fewer patients also discharged themselves against medical advice. These improvements were estimated to reduce hospital use by about \$8400 per patient. Given the average cost of the program was about \$5100 per patient, this represented a return on investment of about \$1.64 per dollar invested.

Housing Support Workers

In 2009, the National Partnership Agreement on Homelessness was established. One of the programs delivered under the agreement was the provision of Housing Support Workers who help people with severe and persistent mental illness who are either homeless or at risk of homelessness when discharged from a mental health inpatient unit.

Wood et al. (2016) estimated that this program reduced overall health costs by about \$111 000 per person each year, largely as a result of fewer days in hospital and psychiatric care. These cost savings significantly outweighed the estimated cost of the program (about \$12 700 per person, excluding housing costs). Therefore, the program delivered a positive return on investment of about \$9 per dollar invested. Compared with other homeless prevention programs tested, this group delivered the largest cost savings and was most likely to retain their tenancies.

²²⁴ Costs and savings inflated to 2019 dollars using CPI numbers for health, weighted average of eight capital cities (ABS 2020a).

Submissions discussed the need for formal, nationally consistent policies of no exits into homelessness.²²⁵

Recommendations calling for a national commitment to ‘no exits’ from institutional care into homelessness for people with mental illness are fully supported by our organisation. (Uniting SA, sub. 807, p. 10)

Each State and Territory should commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and correctional facilities (action 20.2). Implementing this would require comprehensive mental health discharge plans linked to ongoing care coordination provided in the community where needed (chapter 15), and community services to meet the needs identified in the plans.

To ensure that State and Territories are working with service providers, State and Territories should monitor and report on discharging into homelessness under the next version of the NHHA agreement (action 20.2). This could require sharing of information between the relevant departments covering housing and homelessness, health and community services in each jurisdiction (Brackertz et al. 2020).

The Productivity Commission has estimated that the total cost of providing discharge support to help about 3000 people transition out of acute care and into suitable housing could be in the range of \$15 million to \$94 million each year (appendix K). This range reflects the fact that some people will need time-limited housing upon discharge from hospitals, whereas others may have access to housing and require relatively less expensive support to maintain it. However, programs such as these are likely to present an overall saving for taxpayers due to reduced use of health services, including hospital readmissions (box 20.7; Rudoler et al. 2018). Therefore, these programs could deliver an estimated net benefit of \$10 million to \$295 million each year (appendix K).

20.4 Responding to homelessness among people with mental illness

Mental health is closely related to homelessness. As discussed in section 20.1, there is a two-way relationship with homelessness contributing to mental ill-health and vice versa.

Homelessness is not merely ‘rooflessness’. It includes a broader set of people, including those living in non-conventional accommodation (‘sleeping rough’), those living in short-term accommodation (such as shelters and hostels), and those staying with family and friends (‘couch surfing’) (AIHW 2019c).

²²⁵ CHF, sub. 646, p. 17; FOCP, sub. 758, p. 7; Launch Housing, sub. 764, p. 1; MHV, sub. 580, att. 1, p. 33; SAMHC, sub. 691, att. B, p. 4.

State and Territory Governments are generally responsible for providing or funding a range of homelessness services, including directly providing accommodation, tenancy support service, and other related services aimed at responding to or preventing homelessness, such as mental health, family violence, family or relationship, drug or alcohol counselling, legal and financial services (AIHW 2019o). This section examines the effectiveness of existing homelessness services to support people with mental ill-health, and identifies areas for improvement, such as meeting demand for these services, improving service coordination and implementing and scaling up Housing First initiatives.

Many homeless people experience mental ill-health

In Australia, there is a high prevalence of mental illness among the homeless population. Estimates of how many people are in this situation vary depending on the definition of homelessness and mental illness (Fazel et al. 2008; Fazel, Geddes and Kushel 2014), with some estimates of homeless people with mental illness being as low as 12% and others as high as 82% (Johnson and Chamberlain 2011). When substance use disorders are excluded, estimates generally cluster around one-third of the homeless population having mental illness (Flatau 2007; Hodder, Teesson and Buhrich 1998; Johnson and Chamberlain 2011; Rossiter et al. 2003).

Looking at the question in the other direction, it appears about 10–15% of people with mental illness are homeless (ABS 2016a; Culhane, Averyt and Hadley 1997; Folsom et al. 2005; Morgan et al. 2011), much higher than the 0.5% of the general population (ABS 2018a). Westoby (2016, cited in AHURI, sub. 885, p. 13) identified four typical cohorts of people with mental illness who are homeless, including people who:

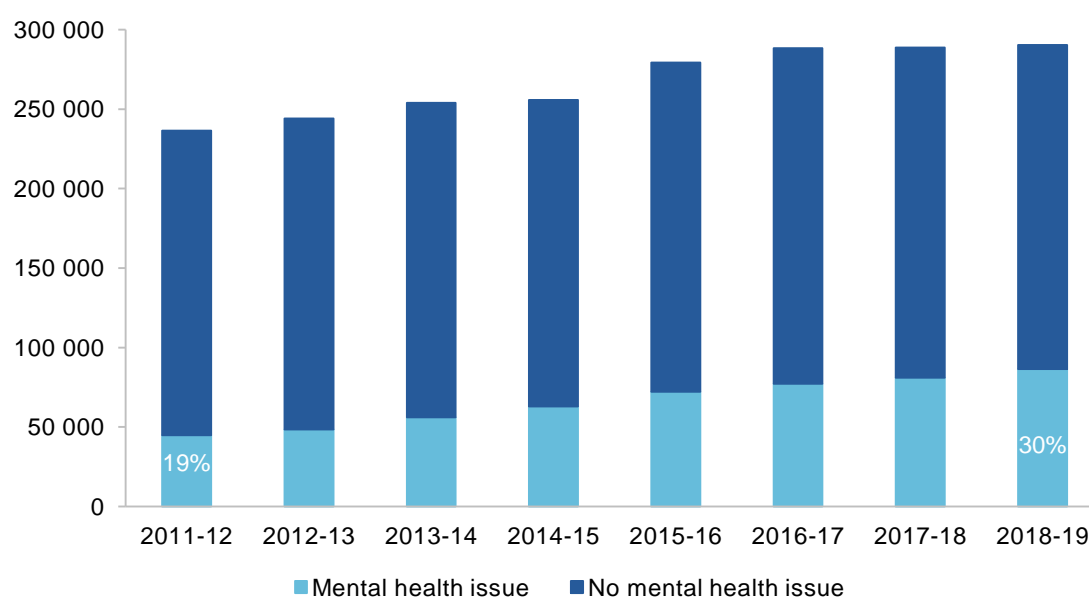
- are homeless and do not receive mental health-related services
- are hospitalised and are not adequately supported when they are discharged from hospital back into the community
- are treated in a psychiatric facility in hospital and remain hospitalised without a discharge or exit strategy back into the community
- experience primary or secondary homelessness in substandard and insecure tenures and who struggle to manage their mental health.

The number of people with mental illness accessing homelessness services has almost doubled over the past seven years (figure 20.6). By 2018-19, about one-third of people (about 86 500 people) accessing these services experienced mental illness, considerably higher than one-fifth of the general population (chapter 2).

This increase in the reported prevalence of mental illness in the homeless population is likely not solely due to an actual increase in mental illness. Greater awareness and reduced stigma may improve identification and self-reporting of mental illness among homelessness service clients. Further, it might reflect improved accessibility or targeting of services. Regardless, as the number of people accessing homelessness services grows, it becomes even more important for services to be effective and efficient.

A variety of risk factors can contribute to homelessness, including mental illness, drug or alcohol abuse, physical health problems domestic violence, inadequate family support, childhood abuse, neglect and disadvantage, unemployment, relationship breakdown, job loss and housing affordability issues (Australian Government 2008; CHP, sub. 145, p. 3; Ian Webster, sub. 626, p. 7). In many cases, mental illness coincides with one or more other risk factors. In 2018-19, over half of all homelessness service clients with mental ill-health also experienced domestic and family violence and/or problematic drug or alcohol use (AIHW 2019d).

Figure 20.6 Number of people accessing homelessness services^{a,b}
By mental health status^c



^a Includes people aged 10 years or older. ^b Homeless status when first seeking assistance. 'Homeless' means the individual is living in no shelter, improvised dwelling, short-term temporary accommodation or couch surfing. 'At risk' means the individual is living in social housing, private housing or an institutional setting. ^c The Australian Institute of Health and Welfare defines a person as having a current mental health issue if they received mental health services in the past 12 months, were referred by a mental health service, reported 'mental health issues' as a reason for seeking assistance, had been in a psychiatric hospital or unit in the past 12 months, or a need was identified for mental health services during their support period. Therefore, this is likely to be an underestimate of the proportion of people accessing homelessness services with mental ill-health.

Source: AIHW (2019q).

Some people are at higher risk of homelessness than others. In 2016, 1 in 28 Aboriginal and Torres Strait Islander people was homeless, and more than 1 in 5 homeless Australians were of Aboriginal and Torres Strait Islander descent (AIHW 2019a). NT Shelter (sub. 333, p. 1, sub. 879, p. 1) also noted that while Aboriginal and Torres Strait Islander people make up one-third of the Northern Territory's population, they account for almost 90% of all homeless persons in the Territory. Evidence indicates that other groups at a higher risk of homelessness include men, people from regional and remote areas, LGBTIQ people and people from refugee and migrant backgrounds (CMY and MYAN, sub. 446, p. 16; Ian Webster, sub. 626, pp. 6–7; National LGBTI Health Alliance, sub. 888, p. 6).

What is the cost of homelessness?

Homelessness can be devastating for individuals and the people close to them. It can be traumatic and stressful, and can have broader effects on people's mental and physical health, employment, education and productivity. Homelessness can also limit people's ability to access mental health services.

Being homeless also limits people's ability to access clinical mental health services. VCOSS members noted that in Victoria, clinical 'catchment areas' are assigned based on a person's home address. If someone is homeless, they may not be assigned to any area. (VCOSS, sub. 478, p. 37)

Homelessness imposes significant costs on government services. In 2018-19, government expenditure on homelessness services across Australia was close to \$1 billion, an average of approximately \$3400 per person (SCRGSP 2020c). This was up from \$777 million (\$3000 per person) in 2014-15, reflecting increases in both the number of people accessing homeless services and the cost per person of providing homelessness services.

Mental ill-health increases the cost of delivering homelessness services. People with mental ill-health tend to use homelessness services more than people without mental ill-health. For example, specialist homelessness services clients with mental ill-health accessed a median 75 days of homelessness services, almost twice as many days as the general homeless population (44 days). People with mental ill-health were also more likely to be persistent users of homelessness services, returning to homelessness services 2.4 times each year, compared with 1.8 times for the general homeless population. (AIHW 2019p)

Homelessness also imposes costs on other government services, including health, justice and education and income support services. For example, the City of Port Philip (sub. 540, p. 7) provided the following case study:

Mr C is a man in his sixties who has been sleeping rough in the City for some time. ... He has been assessed as having below average intelligence and went on to a Disability Support Pension due to a Psychological condition. He has been admitted to several emergency departments at different metropolitan hospitals over the past 2 years ... He has had extensive involvement with Victoria Police since 1991 due to his antisocial behaviours and has been arrested over 30 times with convictions due to behavioural offences ...

Zaretsky et al. (2013) estimated that the average client of homelessness services used \$29 450 more in other government services than the population, on average, each year (2010-11 dollars). This included costs to health (\$14 507), justice (\$5906), income support (\$6620), out-of-home care (\$2342) and evictions (\$75). These costs can accumulate over a person's lifetime and are likely to be greatest for young people. For example, Baldry et al. (2012) estimated the lifetime cost of homelessness to government services ranged from \$900 000 to \$5.5 million per person.

Many homeless people with mental illness do not receive homelessness services

Given the significant costs of homelessness and mental ill-health, and the interaction between the two, it is important that people with mental ill-health who are homeless are supported to find and maintain housing.

However, there is significant unmet demand for homelessness services, meaning that many people who require homelessness services cannot access them. In 2018-19, about 31 000 people with mental ill-health who were either homeless or at risk of homelessness had an unmet need for long-term housing across Australia (figure 20.7). Unmet need can vary greatly between jurisdictions, both in terms of overall numbers and the proportion of people. For example, the Northern Territory Mental Health Coalition (sub. 430, p. 23) and NT Shelter (sub. 879, p. 1) stated that unmet demand in the Northern Territory is twice as high as in other states.

Nevertheless, the number of housing places needed going forward is likely to be less than 31 000 places for two reasons. First, more than one service is sometimes recorded as being suitable for a client. Second, adopting recommendations to reduce the incidence of homelessness among people with mental ill-health (sections 20.2 and 20.3) can be expected to reduce the level of unmet demand for this cohort in the future. For example, assuming that supported housing (between 9000 to 12 500 places) and housing for people discharged from hospitals (about 3000 people) reduces the need for long-term housing, the unmet need would be closer to 15 000 to 19 000 people each year.

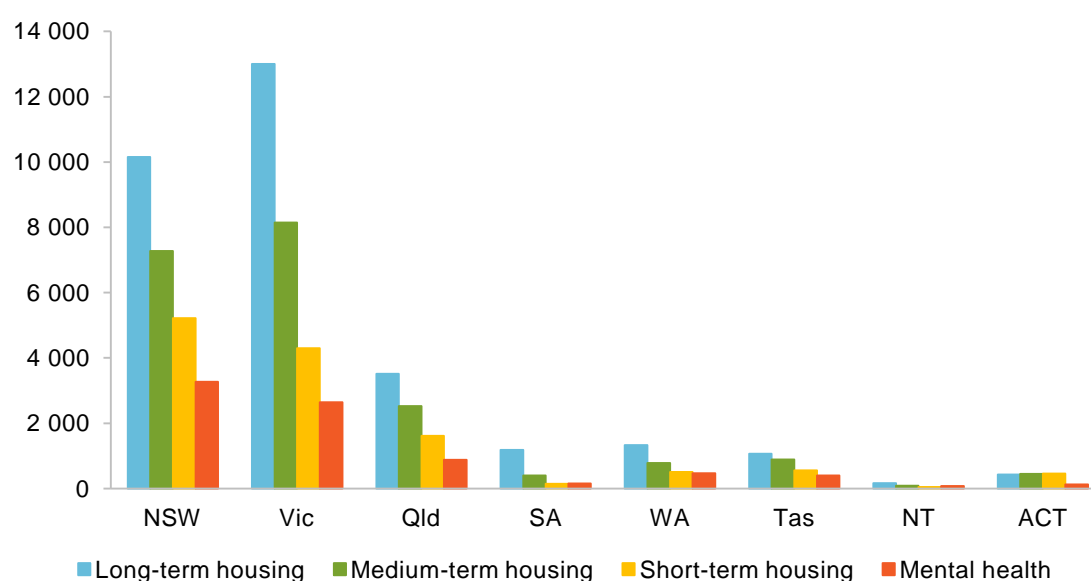
Inquiry participants have also noted the substantial housing shortfall. breakthru (sub. 112, p. 15) stated that one in four people are turned away from homelessness services. Shelter Tasmania (sub. 196, p. 2) noted:

The average number of daily unmet requests for assistance from homelessness services in 2017-18 increased to 28 requests (up from 25 unmet requests per day in the previous year, and 21 two years ago).

There is also evidence that not all clients of homelessness services achieve their goals, including having stable and secure accommodation. In 2018-19, over 60% of people with mental ill-health who were homeless when they began receiving support from homelessness services were still homeless by the end of that support (AIHW 2019p). Further, almost 15% of those who were housed, but at risk of homelessness when they began support became homeless by the end of the support. There was also little change in the non-housing outcomes of homelessness services in the short term. For example, after completing a period of support, the proportion of clients with mental ill-health who were employed increased by about two percentage points, and the proportion participating in education or training decreased by about half a percentage point (AIHW Specialist Homelessness Services Collection, unpublished data).

Figure 20.7 Unmet need for selected services^{a,b,c}

Number of homelessness service clients with a current mental health issue, 2018-19



^a 'Unmet need' means the person was identified as needing a service, but this service was not provided to them or they were not referred elsewhere. ^b Clients may have needs for more than one service. ^c The Australian Institute of Health and Welfare defines a person as having a current mental health issue if they received mental health services in the past 12 months, were referred by a mental health service, reported 'mental health issues' as a reason for seeking assistance, had been in a psychiatric hospital or unit in the past 12 months, or a need was identified for mental health services during their support period. Therefore, this is likely to be an underestimate of the proportion of people accessing homelessness services with mental ill-health.

Source: AIHW (Specialist Homelessness Services Collection, unpublished data).

Improving homelessness services

Responding to the needs of people with mental ill-health who are homeless will involve meeting the unmet demand for homelessness services by increasing the availability of housing (particularly longer-term housing), and improving the quality and integration of homelessness and mental health-related services for this cohort (discussed in section 20.5).

Addressing the unmet demand for homelessness services

As discussed above, the level of unmet need for homelessness services is estimated to be about 14 000 to 17 000 people. The cost of providing private rental accommodation or social housing for these people is estimated to be \$278 million to \$393 million each year (appendix K). That said, the final cost may be lower, given some people may have capacity to fund part of their housing costs. These costs do not include the cost of mental health services, which are considered more broadly throughout this report.

In addition, providing effective homelessness services reduces the cost of providing other services. It has been estimated that providing homelessness services reduces the costs of providing health, justice and income support services by about \$10 600 per person for single women and \$1600 for single men (2019 dollars) (Zaretzky et al. 2013). The net cost to government is therefore expected to be \$211 million to \$261 million each year (appendix K). The savings could be particularly large if programs successfully target people with a diagnosed mental illness, because this cohort tends to have higher healthcare costs (Zaretzky et al. 2017).

To achieve these outcomes, the homelessness services provided need to be effective *for people with mental illness*. Conditions that require the person to be ‘housing ready’ before they can access housing, or that mandate eviction when rules are broken are particularly difficult for many people with severe mental illness. Nonetheless, there are services that have been shown to be effective in helping people with mental illness to maintain housing — Housing First services. In other words, while some homelessness services may fail to meet the needs of those with mental illness, services that are explicitly designed to meet the needs of those with mental illness can be successful.

Housing First for people with severe mental illness

Housing First programs have been shown to improve outcomes for people with severe mental illness who are persistently homeless, and are unlikely (or have failed) to respond positively to existing homelessness services that place strict conditions on housing. Housing First involves providing rapid access to long-term housing that is not conditional on participants becoming housing ready or engaging with support services. Once housing is secured, a multidisciplinary team of clinical and/or non-clinical support workers are available to provide mental health, tenancy support and other services. Unconditional housing is an important distinction. Relaxing the conditions to access and maintain housing gives people with mental

illness a better chance to remain housed. Housing First is likely to reduce the unmet need for homelessness services among this cohort (Johnson, Parkinson and Parsell 2012).

Programs that follow the Housing First model are effective at responding to homelessness among people with severe mental illness (table 20.2). Evaluations of programs have found that:

- most participants remain housed
- participants tended to reduce their need for other government services, particularly healthcare
- non-housing outcomes — such as mental health, employment and quality of life — tended to remain relatively stable, or slightly improve, in the short term (Baxter et al. 2019; Ly and Latimer 2015; Pleace 2016; Tsemberis 2010; Woodhall-Melnik and Dunn 2015).

That said, more evidence is needed to determine if longer-term outcomes improve and are sustained. Evaluations of Housing First programs tend to follow people for a few years to track their outcomes. This short time frame might explain why non-housing outcomes remain relatively stable. These programs primarily target chronic rough sleepers and people with very complex needs who are likely to take more time to recover and achieve their goals.

There have been several small-scale trials of Housing First programs in Australia that have successfully housed several hundred people with severe mental illness (table 20.2). In some cases, trials showed a small net cost or even a potential net benefit to these programs. Governments have an incentive to invest in programs that provide net benefits or small net costs by targeting the highest users of health and justice services, particularly if those programs deliver significantly improved outcomes for people.

Encouragingly, governments are moving in this direction, with more programs being implemented in Australia (table 20.2) and policies increasing including Housing First principles. For example, the *Draft Western Australian Mental Health, Alcohol and Other Drug Accommodation and Support Strategy 2018–2025* supports a Housing First approach (WAMHC 2018b, p. 11, sub. 259). In addition, the Victorian Government (sub. 483, p. 26) noted that the *Victorian Homelessness and Rough Sleeping Plan* is underpinned by Housing First principles.

However, Inquiry participants have argued that some Housing First-related programs being implemented in Australia do not include all the elements of the successful overseas models (NMHC, sub. 118, p. 11). For Housing First interventions to be effective, these programs need to also include access to the non-housing supports people with severe mental illness require (One Door Mental Health, sub. 108, p. 14). The Queensland Mental Health Alliance (sub. 247, p. 13) stated:

One of our members [has] expressed that the Housing First approach will only be successful should adequate supports and services sit alongside the tenancy to ensure capacity building, independence, and financial management – for example paying rent and bills in a timely manner.

Table 20.2 Evaluation results of selected Housing First programs

<i>Program</i>	<i>Location</i>	<i>People</i>	<i>Housing sustained (%)</i>	<i>Mental health</i>	<i>Quality of life</i>	<i>Health service use</i>	<i>Program cost^a</i>	<i>Cost offsets^a</i>	<i>Net cost (benefit)^a</i>
Pathways to Housing	USA	78	80	—	na	↓	na	na	na
At Home/ Chez Soi	Canada	1 158	62–84	—	↑	↓	CA\$22 257	CA\$21 375	CA\$882
MISHA project	NSW	59	89–97	—	—	↓	\$13 683	\$4 424	\$9 260
Common Ground	NSW	52	>63	↑	↑	↓	\$60 904	na	na
Way2Home	NSW	31	90	↑	↑	—	na	na	na
Common Ground	Qld	217	>68	↑	↑	↓	\$14 329	\$27 429	(\$13 100)
Street to Home	Qld	42	95	↑	—	—	na	na	na
50 Lives 50 Homes	WA	147	88	na	na	↓	na	\$9 182	na

^a Average per person expressed as dollars in the years and countries in which the studies were evaluated.
na Not available.

Source: Bullen et al. (2015); Conroy et al. (2014); Gulcur et al. (2003); Johnson and Chamberlain (2015); Mental Health Commission of Canada (2014); Parsell et al. (2015); Parsell, Tomaszewski and Jones (2013b, 2013a); Tsemberis, Gulcur and Nakae (2004); Vallesi et al. (2018).

There is scope for governments to scale up trials of Housing First by increasing the availability of long-term housing set aside for Housing First programs. A lack of available long-term housing is a consistent theme throughout this chapter and a key barrier to providing rapid permanent housing to individuals targeted for a Housing First program (Bullen and Baldry 2018). This can be done through a mix of social housing, private rentals or headleasing a number of private rental properties (section 20.3). For example, the majority of housing in the At Home/Chez Soi program was provided through private rental units, and social housing was offered where available (Mental Health Commission of Canada 2014).

Many Inquiry participants argued for Housing First programs to be used to support homeless people with mental illness, and were supportive of State and Territory Governments scaling up Housing First programs.²²⁶ For example, the Queensland Mental Health Commission (sub. 712, p. 9) submitted:

... the QMHC agrees with the focus on a Housing First approach where safe and permanent housing is the first priority for people experiencing homelessness, with wrap-around support based on individual need.

²²⁶ Anglicare Australia, sub. 376, p. 32; APS, sub. 543, p. 7; Beyond Blue, sub. 275, p. 29; Launch Housing, Melbourne transcript, pp. 50–51; Mental Health Australia, sub. 864, p. 16; MHCC ACT, sub. 517, p. 21; Mind Australia Limited, sub. 380, p. 38; Private Mental Health Consumer Carer Network (Australia), sub. 49, p. 6; Tandem, sub. 502, p. 4, Melbourne transcript, p. 71; VCOSS, sub. 478, p. 37.

Scaling up Housing First programs provides the opportunity for governments to tailor programs to the most vulnerable cohorts at risk, potentially benefiting participants and increasing their rate of success. For example, the Council to Homeless Persons (sub. 145, p. 11) and Primary Mental Health Consumer Carer Network (sub. 49, p. 6) recommended that Housing First needs to be tailored to young people, the South Australian Mental Health Commission (sub. 691, att. B, p. 4) recommended it be tailored to women with children and older people, and the Northern Territory Mental Health Coalition (sub. 430, p. 24) identified the need for housing programs for Aboriginal and Torres Strait Islander people to be culturally capable.

The State and Territory Governments need to work towards meeting the gap for homelessness services among people with mental illness in their jurisdiction. This should include scaling up longer-term housing options such as Housing First programs (action 20.3).

20.5 Increasing the effectiveness of services and prioritising reforms

Housing and homeless services will not be effective in isolation

While housing and homelessness services are needed to help people to find and maintain housing, these services will have limited effectiveness for people with mental illness if they are not well integrated and coordinated with the other supports the person needs.

There is a need to integrate housing/homelessness services and mental health services, particularly for young people. Outside major metropolitan service areas, there are currently inadequate referral pathways and housing services staff are often unable to recognise the presentation of mental health issues until symptoms are quite severe. (Uniting Vic.Tas, sub. 95, p. 7)

Both housing and clinical services need appropriate resources to support people's mental health, especially where people are facing both of these challenges. (Shelter Tasmania, sub. 196, p. 5)

Improving coordination of housing, homelessness and other services and improving information sharing will help ensure the effectiveness of housing and homelessness supports.

Improving coordination of services

Housing and homelessness services that are well coordinated with mental health and other services (such as drug and alcohol or family and domestic violence services) are more effective at supporting people who are homeless. Coordination becomes even more important for people who have severe and complex needs arising from their mental illness.

However, in many cases, the agencies providing these services work independently from each other. Several participants expressed a need to better coordinate or integrate housing, homelessness, mental health and other services (Beyond Blue, sub. 275; CHP, sub. 145; cohealth, sub. 231; Launch Housing, sub. 250; Wellways Australia, sub. 396). A failure to

coordinate is likely to mean each of the component services is less effective at supporting people who are homeless. Brackertz, Wilkinson and Davison (2018, p. 29) found that:

Analysis of state, territory and federal housing, homelessness and mental health policies shows that they are essentially separate systems with little integration ... This contributes to poor housing and health outcomes for people with lived experience of mental ill health.

Coordination of services can be particularly difficult for people who remain homeless for long periods of time. Without a residential address, people's ability to have a driver's licence, open a bank account and receive income support payments is limited. Their access to clinical mental health services can also be reduced (VCOSS, sub. 478, p. 37).

The service eligibility criteria for step up/step downs [accommodation] require that a person has pre-existing accommodation or has secured accommodation in the community. Consequently, the services are not accessible to people who are homeless or who may have lost their accommodation during an extended hospital stay and are seeking to step down into community services. (OAGWA 2019, p. 23)

Care coordination has been shown to be an effective approach to service coordination that reduces homelessness and symptom severity for homeless people with severe mental illness (Brackertz, Fotheringham and Winter 2016; Coldwell and Bender 2007). This approach determines the optimal use of services for each individual, taking into account their circumstances and needs, to treat the person holistically. It involves someone who has responsibility for coordinating, facilitating and integrating the person's service needs. In cases where individuals have particularly high needs, care coordination can encompass a multidisciplinary team, more intensive contacts and direct provision of services.

In Australia, there are some outreach programs that provide mental health and care coordination services for homeless people with severe mental illness, such as the Homeless Outreach Mental Health Service in Melbourne, which offers case management and mental health services to people with severe mental illness and a history of homelessness (cohealth, sub. 231, p. 16).

Chapter 15 recommends providing single care plans and care coordination services for people with moderate and severe mental illness who would benefit from these services. Care coordinators are well placed to work with these individuals and coordinate their homelessness, mental health and other services. Single care plans would also help ensure that the different services providers are communicating and have the information they need to provide integrated care.

Information sharing

Providing integrated, multidisciplinary, person-centred care requires information sharing between service providers. However, Inquiry participants raised concerns about a lack of information sharing leading to poor housing outcomes.

Prevention of people being discharged to no address. More support and information is required while people are admitted to avoid this. (breakthru, sub. 112, p. 11)

The need for effective information sharing across agencies and with support services is recognised as an important prerequisite for coordinated service delivery. Of course, all information sharing must comply with privacy requirements and several memoranda of understanding are in place to meet these requirements and support effective service delivery. (ACT Government, sub. 1241, p. 22)

An area where this has been identified as being a particular problem is people being evicted during to a temporary absence due to a lack of information sharing between mental health services and social housing authorities (or rental agents). For example, an audit of the public housing system's management of disruptive behaviour in Western Australia found that there was no formal information sharing arrangements between agencies and that current memoranda of understanding are out of date.

Staff are not routinely informed of the outcomes of referrals to mental health and child protection service providers for tenant support. This limits the [Department of Communities'] understanding and ability to effectively identify and help vulnerable tenants to succeed in public housing. (OAGWA 2018, p. 8)

Improving information sharing between people with mental ill-health, carers (where relevant), agencies and services providers will reduce the likelihood of poor housing outcomes such as evictions and being discharged from hospital with adequate housing. It will also help to ensure people receive coordinated care. The Productivity Commission has recommended ways to improve coordination across services through formal information sharing arrangements in single care plans and using care coordinators (chapter 15).

Prioritising and costing reforms

The Productivity Commission has made several recommendations to increase the capacity of housing and homelessness services to prevent people with mental ill-health from experiencing housing issues and support people with severe mental illness to find and remain in housing.

As a priority, State and Territory Governments, with support from the Australian Government, should improve the transition for people with mental illness out of hospital and correctional facilities. There is a clear economic benefit to supporting this cohort, who tend to be significant users of health services. Further, State and Territory Governments, with support from the Australian Government, should address the unmet demand for supported housing, long-term supported accommodation and homelessness services.

However, this is likely to take time. Therefore, governments should plan their approach for providing these services. This approach should prioritise providing transitional housing services for people with severe mental illness and who are homeless or at risk of homelessness. Evidence suggests that adequately housing this group can improve their quality of life and lead to significant reductions in costs elsewhere, such as health and justice services.

Overall, the Productivity Commission has estimated that implementing the range of recommendations presented in this chapter would require Australian, State and Territory Governments to increase estimated expenditure, in aggregate, by \$740 million to \$940 million each year (appendix K). A significant portion of this includes additional mental healthcare and psychosocial support services for people living in integrated supported housing and housing programs for people transitioning out of institutional care, while the remainder would be administered by the housing portfolio. While these investments should yield significant savings in acute healthcare (and other government services) that would be primarily captured by State and Territory Governments, it nevertheless involves a significant upfront increase in expenditure.

The Australian Government provides funding to State and Territory Governments to deliver housing and homelessness services according to the 2018 NHHA. This funding amounted to \$1.7 billion in 2018-19 (COAG 2018b).

The Productivity Commission recommends that, as part of the next negotiation of the National Housing and Homelessness Agreement, governments should increase the quantum of funding for housing and homelessness services, with particular attention to expanding provision of housing and homelessness services for people with mental illness.

ACTION 20.2 — NO DISCHARGE INTO HOMELESSNESS

People with mental illness should be supported so that they are not discharged from hospitals, correctional facilities and institutional care into homelessness.

Start now

- Each State and Territory Government, with support from the Australian Government, should commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from hospitals, correctional facilities or institutional care.
- Governments should ensure that people with mental illness who are discharged from hospitals, correctional facilities or institutional care receive a comprehensive mental health discharge plan, and have ready access to transitional housing, while services have the capacity to meet their needs. These programs should integrate care coordination and access to accommodation.

Start later

- As part of the next negotiation of the National Housing and Homelessness Agreement, a requirement should be included for State and Territory Governments to monitor and report on discharging into homelessness.

ACTION 20.3 — SUPPORT FOR PEOPLE TO FIND AND MAINTAIN HOUSING

Housing and homelessness services should have the capacity to support people with severe mental illness to find and maintain housing in the community.

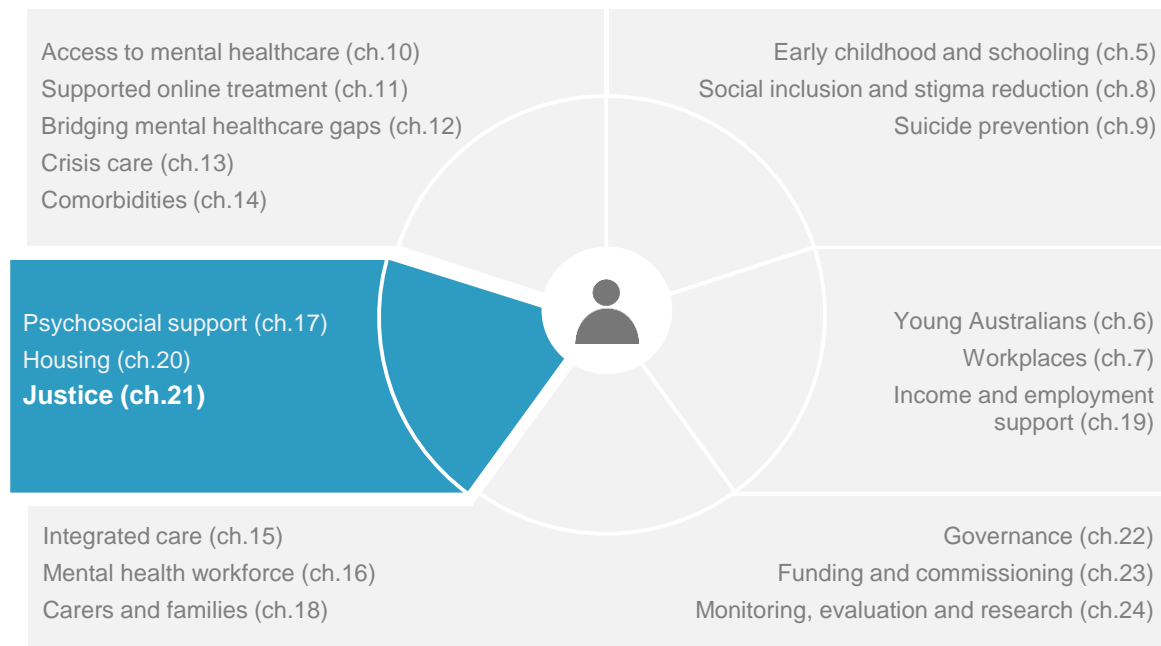
Start now

- The National Disability Insurance Agency should continue to amend its Specialist Disability Accommodation strategy and policies to encourage development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness. This should include lifting the restrictions of the number of people who can reside in newly developed Specialist Disability Accommodation, and providing more detail on how the NDIA will deal with liability problems concerning property damage.
- State and Territory Governments, working with housing support providers and with support from the Australian Government, should address the shortfall in the number of supported housing places for people with severe mental illness by providing a combination of long-term housing options for people with severe mental illness who require integrated housing and mental health supports.
- State and Territory Governments, with support from the Australian Government, should address the gap in homelessness services for people with mental illness, including scaling up longer-term housing options such as Housing First programs.
 - Housing First programs should target people who experience severe and complex mental illness, are persistently homeless, and are unlikely to respond to existing homelessness services.
 - This would require governments to invest in homelessness services that make long-term housing available specifically for these programs.

Start later

- As part of the next negotiation of the National Housing and Homelessness Agreement, governments should increase the quantum of funding for housing and homelessness services, with particular attention to expanding provision of housing and homelessness services for people with mental illness.

21 Justice



The justice system matters because ...

- People with mental illness are over-represented throughout the justice system, including in correctional facilities (where the majority are imprisoned for short sentences and often cycle in and out), and as victims of crime.
 - They are more likely to experience legal problems (such as discrimination and housing issues), but often face barriers to resolving them.
 - The justice system can contribute to improved mental health outcomes by diverting or connecting individuals to appropriate mental healthcare and ensuring they receive it.
 - The justice system is responsible for ensuring people with mental illness have access to justice and services that address their legal needs.
-

RECOMMENDATION 21 — IMPROVE MENTAL HEALTH OUTCOMES FOR PEOPLE IN THE JUSTICE SYSTEM

People with mental illness are over-represented throughout the justice system, including in correctional facilities and as victims of crime. There is considerable scope for improved mental healthcare for people in all parts of the justice system, and improved access to justice for people with mental illness and legal needs.

As a priority:

- State and Territory Governments should implement a systematic approach for responding to mental health related incidents to support all parties involved. Mental health professionals should be embedded in police communication centres and police, mental health professionals and/or ambulance services should be able to co-respond to mental health related incidents. (Action 21.2)
- State and Territory Governments should ensure that people appearing before mental health tribunals, and other tribunals hearing matters arising from mental health legislation, have a right to access legal representation. To facilitate this, State and Territory Governments should adequately resource legal assistance services for this purpose. (Action 21.8)

Additional reforms for people in the justice system that should be considered:

- An early intervention approach should be introduced to identify people with mental illness at high risk of contact with the criminal justice system, and provide supports to reduce the risks of them offending. (Action 21.1)
- State and Territory Governments should work to ensure that people with mental illness who would benefit from mental health court diversion programs, are able to access them. (Action 21.3)
- The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Service Standards to determine how they can be implemented in correctional settings. (Action 21.4)
- State and Territory Governments should ensure that people with mental illness in correctional facilities have access to timely and culturally capable mental healthcare. (Actions 21.4, 21.6)
- The forensic mental health component of the National Mental Health Service Planning Framework should be completed and used by governments to inform planning and funding. (Action 21.5)

Additional reforms to improve access to justice that should be considered:

- State and Territory Governments should develop disability justice strategies and work towards integrating legal and health services (including through health justice partnerships) so that people with mental illness are better supported to resolve legal matters and participate in the justice system. (Action 21.7)
- Supported decision making by and for people with mental illness should be promoted through improved access to individual non-legal advocacy services (Action 21.9) and mental health advance directives. (Action 21.10)
- Governments should ensure that treatment orders in mental health legislation are mutually recognised between States and Territories. (Action 21.11)

Interactions between the mental health and justice systems are important. People with mental illness are over-represented in the criminal justice system, and as victims of crime. They are also more likely to find themselves dealing with legal issues than the general population.

Mental illness and the justice system have a complicated relationship. Involvement with the justice system does not only mean people engaged in the criminal courts or who are incarcerated, but also includes people engaged with civil and family courts, police, and who are victims of crime. While most people with a mental illness, including those with major illnesses, do not commit crimes, people living with a mental illness are more likely to be involved within the justice system. (NMHC, sub. 949, p. 16)

The justice system is relevant to this Inquiry for two key reasons.

First, it can contribute to improved mental health outcomes, in particular, as interaction with the criminal justice system might be the first time a person can access mental healthcare. There are opportunities to connect people who interact with police, courts, corrective services and victim support services to mental healthcare and support. Correctional and forensic mental health facilities are also settings in which people receive mental healthcare. Although the criminal justice system has been subject to many inquiries²²⁷, this Inquiry is different as it approaches the system through a mental health lens, in line with our terms of reference.

Second, the justice system can improve access to justice for people with mental illness. People with mental illness are more likely to experience legal problems, but face barriers accessing legal services, and initiating and participating in legal proceedings. Addressing these barriers can help people with mental illness resolve their legal problems.

This chapter focuses on how people with mental illness who make contact with the justice system can be better supported (the scope of the justice system and other key terms are defined in box 21.1). It analyses how people with mental illness:

- interact with the justice system (section 21.1) — the key ways in which people with mental illness can interact with the justice system, highlighting the important role the system can play in contributing to better outcomes for these individuals
- are connected to mental healthcare through the criminal justice system (section 21.2) — the extent to which the system acts as an effective gateway to mental healthcare for those engaged in offending behaviour and who are victims of crime, and the extent to which mental healthcare is available in correctional and forensic mental healthcare settings
- are able to gain access to justice (section 21.3) — the extent to which people with mental illness are able to resolve their legal problems and disputes, and the degree to which their ability to access justice is promoted and protected.

²²⁷ ALRC (2017a); Commissioner for Children and Young People Western Australia (2011); Forde, Thomason and Heilpern (1999); Johnston (1991); Office of the Inspector of Custodial Services (2018); SCARC (2016a); SCMH (2006); Victorian Ombudsman (2015).

Box 21.1 Definitions of key terms

Bail: refers to when an individual who is charged with an offence is allowed to stay in the community, but required to attend court at a scheduled future date (Legal Aid NSW 2015).

Correctional facility: these facilities hold individuals under the responsibility of corrective services. They include government-operated prisons, privately-operated prisons, transitional centres and court cell complexes (SCRGSP 2019).

Court diversion program: a program that allows magistrates or judicial officers to adjourn matters while defendants engage in support services. Diversionary programs provide services for people who have been accused or convicted in the summary jurisdiction, who require assistance with addiction or mental health (ALRC 2017b).

Criminal justice system: the criminal justice system refers to the collection of interdependent agencies that deal with people suspected or convicted of criminal offences. It consists of the police and prosecution, criminal courts and correctional facilities, community corrections and probation and parole services (Daly and Sarre 2017).

Diversion: this term can have many meanings and is used inconsistently between jurisdictions. However, in this Inquiry it refers to identifiable stages in the criminal justice system at which interventions can effectively, proportionately and responsively be provided to an individual in contact with it (Freiberg et al. 2016, p. 57). This Inquiry does not use the term diversion to mean detours, deviations or cessation of legal proceedings.

Forensic mental health services: services providing assessment and treatment of people with mental illness and a history of criminal offending, or who are at risk of offending. They include services to support people found not guilty of an offence on the grounds of mental impairment and people with mental illness who offend or are at risk of offending (VIC DHHS 2014).

Forensic patient: an individual alleged to have committed a crime who is deemed unfit to plead, unfit to stand trial or not guilty on the grounds of mental impairment. As a result, a forensic or criminal mental health detention order is placed on them (SCARC 2016a).

Justice system: the collection of interdependent agencies including the police, prosecution legal teams, courts, community corrections, custodial corrective services, victim support services and defence legal teams that exist to uphold the rule of law, protect the rights of individuals and to ensure communities are safe and just. In Australia, State and Territory Governments are responsible for most policing and justice functions, with the exception of the ACT, where the Australian Federal Police conducts policing functions (Daly and Sarre 2017).

Juvenile: a juvenile is a person aged between 10 and 17 years of age who is subject to criminal justice proceedings (Richards 2011).

Lower level offences: these refer to low-level summary offences. Summary offences are dealt with in local courts, usually before a magistrate alone. They usually carry a penalty of less than two years imprisonment (Baldry 2014a).

Mental health order: refers to an order made by a mental health tribunal (or other tribunals that deal with matters under mental health legislation) that requires an individual to receive involuntary mental health treatment, either in the community, or in an inpatient mental health facility.

Recidivism rate: refers to the proportion of adults released from correctional facilities or community orders who returned to corrective services with a new correctional sanction within two years (SCRGSP 2019).

Remand: refers to individuals who are held in custody awaiting trial or sentencing (AIHW 2019r).

21.1 Interactions with the justice system

People with mental illness are over-represented in the criminal justice system

The majority of people with mental illness never make contact with the criminal justice system. As Forensicare notes:

Public perception of the interrelationship between mental illness and offending is disproportionate to the actual risks posed, with the majority of individuals living with mental illness never offending. Nevertheless, local and international evidence indicates that serious mental illness is a significant risk factor for offending. (Forensicare 2019, p. 4)

Nevertheless, people with mental illness are over-represented at all stages of the criminal justice system (box 21.2). Prevalence rates appear to vary between states and territories, although the data is not directly comparable (table 21.1).

Table 21.1 Prevalence of mental illness among people in correctional facilities^a
June 2018

	<i>Estimated prevalence</i>
New South Wales	63% had a previous diagnosis of mental illness ^b
Victoria	37% were allocated a psychiatric risk rating at reception assessment ^c
Queensland	39% had a previous diagnosis of mental illness
South Australia	45% of people discharged from prison identified receiving mental health services ^d
Western Australia	25% had a previous diagnosis of mental illness
ACT, Northern Territory, Tasmania	Reliable data was unavailable
Australia	40% of prison entrants had previously been told they had mental illness ^e

^a Small sample sizes and different methods to estimate prevalence limit robust comparisons between jurisdictions. For example, Tasmania, the Northern Territory and the ACT each had fewer than 50 people surveyed (AIHW 2019r). ^b 2018-19. ^c 2017-18. ^d 2016-17. ^e Excludes New South Wales, which did not provide data.

Source: AIHW (2019r); JHFMHN (2019); State and Territory Governments Survey; Victorian Government, sub. 483.

Box 21.2 People with mental illness are over-represented across all stages of the criminal justice system**Police custody and courts**

There is a high prevalence of mental illness among people whom police have arrested and detained at police stations (police detainees). For example, a national study of police detainees found that 43% of men and 55% of women reported a previously diagnosed mental illness Baksheev et al. (2010) found 76% of detainees from two Melbourne police stations met the criteria for mental illness.

Comparable prevalence is observed in courts. A New South Wales study found that 55% of court defendants had one or more psychiatric disorders (NSW LRC 2012). Similarly, over 50% of court defendants at a Western Australian Magistrates Court had mental illness (Baldry 2014b).

Correctional facilities

In 2018, about 40% of prison entrants had been told at some stage in their life that they have a mental illness (including substance use disorders) (AIHW 2019r). This proportion is much higher than that estimated for the general population aged 18 years and over (22%) (2018b), although data is not directly comparable.^a

New South Wales data shows depression as the most common diagnosis, for both men and women at 36% and 61%, respectively (JHFMHN 2017a). This is followed by anxiety disorders and drug abuse and dependence.

People in detention awaiting trial or sentencing

The prevalence of mental illness among people in detention awaiting trial or sentencing (remanded in custody) is estimated to be higher than for those sentenced (Ogloff et al. 2007). In New South Wales, for example, at least half of those remanded in custody are estimated to have some form of mental illness and/or cognitive disability (Baldry 2014b). Moreover, this is a growing population and has been increasing as a proportion of the incarcerated population (ABS 2018c).

^a Estimates of prevalence of mental illness among the general population and prison population are not directly comparable because they are obtained from different surveys, which ask different questions to derive prevalence estimates and have different survey samples.

Prevalence of mental illness is higher among some demographic groups

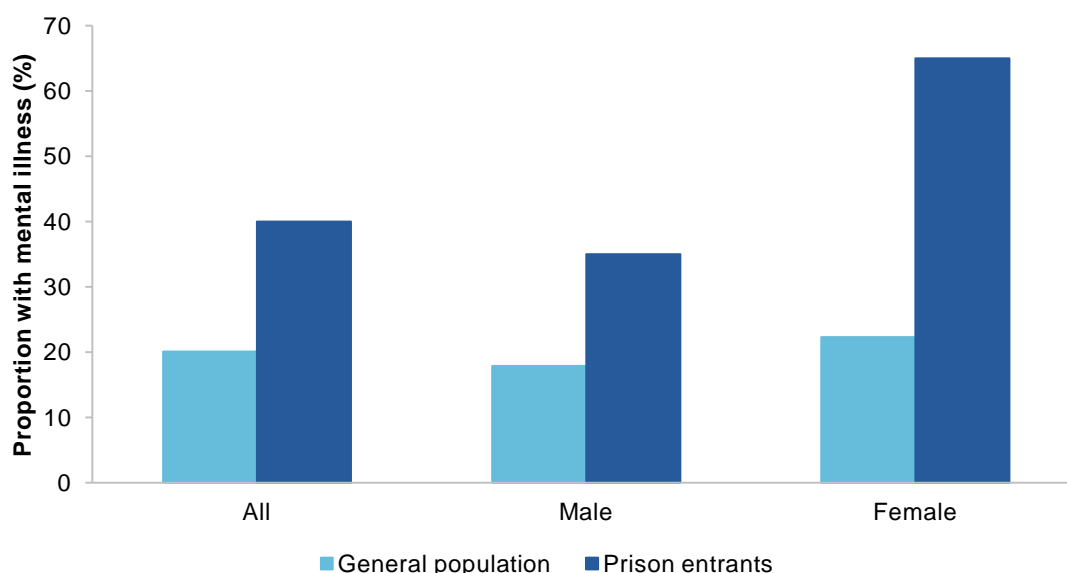
For people held in correctional facilities, the prevalence of mental illness is higher among some demographic groups.

- Women entering prison are far more likely to report a history of mental illness than men (figure 21.1). In 2018, 35% of imprisoned men reported having a previous diagnosis of mental illness compared with 65% of women (AIHW 2019r). This disparity has persisted over decades (AIHW 2010; New South Wales Corrections Health Service 1997).
- Young people in juvenile detention centres have higher rates of mental illness compared to adults in correctional facilities. The latest New South Wales juvenile health survey found about 83% of young people met the threshold for at least one psychological

disorder (JHFMHN 2017b). The Victorian Youth Parole Board (2019) annual survey reported that about 48% of young people presented with mental health problems.

- Aboriginal and Torres Strait Islander people make up about 2% of the adult population, yet represent 27% of the national adult prison population (ALRC 2017a). In the youth justice system, young Aboriginal and Torres Strait Islander people represented between 55–62% of those in detention between June 2015 and 2019, but accounted for only 6% of the general population aged 10–17 years (AIHW 2019s). Despite having lower self-reported rates of mental illness relative to non-Indigenous people (33% compared to 44%, respectively) (AIHW 2019r), the literature shows prevalence among incarcerated Aboriginal and Torres Strait Islander people is 70% to 90% (Heffernan et al. 2012; Ogloff et al. 2013).²²⁸

Figure 21.1 Estimated prevalence of mental illness in the general population and among prison entrants by gender, 2018^{a,b}



^a ABS general population data estimates prevalence based on the number of people reporting they had a current and long-term mental and behavioural condition. Prison entrants data estimates prevalence based on the number of people who had ever been told they had a mental health condition. ^b Data for the general population are not directly comparable to data for prison entrants.

Source: ABS (*National Health Survey 2017-18*, Cat. no. 4364.0); AIHW (2019r).

²²⁸ Studies by Heffernan et al. (2012) and Ogloff et al. (2013) used diagnostic or clinical assessment tools making them more reliable relative to self-reported surveys. Self-reported surveys can underestimate prevalence among Aboriginal and Torres Strait Islander people due to a lack of recognition of disorders and because of cultural bias (McCausland, McEntyre and Baldry 2017).

Overall, there is limited data on the prevalence of mental illness among individuals who make contact with the criminal justice system (box 21.3). This limits the extent to which research and analysis are able to support the development and improvement of services to support these people. There is scope to improve data collection as referred to in box 21.3, which the Productivity Commission supports.

Box 21.3 Data availability

There was limited data available for estimating the proportion of people with mental illness across all stages of the criminal justice system across all states and territories. Further, there is a lack of national data oversight in this area. The AIHW have partly addressed this gap with its prisoner health survey (the first form of national oversight), but not all states and territories consistently participate in the survey.

National data is even more scant for young people involved in the justice system (AIHW 2018c). There is no national set of standards to ensure this type of data is available and consistent across jurisdictions. Although some states (New South Wales and Victoria) conduct annual surveys of their youth justice populations, most do not. AIHW (2018c) recommended the development of a national data collection on the health of young people in the justice system, but ongoing support and funding for this collection has not been confirmed.

Individuals often have complex needs

People with mental illness in contact with the criminal justice system tend to have complex needs, including substance use comorbidities and cognitive and intellectual disabilities (Baldry et al. 2015).

- Substance use comorbidities are common among people in correctional facilities. Prevalence of co-occurring mental and substance use disorders was 29% and was significantly higher among women (46%) than men (25%) (Butler et al. 2011). Of the Aboriginal and Torres Strait Islander people in prison with mental illness, 77% also had a substance use disorder (Baldry et al. 2015).
- A high proportion of people in prison have cognitive and intellectual disabilities, and mental illness — of those with an intellectual disability, 68% also had mental illness or a substance use disorder (Baldry et al. 2015). Of the Aboriginal and Torres Strait Islander people in prison with mental illness, 36% also had a cognitive disability (Baldry et al. 2015).

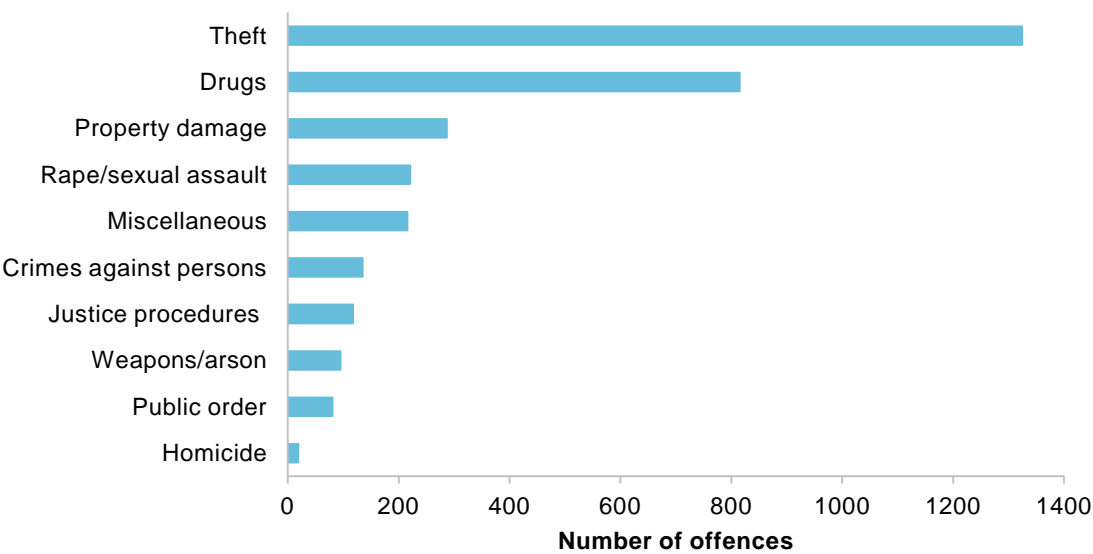
Comorbidities and multiple diagnoses are prevalent among young people in juvenile custody as well. In New South Wales, about 80% of young people reported weekly use of illicit drugs and 96% reported hazardous and/or harmful levels of alcohol consumption (JHFMHN 2019). In addition, 59% had attention or behavioural disorders and 17% had an IQ in the intellectual disability range. In Victoria, 54% of young people had a history of alcohol and drug misuse, 38% had cognitive difficulties affecting daily functioning and 12% were registered with disability services (VIC DJCS 2019).

Many are sentenced with lower level offences and cycle in and out of correctional facilities over long periods of time

The majority of people with mental illness in prisons have been sentenced with lower level offences (Baldry 2017), such as non-violent property damage and theft (figure 21.2) (Forsythe and Gaffney 2012; OPA Victoria 2012).

Many people cycle in and out of correctional facilities, over long time periods. Baldry (2017, p. 2) found that the majority of people ‘cycling in and out’ of prison are from severely disadvantaged backgrounds with serious mental health and disability concerns. However, there are mixed conclusions about whether recidivism rates are higher for people with mental illness, compared to those without (Bonta et al. 1998; Dias et al. 2018; Smith and Trimboli 2010).

Figure 21.2 **Offence types for participants in the Independent Third Person program^a**
Victoria, 2005 to 2010



^a The program assisted people with cognitive impairments and/or mental illness in police interviews.
Source: OPA Victoria (2012).

There is no simple correlation between mental illness and offending behaviour

The over-representation of people with mental illness in the criminal justice system is complex and multi-factored, with no simple correlation between mental illness and offending behaviour, although mental illness can form part of the background to offending (NSW LRC 2012). However, some other drivers include: deinstitutionalisation without

community supports, increased substance use, inadequate community mental health services and social determinants (box 21.4).

Box 21.4 There are multiple factors behind the over-representation of people with mental illness in the criminal justice system

Deinstitutionalisation (the closure of mental health facilities such as asylums) is a widely cited reason for why people with mental illness are over-represented in the criminal justice system. Commentators believe that deinstitutionalisation was not adequately accompanied by more community-based mental health services (Human Rights Watch 2018; NSW LRC 2012).

Increased **use of illicit substances** is another reason (Butler and Allnut 2003). Consequences include increased drug-related mental illness (mainly associated with cannabis and amphetamine dependency) and increased comorbidities (Ogloff et al. 2007). There is evidence that people with substance use comorbidities are at an increased risk of offending compared to those diagnosed with a non-substance mental illness alone (Smith and Trimboli 2010).

The **limited capacity of mental health services** to address the complex needs of this cohort is another reason. Community-based mental health services often work best for those who have reasonable support networks in the community. However, this group is often poorly integrated into the community, with poor access to a range of support services including housing support (Ogloff et al. 2007). Related factors include a lack of adequate diversionary options in the community, inadequate specialist community forensic psychiatric services and a high threshold for admission to appropriate mental health facilities (Butler and Allnut 2003).

Social determinants can also increase the risk of offending behaviour. Risk factors can include disrupted family backgrounds, family violence, abuse, unstable housing, economic insecurity, healthcare inequalities, isolation, a lack of social support, and structural stigma and discrimination (ALRC 2017a; Baldry et al. 2015; NSW LRC 2012). People with mental illness are often more likely to experience these risk factors, and their mental illness can be a significant reason why they experience them in the first place (QAI, sub. 889).

For Aboriginal and Torres Strait Islander people, inter-generational trauma, dispossession and displacement from traditional lands, weakening of culture, the separation of families through past government policies, and discrimination and racism have contributed to disadvantage, poor health and poor social outcomes. The majority of Aboriginal and Torres Strait Islander women in prison have experienced physical and sexual violence, and trauma (ALRC 2017a).

Estimating attributable costs

Commentators argue that the criminal justice system is costly and ineffective, given the high recidivism rates (ALRC 2017a; Jesuit Social Services 2014). Australia spends approximately \$4.9 billion per year to house people in prisons (SCRGSP 2020a). Expenditure on police (\$12.4 billion) and magistrates' courts (\$506 million) were also significant in 2018-19 (SCRGSP 2020a).

The direct costs of managing people with mental illness in the criminal justice system are difficult to determine (NSW MHC 2017). The Productivity Commission has used prevalence data to derive the *relative* likelihood of being sentenced to prison, given the state of an individual's mental health. This was used to estimate expenditure by the criminal justice system that can be attributed to mental illness, which is about \$1.1 billion per year (appendix H).²²⁹

There are also indirect costs associated with imprisonment, particularly for the individual and their families. This includes disrupted housing and employment situations, which may be more complex for people with mental illness who often face additional stigma and disadvantage upon return to the community from prison (Baker 2014).

High rates of mental illness among victims of crime

People with mental illness are *more* likely to be victims of crime than perpetrators (Baksheev et al. 2013; OPI 2012). Rates of mental illness are higher among victims of crime compared to the general population (figure 21.3). Teplin et al. (2005) found that people with severe mental illness were about 11 times more likely to be a victim of crime compared to the general population. Moreover, this likelihood increases in line with the severity of mental illness, with people with severe and persistent mental illness even more likely to be victims of crime (Dowse et al. 2016). However, these studies did not determine if individuals had mental illness before, or as a result of, becoming a victim of crime — they only compared rates of prevalence or incidence. The odds of becoming a victim increased for specific groups of victims with mental illness, including those who were homeless, had a history of substance use and had poorer social and occupational function (Chapple et al. 2004).

Perpetrators with mental illness are also more likely to have been victims of crime. New South Wales data shows that 85% of offenders with mental illness and cognitive disabilities have experienced at least one instance of victimisation (becoming a victim) and over half (65%) have been the victim of violent crime (Dowse et al. 2016).

²²⁹ This is likely to be an underestimate as it does not include expenditure on juvenile justice, courts, individuals held in forensic mental health facilities, or individuals held in police custody.

Figure 21.3 Prevalence of mental illness among victims of crime, 2014^a



^a Victim of assault or break-in in the past 12 months.

Source: ABS (General Social Survey, 2014, Cat. no. 4159.0).

Legal issues are more common for people with mental illness

People living with mental illness are more likely to find themselves dealing with legal issues than the general population. In 2012, people with disability (physical or mental) were more than twice as likely to experience legal problems (Coumarelos et al. 2012). Of those with a physical or mental disability, 61% had experienced legal problems, compared with 47% of those who did not report any disability. Further, many often faced multiple legal problems.

Legal issues faced by people with mental illness often reflect their financial and social disadvantage, and the incapacity that may be caused by their illness (Karras et al. 2006). These include: legal issues relating to mental illness (such as those under mental health acts and adult guardianship issues); discrimination in relation to employment, education and insurance; housing issues; social security issues; or domestic violence. Individuals with mental and physical disabilities are relatively more vulnerable to experiencing legal issues across many different areas, including financial issues related to credit or debt (Coumarelos et al. 2012).

The over-representation of people with mental illness in the criminal justice system (as people who offend and as victims of crime) and higher likelihood of experiencing legal problems highlights the need for the justice and mental health systems to work together. There is potential for the justice system to: connect people to mental healthcare to obtain better outcomes, in particular, recognition of mental health problems for individuals

involved in the criminal justice system (for example, through court diversion programs) (section 21.2); and to ensure people gain access to justice (section 21.3).

21.2 Connecting people in contact with the criminal justice system to mental healthcare

A person's contact with the criminal justice system presents opportunities to improve their mental health, and to reduce the risks of future contact. Globally, governments are turning their attention to initiatives that intervene in earlier stages of the criminal justice system, to make sure people receive the mental healthcare they need, and to reduce the risk of incarceration later on.

For people with mental disorders who have been charged with committing minor offences, the introduction of mechanisms to divert them towards mental health services before they reach prison will help to ensure that they receive the treatment they need and also contribute to reducing the prison population. (WHO and ICRC 2018, p. 3)

In Australia, the focus is on pre-court responses, court diversion programs and mental healthcare in correctional facilities and forensic mental health facilities.

Pre-court responses

Investing in early intervention

Early intervention initiatives that target risk factors, such as unstable housing and isolation (box 21.4), can provide mental healthcare and other social support to individuals with high risks of offending.

Ideally, an early intervention approach, where people with cognitive and/or psychiatric impairment are identified and given appropriate supports, is a more preferable pathway and outcome than attempting to divert a person once they have been charged, are subject to forensic orders or are in prison. (SCARC 2016a, p. 117)

Early intervention initiatives can improve outcomes for individuals and be more cost-effective than imprisonment. McCausland et al. (2013) found that for early intervention initiatives in New South Wales, each dollar spent resulted in savings of between \$1.40 and \$2.40 in the longer term.

Evidence suggests programs targeting high-risk populations early in life are most effective (NZ OPMCSA 2018, p. 13). For example, a longitudinal evaluation of a US program supporting intellectual and social development for preschool children from disadvantaged backgrounds showed offending was significantly lower for program participants. It estimated that the program saved \$7 for every \$1 spent by the time participants were aged 27 years, and \$16 for every \$1 by age 40 years (NZ OPMCSA 2018, p. 13; Parks 2000). An

evaluation of a Canadian mental health program for children with identified behaviour problems saw an 18–33% reduction in offences (Farrington and Koegl 2015).

State and Territory Governments are investing in early intervention initiatives to mitigate risks of offending behaviour. Broadly, initiatives can be categorised into two groups: those that are relatively less targeted, assisting vulnerable groups in general; and those that are more targeted, aiming to support groups identified as being at higher risk of offending. The New South Wales Government's *Their Futures Matter* reform is an example of the former. It aims to provide wrap-around care to vulnerable children, young people and families. However, one of its initiatives (*A Place to Go*) is more targeted, focusing on those in contact with the juvenile justice system — aiming to improve their wellbeing and decrease the likelihood of offending (NSW TFM 2018). The *Youth on Track* program is another example of a more targeted approach. It targets people aged 10–17 years, who have a medium to high risk of long-term contact with the criminal justice system (and often have already had formal contact). It aims to reduce further contact, by offering coordinated support to them and their families, including mental healthcare (CIRCA 2017; NSW MHC 2017).

Another approach that has emerged locally and internationally is 'justice reinvestment'. Justice reinvestment first began in the United States, after recognition that many people who offend come from, and return to, a small number of communities (SLCA 2013). It is:

... a data-driven approach to reduce corrections and related criminal justice spending and reinvest savings in strategies designed to increase public safety. The purpose of justice reinvestment is to manage and allocate criminal justice populations more cost effectively, generating savings that can be reinvested in evidence-based strategies that increase public safety while holding offenders accountable. (Willis and Kapira 2018, p. 2)

There is no one settled definition of justice reinvestment, as different approaches have emerged across countries. In Australia, justice reinvestment is focused on reducing crime and strengthening communities. It has typically involved funding programs tailored to specific communities, particularly Aboriginal and Torres Strait Islander communities, to address factors contributing to crime. This often includes treatment programs to address mental illness and substance use.

Justice reinvestment has gained much support in Australia with several projects in operation (Willis and Kapira 2018). A relatively established one is the *Maranguka Justice Reinvestment* project in Bourke, New South Wales (Just Reinvest NSW 2019). Data showed an 18% reduction in major offences reported and an 8% reduction in reoffending within 12 months of release between 2015 and 2017 (Just Reinvest NSW, sub. 440). However, it is not yet known whether these outcomes are attributable to the project (KPMG 2018b).

Despite developments in the evidence base for early intervention initiatives, clear evidence on what works to reduce offending and imprisonment remains limited, in particular, for Aboriginal and Torres Strait Islander people — a challenge faced by justice reinvestment approaches in Australia (Willis and Kapira 2018). A justice reinvestment approach is dependent on the specific programs implemented being successful and require: cross-sector

support; an understanding of past and projected trends for the custodial population (including factors contributing to offending); and analysis to determine the communities that are disproportionately contributing to the growth in criminal justice populations. All of this requires government support to achieve.

The National Mental Health Commission (sub. 949, p. 16) said that ‘early intervention and prevention initiatives such as justice reinvestment ... [are] reform areas of greatest potential’. State and Territory Governments should support an early intervention approach to address the over-representation of people with mental illness in the criminal justice system. Given that many in this cohort come from disadvantaged backgrounds, any approach should be holistic, addressing the multiple social determinants associated with an individual’s mental illness and risks of offending. State and Territory Governments should trial early intervention initiatives, and ensure frameworks are in place to promote associated evaluation and research, to build an evidence base around what programs work in reducing offending.

ACTION 21.1 — EARLY INTERVENTION IN THE CRIMINAL JUSTICE SYSTEM

An early intervention approach is needed to address the over-representation of people with mental illness across all stages of the criminal justice system.

Start now

State and Territory Governments should support an early intervention approach that would ensure people who are at high risk of coming into contact with the criminal justice system are identified, and provided appropriate support, such as mental healthcare and housing, to reduce their risk of offending.

In doing so, State and Territory Governments should continue trialling early intervention initiatives, such as the *Youth on Track* program, and ensure associated evaluation and research is undertaken to build an evidence base about specific programs that are effective in reducing offending.

A systematic approach to support police interaction with people with mental illness

Police and other emergency workers (chapter 13) often respond to people experiencing a mental health problem. The Police Federation of Australia (sub. 761, p. 2) said:

... policing services are one of the only services readily available on a 24/7 basis and ... are often the first, and quite often, particularly in regional and remote locations, the only responders and then find themselves transporting and/or guarding such persons [with mental illness] in hospitals or other facilities.

Police also face increased risks of developing mental health problems, as they are more likely to be exposed to regular trauma (chapter 7).

All states and territories have mental health legislation that authorises police to apprehend people who appear to have mental illness, and transport them to appropriate treatment facilities. These interactions take up a significant — and increasing — amount of police time. In part, this is because police who transport individuals to hospitals, often must wait with them until they are assessed (Henry and Rajakaruna 2018). In 2018, New South Wales police completed about 14 700 orders under section 22 of the *Mental Health Act 2007* (NSW)²³⁰ (State and Territory Governments Survey). Such interactions have been estimated to account for about 10% of police time (NSW LRC 2012). In Victoria, police facilitated about 14 000 ‘mental health transfers’ to hospital in 2017-18. The number of psychiatric-related events attended by police increased 88% from 2014-15 to 2017-18 (Victoria Police 2019). In Western Australia, police responses involving a mental health element increased from 4766 in 2007 to 18 902 in 2015 (Henry and Rajakaruna 2018). In South Australia, police attended 1130 mental health-related incidents that required transportation to hospitals, in 2018 (State and Territory Governments Survey).

Police are typically not mental health clinicians, so cannot adequately ‘triage’ people to appropriate mental healthcare. Broadly, police have three options to respond to mental health-related incidents:

- transport the individuals to emergency departments
- if an offence has been committed, progress the matter to the next stage of the criminal justice system
- handle the matter informally (Godfredson et al. 2010).

Crisis assessment and treatment services (chapter 13) exist to respond to mental health crises, but have been criticised for major time lags between when police initially respond and when those services arrive on site (Henry and Rajakaruna 2018). Further, and quite reasonably, crisis assessment and treatment teams are often reluctant to attend situations where there are concerns about risks to their health and safety (SCMH 2006).

Recognising this, most State and Territory Governments have implemented initiatives to better support police responding to mental health-related incidents (table 21.2). These generally fall into two categories (Puntis et al. 2018):

- ‘crisis intervention teams’ comprising police who receive mental health training
- ‘co-response models’ whereby mental health professionals and/or ambulance services directly assist police (Henry and Rajakaruna 2018), although variations of co-response models exist (box 21.5).

²³⁰ Under the Act, a police officer may apprehend a person who appears to have a mental illness and take them to a declared mental health facility if: the person is committing or has recently committed an offence, it is probable that the person will attempt to cause harm to themselves or others, or it is beneficial to the person’s welfare.

Table 21.2 Examples of programs to support police responding to mental health-related incidents

	<i>Program name</i>	<i>Description</i>
New South Wales	Mental Health Intervention Team	A unit of specially trained police officers responding to mental health-related tasks and providing mental health training to others in the agency
	Police Ambulance Clinician Early Response Program	A dedicated mental health clinician conducting assessments in the early stages of police responses to mental health crises. This program is currently subject to a six month trial
Victoria	Police Ambulance and Clinical Early Response	A police officer and a mental health clinician attend mental health-related police tasks as secondary responders
Queensland	Police Communications Centre Mental Health Liaison	Mental health clinicians are co-located in the Police Communications Centre. There are two full time clinical positions, supported by an on-call forensic psychiatrist
	Mental Health Co-responders program	Mental health staff accompany police and provide on-site clinical interventions
	Mental Health Intervention Project	A partnership between Queensland Police, Health and Ambulance Service to identify issues, discuss complex cases and develop preventative interventions, alternative referral pathways and review procedures
South Australia ^a	na	na
Western Australia	Police Mental Health Co-Response Team	A multiple staged co-response model which involves the placement of mental health practitioners in: <ul style="list-style-type: none"> • the Police Operations Centre facilitating access to advice, consultation, risk assessment and crisis management • District based mobile co-response teams • in the Perth Police Watch House
Tasmania	Mental Health Officers	Mental Health Officers liaise with police and mental health services in the community, and provide advice to police officers and the executive on policy and strategy
Northern Territory ^a	na	na
ACT	Mental Health Community Policing Initiative	Training is provided to frontline officers to help them understand how to recognise, relate and respond to incidents involving mental health consumers. Mental Health clinicians are also embedded into Police Operations Centres
	Police, Ambulance and Clinician Early Response	A proof of concept of the Mental Health Community Policing Initiative, which supports a tri-service response from police, ambulance and mental health clinicians

^a The South Australian and the Northern Territory Governments currently do not fund specific programs supporting police to respond to mental health-related incidents. **na** Not available.

Source: ACT Policing (2019); Henry and Rajakaruna (2018); NSW Government, sub. 551; QFMHS (2016); Queensland Government (2018a); Tasmania Police (2019). Victoria Police (2019).

Box 21.5 **Wide variation in co-response models**

There is wide variation in the implementation of co-response models. A systematic review identified 19 models that differed according to:

- operating times and days per week
- whether or not the co-response unit was a first or second response option
- whether the police officer and mental health worker were co-located
- whether a mobile mental healthcare unit was dispatched or not
- mode of transportation to the incident (marked or unmarked vehicle).

The study acknowledged that differences are likely due to local context and need.

This wide variation in co-response models should be recognised, as the name itself may suggest that it is a single model, where in practice they are not.

Source: Puntis et al. (2018).

These initiatives are complementary (some states have implemented both) and evaluations of both types showed benefits. Crisis intervention teams were found to help police engage and work better with people with mental illness (Herrington and Pope 2014). Submissions emphasised the need for police to receive appropriate mental health training, including mental health first aid and de-escalation techniques (CHF, sub. 646; QAI, sub. 889; RANZCP, sub. 1200). The Mental Health Legal Centre (sub. 1222, pp. 11–12) said:

... police officers will inevitably come across people experiencing mental illness in their day to day policing work ... [therefore] training about mental illness and how to respond to people experiencing it should be a core part of the education and training of officers.

Police training needs to be relevant to their role. In practice, this includes training related to mental health literacy, the Mental Health Act and how to respond to critical incidents involving people with mental illness. For example, Victoria Police (2019) said a key priority for them is equipping police with the knowledge and skills to deliver appropriately tailored policing responses and services to people experiencing mental health problems.

Co-response models have showed benefits in terms of resource allocation, safety and wellbeing of police and individuals whom police respond to, and greater inter-agency collaboration. For example, they can lead to fewer people being transported to emergency departments, because accompanying mental health professionals are able to effectively triage them and refer them onto appropriate mental healthcare. Evaluations showed transportation to emergency departments were between 27% and 63% lower under co-response models (Allen Consulting 2012; Henry and Rajakaruna 2018; Scott 2000). Police time is also saved. The Allen Consulting Group (2012) estimated that 2.8 hours spent by police per case (without the intervention) could be reduced to 0.7 hours per case (with the intervention).

Some State Governments have trialled and implemented more systematic co-response approaches, with mental health expertise incorporated at multiple stages of police response (box 21.6). This includes having mental health professionals located in police call centres

and as part of co-response teams attending incidents on the ground. A systematic approach can support more efficient use of limited resources (health, police and ambulance services). For example, if mental health professionals are located in police communication centres, they can have state-wide oversight of all mental health-related cases, enabling them to prioritise calls for co-responders to respond to on the ground.

State and Territory Governments have also developed their own memoranda of understanding and other protocols between police, mental health services and ambulance services (PFA, sub. 761). These provide a systematic framework for managing people with mental illness, where different agencies are involved. This includes defining roles and responsibilities, and outlining inter-agency operational protocols (Herrington et al. 2009; NSW LRC 2012). For example, the memorandum of understanding between Queensland Health and the Queensland Police Service enables health information to be shared with mental health professionals and police (QLD FMHS 2016).

State and Territory Governments should implement a systematic approach for co-responding.

In doing so, State and Territory Governments should consider what has been done in Queensland and Western Australia (box 21.6). Although what works in some jurisdictions may not work in others, the Productivity Commission sees merit in considering similar approaches. State and Territory Governments would also need to ensure evaluations are built into programs and may also need to tailor the approach to meet the needs of particular groups, including people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander people. For example, some Aboriginal and Torres Strait Islander people understand and experience mental health differently to many non-Indigenous Australians (chapters 4 and 8) and some may also have negative attitudes toward police due to strong historical antecedents (ALRC 2017a).

The Productivity Commission estimated the cost and potential cost savings of implementing systematic co-responses to support police. The total cost of implementing such an approach nationally was estimated to be between \$15 million and \$23 million. There are potential cost savings from reduced emergency department admissions of between \$4 and \$10 million (2019 dollars), and cost savings in police time estimated at \$7 million (2019 dollars) (appendix K).

Box 21.6 Case studies: a systematic approach to co-responding in Queensland and Western Australia

In Queensland, multiple programs exist to improve interactions between police and people with mental illness. This ensures that police are better supported and people with mental health problems can be referred to appropriate mental health services.

Police Communications Centre Mental Health Liaison Service — Mental health clinicians are located in the police communications centre where triple zero calls are received and first response officers are dispatched (QLD FMHS 2016). The mental health clinicians access and interpret clinical information for police and advise them on how to manage the individual (including communication, de-escalation and engagement strategies).

Mental Health Intervention Project — a tri-agency partnership between police, health and ambulance services to share expertise, resources and respond effectively to mental health crisis situations. Mental Health Intervention Coordinators are established in each health district (Queensland Health, QLD PS and QLD JAG 2008). They liaise between police, ambulance, mental health staff and other relevant stakeholders.

Mental Health Co-Responders program — mental health nurses work alongside Queensland police to respond to police call-outs (where mental health may be a factor) to provide assessments and advice. The nurse can work with individuals on-site to de-escalate the situation and develop a care plan that suits their needs (Queensland Government 2018b).

In Western Australia, mental health expertise is incorporated at each stage of police response under its Police Mental Health Co-Response program. This includes: at the point of dispatch; at the point of physical contact at the scene; and post-arrest within the custody setting.

Police Operations Centre — a mental health practitioner is located within the Police Operations Centre to access health databases and inform dispatchers and radio supervisors. This is expected to improve resource allocation and decision making when responding to mental health-related tasks (Henry and Rajakaruna 2018).

Mental Health Co-Response Mobile Teams — a mental health practitioner co-responds alongside police to mental health-related incidents. The practitioner performs clinical and risk assessments, conducts checks on the mental health database, determines needs and levels of urgency and makes referrals to appropriate mental health and support services.

Perth Watch House — a mental health practitioner is located in the Perth Watch House, and conducts screening and assessment of detained individuals' mental health status. The practitioner has access to health databases. This is expected to provide opportunities for early intervention and diversion, and streamline access to treatment and support.

An evaluation of Western Australia's Police Mental Health Co-Response program recommended it be continued beyond the trial period and expanded beyond the trial districts. Funding has been allocated for the program to continue and expand.

Source: Henry and Rajakaruna (2018); QFMHS (2016); Queensland Government (2018b); Queensland Health, QLD PS and QLD JAG (2008).

ACTION 21.2 — SUPPORT FOR POLICE

Responses to mental health-related incidents should follow a systematic approach, to support both the individual with mental illness and the police responders.

Start now

All State and Territory Governments should implement initiatives that enable police, mental health and ambulance services to collectively respond to mental health-related incidents. Approaches undertaken in Queensland and Western Australia should be considered.

The initiatives should ensure that:

- mental health professionals are embedded in police communication centres to provide real-time information on the individual to whom police are responding, to advise on responses and referral pathways, and to prioritise deployment of co-responder resources
- police, mental health professionals and/or ambulance services are able to co-respond to mental health related incidents if necessary
- roles and responsibilities of all service providers are clearly defined and aligned with existing memoranda of understanding or other protocols between police, mental health services and ambulance services
- approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people or people from culturally and linguistically diverse backgrounds.

Responses to mental health crises will not be fully successful on their own. They rely on the ability for individuals involved to access effective mental healthcare. However, there is evidence of ‘bounce back’ problems, where people transported by police to mental health facilities are unable to access care they may need (NSW LRC 2012). There are several reasons for this, including when:

- mental illness (as defined in mental health legislation) is not the primary impairment
- it is suspected that drugs or alcohol are involved
- the person is behaving violently
- the number of available mental health inpatient beds is limited.

For example, in Victoria, one in five individuals who were transported by police to hospital were assessed and released because they did not meet the criteria for involuntary admission under mental health legislation and did not want to be admitted (Ogloff et al. 2012). However, many of these people would likely benefit from follow up mental healthcare and other support services in the community. Their contact with the hospital — through the police — provides an opportunity to connect them to appropriate care and support.

Police also often interact with the same individuals repeatedly (Clifford 2010). Often these ‘frequent presenters’ do not receive adequate mental health and social support, contributing to repeat mental health-related incidents. The Police Federation of Australia (sub. 761, p. 2) said police ‘often find themselves in the “bounce back” scenario ... where access to treatment for people suffering is limited and police find themselves continually being called back to deal with the same person on numerous occasions’. Available data on the number of frequent presenters is limited, but suggests they ‘account for a large proportion of mental health act events’ within a local area (Herrington et al. 2009, p. 49).

Ideally police should only respond to mental health-related incidents when there is a threat to public safety or when there is an imminent risk to staff involved (Mental Health Commission of New South Wales, sub. 948; Sisters Inside, sub. 1196; VLA, sub. 818). However, as long as mental health services are under-resourced in the community, there will be demand for police to respond. Police responses to people with mental illness can only be effective if there are adequate treatment and support services for police to refer individuals to. Police can be a functioning gateway to mental healthcare, however, people transported by police to hospital emergency departments may not be able to access care or may have to wait a long time for care. This Inquiry recommended actions to improve access to, and provision of, mental health services (chapters 10 and 12), including in emergency settings (chapter 13).

FINDING 21.1 — POLICE RESPONSES RELY ON COMMUNITY MENTAL HEALTH SERVICES

The effectiveness of police responses to mental health related incidents relies heavily on mental health services being available in the community. Police responses are limited by a ‘bounce back’ problem — whereby police respond multiple times to the same individuals experiencing mental health crises. In some cases, these individuals are referred to mental health services by police, but are unable to access appropriate treatment and care, and are discharged without support.

Improving access to court diversion programs

State and Territory Governments have developed court diversion programs that divert people with mental illness away from the criminal justice system, and are intended to enable the court system to respond more effectively to individuals with mental illness.

A better conceptual approach to schemes or programs currently labelled ‘diversionary’ is not to consider them as legal detours or deviations from a true path but as identifiable stages in the criminal justice continuum at which the law can intervene effectively, proportionately and responsively to an alleged crime and to the person who is alleged to have committed it. State actions at these junctures are therefore better described as ‘interventions’ rather than ‘diversions’ ... Interventions can take many forms and take different forms for different purposes at different points of the criminal justice system. (Freiberg et al. 2016, p. 57)

This Inquiry concentrates on two particular types of programs: court liaison services; and mental health courts. All State and Territory Governments have adopted court liaison services, but only some have established mental health courts (table 21.3).

Table 21.3 Court diversion programs

	<i>Court liaison services</i>	<i>Mental health courts</i>
New South Wales	Department of Health: Justice Health Forensic Mental Health Network, from 1999	None
Victoria	Victorian Institute of Forensic Mental Health (Forensicare), from 1994	The Assessment and Referral Court, from 2008
Queensland	Department of Health: Forensic Mental Health Service	None ^a
South Australia	Department of Health: Forensic Mental Health Service, from 2013-14	Treatment Intervention Court (previously the Magistrates Court Diversion Program), from 1999
Western Australia	Department of Health: State Forensic Mental Health Services	Start Court (adult program) and Links (children's program), from 2013
Tasmania	Department of Health and Human Services: Forensic Mental Health Service	The Diversion List, from 2007
Northern Territory	Department of Health: Forensic Mental Health Service, from 2016 ^b	None
ACT	Department of Health: Division of Mental Health, Justice Health & Alcohol and Drug Services: Mental Health Forensic Services	None

^a The Queensland Mental Health Court performs a different role to that of the Mental Health Court programs in other jurisdictions. It is a specialist court which primarily determines issues of fitness to plead and criminal responsibility. ^b Services are limited: the Northern Territory's Forensic Mental Health Service conducts a small number of assessments in police watch houses and community mental health services on an ad hoc basis.

Source: Bradford and Smith (2009); Davidson et al. (2015); Davidson (2018); Heffernan et al. (2015); Richardson and McSherry (2010).

Court liaison services aim to identify people with mental illness who have been charged, and intervene as early as possible, often pre-trial or during the trial process (Davidson 2015). Services include conducting mental health assessments, providing clinical advice and assisting courts to divert individuals to mental health treatment (Davidson et al. 2016). They can also provide short-term mental health support. However, there are differences between jurisdictions. For example, only court liaison services in the ACT, New South Wales, Queensland, Victoria and Western Australia can access health databases to inform service delivery (Davidson 2015).

Mental health courts offer a different 'court model' and can operate alongside court liaison services. They provide a personalised, problem-solving approach that differs from a mainstream court process. Underpinning these models is the principle of 'therapeutic jurisprudence', which seeks to use the law as a therapeutic agent (Davidson 2015). Mental health courts differ between jurisdictions. For example, eligibility criteria can be different — for Victoria's Assessment and Referral Court, people must meet diagnostic, functional and needs criteria (VLA, sub. 818, att. 1), whereas for Western Australia's Start Court

(box 21.7), consideration of the latter two is not explicit. Queensland also has a mental health court, but its role differs in that it specialises in matters relating to forensic patients (such as decisions about fitness for trial).

Box 21.7 Western Australia's Start Court Program

The Start Court in Western Australia is a solution-focused court, adopting principles of therapeutic jurisprudence for people experiencing mental health problems. It consists of experts that provide legal support, clinical and corrections support, social and community support, and drug and alcohol support. The Western Australian Government allocated \$5.9 million (from 2019-20 to 2020-21) to mental health court diversion programs, including the Start Court, in the 2019-20 budget (Western Australian Government 2019b).

The Start Court process aims to run as follows:

1. A Magistrate in any metropolitan court refers an accused person to the Start Court. If the accused meets the eligibility criteria they can continue through the application process. An individual is eligible if they: have a diagnosable mental disorder; have entered or are likely to enter a guilty plea/pleas; are suitable for conditional bail; and provide consent to participate.
2. A clinical team conducts an assessment for inclusion, including interviews and screening.
3. The accused is either accepted or not accepted into the program. To be accepted, the accused must enter a guilty plea to at least a significant proportion of their charges.
4. During the program, the participant is required to 'check-in' to court weekly or fortnightly. An Individual Start Court Plan and outline of goals and strategies is developed and shared with the participant, their lawyer, the Magistrate and the Start Court Team. This may require the participant to attend appointments, including with a psychologist, a GP, a mental health clinic, urinalysis, counselling or employment specialist.
5. The program stage takes approximately six months.
6. The participant graduates from the Start Court Program. Leading up to graduation, a Recovery Plan will be developed for the participant.
7. In sentencing, the Magistrate takes participation in the program into account.

Source: WA DOJ, WA DoH and WAMHC (2018; 2019).

There are other types of court diversion programs that are not directly targeted to people with mental illness. An example is the Court Integrated Services Program that operates in Victoria (box 21.8), which provides case management support to individuals at the pre-trial or bail stage including mental health services and crisis accommodation. Another example is Victoria's Neighbourhood Justice Centre, which is based on a community justice model, and includes a multi-jurisdictional court and support services, such as mental health, drug, alcohol and financial counselling (Morgan and Brown 2015).

Research shows that court diversion programs can result in benefits for individuals and the wider community (Kimberlie Dean, sub. 235). The Western Australian Mental Health Commission (sub. 259, p. 18) stated that:

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.

Box 21.8 Victoria's Court Integrated Services Program

The Court Integrated Services Program (CISP) operates in the Magistrates' Court of Victoria. It aims to improve treatment, court, sentence and recidivism outcomes. CISP offers a coordinated, team-based approach to the assessment and treatment of defendants at the pre-trial or bail stage. The services that it provides includes case management support and links to support services for drug and alcohol, crisis accommodation, disability support and mental health.

A typical CISP process for an eligible participant proceeds as follows.

1. A client is referred to CISP for initial eligibility screening.
2. A case worker completes a comprehensive assessment, including examination of criminal and legal history, the client's need for social and economic support, drug and alcohol use, and physical and mental health needs.
3. The client returns to court where an order is made that they participate in CISP in several ways. Some magistrates make a bail order with conditions relating to CISP, while others merely *recommend* CISP engagement. In addition, some magistrates may order participants to re-appear at a later date for a progress review.
4. The case worker develops a case management plan for the client. This involves referral to a range of treatment and support agencies, and includes a plan for continued supervision.
5. At the end of the period of bail, the client returns to court, enters a plea (guilty or not guilty) and the sentencing outcome is determined. Participation in CISP may be taken into account in sentencing.

Source: VIC DJR (2010).

In addition to improving an individual's health and wellbeing, evaluations have showed reduced recidivism rates among participants. In New South Wales, the recidivism rate was 12% lower for participants in its court liaison service (Albalawi et al. 2019). Evaluations of the mental health courts in Victoria, South Australia, Western Australia and Tasmania also found reduced recidivism rates (Chesser and Smith 2016; Lim and Day 2014; Skrzypiec, Wundersitz and McRostie 2004; WAMHC 2015b). In Victoria, participants of the Court Integrated Services Program had recidivism rates of about 40% compared with the control group's 50% (PwC 2009); and clients of the Neighbourhood Justice Centre had recidivism rates of 33% compared with the control group's 44% (Ross 2015).

Despite evidence of their success, court diversion programs are not accessible by all individuals who may need them (NSW MHC 2017). For example, Victoria Legal Aid (sub. 818, att. 1) said that the Court Integrated Services Program is available in fewer than half of all courts across Victoria. A study found only 57% of individuals deemed eligible for

diversion were diverted in New South Wales (Soon et al. 2018). Although the study could not explain why such a high proportion were not diverted, it found clear differences in socio-demographic and diagnostic profiles between those diverted, and those who were not. For example, individuals who were male, younger, and Aboriginal and Torres Strait Islander were less likely to be diverted.

Geographical limitations, resourcing and capacity limitations and access barriers to community services can affect an individual's ability to access such programs. Just Reinvest NSW (sub. 440, p. 9) said 'poor understanding of diversions from Police and the Courts, insufficient funding of solicitors and program staff and appropriate training' can mean diversion programs are 'theoretically available', but 'in reality do not exist'. Access to court diversion programs can also depend on the location of the court in which the charge will be heard. Therefore, people living in regional and remote areas (who have their charges heard in regional courts) may not be able to access mental health court programs, which are predominantly located in metropolitan areas (Davidson et al. 2016; AASW, sub. 432). Further, under-resourced mental health services in the community may be unwilling or unable to accept referred individuals (VAGO 2014).

State and Territory Governments could expand court diversion programs to improve access to them, but much like police responses, the success of court diversion depends on the availability of mental health and other support services in the community. As mentioned above, people may be diverted to community services, but rejected — either because community services face resource constraints or because they are unwilling to accept individuals referred from the criminal justice system. For court diversion programs to succeed, there needs to be coordination and planning at the agency-level, not just at the program- and service-level. For example, Victoria's court diversion programs are secured through memoranda of understanding with police, health and human services (VAGO 2014).

The cost of expanding these programs to meet need could not be estimated, based on available data. There is little information (beyond anecdotal evidence) on the demand gap for these services. However, the Productivity Commission has estimated what the additional cost would be if court liaison services were provided in all courts, with expenditure scaling up proportionately (Davidson 2018), and if existing funding for mental health courts doubled (in States where mental health courts exist). This provides some indication of the additional expenditure needed to expand court diversion programs. Additional costs were estimated to be about \$32 million (2019 dollars) for court liaison services and \$13.5 million (2019 dollars) for mental health courts (appendix K).

ACTION 21.3 — IMPROVING ACCESS TO COURT DIVERSION PROGRAMS

Court diversion programs can be beneficial to people with mental illness.

Start now

State and Territory Governments should ensure that all individuals with mental illness who would benefit from court diversion programs — that link individuals to appropriate mental health treatment and social support — can access them. This should include ensuring court diversion programs are:

- available and accessible jurisdiction-wide, including in regional and remote areas
- adequately resourced, including funding and appropriately trained staff.

In doing so, State and Territory Governments should ensure there is adequate coordination with relevant agencies providing services to individuals who are referred by the court diversion program, particularly health and housing.

Further, the varied approaches across Australia, and the lack of coordinated evaluation and research, can make it difficult to determine what is best practice in this area (Davidson et al. 2016, 2017a). For example, eligibility criteria — which can be an access barrier to these programs (VLA, sub. 818, att. 1) — differ between jurisdictions, but there is limited evidence about what eligibility criteria would be most appropriate and which groups would benefit most from participating. A comparison of court diversion programs in Australia, and their effects on mental health, social and criminal justice outcomes of people, could be an area for further research (Davidson et al. 2017b).

Mental healthcare in correctional settings — equivalent to that in the community?

Correctional facilities are settings in which people with mental illness that have been sentenced for a crime, or are being held on remand, could receive mental healthcare.

Mental healthcare provided to people in correctional facilities has largely been left out of broader mental health reform. Currently, mental healthcare in correctional facilities is siloed — there are no national standards, no measurement of outcomes or even complete and reliable data on prevalence of mental illness and the mental health needs of this population. There is a common view that policies addressing the needs of people with mental illness in correctional facilities should sit separately from those in the community, but this approach is not improving mental health outcomes for people. As outlined earlier (section 21.1), many people with mental illness are sentenced for minor offences, returning back to the community after short periods of incarceration — and a consistent approach to their treatment and support is important.

Adult correctional facilities

Unlike in the community, State and Territory Governments are solely responsible for funding primary and specialised mental health services in correctional facilities (table 21.4).

Table 21.4 Responsibility for mental healthcare in correctional facilities

	<i>Responsible department(s)</i>	<i>Service model</i>
New South Wales	New South Wales Health	Mental health services are provided by Custodial Mental Health, a service within NSW's Justice Health and Forensic Mental Health Network. ^a
Victoria	Department of Justice and Community Safety	Prison mental health services (provided by Forensicare) delivers treatment and care at prisons/remand centres. ^b Visiting consultant psychiatrists and nurse practitioners also provide services to all publicly-run prisons. Department of Justice and Regulation contracts primary health services.
Queensland	Queensland Health; Queensland Corrective Services	Health Hospital and Health Services provide specialist mental healthcare. Primary care is provided by the Offender Health Services. Corrective Services contract private providers of primary healthcare in the two private correctional facilities.
South Australia	Department for Health and Wellbeing; Department for Correctional Services	Visiting psychiatrists (coordinated by the forensic mental health service) provide care to prisoners and some forensic patients held in custody (via collaboration with Correctional Services). Psychology services are provided by Correctional Services, and primary healthcare is provided by the Prison Health Service.
Western Australia	Partnership between the Department of Health and Corrective Services	The North Metropolitan Health Service provides specialist mental healthcare. The Mental Health and Alcohol and Other Drug Service provides mental health and addiction services, and Corrective Services provides psychology and counselling services.
Tasmania	Department of Health; Corrective Services	Mental health services are provided from within a broader Mental Health and Statewide Services structure. Specialist services may also be provided by psychologists funded by Corrective Services.
Northern Territory	Department of Health	Mental health services are provided by the forensic mental health service, which is comprised of specialist multidisciplinary clinical staff. These services include at-risk assessments, advice regarding treatment and care and case management.
ACT	ACT Health Directorate; Corrective Services	Specialised mental health services are delivered by forensic mental health services, including screening, assessment, care-planning and psychiatric care. Corrective Services provide mild to moderate psychological services.

^a Except at Junee Correctional Centre (private prison) which contracts private health providers. ^b Melbourne Assessment Prison, the Dame Phyllis Frost Centre, the Metropolitan Remand Centre, Port Phillip Prison and the Ravenhall Correctional Centre.

Source: Productivity Commission analysis based on Clugston et al. (2018).

Because State and Territory Governments are responsible for funding correctional facilities and juvenile detention, people held in them do not receive Medicare and PBS funded services and products (AIHW 2019r; Cumming et al. 2018).²³¹

Several reviews, inquiries and studies have highlighted key issues regarding healthcare provided in correctional facilities, including mental health (ALRC 2017a; Commissioner for Children and Young People Western Australia 2011; Office of the Inspector of Custodial Services 2018; SCMH 2006; Victorian Ombudsman 2015). These include poor screening and assessment upon reception, inadequate mental health services and use of practices in correctional facilities that can lead to, or exacerbate, mental illness.

First, the adequacy of screening and assessment processes in some jurisdictions has been questioned. Although all State and Territory Governments routinely screen for mental illness at reception to correctional facilities (Clugston et al. 2018), processes and practices vary. For example, in Victoria, people held in correctional facilities (sentenced and unsentenced) must have a medical screening within 24 hours (Victorian Ombudsman 2015), whereas in Western Australia, assessments are expected to be conducted within 28 days of sentencing (Office of the Inspector of Custodial Services 2019). In Queensland, some people are released from custody without being assessed by the prison mental health services due to long wait lists (Sofronoff 2016).

Screening practices can vary from the use of validated systematic screening protocols, to correctional facility officials merely asking a few questions about mental health history (Schilders and Ogloff 2014). For example, in Tasmania, screening and assessment is not standardised and depends considerably on the goodwill and expertise of staff (Tasmanian Custodial Inspector 2018). The Tasmanian Government has established a Prisoner Mental Health Task Force to examine processes and procedures relating to prisoner psychiatric care, including assessments (TAS DOJ 2018). JusTas Inc (sub. 346, p. 11) reiterated the importance of properly screening and assessing the mental health of people held in correctional facilities:

... if the mental health problems or illnesses of offenders are not adequately identified at [the] beginning of their entry to custody or to prison, such mental health problems will go unaddressed and untreated and individuals will fall through the gaps in regard to receiving effective and appropriate mental healthcare.

Submissions supported the need for screening and assessment to inform mental healthcare in correctional facilities, but emphasised that it must meet the following requirements.

- Conducted by mental health professionals — Sisters Inside (sub. 1196, p. 11) said it has learned from women it supports that ‘sometimes intake health screenings are conducted by prison staff ... not medical professionals’. The Mental Health Legal Centre (sub. 1222) said that screening needs to be undertaken by qualified mental health professionals.

²³¹ Section 19.2 of the *Health Insurance Act 1973* (Cth) states Medicare benefits are not payable if services receive funding from another level of government or statutory body. An exception is where medications fall under Schedule 100 of the PBS, known as the Highly Specialised Drugs Program.

-
- Complement existing mental health information from community mental health services — an individual’s community mental health treatment team could be contacted (if the individual consents to it) to further inform their mental healthcare while imprisoned. This would include information on existing medications. An Inquiry participant said that:

... it’s really quite daunting how many people have their medication removed the second they go into prison. Unless you can provide the evidence of what they were on prior to admission, it then takes quite some time to then get them back on medication. (Mental Health Legal Centre, Melbourne transcript, p. 171).

Second, there is a lack of mental health services available in correctional facilities. Several inquiries have highlighted that increases in prison populations have not been matched with increases in mental healthcare and services for people held in them (Human Rights Watch 2018; SCMH 2006; Sofronoff 2016; Tasmanian Custodial Inspector 2018). Fewer than 1% of prisoners assessed as having an acute or severe mental illness were transferred to appropriate mental health services for further assessment and treatment (Schilders and Ogloff 2014). Participants to this Inquiry (both government agencies and peak bodies) also highlighted difficulties that people held in correctional facilities face in accessing mental healthcare (Australian Red Cross Society, sub. 490; Mental Health Complaints Commissioner (Victoria), sub. 321; SAMHC, sub. 477).

Mental healthcare can be even less accessible for individuals detained while awaiting trial or sentencing, and for those serving short sentences. Individuals detained pre-trial are often released without medical or mental health follow up, as community services are not informed of their release (Stokes 2012). People in correctional facilities on short sentences may also miss out on appropriate mental healthcare due to long waiting lists (Sofronoff 2016).

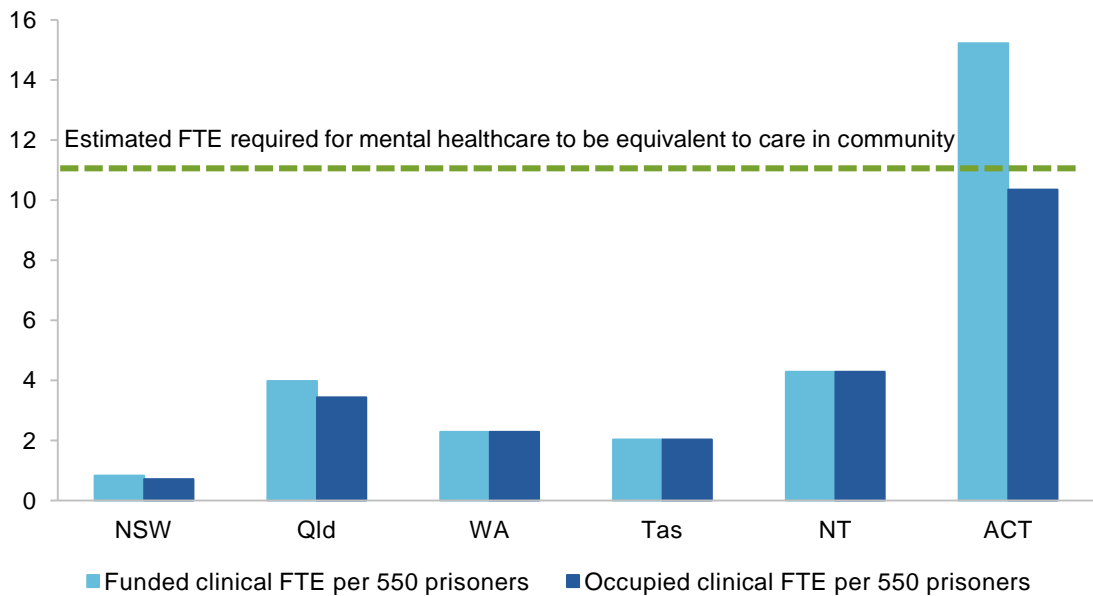
People with mental illness in correctional facilities are entitled to mental healthcare that is equivalent to the level provided in the community. This is outlined in the *Guiding Principles for Corrections in Australia*, which represents a national intent for State and Territory Governments to guide the development of practices, policies and performance standards (CSAC 2018). Australia is also a signatory of the *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)* (Mackay 2017).

However, in practice, this is not always the case. An indicator measure of this is the staffing profile for prison mental health services. The Sainsbury Centre for Mental Health estimated that for prison mental healthcare to be equivalent to community services, there needs to be 11 full-time equivalent (FTE) specialist mental health staff per 550 male prisoners. An additional 3.2 FTE is required to provide a substance use service (Clugston et al. 2018). Based on these estimates, only the ACT is funding mental health services in correctional facilities at a level equivalent to that in the community (figure 21.4).

Finally, some practices or conditions in correctional facilities may lead to or exacerbate mental illness (Jesuit Social Services, sub. 1186; Sisters Inside, sub. 1196). These can include the use of solitary confinement, restraints or other management regimes. The Australian Medical Association (2015) has said ‘solitary confinement is medically harmful

as it may lead to a number of physical and/or mental disorders’. Sisters Inside (sub. 1196, p. 10) said its staff ‘frequently support women who spend extended periods of solitary confinement and consequently suffer a deterioration of their mental health’. Such practices that are harmful to an individual’s mental health should be considered by any review on national standards of care (discussed further below).

Figure 21.4 Estimates of funded and occupied clinical mental health staff (full time equivalent per 550 prisoners)^{a,b,c}
As at 30 June 2016



^a Victoria did not respond to the survey and South Australia does not have a specific prison mental health service. ^b Data from New South Wales was provided for 30 June 2017. ^c Funded clinical full time equivalent (FTE) refers to the number of positions, which funding is allocated to and occupied clinical FTE refers to the number of positions filled, where staff occupying positions that deliver services. In Western Australia, the number of occupied clinical FTE is higher than the number of funded clinical FTE because additional ‘team leader’ staff were delivering services, but not included in the number of funded positions.

Source: Clugston et al. (2018); Davidson et al.(2019).

Juvenile detention centres

Similar to adult correctional facilities, inquiries and reports have raised issues with inadequate screening and assessment, and provision of mental healthcare in juvenile detention centres. This is despite the high prevalence of mental illness among young people in detention centres — up to about 80% in some jurisdictions (JHFMHN 2017b).

Young people entering detention do not always receive adequate mental health screening and assessment. The Western Australian Auditor General (2008, p. 24) found there was no ‘structure or process to ensure that mental health and substance abuse problems associated with repeated offending ... [were] identified’. The *Royal Commission into the Protection*

and *Detention of Children in the Northern Territory* found ‘... there were no systems in place to assess and diagnose children and young people with mental health problems [in Alice Springs]’ (White and Gooda 2017, vol. 2A, p. 362). Another review into juvenile detention centres in Victoria was also critical of assessment practices, calling initial health assessments ‘ad hoc’ (LSIC 2018).

Further, there are concerns that young people in detention centres do not have access to appropriate mental healthcare. A review found mental health services provided to young people in custody were inadequate to deal with the problems those young people presented with. Further, while mental healthcare may be available in theory, this is not always the case in practice. Young people may be prevented from attending counselling sessions or other services because of a lack of staff to escort them to their appointment — even in cases where services are available on-site (LSIC 2018). Youth Mental Health, North Metropolitan Health Service (sub. 895, att. 2, p. 1) said ‘... there are gaps in [mental health] service delivery and there is significant unmet need for young people in contact with the justice system’.

Reviewing national standards of care

Although a range of local and international guidelines and principles cover the provision of mental healthcare in correctional facilities, there are no national standards.

[There is a] lack of Commonwealth and State and Territory cooperation to establish and thereafter enforce national standards to protect, promote and maintain the health and well-being of people held in custody. (PHAA 2013, p. 2)

Within Australia, there are the *Guiding Principles for Corrections in Australia* (mentioned earlier) and the *National Statement of Principles for Forensic Mental Health* (AHMAC 2006). Primary themes that emerge across these principles are listed in box 21.9.

In the broader community, the National Safety and Quality Health Service (NSQHS) Standards apply to health and mental health service organisations, and are overseen by the Australian Commission on Safety and Quality in Health Care. The primary aims of the NSQHS Standards are to ‘protect the public from harm and to improve the quality of health service provision’ (ACSQHC 2017b, p. 1). A user guide has also been developed to support health service organisations implement the NSQHS Standards for mental health services (ACSQHC 2018c). Some health service organisations (such as, hospitals and day procedure services) require accreditation against the NSQHS.

Correctional settings are not explicitly included in the list of locations and settings in which healthcare is provided (ACSQHC 2017b, p. 72). And the Royal Australian and New Zealand College of Psychiatrists (sub. 1200, p. 22) noted that the NSQHS Standards are ‘geared’ towards health service organisations.

Box 21.9 **Main principles guiding correctional facilities in Australia**

There are five primary themes that emerge from international and Australian guidelines and standards regarding the provision of mental health services in correctional facilities.

Equivalence of care: those held in correctional facilities should receive healthcare, including mental healthcare, equivalent to that available in the community with regard to professional, ethical and technical standards.

Early assessment: those held in correctional facilities should be assessed as soon as possible on admission to facilitate the identification and immediate management of mental health problems. This should be accompanied by appropriate treatment plans.

Timely treatment: those held in correctional facilities should have access to treatment for mental illness; resource and staffing should ensure that detainees receive timely access to high-quality mental healthcare.

Continuity of care: ongoing monitoring and care, as well as linking mental health services in correctional facilities with those in the community.

Transfer to hospital: mental health workers should play a role in identifying and arranging for those held in correctional facilities who require involuntary mental healthcare to be transferred to appropriate authorised mental health facilities.

Source: Tasmanian Custodial Inspector (2018).

Nevertheless, the NSQHS Standards should apply to correctional settings to ensure that people in those settings receive safe and high quality mental healthcare equivalent to that expected in the community. This is particularly important given the high prevalence of mental illness among people in correctional facilities, and consequent demand for mental healthcare. Setting safety and quality standards can provide a quality assurance mechanism (ACSQHC 2018c).

Mental health care in prisons should be aligned with the standards and approaches of community based mental health services which includes providing support to manage mental illness within the general community setting of the prison and access to specialist mental health units as appropriate. (MHV and MHLC 2019, p. 16)

Submissions supported the NSQHS Standards applying to correctional settings, but some raised concerns that without additional funding, the NSQHS standards could not be practicably upheld. For example, although the Aboriginal Medical Services Alliance NT (sub. 1190, p. 17) supports a move to apply the NSQHS standards in correctional settings, they also stated that ‘a significant increase in investment, staffing as well as structural reforms’ would be needed. Sisters Inside (sub. 1196, p. 9) said ensuring correctional facilities are adequately resourced provides ‘the best chance of providing a level of mental healthcare approaching a community standard’. If the NSQHS Standards were to apply to correctional settings, governments would need to ensure that mental healthcare services are adequately resourced to effectively implement and uphold them.

Leaving correctional facilities

People leaving correctional facilities can face multiple barriers reintegrating back into the community. Incarceration disrupts a person's housing, financial and employment situations, family responsibilities and social connections (ALRC 2017a; Office of the Inspector of Custodial Services 2019). Barriers to reintegration include: poverty, low levels of education, unemployment, homelessness, drug or alcohol dependencies, and a lack of social support or loss of family ties (QAI 2015).

Mental illness can act as an additional barrier to successful reintegration, and comorbidities (which are common, as discussed in section 21.1) presents further challenges:

... in One Door's experience, people in this situation have very poor outcomes on exit from the facilities, for example: inability to maintain tenancies, and therefore homelessness; increased likelihood of substance misuse; lack of engagement with GPs and other practitioners to seek treatment, including medication and psychological supports; demonstration of frequent challenging or anti-social behaviours; and increased risk of reoffending and return to correctional facilities. (One Door Mental Health, sub. 856, p. 16)

Sisters Inside (sub. 1196, p. 12) said that '[i]t is unrealistic to expect that, immediately following release from prison, a person will be equipped to assume full responsibility for their health care'. People with mental illness can also find it harder to access suitable housing (chapter 20) and face barriers to employment (chapter 19), particularly if there is stigma associated with a criminal history as well as with mental illness (chapter 8).

People can also experience more severe symptoms of mental illness upon release from correctional facilities. People leaving prison had higher rates of hospitalisation for mental illness, compared with the general population (Hobbs et al. 2006; Kouyoumdjian et al. 2018). Average healthcare costs for people leaving prison with mental illness or a comorbidity were between two and three times higher than those without (Justice Health Unit – University of Melbourne, sub. 1237). Spittal et al. (2014) found the likelihood of dying by suicide was 14.2 and 4.8 times higher for women and men leaving prison compared to the general population.

As a result, continued access to mental healthcare can be pivotal. Programs aiming to improve primary care engagement among people leaving prison led to increased engagement with health services in the shorter term, including mental health and drug and alcohol treatment, and reduced emergency department presentations in the longer term (Kinner et al. 2016; Wang et al. 2012; Young et al. 2015). A recent study by the Kirby Institute, the New South Wales Department of Health and the New South Wales Department of Corrective Services found that reoffending decreased when the number of 'mental health service clinical contacts' increased, with the likelihood of reoffending five times higher for people with mental illness who did not receive mental healthcare in the community (NSW Government, sub. 1243, p. 19).

State and Territory Governments need to ensure continued mental healthcare is included in programs supporting people with mental illness to transition from correctional facilities to the community (transition support programs).

However, this is often not the case. Not all state and territory prison mental health services provide a transition service. Instead, referrals are made to community services (Clugston et al. 2018). There is a disconnection between ‘inside’ and ‘outside’ mental health services (Victorian Ombudsman 2015). Inquiry participants reported that:

... despite the fact that Australian correctional policy has for many years articulated a commitment to ‘throughcare’ to improve the continuity of care as people transition from prison to the community, little is done to maintain or build upon the success of custodial health services, after release from custody. (Justice Health Unit – University of Melbourne, sub. 339, p. 8).

There is a poor intersect between effective mental healthcare in a custodial setting and in the community ... Although a discharge summary of medication is meant to be provided to the person upon release, this is often lost in transit. For these reasons, strengthening the relationship between health services in prisons and community health and mental health services is particularly important. (Jesuit Social Services, sub. 441, p. 21)

This appears true for people released on parole too. People released on parole are supervised in the community and often referred to services, including mental health services (Sofronoff 2016). However, people with mental illness can be ‘under-identified and underserved’ (Gelb, Stobbs and Hogg 2019, p. 99). Parole staff can lack experience or have caseloads that are too large, preventing them from adequately managing people with mental illness (Lurigio 2001). JusTas Inc (sub. 346, p. 15) highlighted this:

... [an ex-inmate at an Australian prison identified] that the parole officer assigned to him ... [was] often too busy and had too high a case load to spend more time with him ... He highlighted that inmates suffering from mental health illnesses should have to, as part of their parole and to ensure mental stability, see mental health professionals regularly. If not for these social work and mental health professionals, spiralling of the mental illness may occur for the person, as it did for him.

The NSW Mental Health Review Tribunal (sub. 409) stated that maintaining a person’s mental healthcare when they leave custody is difficult for several reasons. First, often, release dates can be difficult to predict. For example, a person who is remanded and awaiting trial may be discharged suddenly from court. Second, if there is uncertainty around a person’s living arrangements, the person cannot be linked to a local mental health team. And finally, community mental health teams may be reluctant to take on clients who have come out of custody. To address this, the NSW Mental Health Review Tribunal (sub. 409) has been asked to make community treatment orders for people in custody, creating a legal mechanism that requires a person to accept treatment. However, this would only be possible if the person met criteria for a community treatment order, as would apply to individuals in the broader community.

Notwithstanding, there are some examples of mental health transition services. Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212) submitted that Queensland Health funds a transition program that includes the prison mental health service

developing a ‘transition plan’ with the individual and community mental health services prior to release to inform mental healthcare in the community. Further, the prison mental health service remains involved with the individual for up to two weeks after release. However, Mind Australia, Neami National, Wellways and SANE Australia (sub. 1212) also stated that coordination between the prison mental health service and community-based services needs to improve.

Overall, however, ensuring continued mental healthcare forms only one piece of the puzzle that supports reintegration. The Productivity Commission sought further information on the benefits and extent of transition support needed in the draft report. Many submissions responded with information on successful or promising transition support programs (box 21.10).

Box 21.10 Examples of promising transition support programs and pilot programs

- *Extended Throughcare Program* — provides case management for 12 months after release, giving support in five core areas: accommodation, health, basic needs, income and community connections. An evaluation of the program found that it reduced recidivism by 22.6%, helped clients secure or maintain housing because of assistance with advocacy, and had positive mental health and drug and alcohol outcomes (Griffiths, Zmudzki and Bates 2017).
- *ReConnect program* — supported high risk individuals transition back to the community, by providing targeted and intensive outreach services for up to 12 months (Jesuit Social Services 2020). This includes creating individualised transition plans, and providing assertive outreach and practical assistance. Recently, as part of a pilot project, a community health nurse was embedded in the program. An evaluation by the University of Melbourne found that it had significant benefits for participants and staff (Jesuit Social Service, sub. 1186, p. 2).
- *Throughcare Program, Northern Aboriginal Justice Agency* — provides intensive case management, tailored to Aboriginal and Torres Strait Islander people leaving correctional facilities. It is strength-based and provides support for rehabilitation, accommodation, employment, education and training, health, life and problem solving skills, and reconnection to family and community. It won the Australian Crime and Violence Prevention Award from the Australian Institute of Criminology in 2012 (North Australian Aboriginal Justice Agency 2020).
- *Detention Exit Community Outreach Program* — a recovery-focused outreach program providing intensive case management and psychosocial supports for up to three months (Wellways Australia Limited 2020). It helps people in areas including mental health, employment, education or training and housing. From 2015, 93% of participants have not reoffended (Mind Australia, Neami National, Wellways and SANE Australia, sub. 1212, p. 40).
- *Time to Work Employment Service* — aims to assist people leaving correctional facilities find employment and reintegrate into the community upon release (DESE 2020c). *Time to Work Employment Service* has commenced in most states and territories, and is expected to expand to all.

To be successful, transition support programs must aim to help individuals overcome the multiple barriers to reintegration. This includes addressing accommodation, health, basic needs, income and community connections. In particular, many submissions highlighted the importance of securing suitable housing (Jesuit Social Services, sub. 441; Olav Nielssen, sub. 37; QAI, sub. 1222; Sisters Inside, sub. 1196).

Key principles underlying successful transition support include the following.

- Holistic — addresses a range of social supports that an individual needs, providing wrap-around, integrated care. For example, a person may need support from mental health services, but also drug and alcohol services, or housing and employment support.
- Coordinated — roles and responsibilities of services involved must be clearly defined.
- Pre-release planning — planning should occur well before release, while the individual is still held in a correctional facility. Many necessary tasks could be completed before release to ensure timely access to services in the community, for example, ensuring individuals have identification documents. There needs to be clear communication of release dates to all parties involved in an individual's transition back into the community.
- Flexible — care and support should be mobile and flexible, including outreach services. Sisters Inside (sub. 1196) said this is particularly important for women leaving correctional facilities, who often depend on income support, and cannot afford to travel to access services. Further, many face a range of post-release requirements, such as parole conditions and obligations related to child safety and employment. Flexible and mobile care would help lift some of the load placed on these people who are returning back to the community.
- Longer term — care and support needs to be long enough so that individuals can establish reliable links with necessary community supports. The NSW Mental Health Review Tribunal (sub. 409) stated that longer periods of assertive community mental healthcare and other supports are instrumental to maintaining a person's mental health.

Overall, people with mental illness who enter correctional facilities should have access to mental health services that are equivalent to the community, and the mental healthcare they receive should be continued seamlessly after they have left. State and Territory Governments should avoid disruption in care that distinguishes between the 'inside' and 'outside'. Further, although people released from correctional facilities can receive case management (through their parole officer or transition support programs), these are time limited. To ensure this support is continued in the longer term, there should be adequate handover to care coordinators (action 15.4), if required.

The Productivity Commission estimates that improving mental health services in correctional facilities to the point that they are equivalent to those in the community would cost an additional \$48 million to \$110 million (2019 dollars) per annum nationally (appendix K).

ACTION 21.4 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE

Mental healthcare in correctional facilities should be equivalent to that in the community and mental healthcare should be continued seamlessly as people enter and leave correctional facilities.

Start now

The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Health Service Standards to determine how they apply to, and can be implemented in, correctional settings.

All State and Territory Governments should ensure that:

- there is mental health screening and assessment of all individuals (whether sentenced or not) by a mental health professional on admission to correctional facilities, and on an ongoing basis where appropriate
- mental health information obtained from screening and assessment is comprehensive enough to inform resourcing of mental health services in correctional facilities
- with consent from the individual, there is communication with any of their existing mental health providers to further inform mental health needs
- individuals in correctional facilities are able to access timely and appropriate mental healthcare, of a standard equivalent to that in the community
- mental health information obtained from screening and assessment is used to inform transition planning for the individual upon release. Transition planning should be completed and, with consent from the individual, shared with community based mental health services, case managers and other relevant parties, at a time before release that is reasonable for the planning of continued mental healthcare of the individual in the community.

Shortfalls in forensic mental healthcare

Mental health treatment is provided in forensic mental health facilities to people who are alleged to have committed a crime, but deemed unfit to plead or unfit to stand trial (forensic patients), and people who have been sentenced for a crime, but need inpatient mental healthcare. Often these individuals are very unwell and need intensive mental health treatment (MHLC, sub. 1222). In some cases, they require compulsory treatment, which cannot be provided in correctional facilities, as they are not designated mental health facilities.

The *National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment* was developed by the Council of Attorneys-General, and endorsed by all states and territories, with the exception of South

Australia, at the time of writing.²³² The principles aim to ensure that people who are unfit to plead or found not guilty by reason of cognitive or mental health impairment receive treatment that is tailored, inclusive and recovery oriented (Attorney-General's Department 2019).

The national principles provide a framework to guide improvements in legislation, policy and procedures. However, much change is required to ensure these principles are implemented in practice.

There are serious shortages of forensic services and beds in inpatient forensic facilities in all states and territories, particularly for young people (Northern Territory Mental Health Coalition, sub. 430; Office of the Inspector of Custodial Services 2018; SCARC 2016a). As a result, people who are forensic patients can be placed in correctional facilities rather than hospitals. For example, the Mental Health Commission of New South Wales (sub. 948) said there were 30 male forensic patients in custody, waiting to be transferred to a forensic hospital as at 30 June 2019, and that people can wait up to four and a half years for this. People sentenced and held in custody who require inpatient treatment can also face long wait times. A report by the Office of the Inspector of Custodial Services (2018) found 61% of referrals from a custodial setting lapsed without a hospital placement. Inquiry participants also shared their own experiences:

Even now when [he] was found not guilty because of mental illness, he remained in gaol, put in corrections for 12 months. That is terrible by anyone's word ... they [said] he was transferred to other sections but gaol is gaol, there's no ifs or buts. The law should be changed, once a person is found not guilty, they should be out of corrections within seven days, and the government needs to find enough money to finance this ... There's not enough beds in the mental health system and that's causing a backlog in the gaol. They're just held in gaol until they can get a bed ... even now, [he's] recently been approved to go to [a] unit. But there's an approximately a six month wait, so that's more proof there's not enough beds in the system. (Patricia and Andrew Anderson, Sydney transcript, p. 9)

The shortage of forensic services and beds in inpatient forensic facilities prevents some people from accessing appropriate mental healthcare, and puts a heavy strain on the prison system more broadly (MHLC, sub. 1222).

Forensic mental healthcare is highly specialised and costly. On average, about \$1200 per patient day is spent on forensic mental health services (AIHW 2020c). This compares to recurrent expenditure per prisoner per day of \$310 (SCRGSP 2020a). There are fewer than 2000 forensic patients nationally (table 21.5). However, there is unreliable data on the number of people in correctional facilities who require inpatient treatment in forensic facilities.

²³² While the South Australian Government supports the objectives of the National Principles, it has not endorsed them due to inconsistencies with current legislative provisions, policies and procedures (Attorney-General's Department 2019).

Those receiving forensic mental healthcare generally receive a very high standard of mental healthcare, and treatment can be compulsory (NSW Mental Health Review Tribunal, sub. 409). It can be delivered in high security settings, such as forensic hospitals, or in medium and low security mental health units. Care is often not limited to psychiatric treatment, and may also include: individual therapies that support cognitive skills, drug and alcohol abstinence, a better understanding of mental illness, anger management and behavioural regulation. Forensicare (Victoria's state-wide provider of clinical forensic mental health services) said the average period of inpatient treatment is 6–8 years (Forensicare 2019). Treatment often also includes a slow, graduated program of leave in the community.

Table 21.5 Number of forensic patients/orders^a

As at 30 June 2019

	<i>Estimated number of forensic patients/orders</i>
New South Wales	618 ^b
Victoria	173 ^c
Queensland	798
South Australia	85
Western Australia	42
Tasmania	46 ^d
Northern Territory	45
ACT	0 ^e

^a These are estimates based on statistics from State and Territory Government annual reports and data collections, and are not directly comparable due to different definitions and reporting processes. ^b New South Wales data is the number of forensic and correctional patients. ^c Victorian data is the number of supervision orders under the State's *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic). ^d Tasmanian data is the number of orders made during the period 2005–June 2018. ^e The ACT Civil and Administrative Tribunal has not made a forensic mental health order to date, as at 30 June 2019 (ACAT 2019).

Source: Forensicare (2018); McGrath et al. (2019); NSW MHRT (2019); Queensland Health (2019a); SA DHW (2019); Tasmania Law Reform Institute (2019) Western Australian Government (2019a).

Forensic mental healthcare is effective in improving mental health outcomes, as well as reducing reoffending. The NSW Mental Health Review Tribunal (sub. 409, p. 5) said many people would 'benefit enormously from the intensive and holistic mental health treatment' provided by forensic teams. Further, a study found that:

... the 12-month rate of re-offending for released forensic patients is 6.3% for a cohort accrued over the past 25 years ... this compares to a rate typically over 40% for released prisoners in NSW. Our findings are consistent with those across jurisdictions internationally supporting the notion that forensic mental health services are effective at reducing post-release contact with the justice system, vital for supporting social and economic participation for this high-risk and high-needs group (Kimberlie Dean, sub. 235, p. 3).

State and Territory Governments should ensure forensic services and facilities are adequately resourced to reduce wait times for both forensic patients and people held in correctional facilities who require inpatient mental healthcare. Some investment has already been made. In 2017-18, the Victorian Government allocated \$83 million toward forensic mental health in its 10-Year Mental Health Plan, including funding for a secure forensic mental health unit for youth justice clients (Victorian Government, sub. 483). The Western Australian Mental Health Commission has planned to develop a 92-bed forensic inpatient facility by the end of 2025 (WAMHC 2015a).

The National Mental Health Service Planning Framework does not include the provision for modelling forensic mental healthcare (WAMHC 2015a), a forensic mental health component is in development (Western Australian Mental Health Commission sub. 259). This will assist State and Territory Governments identify the gap between current and optimal levels of forensic services, and therefore help inform the resourcing of them. Upon completion of the forensic mental health component of the National Mental Health Service Planning Framework, State and Territory Governments should use it to quantify the level of unmet demand for forensic mental healthcare to inform planning and funding.

ACTION 21.5 — FORENSIC MENTAL HEALTHCARE

Start now

The Australian, State and Territory Governments should complete the forensic mental health component of the National Mental Health Service Planning Framework, which should then be used by State and Territory Governments to quantify the level of unmet demand for forensic mental healthcare. This should inform planning and funding of forensic mental healthcare, including forensic services and facilities, for adults and young people. The plans developed for forensic mental healthcare should be made publicly available.

The extent to which forensic orders are likely to lead to indefinite detention is a further issue. Most states and territories have limiting terms for forensic orders or mandatory reviews of orders on a regular basis. However, Victoria, Western Australia and the Northern Territory still allow for indefinite detention (SCARC 2016a). The Senate Community Affairs References Committee recently conducted an inquiry into this issue, although the Australian Government has not yet responded (Parliament of Australia 2019). The Productivity Commission recognises that indefinite detention is a complex issue, but a review of the relevant legislation in state jurisdictions is beyond the scope of this Inquiry.

Addressing the needs of Aboriginal and Torres Strait Islander people

The incarceration of Aboriginal and Torres Strait Islander people, its causes and devastating effects have been the subject of a number of inquiries and Royal Commissions, the most recent being the ALRC (2017a) inquiry. Aboriginal and Torres Strait Islander people are grossly over-represented in the criminal justice system and a large proportion are diagnosed with mental illness and cognitive disabilities (section 21.1).

However, in addition to the general issues raised in this chapter, mental health services for Aboriginal and Torres Strait Islander people in contact with the criminal justice system need to address three interconnected issues to be effective.

First, they need to be culturally capable. A study found ‘the current model of mental healthcare provided in prisons is not embedded within a culturally sensitive context and may not be meaningful to Koori people’ (Ogloff et al. 2013, p. 16). Where specific programs exist (such as healing programs), places can be limited (Ogloff et al. 2013).

Second, culturally capable care needs to deal with the specific underlying mental health problems facing Aboriginal and Torres Strait Islander people, which can differ from other population groups. For example, Aboriginal and Torres Strait Islander women who are imprisoned can face greater barriers to accessing culturally capable mental healthcare, which is often inextricably linked with traumatic experiences of family violence, victimisation, sexual abuse and addiction (Blagg et al. 2005; Heffernan et al. 2015). However, few programs in correctional facilities are designed for Aboriginal and Torres Strait Islander women (COAG 2016) and mental health problems are often addressed by issuing medication (Blagg et al. 2005).

... prisons do not appear to provide adequate support for people with mental health issues. It is reported that women with disabilities, particularly Aboriginal and Torres Strait Islander women with disabilities: experience higher rates of poverty, homelessness, domestic and sexual violence, and abuse than non-indigenous peers and peers without disabilities. Being put in custody often only heightens psychosocial disabilities associated with this trauma. (NSW Council for Civil Liberties, sub. 484, p. 6)

Third, many Aboriginal and Torres Strait Islander people are incarcerated for short periods of time (relative to non-Indigenous people in correctional facilities) — either on detention awaiting trial or sentencing or while serving a short sentence. Prison census data showed about 30% of Aboriginal and Torres Strait Islander people in correctional facilities were detained pre-trial (ABS 2019e) and almost half were handed sentences of less than six months (ALRC 2017a). As the Human Rights Law Centre (2019, p. 22) notes:

... [inadequate access to programs] is felt most acutely by Aboriginal and Torres Strait Islander people in prison, who are more likely to be held on remand and be incarcerated for short periods, and are therefore more likely to be in a situation where they are denied access to culture, community, education and mental health services.

Short periods of incarceration increase the importance of the justice system acting effectively as a gateway to culturally capable services in the justice system itself, and as a link to these services in the community.

According to the ALRC (2017a), culturally appropriate programs for Aboriginal and Torres Strait Islander people should be:

- designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible
- trauma-informed, especially where being delivered to women in correctional facilities
- focused on practical application, particularly for those on remand or short sentences who need the skills to reintegrate once released.

A model of care that is growing in recognition is the Winnunga Holistic Health Care Prison Model in the ACT (box 21.11). Under this model, the Aboriginal Community Controlled Health Organisation, Winnunga Nimmityjah, provides dedicated in-reach health services under a standalone and defined model of care (ACT Government, sub. 210). The ACT Government has committed \$8.3 million to integrate the Winnunga model at the Alexander Maconochie Centre correctional facility (Rattenbury 2019). South Australia recently developed a Model of Care for Aboriginal Prisoner Health and Wellbeing drawing on the Winnunga model, although it differs in scope (Sivak et al. 2017). The Productivity Commission estimated that implementing the Winnunga model nationally would cost about \$170 million (2019 dollars) (appendix K).

In many instances, trauma-informed approaches should also be adopted. Many Aboriginal and Torres Strait Islander people in correctional facilities, particularly women, have experienced trauma. Approaches to trauma-informed care are well described internationally and locally (Heffernan et al. 2015). Historically, these have been at odds with conventional approaches, but experiences internationally and in Australia are changing views. For example, the *Dilly Bag Program* in Victoria provides ‘intensive assistance’ to Aboriginal women in correctional facilities who are recovering from traumatic experiences (ALRC 2017a).

In the Productivity Commission’s view, State and Territory Governments should continue working with Aboriginal and Torres Strait Islander organisations to ensure that Aboriginal and Torres Strait Islander people in correctional facilities are connected to Aboriginal and Torres Strait Islander health services in the community following release. Several submissions were in support of this, including Consumers Health Forum of Australia (sub. 646), Mental Health Commission of New South Wales (sub. 948), Sisters Inside (sub. 1196), South Australian Mental Health Commission (sub. 691) and Victoria Legal Aid (sub. 818).

Box 21.11 **The Winnunga Holistic Health Care Prison Model**

The Winnunga Holistic Health Care Prison Model (Winnunga model) is a model of care for Aboriginal prisoner health (Sivak et al. 2017). It was developed by Winnunga Nimmityjah Aboriginal Health and Community Service in 2007 (Sivak et al. 2017).

The Winnunga Model addresses:

- incarceration — provides holistic care during incarceration and planning for release
- release from correctional facilities — provides post-release health service coordination, and family and community reintegration strategies
- the cycle of incarceration — provides early family, and other intervention strategies.

In 2017-18, Winnunga Nimmityjah Aboriginal Health and Community Service provided 178 clients with 1281 occasions of service at the Alexander Maconochie Centre and Bimberi Youth Detention Centre. This represented a 26% increase in client numbers and a 75% increase in encounters from the previous year (Winnunga AHCS 2018).

Source: Poroach et al. (2011); Sivak et al. (2017); Winnunga Nimmityjah AHCS (2018).

ACTION 21.6 — ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE WHO ARE INCARCERATED

Start now

State and Territory Governments should ensure Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally capable. These services should be:

- designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible
 - trauma-informed, particularly when services are delivered to Aboriginal and Torres Strait Islander women
 - focused on practical application particularly for those on remand or short sentences who need to reintegrate into the community
 - connected to culturally capable mental healthcare and psychosocial supports in the community for Aboriginal and Torres Strait Islander people upon release from correctional facilities.
-

Supporting victims of crime with mental illness to access mental healthcare

The high prevalence of mental illness among people who are victims of crime (section 21.1) means that their interaction with victim support services can serve as a gateway to mental health and other support services. Establishing links between victim support and mainstream mental health services is necessary to ensure that this is efficient and effective.

State and Territory Governments acknowledge the mental health needs of people who are victims of crime, with each jurisdiction funding victim services that provide counselling (among other supports such as financial assistance) (Chan et al. 2013). Victim services have become increasingly formalised as State and Territory Governments assumed greater roles in providing these services (Freeman and Smith 2014). In some States, the number of counselling applications made by victims has been increasing. For example, in New South Wales, 16 730 counselling applications were lodged in 2017-18 — almost double the number reported five years earlier (NSW DoJ 2018).

It is desirable that these victim services serve as a gateway to mainstream mental healthcare for a number of reasons. First, timely access to support can be important to prevent mental health and social outcomes from deteriorating.

... for many people with complex needs [mental illness and cognitive disabilities], victimisation is understood as having multiple flow-on effects across their lives. Victimisation experiences that are not adequately recognised and addressed are seen to ultimately lead to further issues including homelessness, problematic substance use and poor mental health. (Dowse et al. 2016, p. 62)

Second, although victim of crime schemes provide counselling services, they may not always be appropriate. Severe mental illness can be prevalent among people who are victims of crime (Dowse et al. 2016). Counselling services alone may not adequately meet the needs of all victims with mental illness, particularly if they are short-term services. For example, the New South Wales' victim counselling services limits counselling to 22 hours (NSW DCJ 2019), although the victim counselling services can approve more hours.

Finally, victims with mental illness may need support to access mental health services and other community supports. There are several reasons for this, including limited awareness of mental health services, difficulties in communication and difficulties in attending appointments (Dowse et al. 2016; McCart, Smith and Sawyer 2010).

For these reasons, it is desirable that State and Territory Governments ensure that this gateway to appropriate mental healthcare and other support is efficient and effective. Section 21.3 (action 21.7) outlines how governments can achieve this.

21.3 Improving access to justice

As discussed in section 21.1, people with mental illness are more likely to encounter legal issues, compared to the general population. Legal issues can range from fines, evictions and problems concerning welfare payments, to criminal charges or as victims of crime (Coumarelos et al. 2012). Issues can also result from mental health legislation.

However, people with mental illness often face barriers to participating in the justice system. These barriers can prevent them from initiating and participating in legal proceedings (box 21.12). There can be multiple reasons for this, including: poor knowledge about legal rights and available remedies (Balmer et al. 2010); communication problems (Karras et

al. 2006); and health and other non-legal needs (Coumarelos et al. 2012). People with mental illness can also face barriers in exercising their rights as victims (box 21.13).

As a result, there is unmet demand for legal assistance among people with mental illness.

Unresolved legal issues can lead to mental ill-health. There is a significant and strong association between legal problems and mental illness, with the incidence of legal problems being higher for people with mental illness (Pleasence and Balmer 2009). Moreover, legal problems can cause or exacerbate mental illness as well (Coumarelos et al. 2012). Unresolved legal issues can reinforce and entrench disadvantage (Health Justice Australia, sub. 749) — a risk factor for further contact with the justice system, including the criminal justice system (section 21.2).

Box 21.12 Barriers to participating in the justice system

Initiating legal proceedings

People with mental illness can face barriers to initiating legal proceedings. Many people with serious mental illness are financially disadvantaged, and therefore more reliant on legal aid, community legal centres and pro bono legal advice (Karras et al. 2006). It is well recognised that resource constraints exist in the legal assistance sector including specialist disability legal services (Law Council of Australia 2018; PC 2014). This has particular implications for people with mental illness who may require more intensive support. For example, they may have difficulties communicating, requiring more time with lawyers (Karras et al. 2006). In some instances, legal services may have to refer people with mental illness on to other services as they do not have resources to assist themselves.

Participating in legal proceedings

People with mental illness can face barriers to participating in legal proceedings due to the inflexible and adversarial nature of courts. The ACT Government (2019b, p. 10) stated that the justice system 'is at its core an adversarial one ... as such it is not a system designed for people who experience any degree of complexity in demonstrating legal capability such as people with [physical and mental] disabilities'. Karras et al. (2006, p. 153) said:

... it is apparent that people with a mental illness have particular needs that must be addressed during the legal process. They might need more time to communicate, [more] breaks in proceedings in order to address anxiety and stress, and clarification of the process itself.

Negative attitudes and stigma within the legal system is an additional barrier. The Law Council of Australia (2018, p. 34) found that 'people with [mental and physical] disability continue to face negative stigma, prejudice and discrimination, which creates significant barriers to accessing justice'. This prejudice against people with mental illness can be seen across multiple areas in the justice system including the police and courts. For example, people with mental illness are often not viewed as 'credible' victims or witnesses (Karras et al. 2006).

Box 21.13 Access to justice for victims of crime

Victims with mental illness can face barriers reporting crime and thereby accessing their legal rights. Low rates of crime reporting are evident for victims of crime more generally (McCart, Smith and Sawyer 2010), but people with mental illness can face additional barriers. For example, a person's mental illness can affect their ability to explain and retell events properly. Further, victims with mental illness may mistrust or fear authority and the justice system, as a result of previous bad experiences, which discourages them from reporting crime (Law Council of Australia 2018).

Moreover, when people with mental illness do report crime to the police, they may not be taken seriously (Karras et al. 2006). Victoria Police (2019, p. 14) said:

... victims/survivors with mental health conditions [who] report abuses to organisations including hospitals and police ... may have their story seen as a false report, and/or not have their case proceed to court ... [because they may be] perceived as unreliable informants about their life experiences.

Victims with mental illness also face barriers accessing their legal rights even after reporting the offence. For example, they may face difficulties participating in the victims claims process. And often, they may have no knowledge of entitlements under victim compensation schemes (Karras et al. 2006). In cases where proceedings have commenced, processes that are not 'trauma-informed' can re-traumatise people (VLRC 2018). Slow and complex claims processes can further affect their mental health (Collie 2019).

Disability justice strategies

There are a range of different programs and initiatives that can alleviate the barriers discussed above, including: establishing mental health legal centres, case management, providing adequate training to staff working in the justice system, and involving independent intermediaries in police interviews and courts (box 21.14). Recognising that a range of initiatives and programs exist to promote access to justice for people with mental illness, an assessment of these programs is beyond the scope of this Inquiry.

However, it is desirable for State and Territory Governments to adequately fund and support programs that have been shown to be effective in promoting access to justice for people with mental illness. A mechanism through which this could be achieved is through disability justice strategies. The Australian Human Rights Commission (2014, p. 6) recommended State and Territory Governments each develop a Disability Justice Strategy that provides a holistic, over-arching response and sets actions to implement. Not all jurisdictions have established these strategies. State and Territory Governments should develop and implement disability justice strategies to ensure the rights of people with mental illness are promoted in the justice system.

Disability justice strategies should aim to holistically support the needs of individuals, connecting them to other support services they may need (beyond the justice system), including community mental health services. For example, the ACT's *Disability Justice Strategy 2019–29* has 'better service delivery' as a focus area, including effectively linking individuals in contact with the justice system with human services in the community to provide more 'complete' services and supports, benefiting the individual (ACT Government 2019a, p. 18).

Box 21.14 Some initiatives to reduce barriers to accessing justice**Helping people with mental illness initiate legal proceedings**

Different initiatives aim to address barriers people face in initiating legal proceedings. This includes the establishment of specialist mental health legal centres that employ solicitors with appropriate communication skills (Karras et al. 2006). Examples include Victoria's Mental Health Legal Centre and Western Australia's Mental Health Law Centre. Additionally, legal aid and community legal centres provide training on mental illness to their solicitors, including on how to identify mental illness and how to work with people with mental illness (Karras et al. 2006).

Supporting people with mental illness participate in legal proceedings

An approach to support people with mental illness participate in legal proceedings is to provide case management. Case management can increase participation and improve the efficiency of proceedings by reducing delays (Karras et al. 2006). Even where informal legal processes (such as alternative dispute resolutions) are used, people with mental illness may still need support (Karras et al. 2006).

Providing adequate training to staff working in the justice system can help challenge those negative stereotypes about mental illness that can create barriers for people (Law Council of Australia 2018). Although the importance of training is recognised and supported in Australia, there are concerns that existing training is inadequate (Law Council of Australia 2018).

There are also initiatives that involve independent third parties supporting people with mental illness to better communicate and engage. For example, Victoria's *Intermediary Pilot Program* places communication specialist intermediaries in police interviews with victims and at court. The program aims to support individuals with a range of needs, including mental illness and complex trauma (VIC DJR 2018; Victoria Police 2019).

Access to legal services in mental healthcare settings — health justice partnerships

People with mental illness are more likely to experience legal problems, but it also shows that they are more likely to speak to non-legal advisors about legal issues, including healthcare providers (Coumarelos et al. 2012). However, non-legal advisors often lack legal knowledge or knowledge about where to refer individuals to assist them (Karras et al. 2006). For example, in some states and territories, a person with mental illness is eligible to have their fines reviewed and revoked, if it can be shown that they had a mental illness at the time the fine was incurred (VLA 2019b). However, a specialist mental health professional may not know this.

Recognising this, there has been movement towards a more 'integrated' approach to support individuals (Coumarelos et al. 2012). Health justice partnerships (HJPs) (also known as medical justice partnerships) embed legal services into healthcare settings, providing a holistic approach to addressing vulnerable individuals who have both mental health and legal issues (NSW MHC 2016).

There were 73 HJPs operating in Australia in 2018, with most located in New South Wales and Victoria (table 21.6). HJPs have been gaining traction in Australia from 2014, increasing four-fold between 2014 and 2018 (Forell and Nagy 2019). Few HJPs are co-located within community mental health services, or focus on people with mental illness (Health Justice Australia 2020; Mind Australia 2018a). The structure and nature of HJPs can vary substantially, reflecting differences in local needs. However, common elements include: their promotion of integration, early intervention, systemic change and person-centred services. The legal support they provide varies across a spectrum of needs: from ‘advocating for public housing tenants to address untreated mould’ to ‘assisting people with accumulated fines or debt’ (Health Justice Australia 2019, p. 2).

Table 21.6 Health Justice Partnerships
2018

	<i>Estimated number of Partnerships</i>
New South Wales	29
Victoria	28
Queensland	7
South Australia	1
Western Australia	1
Tasmania	0
Northern Territory	3
ACT	4
Australia	73

Source: Adapted from Forell and Nagy (2019).

Evaluations of HJPs show they improved access to legal advice, built capacity among health professionals to identify legal issues and improved health outcomes for people (Ball, Wong and Curran 2016; Beeson, Mcallister and Regenstein 2013; Redfern Legal Centre 2015). They can be particularly effective for some population sub-groups — for example, Aboriginal and Torres Strait Islander people, and especially where the HJP included an Aboriginal Community Controlled Health Organisation (Allison 2019).

Health justice partnerships [with Aboriginal Community Controlled Health Organisations] ... address people’s fears and distrust about the justice system. These partnerships provide a culturally safe setting in which to have conversations about legal matters. (NACCHO, sub. 1226, p. 12)

However, funding constraints have challenged the operation and expansion of HJPs. Youth Law Australia (sub. 433, p. 2) stated that the ‘primary barrier’ to expanding HJPs is funding, noting that HJPs are expensive — a well-resourced program would require mental health staff with training in identifying legal issues, and legal professionals to provide advice and advocacy support. Kingsford Legal Centre (sub. 469) and the Mental Health Legal Centre (sub. 1222) stated that more funding is required to support the expansion and ongoing operation of HJPs.

Currently, most HJPs are ‘single-site’, involving a single mental health service and a community legal service, but there is scope for HJPs in mental health to operate at a ‘multi-site’ level to help more people with mental illness access legal services. This is an innovative approach in Australia and has gained some support in practice. For example, Mind Australia recently received a \$430 000 grant (which will be delivered over two and a half years) to expand its single-site HJP to a multi-site one, between its community mental health services and six community legal services (Mind Australia 2018b; sub. 380).

Multi-site HJPs would enable better evaluation and research to inform policy and program development in this area. Single-site HJPs can limit data collection and analysis because sample sizes can be small. For example, Mind Australia’s single-site HJP with WEStjustice assisted 38 clients over a period of 22 months (Mind Australia, sub. 380). Enabling better evaluation and research for local HJPs is important because the empirical evidence is underdeveloped (Health Justice Australia, sub. 749).

Multi-site HJPs could also enable opportunities to build system capacity, for example, by providing education and training programs, which are costly (and less worthwhile) for single-site HJPs with fewer staff.

Many submissions emphasised support for HJP approaches, and for government to help build the evidence base (for example, APS, sub. 543; MHLC, sub. 315; NMHC, sub. 949; QAI, sub. 889; VLA, sub. 500).

Health justice partnerships are relatively new in Australia, so properly-evaluated ‘empirical evidence’ of a standard likely to satisfy government is unlikely to exist. Rather, QAI urges the Commission to consider supporting such partnerships on the basis of (1) the significant body of research into their philosophy, approach and design, and (2) the underlying philosophy of coordinating and co-mingling cooperative health and legal services, given the identifiable needs of what are in practice many shared clients (about whom much is already well-known). (QAI, sub. 889, p. 10)

There is value in better integrating legal and health services, and HJPs show promise. Although qualitative evaluations support HJPs, the evidence base is underdeveloped. State and Territory Governments should fund pilot programs of multi-site (rather than single-site) HJPs to improve access to legal services for people with mental illness, which would also enable greater data collection for more rigorous evaluation and better inform future policy and program development. In doing so, State and Territory Governments should consult with relevant stakeholders to ensure a nationally coordinated approach. Assuming each pilot program costs \$430 000 (as is the case for Mind Australia’s project), establishing them in other states and territories would cost about \$1.2 million per year. However, the costs would depend on the number of mental health and legal services involved in the multi-site HJP and the number of multi-site HJPs established (appendix K).

ACTION 21.7 — HEALTH JUSTICE PARTNERSHIPS AND DISABILITY JUSTICE STRATEGIES

Integrating legal and health services for people with mental illness can lead to better outcomes for both individuals and the justice system.

Start now

State and Territory Governments should fund pilot programs of multi-site health justice partnerships to:

- improve access to legal services for people with mental illness
- enable larger volumes of data to be collected and build an evidence base
- inform future policy and program development in this area.

Funding should also be allocated to rigorous evaluations of the pilot programs.

State and Territory Governments should consult with relevant stakeholders to ensure a coordinated approach.

Start later

All State and Territory Governments should continue to develop and implement disability justice strategies to ensure the rights of people with mental illness are protected and promoted in their interactions with the justice system. Disability justice strategies should consider how people with mental illness can be better supported to:

- initiate legal proceedings
- participate in the justice system
- access other appropriate support in the community, where required.

Legal representation in mental health tribunals

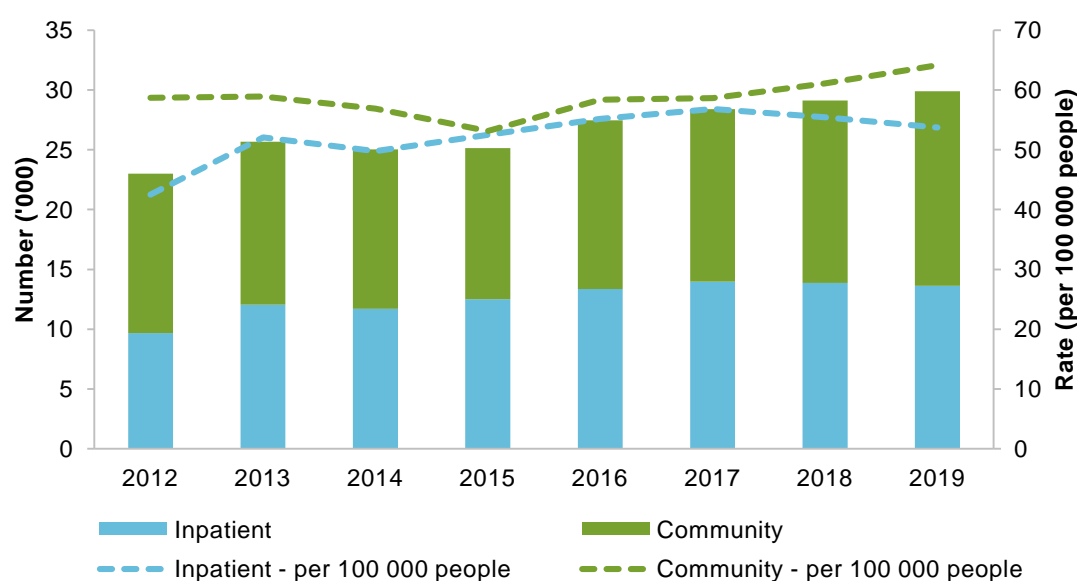
All states and territories have mental health legislation that enables the involuntary commitment and treatment of people with acute psychiatric illness (RANZCP 2017) — referred to as ‘mental health orders’ in this report. Mental health orders require individuals to receive involuntary treatment in inpatient facilities or in the community. Individuals can also be subject to involuntary electro-convulsive treatment under mental health legislation.²³³ The number of mental health orders (both inpatient and community) has increased over the past several years (figure 21.5).

In most cases, mental health tribunals determine whether or not compulsory mental health treatment (as set out in legislation) applies to persons appearing before them. In South Australia and the ACT, civil and administrative tribunals hear those applications (RANZCP 2017). This chapter uses ‘mental health tribunal’ as an umbrella term to cover all tribunals that deal with matters under mental health legislation.

²³³ Electro-convulsive treatment is a medical procedure that is used to treat a range of mental illnesses. The treatment induces controlled seizures by placing small electrodes at specific locations on the head.

There are concerns that people appearing before mental health tribunals often do not have legal representation. The Mental Health Legal Centre (sub. 1222) said rates of legal representation at mental health tribunals can vary widely across Australia. For example, in 2018-19, individuals had legal representation at only 13% of hearings at Victoria's mental health tribunal (VIC MHT 2019a). This compares with 83% and 87% in New South Wales (NSW MHRT 2019) and the Northern Territory (NT MHRT 2019), respectively.

Figure 21.5 Estimated number of mental health orders made^{a,b,c,d}



^a These estimates are based on statistics from a series of State and Territory Government annual reports.

^b Northern Territory data was not available between 2012 and 2016. ^c ACT data was not available in 2012.

^d Queensland data on the breakdown of mental health orders (proportion that was inpatient compared to community) was not available between 2012 and 2016, and was estimated based on the average proportions reported between 2017 and 2019.

Source: ACAT (2019); ACT Health (2016); NSW MHRT (2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019); NT MHRT (2019); Queensland Health (2012, 2013, 2014, 2015, 2016, 2017, 2018a, 2019a); SA DoH (2013b, 2019); TAS MHT (2015, 2018, 2019); VIC MHT (2014, 2016, 2019b); WA MHAS (2019a); WAMHT (2017).

Available data suggests there are differences in outcomes if people are legally represented. For example, Victoria Legal Aid (sub. 818, att. 1) stated that in hearings for electro-convulsive treatment where legal representation was provided, 50% had the application refused, compared with 14% overall.²³⁴ The Mental Health Legal Centre (sub. 1222) also said people who were legally represented were given longer hearings and shorter periods of compulsory treatment orders, compared with those who were not. There

²³⁴ Some caution needs to be taken in comparing these statistics as the Victoria Legal Aid sample is not representative of all individuals with matters before the tribunal. This is because Victoria Legal Aid applies a representation guideline and cannot represent those who do not have capacity to give instructions, or do not want legal representation (Victoria Legal Aid, sub. 818, att. 1)

may be several reasons for this, including: legal representation can help people with mental illness better present their cases, and may also encourage people to attend their hearing, influencing outcomes (Victorian Mental Health Tribunal, sub. 748). For example, in Victoria where legal representation is lower, 56% of hearings had individuals attend their own hearing, compared to an 86% attendance rate in New South Wales, where legal representation is higher (NSW MHRT 2019; VIC MHT 2019a).

However, the Victorian Mental Health Tribunal (sub. 748) submitted that care should be taken, when drawing conclusions about the link between legal representation and outcomes of mental health tribunals. Legal representation should not be asserted as a primary determinant of hearing outcomes, because there is a ‘complex mix of factors and potential biases’ (Victorian Mental Health Tribunal, sub. 748, p. 7). For example, individuals with more severe or complex mental illness are potentially under-represented in the cohort of people with mental illness who are legally represented, to the extent that they may face difficulties speaking to or instructing lawyers.

Regardless of other factors that also influence tribunal decisions, it is the Productivity Commission’s view that individuals appearing before mental health tribunals should have the right to access legal representation if they choose. Mental health tribunals make decisions that can affect some of the most fundamental rights of individuals. People with mental illness can face difficulties representing themselves, either because of their illness itself or other communication barriers (Law Council of Australia 2018). These difficulties can apply to court settings as well as in more informal settings, such as tribunals (Karras et al. 2006).

Currently, legal representation is not an automatic right in all states and territories. For example, in Victoria, it is the responsibility of the person appearing before a mental health tribunal to access legal assistance, as there is no automatic right to legal representation (MHLTC, sub. 1222). As a result, processes (at a system level) may not be in place to facilitate access to legal assistance. In Victoria, the provision of hearing lists, sharing of an individual’s information and access to individuals by legal assistance services, is largely at the discretion of mental health services (VLA 2019a).

Further, there is inadequate resourcing of legal assistance for these matters. The Mental Health Law Centre in Western Australia, Queensland Advocacy Incorporated and the Northern Territory Legal Aid Commission have stated that they face difficulties in providing assistance to individuals most in need (including those appearing before mental health tribunals) as a result of low levels of resourcing (Law Council of Australia 2018; NTLAC, sub. 410). In this regard, a review of South Australia’s *Mental Health Act 2009* (SA) said increased legal assistance should be considered (Corkhill 2014). Even where mental health-focused legal assistance services are provided, resourcing constraints in the broader justice system can place pressure for resolution of cases (Law Council of Australia 2018).

Given persistent difficulties in lifting the resourcing of the overall legal assistance sector, one option is for State and Territory Governments to provide grants to legal assistance providers specifically for cases under mental health legislation. This could be modelled on the approach taken under the National Disability Insurance Scheme, where specific funding

(separate from other legal aid funding) is made available to legal aid commissions for appeals relating to the scheme. In particular, grants decisions are made with consideration of the applicant's capacity to self-represent or obtain other legal assistance (DSS 2018i).

The Productivity Commission estimated that the cost of ensuring people appearing before mental health tribunals receive legal representation was about \$49 million (2019 dollars), based on an estimated cost of \$1128 per case (2019 dollars) (appendix K).

ACTION 21.8 — LEGAL REPRESENTATION AT MENTAL HEALTH TRIBUNALS

People with mental illness require appropriate legal representation to protect their rights.

Start now

State and Territory Governments should ensure people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation have a right to access legal representation. To facilitate this, State and Territory Governments should adequately resource legal assistance services for this purpose — for example, through broader legal assistance funding or a specific legal assistance grant.

The importance of supported decision making

All states and territories have reformed or amended their mental health legislation, after the ratification of the *UN Convention of the Rights of Persons with Disabilities* in 2008 (Callaghan and Ryan 2016; Ouliaris and Kealy-Bateman 2017). Specifically, the aim was to replace the model of 'substituted decision making' with a 'supported decision making' model — where a person makes treatment decisions themselves, with support, if required. The Law Council of Australia (sub. 1204, p. 9) said 'supported decision making model should always be the starting point, with substituted decision making a last resort'.

Not all Australian jurisdictions have achieved a supported decision making model (Ouliaris and Kealy-Bateman 2017). There are concerns that clinicians or tribunals can make treatment decisions on behalf of individuals. This contradicts the fundamental principle that people should be empowered to make their own choices about their own care and treatment (chapter 4).

A review of state and territory mental health and guardianship legislation was beyond the scope of this Inquiry, but the Productivity Commission has reviewed and recommended existing interventions and mechanisms to strengthen supported decision making, including:

- individual non-legal advocacy services
- mental health advance directives.

Individual non-legal advocacy services

The aim of state and territory mental health legislation is to ensure people are provided treatment and care, and that their rights are protected.

In theory, individuals at risk of, or subject to, compulsory treatment must have their participation in treatment decisions actively promoted. This is aligned with the broader principle that people should be involved in their treatment (ACSQHC 2017b). Having individuals participate in their treatment decisions can ensure that the least possible restriction is imposed on their freedom, as intended by mental health legislation. Although treating professionals and others may aim to consider the ‘best interests’ of the individual, it is important that, wherever possible, they support that person to present their own wishes about their treatment (VLA, sub. 500, att. 1).

However, in practice, individuals may face difficulties participating in treatment decisions. Some individuals subject to mental health orders have identified instances where mental health services have not provided treatment information, or adequately explained treatment to them (VLA, sub. 500, att. 1). Victoria’s Mental Health Complaints Commissioner (2019b, p. 36) said that:

[it] is clear from complaints to the MHCC [Mental Health Complaints Commissioner] that many people receiving treatment, particularly compulsory inpatient treatment, do not receive sufficient support to exercise their right to make decisions about their mental health treatment.

Individual non-legal advocacy services can ensure the rights of people are better protected. They are provided by professionals from a range of backgrounds (including consumer advocacy and social work) who empower people, by advising them on their rights, representing their wishes in day-to-day decision making, and identifying and addressing issues (WA MHAS 2019b; VLA, sub. 500, att. 1). Non-legal advocacy services differ from legal advocacy or services, and are not substitutable. For example, non-legal advocates are not trained to interpret mental health legislation and cannot provide legal representation.

All State and Territory Governments fund non-legal advocacy services that assist people who are subject to, or facing the prospect of, involuntary treatment. However, service delivery models differ across jurisdictions.

- New South Wales and Victoria provide these services through parts of the state legal aid commissions (separate to the legal teams).
- Queensland and Tasmania provide these services through separate incorporated entities, with both State and Australian Government funding.
- South Australia and the ACT provide these services through their Office of the Public Advocate.
- Western Australia provides these services through the Chief Mental Health Advocate, which is a statutory office.
- The Northern Territory provides these services through its Community Visitor Program.

The Productivity Commission has not rigorously assessed the different delivery models across states and territories, but recognises some benefits of the Western Australian model, where non-legal advocacy services are established in legislation and provided by a statutory agency (Western Australia Chief Mental Health Advocate sub. 934). This can result in clearer functions and relatively strong powers for advocates — for example, the right to question mental health professionals and to view medical files. The model can also ensure greater responsibility and accountability, and can lead to more consistent funding.

There is merit in State and Territory Governments adequately funding non-legal advocacy services to promote supported decision making. Consumers value these services, and feel they improve their capacity to self-advocate (VLA, sub. 500, att. 1).

However, there are concerns these services are unable to meet demand as a result of under-resourcing. For example, an evaluation of the Individual Mental Health Advocacy (IMHA) program found insufficient resourcing as a key barrier to its continued success (VLA, sub. 500, att. 1). The IMHA needs ‘twice as many advocates’ to meet demand within the current system. In Western Australia, individuals are appointed an advocate as soon as they are subject to an involuntary hospitalisation or treatment order (unless they opt out) (*Mental Health Act 2014* (WA), s. 357). However, concerns of under-funding have been raised in Western Australia as well (WA MHAS 2018).

Further, individuals subject to compulsory treatment, and their families and carers may be unaware of non-legal advocacy services. Elucidate (sub. 755, p. 1) said it ‘still encounters consumers and families that do not know [about the] Mental Health Advocacy Service’. One way to raise awareness could be through better education — mental health professionals and facilities could explain to individuals what these services are, how they are beneficial and how to access them. Another option could be to ensure non-legal advocacy services are automatically notified and referred cases where people become subject to involuntary hospitalisation or a treatment order, with the option for the individual to opt out. This was a recommendation made in the evaluation of IMHA (VLA, sub. 818). In the ACT, the public advocate must be notified, if an individual is detained at a mental health facility (*Mental Health Act 2015* (ACT), s. 65). The Productivity Commission is of the view that the latter option has potential to be more effective.

The cost of non-legal advocacy services would vary depending on the number of mental health orders made. The number of orders varies by state and territory (table 21.7), although they are consistently small as a proportion of the population.

The cost of funding non-legal advocacy services was estimated based on data from the Western Australia Mental Health Advocacy Service. The total cost to provide such services nationally was estimated to be about \$13 million. This assumes everyone subject to mental health orders demands non-legal advocacy services, which may not be the case (appendix K).

Table 21.7 Estimated number of mental health orders^a
Made during 2018-19

	<i>Inpatient treatment orders</i>	<i>Community treatment orders</i>
New South Wales	5 521	5 599
Victoria	2 462	3 835
Queensland	941	4 392
South Australia	126	1 377
Western Australia	3 266	850
Tasmania	421 ^b	na
Northern Territory	281	209
ACT	608	13

^a These are estimates based on statistics from State and Territory Government annual reports and are not directly comparable. Data from Queensland and South Australia refers to the number of mental health orders as at June 2019. There are also variations across jurisdictions in the way involuntary mental health orders are defined. ^b A break-down of Tasmanian data between inpatient and community treatment orders was not available. **na** Not available.

Source: ACAT (2019); NSW MHRT (2019); NT MHRT (2019); Queensland Health (2019a); SA DHW (2019); TAS MHT (2019); VIC MHT (2019a); WA MHAS (2019a).

ACTION 21.9 — INDIVIDUAL NON-LEGAL ADVOCACY SERVICES

Non-legal advocates can help support individuals subject to involuntary detention under mental health legislation.

Start later

State and Territory Governments should ensure individual non-legal advocacy services are available for any individual detained under mental health legislation. In particular, services should:

- focus on facilitating supported decision making by individuals
- be adequately resourced to provide assistance to individuals who require it
- not replace legal advocacy services.

Where an individual is detained under mental health legislation, or agrees to mental health treatment in lieu of being detained under mental health legislation, the treating facility should notify non-legal advocacy services and the individual's family or carer.

Mental health advance directives

Mental health advance directives (also known as advance statements or agreements) are a key legislative tool available in some states and territories to formally facilitate supported decision making by mental healthcare consumers. They are prepared when a person anticipates they may become subject to compulsory mental health treatment in the future, due to the episodic nature of their illness (Maylea et al. 2018). Advance directives enable individuals to state their personal values and preferences regarding future treatment and their recovery (Henderson et al. 2008). This can include, for example, identifying preferences for medication, nominating carers and specifying the types of information to be shared with them (chapter 18), detailing previous trauma, asking for access to music or writing materials.

The ACT, Queensland, Victoria and Western Australia have recognised advance directives in legislation, but differences exist (table 21.8) (Ouliaris and Kealy-Bateman 2017).²³⁵

The ACT's legislation appears to offer the strongest safeguards compared to other states and territories, with a mental health specific approach — allowing consumers to create an 'advance agreement' or 'advance consent direction' (Maylea et al. 2018, p. 3).²³⁶ In the ACT, the treating professional is legally required to tell individuals as soon as possible that they can enter into an advance agreement or advance consent direction. If an individual has an advance consent direction, the treating professional must receive consent from that individual or their guardian to deviate from it. Otherwise, the treating professional must apply to the ACT Civil and Administrative Tribunal to override it (*Mental Health Act 2015* (ACT), s. 28).

Studies have found advance directives can reduce coercion, increase consumer satisfaction and improve therapeutic relationships (Maylea et al. 2018; Ouliaris and Kealy-Bateman 2017). However, research also found advance directives led to no significant difference in hospital admissions, compliance with treatment or self-harm (Campbell and Kisely 2009).

There is support for advance directives. Submissions highlighted their importance in empowering consumers (for example, Justice Action, sub. 929; MHLC, sub. 1222; MHV, sub. 580, att. 2; Karola Mostafanejad, sub. 570, att. 1). The Mental Health Legal Centre (2019) said its clients found completing advance statements (as they are referred to in Victoria) validating, helping them understand the trajectory of their treatment and recovery, and build trust and confidence in treatment. The ACT Mental Health Consumer Network

²³⁵ *Mental Health Act 2007* (NSW), *Mental Health Act 2014* (Vic), *Mental Health Act 2016* (QLD), *Mental Health Act 2009* (SA), *Mental Health Act 2014* (WA), *Mental Health Act 2013* (Tas), *Mental Health and Related Services Act 1998* (NT), *Mental Health Act 2015* (ACT).

²³⁶ An advance agreement is entered into by a consumer with their treating team. It sets out information relevant to their treatment, care or support that is not considered appropriate to include in an advance consent direction (such as nominated contact persons), as well as any preferences concerning practical help (such as arranging for payment of bills or caring for a close relative or friend). An advance consent direction can be made by a consumer to specify the treatment, care or support they consent to, including particular medications or procedures (*Mental Health Act 2015* (ACT), ss. 26-27).

developed the *My Rights, My Decision* program, to support individuals to create advance agreements and advance consent directions (PACYPC, sub. 291).

Table 21.8 Legislation provisions for advance directives
2020

	<i>Legislation provision for advance directive?</i>	<i>Is the advance directive legally binding?</i>	<i>The advance directive does not need to be followed if:</i>
New South Wales	No	na	na
Victoria	Yes — advance statements	No. An authorised psychiatrist must have regard to the views and preferences expressed in a person's advance statement	The authorised psychiatrist is satisfied that the preferred treatment is not clinically appropriate or is not provided by the designated mental health service
Queensland	Yes — advance health directives	Yes. An advance health directive must be used in preference to an involuntary order and an authorised doctor must take reasonable steps to find out if the person has one	The authorised doctor explains to the person reasons why the decision was made and records the reasons in the consumer's health records
South Australia	No	na	na
Western Australia	Yes — advance health directives	No. A person or body required under the Act must have regard to any treatment decision in an advance health directive	The psychiatrist records the reasons why the decision was made and provides a copy to the patient and other specified parties
Tasmania	No	na	na
Northern Territory	No	na	na
ACT	Yes — advance agreement and advance consent direction	Yes. A person must be informed and given the opportunity to make an advance agreement or an advance consent direction and a mental health professional must take reasonable steps to find out if one is in force and act accordingly	A mental health professional believes on reasonable grounds that giving treatment, care or support in accordance with the advance consent direction is unsafe or inappropriate and the person or their guardian, health attorney or attorney gives consent; <i>or</i> The ACT Civil and Administrative Tribunal, on application by the mental health professional, makes an order to do so

na Not available.

Source: Productivity Commission analysis based on Ouliaris and Kealy-Bateman (2017).

Despite this, only a small proportion of mental health consumers complete advance directives. For example, in Victoria, only 2.8% of consumers of public mental health services had an advance statement recorded in 2018-19 (VIC DHHS 2019b). This compares with 15% of consumers at the ‘best performing’ mental health service in the State (OPA Victoria 2019, p. 14). There are a few reasons for the low uptake, including that:

- consumers are not aware of them (Maylea et al. 2018)
- consumers view them as having little value given enforcement limitations (VLA, sub. 500, att. 1)
- consumers can face difficulties drafting advance directives (MHLC 2019).

State and Territory Governments could do several things to increase the use of advance directives among consumers, to facilitate supported decision making. First, they could be made a requirement for mental health professionals to inform consumers of their right to complete advance directives. This is the case under ACT legislation (*Mental Health Act 2015* (ACT), s. 25).

Second, State and Territory Governments could ensure advance directives are better safeguarded, to strengthen their ability to facilitate supported decision making, and therefore, their appeal to individuals. As table 21.8 shows, advance directives are only legally binding in Queensland and the ACT, and only specific to mental health in the ACT. State and Territory Governments could examine the regime in the ACT, to give mental health advance directives more weight, encouraging greater uptake. This would be a matter for further consultations for those jurisdictions.

Third, State and Territory Governments could make advance directives more accessible among mental health professionals. For example, in Victoria, the existence of an advance statement (as they are referred to in Victoria) is noted on an individual’s record, but not centrally located (MHLC, sub. 1222). Therefore, the individual must have ready access to their advance statement if they present at an unfamiliar mental health service — an unreasonable expectation if the person is experiencing a mental health crisis. In Queensland, the Chief Psychiatrist is required to maintain an electronic records system of advance health directives (*Mental Health Act 2016* (QLD), s. 225). The Mental Health Legal Centre (2019) said a central repository for advance statements, with oversight from the mental health tribunal, could be considered. First responders could also have access, if the consumer consents (Mental Health Complaints Commissioner (Victoria), sub. 916; MHLC, sub. 1222).

Finally, State and Territory Governments could ensure individuals are supported to complete mental health advance directives, if needed. There are different ways to provide support to consumers — for example, it could be through outreach services located at mental health facilities (MHLC 2019), or through online resources and supporting workshops (ACT MHCN 2019).

However, service providers highlighted that there is inadequate funding for such support services. For example, Victoria Legal Aid (sub. 500, att. 1, p. 34) said its IMHA service

‘consistently passed on information [about advance statements] ... but often did not actually provide support to make one’ due to insufficient funding.

The MHLC has spent over 12 years campaigning for and promoting advance statements which were introduced in the Mental Health Act 2014. We were concerned that the Department of Health and Human Services were not funding practical supports for people to prepare advance statements and sought philanthropic backing to support this critical service. (MHLC 2019, p. 9)

The cost of providing support would depend on the approach. For example, an outreach model would likely cost more than the provision of online resources and supporting workshops. The Productivity Commission was advised that the cost per advance statement under an outreach model was about \$750 (General Manager, MHLC, pers. comm., 11 March 2020). This was multiplied with the number of mental health orders — which was used as a proxy for the number of people who want or need an advance directive. Based on this, the total cost to provide support services would be \$22 million (2019 dollars) (appendix K).

ACTION 21.10 — MENTAL HEALTH ADVANCE DIRECTIVES

Mental health advance directives can help ensure that the wishes of a person with mental illness are able to be met.

Start now

State and Territory Governments should ensure that advance directives are:

- formally recognised in mental health legislation
- actively promoted to raise awareness among mental health consumers of the scope to use such an instrument to state their preferences regarding future treatment and recovery, to nominate a carer, and to specify the types of information to be shared with that carer
- contain safeguards that balance consumer choice against urgent treatment needs
- easily accessible by any mental health service.

State and Territory Governments should seek to ensure individuals can access support to help them complete an advance directive, if it is required.

Mutual recognition of mental health orders

Mental health orders created in one state or territory may not have effect in others — or, in other words, there is not always ‘mutual recognition’ of mental health orders. This stems from states and territories having their own mental health legislation.

As a result, this can hinder a consumer’s ability to receive seamless and continued care, if they are subject to a mental health order. The Productivity Commission heard of experiences where people had absconded from hospital and travelled interstate, but, because their mental

health order was not recognised, they did not receive ongoing mental healthcare, and became seriously unwell (David Asten, Tasmania transcript, p. 41).

Without mutual recognition of mental health orders, the capacity for states and territories to ensure seamless and safe care for individuals who wish to move interstate is compromised. It is difficult for care to be continued unless a similar order is made in the new jurisdiction.

State and Territory Governments have long acknowledged these issues, and have attempted to address them since the First National Mental Health Plan in 1993 (table 21.9). The Fifth National Mental Health and Suicide Prevention Plan included action 26, calling for governments to ‘improve consistency across jurisdictions in mental health legislation’ (COAG Health Council 2017a, p. 44). The Safety and Quality Partnership Standing Committee was tasked with implementing this (COAG Health Council 2017b, p. 28).

Table 21.9 Attempts to ensure mutual recognition of mental health orders

Between 1993 and 2015

	<i>Committed actions and developments</i>
First National Mental Health Plan (1993–1998)	‘by 1 July 1995 to have in place administrative and legislative arrangements which facilitate the transfer of people with mental disorders across State/Territory borders’
Second National Mental Health Plan (1998–2003)	Noted the development of ‘model legislation to assist in achieving consistency in State/Territory legislative reform’
Third National Mental Health Plan (2003–2008)	‘Ensure the capability exists to permit interstate transfer of individuals detained under mental health legislation’
Fourth National Mental Health Plan (2009–2014)	‘Review and where necessary amend mental health and related legislation to support cross border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation’
Fifth National Mental Health and Suicide Prevention Plan (2015–2020)	‘... improve consistency across jurisdictions in mental health legislation. This will be based on an understanding of their impacts on consumer and carers and consistent with the 1 July 2016 <i>United Nations Human Rights Council Resolution on Mental Health and Human Rights</i> and the 2006 [<i>Convention on the Rights of Persons with Disabilities</i>] CRPD’

Source: AHMAC (1992, 1998, 2003); COAG (2009b); COAG Health Council (2017a).

All states and territories have made legislative provisions for interstate arrangements; however, they are not all operational. For legislative provisions to come into force or be ‘activated’, bilateral (or Ministerial) agreements must be signed (Tasmanian Office of the Chief Psychiatrist 2019, p. 96). Western Australia, Tasmania and the Northern Territory do not have any bilateral agreements currently in place.

There are several reasons why states and territories have not developed or maintained bilateral agreements. For example, a recent review of Tasmania’s mental health legislation found that:

The legislation in place in jurisdictions uses distinct frameworks and terminology and imposes unique requirements for transfer, all of which makes development and implementation of agreements complex and time consuming. As a small jurisdiction Tasmania has also found it difficult to prioritise development of agreements over other work. (Tasmanian Office of the Chief Psychiatrist 2019, p. 96)

Recognising that bilateral agreements have unintentionally created barriers to interstate arrangements, the Safety and Quality Partnership Standing Committee (in implementing action 26 of the Fifth National Mental Health and Suicide Prevention Plan) has investigated better options for mutual recognition of mental health orders. A national legislative scheme has been proposed (Tasmanian Office of the Chief Psychiatrist 2019) although the Productivity Commission was informed that further scoping work is required before it can be progressed for review by Australian, State and Territory Government health ministers.

State and Territory Governments must ensure there is mutual recognition of mental health orders across Australia. Any national approach to ensure mutual recognition of mental health orders, whether it is a national legislative scheme or not, should also consider barriers to implementation and the development of a supporting implementation plan or strategy. For example, any such approach would need to consider how information would be accessed and shared between states and territories to ensure mutual recognition can work in practice. This may require development of appropriate information sharing systems.

ACTION 21.11 — MUTUAL RECOGNITION OF MENTAL HEALTH TREATMENT ORDERS

State and Territory Governments should ensure there is mutual recognition of mental health treatment orders across Australia.

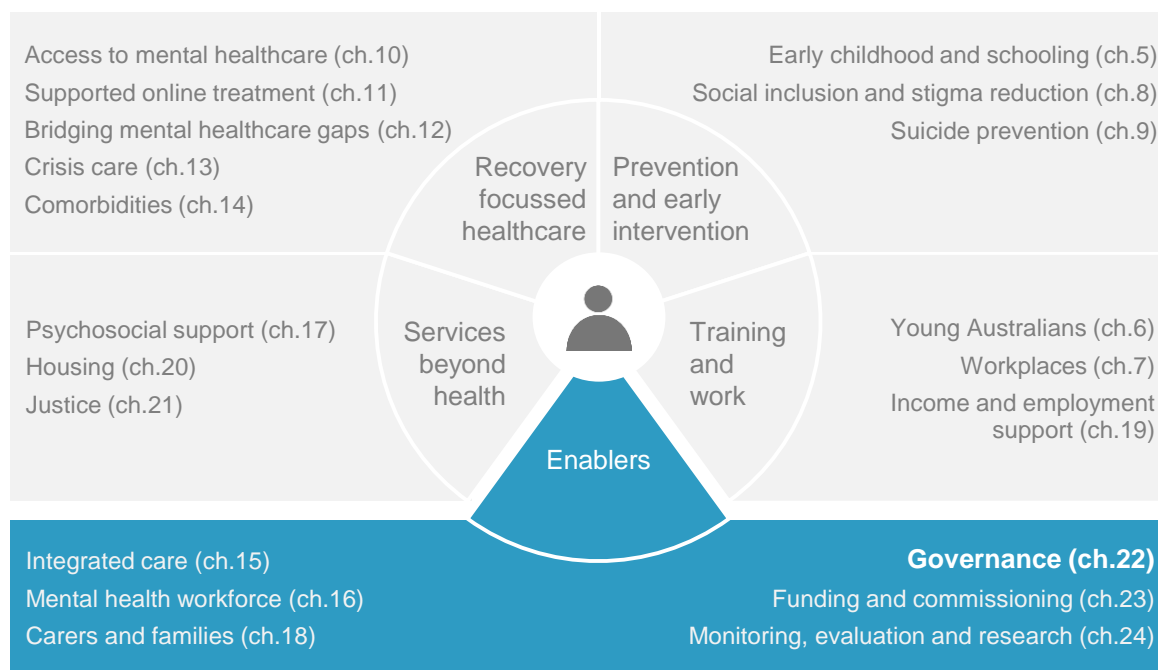
Start later

The Safety and Quality Partnership Standing Committee should complete work on an appropriate national approach to ensure mutual recognition of mental health treatment orders. The national approach should consider both legislative mechanisms and implementation needs, and be agreed to by all State and Territory Governments. This should be completed by 2025.

All State and Territory Governments should work collaboratively to implement the national approach.

Part V – ENABLERS OF REFORM

22 Governance



Stronger governance of Australia's mental health system matters because ...

- The mechanisms for holding jurisdictions accountable for mental health outcomes are weak and poorly developed.
 - Strategic planning in mental health focuses on the health sector without adequately integrating other sectors.
 - A lack of consumer and carer involvement in strategy, programs and accountability lowers the quality of decision making and system performance.
 - The absence of a robust culture that requires demonstration of program impact and evaluation impedes system innovation and continuous improvement.
-

RECOMMENDATION 22 — BEST PRACTICE GOVERNANCE TO GUIDE A WHOLE-OF-GOVERNMENT APPROACH

Governments should, in collaboration with consumers and carers, commit to a more strategic and cross-portfolio approach to mental health that promotes genuine accountability and that prioritises prevention, early intervention and recovery.

As a priority:

- The Australian, State and Territory Governments should develop a new whole-of-government National Mental Health Strategy that aligns the collective efforts of health and non-health sectors. (Action 22.1)
- The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023. (Action 22.2)
- The Australian, State and Territory Governments should establish a clear, ongoing role for consumers and carers in all aspects of mental health system planning, design, monitoring and evaluation. (Action 22.4)
- The National Mental Health Commission should have statutory authority. It should lead the evaluation of government-funded mental health and suicide prevention programs, and other government-funded programs that have strong links with mental health outcomes, including those in non-health sectors. (Action 22.7)

Additional reforms that should be considered:

- The Australian, State and Territory Governments should establish a Special Purpose Mental Health Council to facilitate mental health reforms across health and non-health portfolios. (Action 22.3)
- The Australian Government should fund separate representative peak bodies to represent the views, at the national level, of people with mental illness, and of families and carers. (Action 22.4)
- A national, independent review of Australia's system for handling consumer complaints that relate to the use of mental healthcare services and supports should be instigated. (Action 22.5)
- Where a body does not exist, State and Territory Governments should each establish a body (such as a mental health commission) that is responsible for strengthening government capability to pursue continuous policy and program improvement and fostering genuine accountability for mental health reform. (Action 22.6)

Major reforms are needed to the governance arrangements that underpin Australia's mental health system. Inquiry participants concurred that the existing arrangements lack effectiveness and contribute to system failure.

Clearly the [Productivity] Commission, after meetings and consultations right across the country, has already heard the message that 'the system' is broken. Fragmentation, gaps, duplication, lack of accountability, lack of evaluation, lack of funding, lack of cohesion, lack of strategy, lack of governance. (Quinlan 2019)

The issue of governance is particularly important when addressing adverse experiences for people in emergency departments, and the interface of responsibilities of emergency department staff and mental health service staff, and the roles played by security staff in these environments. (Mental Health Complaints Commissioner (Victoria), sub. 321, p. 4)

These reforms are long overdue for issues have continued to accumulate, rather than abate. To begin with, governance has not kept pace with decision making by both the Australian and State and Territory Governments and issues raised in major reviews persist (box 22.1). Further, a shared responsibility and a vertical fiscal imbalance have seen the Australian Government shift from having no mental health responsibilities to playing a major role, particularly since the mid-2000s.

Box 22.1 Governance issues raised by major reviews

Dissatisfaction with funding arrangements prompted a national survey of the mental health system in 1955 when State and Territory Governments were responsible for all mental health services (Stoller and Arscott 1955). Although the Stoller Report regarded the extent to which the Australian Government should be involved in mental health as a political decision, it suggested several roles that it could take on, namely: funding (possibly including prevention), monitoring and reporting, and disseminating knowledge.

The Burdekin Report (HREOC 1993) applied standards set by the United Nations human rights principles to examine the effectiveness of accountability mechanisms, notably: quality assurance and accreditation, minimum standards and monitoring mechanisms, patient advocacy and complaints procedures. It recommended that the Australian Government should ensure that every jurisdiction had a consistent set of basic controls and standards for protecting the rights of people with mental illness and ensuring they receive appropriate care (HREOC 1993).

The need to resolve governance issues on a wide front had become acute by the time of the National Mental Health Commission's (2014a) review. Along with numerous other independent and governmental reviews, it identified fundamental shortcomings in the structure of the mental health system and a record of 'poor implementation or the failure to sustain initiatives' (NMHC 2014c, p. 13). Many issues had stemmed from governance failures. The National Mental Health Commission recommended clarifying federal roles and strengthening accountabilities for outcomes.

This chapter is the first of three that aim to improve public governance. Chapter 23 focuses on reforms that clarify the funding roles and responsibilities of both tiers of government. Chapter 24 concludes with reforms to promote accountability through an improved framework for monitoring and evaluating system performance. The governance reforms recommended in this chapter are directed at:

- strengthening the National Mental Health Strategy (section 22.2)
- facilitating a cross-portfolio approach (section 22.3)
- enhancing consumer and carer involvement in system design, implementation and review (section 22.4)
- improving accountability (section 22.5)
- simplifying complaints processes (section 22.6)
- building a culture that expects demonstrable program performance (section 22.7).

Section 22.7 provides the institutional architecture needed to enable delivery of the reforms outlined in chapter 24 (Framework for monitoring, evaluation and research).

22.1 Current governance arrangements

Public governance is the framework of institutions, rules, conventions, systems, processes and informal customs that guide how government manages its business. The governance arrangements set by most jurisdictions tend to reflect four core principles: clarity of purpose, accountability to Parliament, transparency to the public and optimisation of efficiency and performance (Department of Finance 2015a). Good public governance plays three key roles:

- encouraging closer coordination and integration of services
- promoting public trust in decision making
- assisting governments to achieve the aims and actions to which they commit.

In the mental health sector, specific governance arrangements aim to: clarify roles and responsibilities; give decision makers powers to deploy public resources to improve mental health outcomes; create incentives for efficient resource allocations; facilitate engagement with non-government parties (including consumers and carers); enable monitoring of service use and outcomes; and maintain agreed levels of accountability. These cover the Australian and State and Territory Governments, which share responsibility for mental health.

Australian Government roles and responsibilities

The Australian Government's functions in the mental health and suicide prevention system primarily relate to national leadership, policy direction and funding. In its response to the National Mental Health Commission's (NMHC 2014c) review, the Australian Government

declared that it would lead national mental health reforms and continue to fulfil its responsibilities for: promoting mental health; preventing mental ill-health; reducing stigma; supporting consumer and carer engagement; building the evidence base; and monitoring system performance (DoH 2015). It would also lead the development of national policies such as improving integration of mental healthcare within the primary health context through regional planning and commissioning (Australian Government Department of Health, sub. 556).

The Australian Government has a key role in supporting and funding primary mental healthcare, which includes early intervention, treatment and referral, as well as crisis helplines, mental health education and promotion (COAG 2012). In addition, the Australian Government provides some clinical and non-clinical community-based mental healthcare, partners with non-government organisations to provide a range of community and social support programs that relate to mental health, and subsidises private specialist mental healthcare via Medicare and the Pharmaceutical Benefits Scheme.

Of relevance to this Inquiry, the Australian Government has primary responsibility for physical health services subsidised by the Medicare Benefits Scheme and commissioned through the Primary Health Networks, and other services and supports that assist consumers and carers, namely:

- employment (including the provision of employment services)
- income support for people with psychosocial disabilities, carers and families
- majority funding for non-government schools and universities
- veterans' affairs.

There are no formal arrangements to guide how the Australian Government as a whole should act to improve population mental health and the social and economic participation of people with mental ill-health, with one exception. The National Indigenous Australians Agency was established in 2019 'to lead and coordinate Commonwealth policy development, program design and implementation and service delivery for Aboriginal and Torres Strait Islander people' (Australian Government 2019b). Health and wellbeing are focus areas among others.

The Department of Health is the mental health policy lead for the Australian Government. The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) highlights its role in providing funding and policy direction, and its central role in supporting the infrastructure of the mental health system through funding research and digital service delivery (COAG Health Council 2017a). The Australian Government established the National Mental Health Commission in 2012 to play a leading role in the governance of Australia's mental health system.

State and Territory Government responsibilities

State and Territory Governments, being based where service delivery occurs, play a key role by providing hospital-based, specialised, clinical and community-based mental health services to people with severe and persistent mental illness (COAG 2012). They provide these services both directly and through partnerships with non-government organisations. In addition, they play a role in promotion and prevention, as well as in reducing stigma and discrimination within the community. They also have primary responsibility for the planning and delivery of public health and hospital services, education, early childhood services, housing, disability services, drug and alcohol services, police, justice and corrections services.

In recent years, many States and Territories have established mental health commissions or a variant, often with strong stakeholder networks. Although they all share common purposes — to drive reform and improve accountability — they all differ according to their level of independence and role. There are currently mental health commissions in New South Wales, South Australia, Western Australia (which also commissions mental health services) and Queensland; an Office for Mental Health and Wellbeing in the ACT; and a Mental Health Complaints Commissioner in Victoria. The Victorian agency differs from the other mental health commissions by specifically handling mental health complaints, as well as having an oversight role in recommending service and system improvements. There is no mental health commission in the Northern Territory or Tasmania.

State and territory mental health commissions and the NMHC collaborate on a range of projects both as a collective whole and severally in areas where they have a common interest. These collaborations have underpinned the production of, among other things, the *Equally Well National Consensus Statement* (NMHC 2016), research by the Australian Housing and Urban Research Institute on the link between homelessness and mental health (Brackertz, Wilkinson and Davison 2018) and research on the potential economic and social gains from investing in mental health promotion, prevention and early intervention (NMHC 2019c). All parties recognise the innate usefulness of collaborating, including through biannual/ triannual Commissioners' meetings (National, State and Territory Mental Health Commissions, sub. 731).

National arrangements

Two strategies outline the direction of mental health policy at a national level. These are the:

- *National Mental Health Strategy*
- *National Disability Strategy*.

The National Mental Health Strategy

The set of documents badged as the National Mental Health Strategy is the policy framework that guides mental health reform nationally. Its purpose is to define 'a national direction and a framework for governments to work together to change a system that was widely

acknowledged as inadequate and long neglected by policy makers' (National Mental Health Strategy Evaluation Steering Committee 1997, p. 3). The Strategy currently comprises:

- the *National Mental Health Policy 2008*, which states the strategic intent for Australia's mental health system by: declaring its long-term aims and setting out its future direction; and providing context for, and influence over, the development of state and territory mental health plans (NT DoH 2019; VicHealth and Partners, sub. 131)
- the *National Mental Health Statement of Rights and Responsibilities 2012*, which 'seeks to ensure that consumers, carers, support persons, service providers and the community are aware of relevant rights and responsibilities and can be confident in exercising them' (Standing Council on Health 2012, p. 3)
- the *Fifth Plan* (COAG Health Council 2017b) and its associated *Implementation Plan* (COAG Health Council 2017b). The purpose of national plans is to achieve the intent of the National Mental Health Policy by governments agreeing to collaborative actions over a 5-year period. The Fifth Plan commits governments to integrate the mental health system and to improve its transparency, accountability, efficiency and effectiveness
- Four previous national plans in 1992, 1998, 2004 and 2009 (COAG Health Council 2017a).

Various national bodies contribute to mental health governance including: the Australian Commission on Safety and Quality in Healthcare; the Australian Health Practitioner Ombudsman and Privacy Commissioner; and the Australian Institute of Health and Welfare.

Until recently, COAG Health Council provided the overarching intergovernmental forum for cooperation on mental health issues, including implementation of the *National Mental Health Strategy* (COAG Health Council 2014). It comprised the Australian, State, Territory and New Zealand Government Ministers for health, and the Australian Government Minister for Veterans' Affairs.

However, in mid-2020, the National Cabinet agreed to cease the COAG model and form the National Federation Reform Council to support its single agenda of creating jobs in the wake of the COVID-19 pandemic (Morrison, S. (Prime Minister) 2020a). The National Cabinet identified health as a priority areas of reform to be led by one of six National Cabinet Reform Committees (Morrison, S. (Prime Minister) 2020b). The extent to which the National Cabinet Reform Committee for Health would take over the work of the former COAG Health Council, including implementation of the Fifth Plan, had not been confirmed prior to the finalisation of this report.

The National Disability Strategy

The *National Disability Strategy 2010–2020* is a 10-year plan for improving the lives of people with disability, their families and carers. It covers those with a psychosocial disability as defined in the *Disability Discrimination Act 1992* (Cth). The National Disability Strategy aims to ensure that all mainstream services and programs across the country — including healthcare, education, Indigenous program reform and housing — address the needs of people with disability.

Responsibility for implementation of the National Disability Strategy has, until recently, rested with ministers responsible for disability and treasury portfolios through the COAG Disability Reform Council. Among other things, this council advised first ministers (the Prime Minister, premiers and chief ministers) on the implementation of the *Principles to Determine the Responsibilities of the NDIS and Other Service Systems* (COAG 2015), which clarify the interface between the NDIS and the mental health system (COAG 2018a). The National Cabinet had not announced future governance arrangements for the National Disability Strategy prior to finalisation of this report.

Gayaa Dhuwi Declaration

The *Gayaa Dhuwi (Proud Spirit) Declaration* (NATSILMH 2015) is a policy framework to embed and support Aboriginal and Torres Strait Islander leadership within the mental health system. It advocates an approach based on concepts of social and emotional wellbeing and cultural connection and healing, while working holistically with culturally capable clinical services to ensure the ‘best of both worlds’ (Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATISIP) and National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), sub. 1217).

Underpinning the Declaration is an understanding that Indigenous concepts of mental health and social and emotional wellbeing differ among Aboriginal and Torres Strait Islander people, and more so when compared with those of some non-Indigenous people. Not understanding this challenges policy making and may, in turn, hamper the effectiveness of mental healthcare for Aboriginal and Torres Strait Islander people. Exacerbating this is the dominance of imposed non-Indigenous mental health paradigms, a lack of cultural competence among mainstream professionals and a lack of cultural capability in services and programs (NATSILMH 2015). The Declaration’s Implementation Guide (NATSILMH 2018, p. 5) emphasises the need for Aboriginal and Torres Strait Islander leadership across all parts of Australia’s mental health system to:

- champion and promote Aboriginal and Torres Strait Islander concepts of mental health and social and emotional wellbeing, and Aboriginal and Torres Strait Islander cultural strengths as sources of mental wellness, healing and resilience for Aboriginal and Torres Strait Islander people
- highlight mental health challenges faced by Aboriginal and Torres Strait Islander people
- champion and promote Aboriginal and Torres Strait Islander mental health as a specialised area of practice.

The Fifth Plan (COAG Health Council 2017a, p. 52) affirms that the Gayaa Dhuwi Declaration’s five themes (box 22.2) are central to developing and implementing its actions. More specifically, action 12.3 of the Fifth Plan states:

Governments will improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with ACCHSs [Aboriginal Community Controlled Health Services] and other service providers by: ... recognising and promoting the

importance of Aboriginal and Torres Strait Islander leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration. (COAG Health Council 2017a, p. 34)

Box 22.2 Themes of the Gayaa Dhuwi (Proud Spirit) Declaration

The Gayaa Dhuwi Declaration comprises five themes containing 14 articles. The five themes are:

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.
2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.
4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.
5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

Source: National Aboriginal and Torres Strait Islander Leadership in Mental Health (2015, pp. 2–3).

International obligations

Australia has ratified several United Nations conventions that aim to protect the rights of people with mental ill-health. In particular, the *Convention on the Rights of Persons with Disabilities* (Article 25) obliges Australia to promote, protect and ensure that persons with mental ill-health have the right to enjoy the highest attainable standard of health. The introduction of Australian legislation establishes much of the machinery of enforcement of Australia's international obligations. Other conventions that have influenced Australian mental health policy include the:

- *Optional Protocol²³⁷ to the Convention on the Rights of Persons with Disabilities*
- *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*
- *International Covenant on Economic, Social and Cultural Rights*
- *Convention on the Rights of the Child.*

²³⁷ An optional protocol complements or adds to a treaty. It is optional because it is not automatically binding on countries that have already ratified the original treaty.

In addition, Australia has signed the *Declaration on the Rights of Indigenous Peoples*. Unlike conventions, declarations are not intended to be legally binding by their adoption — they are intended to represent the aspirations of signing countries (UN nd). Under this declaration, Australia has agreed that Aboriginal and Torres Strait Islander people have rights to:

- life, physical and mental integrity, liberty and security of person (article 7.1)
- the enjoyment of the highest attainable standard of physical and mental health. (article 24.2).

22.2 Revitalising a national approach to mental health

The National Mental Health Strategy has guided reforms to mental health services and supports since it was introduced nearly 30 years ago. It now falls well short of consumer and carer expectations and should be strengthened by: facilitating a genuine whole-of-government approach; linking funding with strategy; setting a clearer vision; ensuring greater coherence; and widening stakeholder engagement.

Facilitating a genuine whole-of-government approach

The National Mental Health Strategy remains focused primarily on clinical aspects of mental health. While the *National Mental Health Policy 2008* declares that it ‘provides a strategic vision for further whole-of-government mental health reform in Australia’ (AHMC 2009a, p. 1), non-health portfolios neither share the vision nor collaborated in its development. The strategy does not articulate how health and non-health sectors should collaborate. In particular, it is unable to catalyse broader system reform because it lacks clarity about specific roles and responsibilities across all mental health-related services and suicide prevention activities. Although the national strategy aims to integrate mental health services and attendant supports, its main approach relies on an important, but nevertheless small and often ineffective aspect of the system — the collaborative efforts of Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) (COAG Health Council 2017b).

Developing and implementing a truly whole-of-government strategy is necessary for both tiers of government to be able to address prevention and early intervention. It could, over the long run, make an enduring improvement to mental health outcomes by reducing the adverse risks that various societal and non-health factors present for many individuals. Without participating in the development of a whole-of-government strategy, non-health portfolios will struggle to improve policies in their own areas that affect mental health outcomes and improve people’s lives, and to fund programs that would lead to cost savings in health portfolios, possibly many years hence.

The Australian, State and Territory Governments should develop a new National Mental Health Strategy that comprehensively integrates health and non-health sectors. This is necessary to guide the efficient allocation of resources over the long term. Without an agreed strategy that aligns the collective efforts of relevant sectors in all jurisdictions, there will be

undue reliance on health-centric solutions and too little attention given to addressing the wider determinants of mental health. Inquiry participants generally agree with the imperative to develop a strategy that integrates all relevant government portfolios and industry sectors.²³⁸ Section 22.3 recommends specific reforms to facilitate cross-portfolio collaboration.

Linking funding with strategy

The National Mental Health Strategy is not specifically linked to funding commitments. In the view of some participants, this omission explains why governments have failed to successfully implement past mental health reforms.

Proposed reforms have generally not been supported by an appropriate funding investment, which makes them difficult to realise. (Queensland Advocacy Incorporated, sub. 116, p. 6)

[Previous reforms] ... were major social infrastructure projects and they failed because they were underfunded, just as you cannot construct a physical bridge that will stay up if it is seriously underfunded. (Community Mental Health Australia, sub. 449, p. 5)

Chapter 23 of this report recommends a new intergovernmental agreement — the National Mental Health and Suicide Prevention Agreement — that codifies new funding arrangements to improve mental healthcare outcomes. However, progress in implementing the strategy will depend in large measure on the extent to which governments allocate matching funding.

Setting a clearer vision

There is no clear vision for mental health in Australia. The national vision is largely for a better system, whereas State and Territory Governments have typically adopted person-centred visions that pursue individual wellbeing (table 22.1). No jurisdiction refers to the national vision in its mental health strategies.

The Australian, State and Territory Governments should develop a national vision statement that reflects the mental health outcomes that have value to consumers and carers, with a commensurate level of ambition for national mental health reforms. This would serve to align the collective efforts of all stakeholders more closely and focus attention on outcomes rather than activities.

²³⁸ Advocacy for Inclusion, sub. 935; Anglicare Australia, sub. 1206; Australian Medical Association, sub. 633; Community Services Industry Alliance, sub. 915; Consumers Health Forum of Australia, sub. 646; Flourish Australia, sub. 729; Mental Health Carers NSW, sub. 1231; Mental Health Victoria, sub. 942; Mind Australia Limited, Neami National, Wellways and SANE Australia, sub. 1212; Office of the National Rural Health Commissioner, sub. 1185; People Power International Pty Ltd, sub. 690; PHN Cooperative, sub. 850; Prevention United, sub. 768; Psychotherapy and Counselling Federation of Australia (PACFA), sub. 883; Queensland Mental Health Commission, sub. 712; Relationships Australia Victoria, sub. 1197; SA Mental Health Commission, sub. 691; SuperFriend, sub. 873; TAL Life Limited, sub. 643; and Women's Health Victoria, sub. 773.

Table 22.1 Government mental health vision statements^a

<i>Jurisdiction</i>	<i>Vision statement</i>
New South Wales	The people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms.
Queensland	A fair and inclusive Queensland where all people can achieve positive mental health and wellbeing and live lives with meaning and purpose.
Victoria	... all Victorians enjoying the highest attainable standards of health, wellbeing and participation at every age.
South Australia	South Australia is internationally recognised as a resilient, compassionate and connected community that takes a whole-of-person, whole-of-life, whole-of-government and whole-of-community approach to building, sustaining and strengthening the mental health and wellbeing of South Australians in order to grow the state's mental wealth.
Western Australia	A Western Australia where everyone works together to encourage and support people who experience mental health problems and/or mental illness to stay in the community, out of hospital and live a meaningful life. To achieve a Western Australian community that experiences minimal alcohol and other drug-related harms and optimal mental health.
Tasmania	Tasmania is a community where all people have the best possible mental health and wellbeing.
Northern Territory	A community that understands social and emotional health and wellbeing, mental health and mental illness, and that all Territorians, including the most marginalised have access to timely and appropriate early intervention services, integrated recovery-focused and evidence-based treatment and care, and community supports that enable and encourage full participation in the community.
ACT	A kind, connected and informed community working together to promote and protect the mental health and wellbeing of all.
National	The vision ... is for a mental health system that: a) enables recovery; b) prevents and detects mental illness early; and c) ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

Source: ACT Government Health (2020); Australian Health Ministers Conference (2009a); Northern Territory Department of Health (2019); NSW Mental Health Commission (2014); Queensland Mental Health Commission (2018); South Australian Mental Health Commission (2017); Tasmanian Government Department of Health and Human Services (2015); Victorian Government (2019b); Western Australia Mental Health Commission (2011, 2018a).

Ensuring greater coherence

The current practice of augmenting the National Mental Health Strategy with each new national mental health plan, rather than replacing previous ones, means that it lacks coherence. The strategy currently comprises seven documents totalling over 300 pages. Insofar as it retains priorities of past plans, it risks everything becoming a priority and little being fully accomplished.

The Australian, State and Territory Governments should ensure that the National Mental Health Strategy is a single, coherent document that outlines a comprehensive approach to improving mental health outcomes. This would better enable all stakeholders to align their own strategies with the national strategy. We note that the Australian Health Ministers' Advisory Council has committed to renew the *National Mental Health Policy*, which would

support development of a sixth plan (COAG Health Council 2017b). This would be an opportunity to draw up an enduring vision and high-level strategy by separating longer-term strategic intent from shorter-term action plans that are subject to periodic renewal. Among other things, a new National Mental Health Strategy should include and be based on the aims and principles set out in the National Mental Health Policy, as scheduled for review.

The Australian, State and Territory Governments should take a long-term view in developing a new strategy. Given that poor outcomes have persisted over the 28-year life of the current strategy, a time planning horizon that is generational — about 30 years — would be appropriate. The new strategy should begin by clearly aligning stakeholder expectations and avoiding any notion that governments can dislodge deep-seated mental health issues within a term of government, or worse, a 12-month funding period for organisations tasked with providing essential services and supports in this area.

Widening stakeholder engagement

In response to the Inquiry Draft Report, participants provided feedback directed at improving the relevance of the existing strategy by widening the range of stakeholders engaged in its development. A lack of collaboration with key stakeholder groups in strategic planning leads to inefficient planning and resource allocation.

Various participants raised concerns about the current strategy not adequately reflecting the role and significance of the private mental health sector (Anthony Jorm, sub. 45; Beyond Blue, sub. 275; Health Services Union, sub. 237; Youth Health Forum, sub. 404). For example:

... the National Mental Health Strategy including the Plans rarely if ever, reflect on the private sector. As a consequence, consumers and carers which our Network represents feel that their mental illnesses don't count, are seen to be less acute, feel invalidated and forgotten. The people obtaining services from mental health settings within the private sector are a significant volume of those seen across Australia. (Private Mental Health Consumer Carer Network (Australia), sub. 49, p. 24)

There are examples where governments have undertaken reforms involving the private sector in parallel with the national strategy rather than as an integral component. For example, the Australian Government unilaterally undertook reforms (Better Access being a prime example) and provided funding to the Primary Mental Health Alliance, which is the private sector equivalent of the Australian Mental Health Outcomes and Classification Network.

In recent years, health ministers have sought to strengthen engagement with the private sector. For example, in 2017, they established a Mental Health Expert Advisory Group (now the Mental Health Reform Stakeholder Group), which includes representatives from the private sector (COAG Health Council 2017b, p. 12). Current membership includes peak bodies that represent professions predominantly employed within the private sector.

Various participants voiced similar concerns regarding the role of local governments, which is sometimes overlooked, yet can be key to leading improvements in mental health and

wellbeing in local communities (Centre for Rural and Remote Mental Health, sub. 465; David Clark, sub. 809; Hobsons Bay City Council, sub. 176; Local Government Association of SA, sub. 242; Moonee Valley City Council, sub. 670; National Rural Health Alliance, sub. 353; Wesley Mission, sub. 840).

The Australian, State and Territory Governments should ensure that broad consultation distinguishes the development of the new strategy. While its co-design must involve consumers and carers (consistent with action 22.4), applying this approach with all stakeholder groups would be beneficial, including with the private sector and local governments. Apart from enhancing its effectiveness, authentic collaboration serves to cement the legitimacy of the strategy. The Community Services Industry Alliance (sub. 915, p. 2) also noted the benefit of:

... stronger connection to and understanding of the role and significance of community services in supporting better mental health outcomes for people. This includes but is not limited to community mental health and disability services.

NMHC's strategic work presents an opportunity

Since the Inquiry Draft Report's release, the NMHC has progressed its strategic work and released a consultation version of its blueprint for mental health and suicide prevention in Australia — *Vision 2030* (box 22.3). It has now turned to developing long-term strategies and plans to realise this vision as part of its Roadmap project.

The NMHC's strategic work presents an opportunity insofar as it addresses some of the recommendations of our Inquiry Report. *Vision 2030* articulates desired outcomes for the performance of the mental health system as well as for the lives of individual people living with mental ill-health (NMHC 2020). The NMHC's work also goes some way to separating long-term strategic intent (as set out in *Vision 2030*) from medium-term planning, which the Roadmap project will articulate. While there is no suggestion that the lives of all individuals would be transformed to the stated level of ambition, nor within the nominated 10-year time frame, an enduring vision would nevertheless help governments to remain focused on working towards achieving the outcomes that matter most for consumers and carers.

Vision 2030 identifies two fundamental systemic changes that the NMHC (sub. 949) believes are necessary for delivering the vision, namely:

1. shifting from a mental health 'alone' approach to a wellbeing approach, which necessitates establishing connections with the physical healthcare system and social determinants of mental health, including housing, education and employment
2. formulating a balanced community-based approach across the mental health and suicide prevention system, which offers choice in the delivery of prevention, assessment, treatment and recovery, to better match the varied contexts and needs of diverse communities.

Box 22.3 Vision 2030 and the Roadmap

In July 2019, the National Mental Health Commission (NMHC) began a national conversation through the Connections Project to develop a long-term strategy to guide investment and coordination in the mental health and suicide prevention systems. The NMHC connected with over 3000 people (including many consumers and carers) and organisations to hear about their experiences of mental healthcare and their needs and expectations of an improved system.

This information was analysed to identify key themes and consensus about the barriers experienced, community needs and opportunities to improve the experience of mental healthcare. Led by these themes, the NMHC developed Vision 2030; Blueprint for Mental Health and Suicide Prevention.

Vision 2030 casts a national direction for mental health and wellbeing in Australia. It is a long-term blueprint for a successful, connected, and well-functioning mental health and suicide prevention system meeting the needs of all Australians.

Vision 2030 will be accompanied by an implementation Roadmap. The Roadmap will identify the strategies for investment, coordination, development and performance measurement required to achieve the goals and objectives of Vision 2030.

A draft of Vision 2030 was completed in December 2019 and is available to inform consultation on the development of the implementation Roadmap. The NMHC is working with States and Territories as partners with the Commonwealth, alongside a range of community stakeholders to ensure a collaborative, consistent approach to Vision 2030 and its Roadmap. The final Vision 2030 Blueprint including Roadmap is to be completed in 2020.

Source: NMHC, pers. comm., 26 April 2020.

The Australian, State and Territory Governments should authorise the NMHC to lead development of the new national mental health strategy and the next national mental health action plan in collaboration with all jurisdictions. There are clear advantages in giving this role to the NMHC. The NMHC brings a mandate to work across all areas that impact on mental health and it has a strong interest in realising a strategic approach to investment across the multiple outcome areas and government portfolios (NMHC, sub. 949). Further, the NMHC has established working relationships with a wide range of stakeholder organisations, governments and state and territory mental health commissions.

Stronger implementation oversight of a national strategy

Successful implementation of the new national strategy, including through the next version of the national mental health plan, will require independent and transparent oversight. This is particularly important as accountability for mental health outcomes will remain shared across multiple portfolios within jurisdictions and across both tiers of government, notwithstanding the funding reforms recommended in chapter 23.

To improve accountability for the strategy's implementation, the Australian, State and Territory Governments should:

- authorise the NMHC to undertake annual monitoring and reporting on the strategy's implementation; this responsibility should bring a perspective to the strategy as a whole, as well as progress against implementing agreed commitments in the next national plan
- ensure that progress in implementing the strategy is independently and transparently reviewed and improvements recommended every five years.

ACTION 22.1 — A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY

A national strategy that integrates services and supports that are delivered in health and non-health sectors should guide the efficient allocation of government funds and other resources to improve mental health outcomes over the long term.

Start now

The Australian, State and Territory Governments should develop a new National Mental Health Strategy that comprehensively integrates the roles played by health and non-health sectors. In developing the new strategy, they should ensure that:

- it involves broad collaboration with relevant health and non-health portfolios of Australian, State and Territory Governments, consumers and carers, and the private and community sectors
- its vision reflects the outcomes that consumers and carers value and a corresponding level of ambition for mental health reforms
- it is a single coherent document that outlines a comprehensive approach to improving mental health outcomes
- it has the demonstrable support of consumers and carers.

The Australian, State and Territory Governments should request the National Mental Health Commission to lead development of the new national mental health strategy and the next national mental health action plan in collaboration with all jurisdictions and for endorsement by them. The strategy should identify priority areas for whole-of-government action to be considered by all governments for inclusion in the work program of the recommended interjurisdictional Special Purpose Mental Health Council (action 22.3).

To improve accountability for the strategy's implementation, the Australian, State and Territory Governments should:

- request the National Mental Health Commission to undertake annual monitoring and reporting on the strategy's implementation
- ensure that progress in implementing the strategy is independently and transparently reviewed and improvements recommended every five years.

Improving planning and service delivery with Aboriginal and Torres Strait Islander people

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (AHMAC 2017) is the national strategy for improving the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander people. Its guiding principles aim to fundamentally improve the way reforms to mental health and wellbeing services delivered by both Aboriginal and Torres Strait Islander and mainstream providers are conceived, developed, implemented and improved (box 22.4).

Box 22.4 Principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people's health problems generally, and mental health problems, in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.
5. The human rights of Aboriginal and Torres Strait Islander people must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health. Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.
7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander people may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.
9. It must be recognised that Aboriginal and Torres Strait Islander people have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

Source: AHMAC (2017, p. 3).

From a governance perspective, the centrality of ‘Aboriginal and Torres Strait Islander leadership, engagement and partnership in the planning, delivery, evaluation, and measurement of services and programs is critical in fostering greater trust, connectivity, culturally appropriate care and effective outcomes’ (AHMAC 2017, p. 12). In this respect, the *Gayaa Dhuwi (Proud Spirit) Declaration* provides the policy framework for embedding and supporting Aboriginal and Torres Strait Islander leadership within the mental health system while also promoting a ‘best of both worlds’ approach — clinical and culturally capable practice (section 22.1).

Many Inquiry participants voiced concerns that Governments had not fully implemented the Framework. In their view, this inaction was impeding efforts to improve the health of Aboriginal and Torres Strait Islander people.

The efficacy of Aboriginal and Torres Strait Islander specific programs depends on the amount of community input there is in designing them. The most effective programs are those delivered by communities, for communities ... Informed frameworks such as the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing ... continue to highlight this fundamental principle yet little action results from them. (National Aboriginal Community Controlled Health Organisation, sub. 507, p. 7)

The Closing the Gap 10 Year Review (Close the Gap Campaign Steering Committee for Indigenous Health Equality (Australia) 2018, p. 4) proposed that an implementation plan for the Framework be ‘developed, costed and implemented by the end of 2018 in partnership with Aboriginal and Torres Strait Islander health leaders and communities’.

The Australian Government should expedite the development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023*. Implementation of the Framework would serve to infuse the principles in the *Gayaa Dhuwi (Proud Spirit) Declaration* into the mental health system and expand access to culturally capable, effective mainstream services. There is little benefit in not implementing a strategy that was endorsed by the Australian Health Ministers’ Advisory Council and is highly regarded by both Indigenous and non-Indigenous peak bodies. Many participants supported this recommended action.²³⁹

²³⁹ Allan Fels (sub. 303); Beyond Blue (subs. 275, 877); Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATISIP) and National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) (sub. 1217); Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) (sub. 75); Institute for Urban Indigenous Health (sub. 1108); Mental Health Australia (sub. 864); Mental Health Carers NSW (sub. 1231); Mental Health Victoria (sub. 942); Mental Health Victoria (MHV) and Victorian Healthcare Association (VHA) (sub. 1184); National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH), Indigenous Allied Health Australia (IAHA) and Australian Indigenous Psychologists Association (AIPA) (sub. 418); National Aboriginal Community Controlled Health Organisation (subs. 507, 1226); Queensland Aboriginal and Islander Health Council (sub. 1235); Queensland Mental Health Commission (sub. 712); Royal Australian and New Zealand College of Psychiatrists (sub. 1200); Thirrili Ltd (sub. 549); Mental Health Victoria (MHV) and Victorian Healthcare Association (VHA) (sub. 1184).

Further, the Australian Government should entrust development of the implementation plan to Aboriginal and Torres Strait Islander people and their representative leaders in mental health. The peak body for Indigenous social and emotional wellbeing, mental health and suicide prevention, Gayaa Dhuwi (Proud Spirit) Australia, working with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, should lead its development, including the costing of putting it into practice. The Australian Government should support adequate resourcing for the development and operationalisation of the implementation plan to ensure that it effectively guides and informs reforms.

ACTION 22.2 — IMPROVING PLANNING AND SERVICE DELIVERY WITH ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* has not been fully implemented, to the detriment of the mental health of Aboriginal and Torres Strait Islander people.

Start now

The Australian Government should:

- expedite the development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*
- entrust development to Gayaa Dhuwi (Proud Spirit) Australia, working with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
- ensure that development and operationalisation of the implementation plan is well resourced.

Leadership

Effective leadership is central to reforming the mental health system.²⁴⁰ It ‘breathes life’ into governance, embeds values and behaviours, and promotes interagency collaboration (Edwards et al. 2012; ’t Hart and Uhr 2008). It is also what Australians want.

People asked for strong leadership and clear governance, responsibility and accountability for a whole-of-government approach to mental health and wellbeing, with mechanisms in place to oversee resourcing and implementation of government-wide strategic actions. (SA Mental Health Commission, sub. 477, p. 34)

²⁴⁰ Latrobe Health Advocate (sub. 364); Mental Health Complaints Commissioner (Victoria) (sub. 321); Relationships Australia South Australia (sub. 420); WentWest Limited (sub. 445).

In the view of many Inquiry participants, a lack of system leadership contributes to poor integration, resourcing and access, and absolved responsibilities.²⁴¹ As the Mental Health Commission of New South Wales (sub. 486, p. 13) put it:

Leadership for implementation is often missing. Policy documents, strategic plans and roadmaps abound. What is often missing is leadership and skilled oversight of the implementation of these policies.

The complexities of Australia's mental health system impose particular leadership challenges — in particular, the array of health and non-health portfolios that need to coordinate to improve consumer outcomes, plus multiple levels of government across which this coordination is necessary.

Effective leadership will be essential if the national mental health strategy is to significantly improve outcomes for people with mental ill-health and their carers. Good strategies usually fail because of poor execution (Wery and Waco 2004). More broadly, effective leadership will be necessary to implement the wide-ranging reforms recommended in this Inquiry, both in the short to medium term and in the decades to follow. While this is generally true for policy reform, it is especially true for mental health, where complex policy issues require cross-portfolio solutions and, in some cases, deep-seated cultural change.

Addressing these challenges requires 'leaders who are willing to embed purpose and drive change — and who are both empowered and required to do so' (Commonwealth of Australia 2019, p. 27). The Australian Mental Health Leaders Fellowship, which was developed by the NMHC in 2018, is an example of one initiative designed to meet the needs of emerging leaders with a passion and commitment to mental health. In addition, the Australian Government recently appointed Australia's first Deputy Chief Medical Officer for Mental Health (Australian Government Department of Health 2020). However, it is imperative that governments and other stakeholders further consider, resource and develop the skills and experience necessary to drive the systemic and cultural changes that are required to improve population mental health outcomes.

22.3 Facilitating a cross-portfolio approach

The cross-portfolio challenge

The challenge to efficiently balance mental health expenditure on treatment with that on prevention, early intervention and recovery becomes greater when the solutions for these lie beyond the health portfolio. Policies and programs in portfolios such as housing, workplace/employment support, social/community services, justice and education can promote mental health, or present risk factors that contribute to mental ill-health. However, all other things equal, there is little incentive for health ministers to fund reforms of matters

²⁴¹ For example, David Clark (sub. 205); NSW Nurses and Midwives' Association (sub. 246); Rural Doctors Association of Australia (sub. 475, appendix A).

for which other ministers have responsibility, would accrue budgetary benefits and would realise political kudos (Knapp and Iemmi 2016).

Public sector reviews have long sought to improve cross-portfolio collaboration and strategic leadership (Advisory Group on Reform of Australian Government Administration 2010). The Thodey Review (Commonwealth of Australia 2019, p. 27) recently re-emphasised the need for the Australian Public Service to be run as an integrated organisation. It saw single agencies that work largely independently as missing opportunities to deliver high-quality services in complex areas that cut across portfolio boundaries. Its conclusion about the need for more frequent cross-portfolio collaboration applies to all governments, especially on mental health issues, one of the most complex policy spaces.

The Fifth Plan recognises the need for closer cross-portfolio collaboration (as did previous national mental health plans), but focusses on promoting it at a regional level. Some issues can be solved at the regional level, but change at a jurisdictional or national level is often necessary to create an enabling environment. Better cross-portfolio coordination is also essential to address the social, economic, health, occupational, cultural and environmental factors involved in suicide prevention (Suicide Prevention Australia, sub. 523). For its part, this report makes many recommendations that will require action by non-health portfolios to improve the lives of consumers and carers.

Of course, health and other portfolios have collaborated on specific mental health matters. Under the former COAG Health Council, the Mental Health Principal Committee worked with other ministerial advisory bodies through its sub-committees and informal channels, typically on a topic-by-topic basis. In addition, the Committee has established two formal groups with members from outside mental health:

- the Action 9 Working Group, which includes members from the Mental Health subgroup of the Disability Reform Council Senior Officers Working Group
- the Steering Group for the National Mental Health Policy Renewal, which includes members from first ministers' Departments who bring a whole-of-government perspective when discussing the renewal of mental health policy.

Authorising cross-portfolio action through a new national council

Facilitating effective cross-portfolio action in a nationally consistent manner requires an authorising environment at the ministerial level (Commonwealth of Australia 2019, p. 233). It requires a forum or mechanism that would enable health and non-health portfolios to consider (jointly, systematically and comprehensively) how their policies interact in order to develop more effective and efficient approaches for improving mental health.

A key area where national coordination and oversight can be beneficial is in monitoring and advocating for redistributions of funds across portfolios where there are opportunities to improve the investment mix (NSW Government, sub. 1243). Various participants highlighted the need for, and benefits of, a more strategic approach to investment and/or stronger cross-portfolio collaboration between the Australian, State and Territory

Governments.²⁴² For governments to reallocate resources more efficiently across portfolios, there needs to be:

- a shared understanding of the relationships and long-term effects of social determinants on prevention, early intervention, recovery and mental health outcomes more broadly
- an agreed policy framework to guide consideration of, and decision-making on, cross-portfolio resource allocations over the long term
- reform actions that will serve to prevent or reduce avoidable harm and disadvantage that arises from mental ill-health. These may involve considering budgetary mechanisms that take account of the costs and benefits that ‘spill-over’ administrative boundaries.

The scale and complexity of many mental health policy issues has thus far exceeded the design of national committee structures. There is currently no national cross-portfolio ministerial forum that is well suited to leading a truly whole-of-government approach to social policy issues such as mental health. We do not consider that the National Cabinet should necessarily take on this lengthy commitment themselves.

Instead, the Australian, State and Territory Governments should establish a Special Purpose Mental Health Council (SPMHC) to facilitate a whole-of-government approach to prevention and early intervention in mental health. Membership of the new council should comprise Australian and State and Territory Government health/mental health ministers as permanent members plus ‘partnering’ ministers from selected social policy portfolios on, say, 18-month rotations. It is envisaged that partnering portfolios would likely include housing, workplace/employment, social and community services, justice and education.

This progressive or staged approach to policy reform is necessary to support closer cooperation and collaboration between health/mental health and other social policy portfolios. For the reasons outlined above, it would not be practicable to undertake a single reform project that simultaneously involves tens of ministers from both tiers of government who are responsible for all the social policy portfolios that are relevant to mental health.

The objective of the SPMHC would be to develop and implement a series of national 5-year action plans that serve to promote prevention, early intervention and recovery in mental health. Each plan would be developed collaboratively by health and partnering social policy portfolios, each reflecting the new national mental health strategy (section 22.2). It is not practicable to develop simultaneously a single cross-portfolio action plan.

To support effective implementation, each action plan should include a requirement for partnering portfolios to arrange for the preparation and publication of a final report, independently prepared, that:

- discusses and evaluates implementation of their action plan (including impediments and successes)

²⁴² For example, ACT Government (sub. 1241); Mental Health Australia (subs. 407, 538, 544); Mental Health Commission of NSW (sub. 486); NSW Government (sub. 1243); NMHC (sub. 949); VicHealth and Partners (sub. 31); Victorian Government (sub. 483).

-
- presents and analyses results against KPIs
 - examines what more needs to be done.

It is envisaged that a group of Senior Officials and an interjurisdictional working group would support the new council. These would comprise officers from health/mental health portfolios and members from each social policy portfolio as they rotate in every 18 months. Each jurisdiction should ensure that adequate resources are allocated to accomplishing this task.

Health ministers would remain responsible for the oversight of mental health reforms that are distinctive to the health and mental health sectors. In addition, they would become jointly responsible for mental health reforms endorsed by the SPMHC.

Work plan development

Without limiting the scope of the SPMHC's work program, the NMHC would be best placed to provide key cross-portfolio topics for its consideration. It is envisaged that other reform areas would emerge as each partnership matures over the rotation. In all instances, work plan development would be guided by the national vision for the mental health system (action 22.1), but be sufficiently flexible to address the biggest issues of the day in the event that some change in direction or scale is warranted.

In identifying potential reform areas, each portfolio partnership could consider the scope to improve the ways their sectors intersect through three lenses:

- governance (for example, coordination and arrangements for sharing care data and escalation protocols between portfolios)
- administration (for example, to ensure that policies and procedures in non-health portfolios do not exacerbate mental health issues)
- strategic policy (to consider the scope for joint approaches to realising better outcomes about long standing issues).

In addition, these collaborations provide an ideal opportunity to consider the integration of their existing strategies. A significant weakness of the current mental health governance arrangements is that other national strategies that affect mental health outcomes are not well integrated with the National Mental Health Strategy. Some, such as the *National Disability Agreement*, do not articulate their role in improving mental health, yet they assist a large number of people with mental ill-health.

Many participants noted the importance of integrating mental health strategies with other strategies.²⁴³ In particular, closer alignment with mental health was advocated for:

- alcohol and drug policies and programs (Families and Friends for Drug Law Reform, sub. 701; Prevention United, sub. 768)
- a new LGBTIQ mental health prevention strategy (National LGBTI Health Alliance, sub. 494; Rainbow Health Victoria, sub. 695)
- a new suicide postvention workforce strategy (United Synergies Ltd, sub. 682)
- a National Pain Strategy (Painaustralia, sub. 680)
- a new national mental health research strategy (ANU College of Health and Medicine, sub. 669).

As part of their action plans, each partnering portfolio could commit to ensuring that its relevant national, Australian Government, and State and Territory Government agreements and strategies that affect mental health outcomes articulate explicitly how they contribute to meeting the aims of the new National Mental Health Strategy.

ACTION 22.3 — FACILITATING A CROSS-PORTFOLIO APPROACH

All Governments should commit to a nationally consistent whole-of-government approach to prevention, early intervention and recovery in mental health.

Start later

The Australian, State and Territory Governments should establish a Special Purpose Mental Health Council (SPMHC) to facilitate a whole-of-government approach to prevention, early intervention and recovery in mental health.

- Membership of the SPMHC should comprise Australian and State and Territory Government health/mental health ministers (permanent members) plus ministers of selected social policy portfolios on 18-month rotations (partnering members).
- The SPMHC should develop and implement a series of national 5-year cross-portfolio action plans that serve to promote prevention, early intervention and recovery in mental health.
- Each partnering portfolio should adequately resource its contribution to the SPMHC.

²⁴³ ACT Government (sub. 210); Brotherhood of St Laurence (sub. 394); cohealth (sub. 231); Douglas McIver (sub. 181); Kingsford Legal Centre (sub. 469); Mental Health Coordinating Council (sub. 214); Mental Health Council of Tasmania (sub. 869); National LGBTI Health Alliance (sub. 494); Relationships Australia South Australia (sub. 420); Victorian Council of Social Service (sub. 478).

22.4 Enhancing consumer and carer collaboration

Many participants raised concerns about governments not collaborating with consumers and carers in all aspects of system governance, including mental healthcare system planning, design, monitoring and evaluation. In their view, governments are forgoing insights and advice that are useful for developing and implementing more efficient and effective policies. Moreover, it is important for both consumer and carer voices to be clearly heard — noting that many people who are *users* of mental health services and supports, and many *family* members who support them, do not think of themselves as either ‘consumers’ or ‘carers’, respectively, but their voices should nevertheless be heard and valued (chapter 18 discusses hidden carers).

While consumers and carers often share similar experiences, this is not always the case. And even where they have similar experiences, consumers and carers bring different perspectives and perceptions to those experiences. As discussed below, governments can improve system performance by fully committing to consumer and carer collaboration, strengthening systemic advocacy and supporting the establishment of national peak organisations.

Fully committing to consumer and carer collaboration

Many participants regarded the level of consumer and carer participation in system governance as inadequate and not at a level where it could significantly improve policies. They were unsure whether their engagement was authentic or tokenistic — whether policy makers genuinely sought their views and perspectives, or ‘ticked boxes’ (Private Mental Health Consumer Carer Network (Australia), sub. 547, p. 2). Some contended that a lack of authentic consultation had curbed the effectiveness of past reforms (Queensland Advocacy Incorporated, sub. 116; Community Mental Health Australia, sub. 449). The Mental Health Community Coalition of the ACT noted that while many factors can limit the efficacy of reforms, an important one is the:

... lack of a true partnership approach from government with service providers, consumers and carers which values the range of expertise, experience and perspectives they bring ... A partnership approach leads to better outcomes and helps avoid costly mistakes ... (Mental Health Community Coalition ACT, sub. 517, p. 16)

A former auditor with lived experience concluded:

The reason why it, the Federal Government, has continually failed is due to its unwillingness to engage the voices of lived experience in the design, delivery and evaluation of fit for purpose mental health services ... Taxpayers monies are wasted due to Government failure to listen to the voices of lived experience ... (David Clark, sub. 205, pp. 2–4)

Consumers and carers are becoming more embedded in policy and planning. At the national level, they have been serving on various national committees (Mental Health Information Strategy Standing Committee, the Safety and Quality Partnership Standing Committee and the Mental Health Principal Committee) and there is also representation on working groups established under the Fifth Plan.

Notwithstanding this (and the fact that mental health has already considerably more consumer involvement than some other health areas), participants maintained that collaboration should be improved. Some urged governments to listen to the voices of lived experience and increase their involvement in the management and delivery of services (Community Mental Health Australia, sub. 449). The Private Mental Health Consumer Carer Network (Australia) (sub. 547, p. 2) stated ‘surely it is crucial to design services to meet the needs of consumers, rather than designing services first and expecting consumers to fit the services’. The Brotherhood of St Laurence (sub. 394) argued for co-designing of policy frameworks with consumers and providers.

Expectations about consumer and carer collaboration in system governance

Consumers and carers should expect to participate in the design of government policies and programs that affect their lives. The Australian, State and Territory Governments have codified this right in the *National Mental Health Policy 2008*, which states that people with mental illness:

... have the right to contribute to the formulation of mental health legislation and policy, and to the design, implementation and evaluation of mental health services at national, state/territory and local levels to ensure that services comprehensively meet their needs, including from a cultural perspective. (AHMC 2009a, p. 12)

Two sets of standards guide the extent to which consumers and carers should participate in governance: the National Standards for Mental Health Services (Australian Government 2010) and the National Safety and Quality Health Service Standards (ACSQHC 2017b). These require health organisations to develop processes that enable consumers and carers to be actively involved in the governance of the services they receive. Standard 2 (‘Partnering with consumers’) of the National Safety and Quality Health Service Standards applies to organisations with system-wide responsibilities — government departments and/or whole health services. It emphasises the need to partner with consumers, carers and their representatives as ‘full members’ of key governance committees (ACSQHC 2018d, p. 2). Similarly, governments expect LHNs and PHNs to partner with consumers and carers in developing regional plans (DoH 2018a).

Consumers and carers expect collaboration to entail:

... meaningful and significant or genuine partnership (co-design) approach founded on mutual respect right at the very beginning, where all parties are equal, have expertise in different areas, and bring real value and shared knowledge to the table. (Private Mental Health Consumer Carer Network (Australia), sub. 547, p. 3)

In this regard, the National Mental Health Consumer and Carer Forum declared that ‘it is only co-production and/or co-design if consumers and carers agree that it is’ (box 22.5).

Challenges in fostering collaborative partnerships

Adopting a genuine co-design approach to governance challenges the established way of doing things. It may require professionals to ‘let go’ and let administrative systems become more responsive, or consumers and carers to think about mental healthcare in different ways (Foot et al. 2014). In addition, while some consumers and carers may understand how the system worked (or did not) in their own situation, or be able to identify gaps and shortcomings in access to services, they may not have sufficient system literacy, confidence or skills to engage in system-wide co-design and co-production (Consumers Health Forum of Australia, sub. 496; Sarah Sutton, sub. 508).

Of course, not all consumers and carers have the same experience. Consumer and carer input are most valuable when there is alignment between the issues being considered and the consumers’ and carers’ experience. For example, in planning a service for eating disorders, it is important to have consumers and carers with lived experience with such disorders providing input to the planning process.

Box 22.5 Co-design and co-production defined

Consumers and carers should expect to participate in developing policies that directly affect them and to receive strong assurances from government about its commitment to this approach. This expectation is not unique to mental health, nor Australia. Rather, it reflects growing dissatisfaction in governance arrangements that struggle to address many of the big issues facing society (Barnes, G. in Richards (2019, p. 44)).

Peak lived experience organisations distinguish traditional consultation and mere participation from ‘authentic partnerships’ that are underpinned by ‘early engagement, inclusivity, transparency, shared power and equity of knowledge’ (Mental Health Australia 2017, p. 1). The National Mental Health Consumer and Carer Forum (NMHCCF 2017) provides the following definitions and test.

- **Co-design:** identifying and creating an entirely new plan, initiative or service, that is successful, sustainable and cost-effective, and reflects the needs, expectations and requirements of all those who participated in, and will be affected by the plan.
- **Co-production:** implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in an equal and reciprocal relationship, with shared power and responsibilities, to achieve positive change and improved outcomes.
- **Test:** irrespective of how governments may describe their consultation and engagement processes, ‘it is only co-production and/or co-design if consumers and carers agree that it is’.

Further, consumers and carers have different lived experiences. For example, the lived experience of an eating disorder for a consumer is clearly different to the lived experience of the carer(s) who assist that same consumer. While this lived experience is a crucial input to all stages of mental health service design and delivery, it is important to recognise that consumers and carers necessarily speak with different voices and reflect different experiences. They are not substitutes. Both are needed.

Mistakes made by organisations seeking to partner with consumers and carers include:

- involving consumers and carers too late
- using consultation processes to inform rather than to genuinely get input
- underestimating the value that consumers and carers can add to service design
- failing to plan for a role for consumers and carers in implementation and review, particularly given the important role of consumers in supporting accountability (Integrated Regional Planning Working Group 2018b).

Benefits of strong consumer and carer collaboration

Inquiry participants emphasised the benefits of strong consumer and carer collaboration.²⁴⁴ In their view, consumers and carers are an essential source of information about mental health services, on service availability, accessibility, appropriateness, effectiveness and quality. They know what does and does not work as they are the ‘experts on the impact of mental ill-health and the types of measures and initiatives that are genuinely helpful’ (Queensland Advocacy Incorporated, sub. 116, p. 5). Their insights can complement official statistics as an effective feedback channel to drive innovation and continuous improvement.

Enabling consumers and carers to be more involved in governance should enhance the performance of a system which exists to meet their needs. Although there is not yet an agreed best-practice approach (ACSQHC 2018d, p. 2), governments nevertheless regard their involvement in all planning steps as ‘vital ... to get the best results’ (Integrated Regional Planning Working Group 2018b, p. 20). In particular, consumer and carer input in developing goals, standards, programs and monitoring regimes has the potential to drive a more efficient allocation of resources (Angelmar and Berman 2007).

Governments should commit to collaboration

In the Inquiry Draft Report, we recommended that the Australian, State and Territory Governments should collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation. This is additional to reforms elsewhere in this report that aim to empower individual consumers, including to actively participate in decisions about their own recovery (chapter 4).

Many participants strongly agreed with the general thrust to strengthen consumer and carer participation, while suggesting ways to achieve this.²⁴⁵ Some emphasised the importance of

²⁴⁴ headspace – National Youth Mental Health Foundation, sub. 947; Mental Health Commission of New South Wales, sub. 486; National Mental Health Consumer and Carer Forum, sub. 476; Penington Institute, sub. 264; Queenslanders with Disability Network (QDN), sub. 662; Victorian Government, sub. 483.

²⁴⁵ Advocacy for Inclusion (sub. 935); ANU College of Health and Medicine (sub. 669); Commissioner for Children and Young People (WA) (sub. 640); Consumers Health Forum of Australia (sub. 646); headspace – National Youth Mental Health Foundation (sub. 947); Mental Health Complaints

explicitly articulating the need to involve people with lived experience from the beginning of all decision-making processes (Mental Health Complaints Commissioner (Victoria), sub. 916). Others emphasised the importance of ensuring that particular subgroups were not overlooked in the co-design of mental health services and programs, namely:

- children and young people (Commissioner for Children and Young People (WA), sub. 640)
- consumers and carers in rural and remote Australia — Aboriginal people, Torres Strait Islander people and non-Indigenous Australians (Royal Flying Doctor Service, sub. 685)
- women and girls with lived experience and those who are carers (Women’s Health Victoria, sub. 773)
- gender diverse consumers and carers (Women’s Health Victoria, sub. 773)
- people in prisons, hospitals, ‘care’ homes and detention centres (Justice Action, sub. 929).

Governments should, at a minimum, adhere to Standard 2 ‘Partnering with consumers’ of the National Safety and Quality Health Service Standards. Obviously, it is not practicable to have every population subgroup involved in every design, implementation, delivery and evaluation process. But it is reasonable to have consumer and carer representatives from particular population subgroups where they are the policy target. In this regard, all Governments should collaborate with consumers and carers in the development of a new whole-of-government National Mental Health Strategy (action 22.1). And development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2017–2023* should not just be led by Aboriginal and Torres Strait Islander people, but should include Aboriginal and Torres Strait Islander people who have lived experience of mental illness and who are carers.

Systemic advocacy

Some participants contended that governments underinvest in systemic advocacy (One Door Mental Health, sub. 108; Sarah Sutton, sub. 508; Victorian Government, sub. 483). Systemic advocacy enables people with lived experience to participate collectively in system governance through an advocate (box 22.6). Mental Health Australia questioned whether governments see it as an integral part of the mental health system.

It appears that both individual and systemic advocacy are largely missing from the ecosystem imagined by governments. An ideal mental health system includes independent voices that hold governments to account for their commitments and encourages continuous improvement, through systemic advocacy. (Mental Health Australia, sub. 407, p. 36)

Commissioner (Victoria) (sub. 916); Mental Health Coordinating Council (sub. 920); Mental Health Legal Centre (sub. 1222); Mental Health Victoria (sub. 942); Royal Australian and New Zealand College of Psychiatrists (sub. 1200); SA Mental Health Commission (sub. 691); Victorian Mental Illness Awareness Council (sub. 844); Women’s Health Victoria (sub. 773).

Governments fund independent systemic advocacy for several reasons, although this is not without contention. On the one hand, funded advocates may have greater means to openly criticise government decisions and demand greater government accountability. On the other hand, systemic advocates can inform the development of policies and programs, and play an implementation role by acting as a trusted conduit between their members and government, and be a low cost source of information on some (localised) aspects of system shortcomings (Mental Health Australia, sub. 407).

Box 22.6 What is systemic advocacy and why fund it?

Advocacy is ‘taking action to help people say what they want, secure their rights, represent their interests and obtain services they need (Lewington and Clipson 2004, p. 4, quoted in Daly, Barrett and Williams 2017, p. 10). Systemic advocacy is speaking up for, or taking action on behalf of, groups of people who face common issues, such as barriers and discrimination. It enables consumers and carers to have an influence over the design of policies and programs that affect their lives. In particular, it gives a voice to the disadvantaged and vulnerable to ensure their interests are represented in the policy process.

Systemic advocacy differs from individual advocacy, which supports individuals to exercise their rights and to promote, protect and defend their welfare and justice (chapter 21). However, the two are related. Organisations that represent consumers and carers, and some non-government service providers and legal advocates often take individual experiences and turn them into policy advice to improve the mental health system or into test cases to reform the justice system (Mental Health Australia, sub. 407; Victoria Legal Aid, sub. 500). Peak mental health bodies also supply representatives with lived experience who can collaborate with government in system planning, monitoring and evaluation.

The improvements in program design and implementation possible with consumer and carer involvement can lead to a more efficient allocation of mental health resources. However, the extent to which additional funding for systemic advocacy would necessarily lead to more efficient resource use is unclear. For example, a lack of consumer and carer involvement can reflect a ‘free rider’ problem:

Even though consumers in aggregate might place a high value on consumer advocacy, each individual consumer has an incentive to ‘free ride’ on the contributions of others, meaning that consumer organisations may find it difficult to attract commensurate resources — whether in the form of volunteered time or donated money — from them. (PC 2008, vol. 2, p. 279)

Testing for funding adequacy

There is little data publicly available for assessing whether governments are underinvesting in systemic advocacy compared with other mental health activities as governments do not routinely collect data on expenditure for this purpose. However, the returns to mental health advocacy could be relatively high. For example, Daly, Barrett and Williams (2017, p. 44) estimated a benefit cost ratio for independent disability advocacy of 3.5:1, which they argue is a high return relative to other government investments in Australia.

One test for funding adequacy is material gaps in consumer and carer input into policy processes. Although such gaps may be difficult to detect and attribute to underfunding, some participants presented evidence of increased demand for systemic advocacy, including:

- increased calls by government for consumer and carer engagement and participation across the mental health sector (National Mental Health Consumer and Carer Forum, sub. 476, p. 8)
- calls for a national consumer and carer peak body and/or peak bodies in some jurisdictions²⁴⁶
- a lack of resources limiting the ability to be a ‘strong voice’ (Mental Health Carers Australia, sub. 489, p. 13)
- the need to include the views of children and young people at a systemic level, which are often overlooked (Commissioner for Children and Young People (WA), sub. 640, p. 7).

Concerns about funding adequacy are more acute when considered against the backdrop of short funding cycles. These create a challenging operating environment for some organisations, which negatively affects service delivery and support, as discussed for other parts of the mental health system elsewhere in this report (chapters 17 and 23). Mental Health Australia described the current situation:

Peak bodies, which carry out systemic advocacy, are subject to funding uncertainty created by unpredictable and short term contracts that do not provide enough funding to ensure organisational sustainability. This has resulted in inadequate support for robust systemic advocacy in a period of significant change and upheaval, precisely when such activities are needed most. (Mental Health Australia, sub. 407, p. 36)

Total government funding for peak consumer and carer bodies has varied significantly over the past 10 years (figure 22.1). In some States and Territories, year-on-year funding fluctuations were considerably greater.²⁴⁷

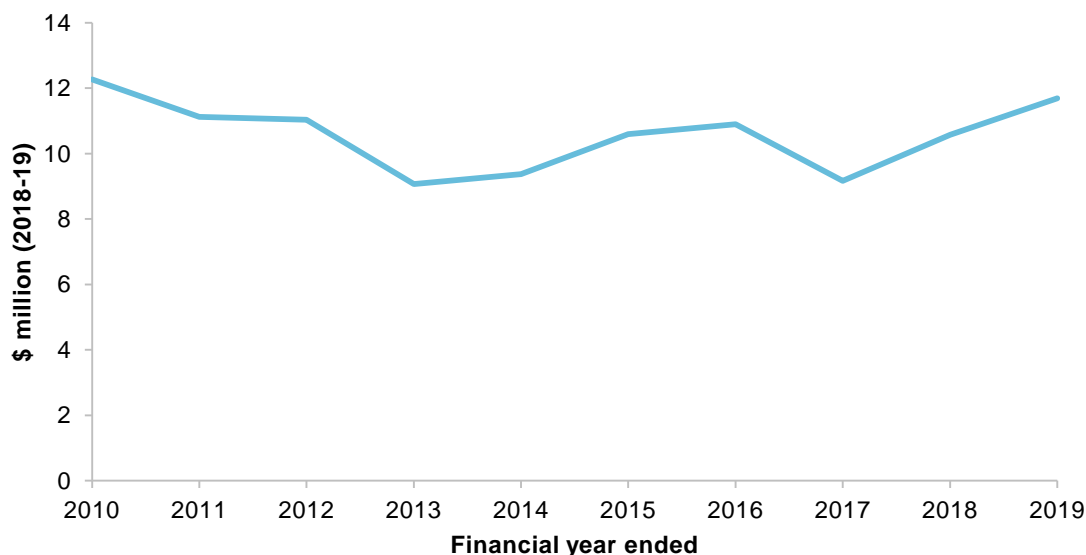
Reliability in the funding of system advocacy

In the Inquiry draft report, we recommended that governments should strengthen systemic advocacy by making funding more predictable. It is inefficient to contract on a short-term basis with peak representative bodies that have an enduring role, yet expect them to develop strong capabilities to provide high-quality advice. Specifically, we recommended funding cycles of at least five years to improve business planning and capability development. We also recommended that renewal negotiations should conclude well before contracts expire. This would enable peak bodies to operate more efficiently and to better manage risks of losing high-performing staff. Last minute indecision by government about future arrangements compounds business uncertainty.

²⁴⁶ Including, for example, Being and Consumers of Mental Health WA (sub. 928); Consumers Health Forum of Australia (sub. 496, p. 12); Mental Health Australia (sub. 407, pp. 26–27); Mental Health Coalition of South Australia and the Lived Experience Leadership & Advocacy Network, (sub. 360, p. 17); National Mental Health Consumer and Carer Forum (sub. 476, p. 4); Tim Heffernan, (sub. 552, attachments 2–5).

²⁴⁷ The coefficient of variation (a statistical measure of variability) was up to 78% for some jurisdictions compared with 10% for the nation as a whole.

Figure 22.1 **Estimated total government expenditure on mental health systemic advocacy via peak consumer and carer bodies^a**



^a Values adjusted for the effect of inflation and expressed in 2018-19 dollars. Includes core funding provided by Australian, State and Territory Governments to peak mental health bodies plus estimated expenditure on mental health advocacy by some peak health bodies. Excludes ad hoc amounts for building systemic advocacy capacity and systemic advocacy undertaken via other channels, including government advocacy bodies, non-peak systemic advocacy bodies, non-government service providers and legal advocates.

Source: Productivity Commission estimates based on information collected from Australian, State and Territory Governments and peak bodies representing mental health and health consumers and carers.

Carers Victoria summarised the views of a number of Inquiry participants about longer funding cycles for peak bodies, suggesting they would:

... increase efficiency in the workplace by providing greater certainty in business and workforce planning, reducing the costs of staff turnover including the associated loss of knowledge and expertise. (Carers Victoria, sub. 664, p. 10)

We recommend that governments should extend the default contract length for peak bodies that represent consumers and carers to at least five years (action 22.4).

To support implementation of these recommendations, the Australian, State and Territory Governments should disclose total expenditure by their departments and agencies on systemic advocacy in mental health that is provided by peak representative bodies. The Australian, State and Territory Government health ministers should task the Australian Institute of Health and Welfare with collecting this data annually. At the Commonwealth level, the Department of Health and the Department of Social Services should both supply expenditure data.

In addition, the NMHC should report annually on the state of systemic advocacy for mental health in Australia, including total expenditure by jurisdiction. This would serve to underscore the importance of systemic advocacy for mental health and enable stakeholders to form views about the adequacy of public funding.

Lived experienced representation at the national level

Various Inquiry participants called for stronger lived experience representation at the national level.²⁴⁸ While multiple bodies represent consumers and carers nationally, the lack of a body that focuses solely on consumers, in particular, and that chooses representatives independently of government processes, has been raised by Inquiry participants as a concern (box 22.7).

Why consumers should have a separate voice

At issue is whether existing organisations adequately represent the views of consumers at the national level. There is a contested view about whether a peak body should be for consumers and/or carers (National Mental Health Commission, sub. 949).

On the one hand are organisations that represent both consumers and carers — in particular, Lived Experience Australia and the National Mental Health Consumer and Carer Forum. While they can speak separately for either, much of their work covers areas of shared concern. In this regard, the roles of consumers and carers can interchange — when a consumer is or becomes a carer and vice versa (Emerging Minds, sub. 944). Moreover, development of effective solutions often requires consumers and carers to collaborate.

Discussions about engagement and participation must include all people who are impacted, whether they are primary users of the system, or families and other support people. There is extensive recognition that everyone needs to be in this together — that a ‘them and us’ approach is not the pathway to success. (NMHC 2018b, p. 8)

²⁴⁸ Being (sub. 918); Being and Consumers of Mental Health WA (sub. 928); Consumers Health Forum of Australia (subs. 496, 646); Emerging Minds (sub. 944); Mental Health Australia (sub. 407); Mental Health Coalition of South Australia (MHCSA) and the Lived Experience Leadership & Advocacy Network (LELAN), subs. 360 and 771; National Mental Health Consumer and Carer Forum (subs. 476, 708); Sarah Sutton (sub. 737); Tim Heffernan (sub. 552); Victorian Mental Illness Awareness Council (VMIAC, sub. 844).

Box 22.7 **Consumer and carer representation at the national level**

Various organisations advocate for mental health consumers and carers at the national level. Mental Health Australia represents a broad range of stakeholders through peak bodies that represent consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers, and state and territory mental health peak bodies. For some peak bodies, mental health consumer and carers form a subgroup of their membership, such as Consumers Health Forum of Australia and Carers Australia. Listed below are those that focus on mental health consumers and carers.

The **National Mental Health Consumer and Carer Forum**, which is a national voice for mental health consumers and carers. Its membership comprise a consumer and a carer from: each state and territory; each of blueVoices, Carers Australia, Consumers Health Forum of Australia, Grow Australia, Mental Health Carers Australia, Lived Experience Australia, and CALD Mental Health Consumer and Carer Group Australia; and Aboriginal and Torres Strait Islander peoples.

Lived Experience Australia, previously the Private Mental Health Consumer Carer Network (Australia), which is a representational organisation for Australian mental health consumers and carers. Its State Advisory Forums exist to identify issues and needs of consumers and carers.

The **National Register of Mental Health Consumer and Carer Representatives**, which is a pool of trained mental health consumer and carer representatives from across Australia who work at the national level to provide a strong consumer and carer voice. Mental Health Australia provides its secretariat.

Mental Health Carers Australia, which is the only national advocacy group solely concerned with the wellbeing and promotion of mental health carer needs. Its members are State and Territory carer peak bodies: Arafmi Queensland; HelpingMinds – WA; Mental Health Carers ARAFMI NSW; Mental Health Carers Tasmania; Mental Illness Fellowship of Australia (NT); Mind Australia (National member); and Tandem (Victoria).

The **National Consumer Peak Alliance**, which is an alliance of State and Territory consumer peak bodies that recently committed to the establishment of a National Consumer Peak Alliance to influence, lead and advocate on behalf of people who experience mental health challenges (CoMHW 2019). It would be led and owned by six consumer peak bodies: Victoria (VMIAC), New South Wales (Being), Tasmania (Flourish), South Australia (South Australia Lived Experience Leadership and Advocacy Network), the ACT (ACT Mental Health Consumer Network) and Western Australia (Consumers of Mental Health WA).

Source: Consumers of Mental Health WA (2019); Lived Experience Australia (2020); Mental Health Australia (2020b, 2020a); Mental Health Carers Australia (2020b); NMHCCF (2020).

On the other hand, proponents of a national consumer peak body contend that consumer and carer groups should not necessarily belong together (Being, sub. 918; Being and Consumers of Mental Health WA, sub. 928; Victorian Mental Illness Awareness Council, sub. 844). While they acknowledge the large amount of work that has been done collaboratively, they see an autonomous consumer peak body as having more influence on national policy. In their view, consumers and carers often share experiences, but in fundamentally different ways — Being (sub. 918, p. 14) report view of three consumers:

No one knows what I have been through, not even my family. How can they advocate for me when they didn't receive the drugs, the ECT, or get locked in seclusion. They can't, they saw it from a different perspective.

I don't have family, I live in isolation, why are carers representing me through advocacy. We need our own voice, our own advocates, our own national peak body.

I love my carers, I need them and I want them in my life particularly when I am unwell. But should they be representing me at a state and national level, absolutely not!

Being (sub. 918) and Being and Consumers of Mental Health WA (sub. 928) stated other reasons which, in their view, support the establishment of a consumer-only peak body, namely:

- power imbalances when carers speak on behalf of consumers, which may negate consumer experiences and/or potentially lead to reforms that could compromise the health outcomes for consumers
- the health and wellbeing risks of combined consumer and carer organisations further disenfranchising and inadequately representing consumers who do not have carers
- rights under the *UN Convention on the Rights of People with Disability* (article 21) to express opinions on an equal basis with others, such as national carer organisations.

Australia's adoption of the *UN Convention on the Rights of People with Disability* in 2006 has supported efforts for consumers to be able exercise autonomy and independence, including the freedom to make their own choices on an equal basis with others. To this end, Australia's National Standards for Mental Health Services recognise the right for consumers to involve or not involve carers (Standard 1, criteria 1.11) and to independently determine who represents their views (Standard 3, criteria 3.4) (Australian Government 2010).

The Commission's assessment

The recognised rights of consumers, in conjunction with the individuality of the consumer experiences, create a case for there being a peak body for consumers at a national level that is separate to the representation of carers. However, for governments to understand the views of consumers and carers collectively, they must also appreciate the diversity of circumstances and needs — to enhance the effectiveness and efficiency of their policies and programs. Engaging the relevant lived experience is important. Some participants highlighted particular groups of consumers and carers who would benefit from a stronger voice nationally, including children, parents and families (Emerging Minds, sub. 944).

The Australian Government should facilitate a process through Mental Health Australia to establish peak bodies that are able to represent the diverse views of consumers and of carers at the national level. The process should be developed in collaboration with national, state and territory organisations that represent mental health consumers and carers. Given the extent of preparatory work that has already been undertaken (Craze Lateral Solutions 2009; DoHA 2011; Mental Health Australia 2015), a successful outcome within two years should be achievable.

Further, the new peak bodies should have transparent processes for engaging with consumers and carers and representing them. Although a single voice cannot *fully* represent every consumer or carer, a single body for each should be able to establish processes to effectively

fulfil this role at the national level. This includes considering the mechanisms by which consumers and carers determine who represents them. Where possible, the new consumer peak body should liaise with other peak organisations (such as the Consumers Health Forum of Australia) to develop consistent policy positions. The new carer peak body should similarly collaborate with other family and carer organisations (such as Mental Health Carers Australia). Mental Health Australia should create formal mechanisms to bring the new consumer and carer peak bodies together regularly to progress issues of mutual interest and develop common policy positions and advice.

The Australian Government should provide funding for the new national mental health consumer and carer peak bodies. Compared with State and Territory Governments, the Australian Government is set to benefit more from stronger consumer and carer engagement on issues that affect all consumers and carers. Strong independent consumer and carer voices would improve understanding of: needs and priorities; the policies and programs that are most effective for people; and the extent to which policies and programs are working effectively and efficiently. Requiring State and Territory Governments to provide additional funding for consumer and carer peak bodies in their own jurisdictions to support a national organisation risks a ‘free riding’ problem where some jurisdictions fail to contribute, yet their consumers and carers benefit.

The level of funding should cover initial establishment and ongoing functions of the new peak bodies. The role for these bodies is large and complex given the diversity of consumers and carers and the extent to which co-design should underpin all aspects of system planning, design, monitoring and evaluation.

In considering an appropriate level of resourcing, the Australian Government should recognise that without additional funding, it is difficult to see how they could meaningfully engage with consumers (and carers) given the scale of reforms this Inquiry recommends.

This increased level of engagement adds to existing work on national policies and programs that continue to generate issues for mental health consumers and carers, including:

- NDIS (National Disability Insurance Scheme) transition issues (Being, sub. 918)
- privacy issues relating to My Health Record (Being, sub. 918; Mental Health Legal Centre, sub. 1222)
- issues related to accessing and maintaining access to the Disability Support Pension for people with psychosocial disabilities (Being, sub. 918)
- calls for the development of nationally consistent guidelines for appropriate consumer and carer remuneration in the development of policies and programs.²⁴⁹

²⁴⁹ BrainStorm Mid North Coast (sub. 803); Justice Action (sub. 929); Mental Health Carers Australia (sub. 898); National Mental Health Consumer and Carer Forum (subs. 476, 708); NSW Government (sub. 1243); Western Australian Department of Local Government, Sport and Cultural Industries (sub. 78).

ACTION 22.4 — ENHANCING CONSUMER AND CARER COLLABORATION

Consumers and carers should have the opportunity to participate in the design of policies and programs that affect their lives.

Start now

- The Australian, State and Territory Governments should establish a clear, ongoing role for consumers and carers to participate in all aspects of mental healthcare system planning, design, monitoring and evaluation and seek involvement from people with lived experience from the beginning of these processes.
- The National Mental Health Commission should report annually on the state of systemic advocacy in mental health in Australia at a State, Territory and national level.
- The Australian Government should facilitate a process through Mental Health Australia to establish peak bodies that are able to represent the separate views of mental health consumers, and of carers and families, at the national level. It should provide sufficient funding to cover the development, establishment and ongoing functions of these peak bodies.

Start later

- Mental Health Australia should create formal mechanisms to bring the new peak bodies together regularly to progress issues of mutual interest and develop common policy positions and advice.
- The Australian, State and Territory Governments should extend the funding cycle length for their relevant peak bodies to at least five years.

22.5 Improving accountability

‘The heart of good governance is having a razor sharp focus on understanding genuine accountability and making it happen in a practical way on a daily basis’ (Comley 2017). Good governance is essential for implementing strategies successfully. All parts of the mental health system should be accountable for their performance. Stakeholders who have an enduring interest in genuine accountability within Australia’s mental health system include:

- consumers and carers, for the quality of care and standard of services
- taxpayers, for the outcomes and economic return on government interventions
- communities, for decisions that have community-wide consequences
- service providers, for professional satisfaction and integrity.

Lack of accountability was *the* major governance issue raised by participants. Many submissions from a wide cross-section of stakeholders (particularly peak organisations) pointed directly at this issue.²⁵⁰ In their view, a lack of accountability for expenditure on mental health and individual outcomes significantly contributed to strategic failures in the mental health sector. As Rosenberg and Salvador-Carulla (2017, p. 50) concluded:

Leaving aside the inability to use benchmarking for service quality improvement, Australia's current outcome blindness means it is not possible to justify existing spending or call for more resources in mental health. This is a vulnerable position when competition for health resources is fierce.

Chapter 24 discusses the chief means for promoting accountability — transparent monitoring, reporting and evaluation — as well as the case for setting specific targets.

22.6 Simplifying complaints processes

Failures in individual services or in the mental health system as a whole have the potential to harm people (Mental Health Victoria, sub. 479). A fair, effective and efficient complaints system is thus important for two reasons. First, consumers and carers have the right to complaint and redress mechanisms (ACSQHC 2019b; Standing Council on Health 2012, pp. 14, 19). For individual consumers, an effective complaints system might include an ability to obtain financial compensation, an apology in relation to treatment and/or a mechanism to ensure that other people do not have the same experience. It is an important safeguard that formally makes services and the practitioners within them accountable for their actions (Being, sub. 918, p. 16). Second, it helps to improve system performance where issues are not just individual, but cultural or systemic. This is often a particularly important aspect of the work of complaints bodies and Ombudsmen.

Poor consumer experience with complaints system

Participants described the systems and processes for handling complaints as arduous and ineffective.²⁵¹ They raised many issues, such as processing delays (Name withheld, sub. 10), resistance to investigations (Australians for Safe Medicines, sub. 313) and challenges faced by

²⁵⁰ For example, Law Council of Australia (sub. 492); Mental Health Australia (subs. 407, 544); Mental Health Commission of New South Wales (sub. 486); Mental Health Victoria (sub. 479); National Mental Health Commission (sub. 118); SA Mental Health Commission (sub. 477); and the Victorian Government (sub. 483).

²⁵¹ Being (sub. 918); Consumers Health Forum of Australia (sub. 496); Coronial Reform Group (sub. 39); Emma Spinks (sub. 573); Ian and Rhonda McNees (sub. 505); Independent Private Psychiatrists Group (subs. 473, 742); Kingsford Legal Centre (sub. 469); Matthew Fitzpatrick (sub. 936); Mental Health Carers NSW Inc (sub. 1231); Mental Health Complaints Commissioner (Victoria) (sub. 916); Mental Health Victoria (sub. 580); Name withheld (sub. 482); Name withheld (sub. 592); Niall McLaren (sub. 44); Northern Territory Mental Health Coalition (sub. 430); Patricia Sutton (sub. 173); Sarah Sutton (sub. 508); Sjon Kraan (sub. 667); SleeplessNoMore (Eyrie Pty Ltd) (sub. 100); Victoria Legal Aid (sub. 500); Western Australian Association for Mental Health (sub. 416).

young people (Commissioner for Children and Young People Western Australia, Perth transcript, p. 63). Others saw missed opportunities to make full use of complainants' information to improve services (Matthew Fitzpatrick, sub. 936; Niall McLaren, sub. 44). Consumers frequently described efforts to complain about government services that did not relate to involuntary treatment as 'frustrating and fruitless' (Being, sub. 918, p. 17).

Difficulties in making complaints about psychiatric care drew particular attention. A common experience was feeling dismissed, as though no one was treating them seriously (Niall McLaren, Brisbane transcript, p. 103; Justice Action, sub. 929; Christine Newton, Brisbane transcript, p. 44; Supportive Residents and Carers Action Group Inc, sub. 11). For some, the stress of feeling unlistened to further damaged mental health (Matthew Fitzpatrick, sub. 936).

I think it's incredibly hard to complain about a treatment at the hands of a psychiatrist. And I think most people just don't bother. (Pippa Ross, Launceston transcript, p. 33)

In addition, some people found the network of complaints bodies to be complex. The different level of governments, jurisdictional limits and regulations of professions involved in the health sector complicate the complaints process with a plethora of multiple 'possible' complaints mechanisms. For example, there is rarely a single contact point to lodge complaints about multiple services that can be involved in a single admission to a mental health facility (Matthew Fitzpatrick, sub. 936). Mental Health Victoria (sub. 479) maintained that there was no clear mechanism to raise complaints about personal safety and human rights matters. Participants also raised concerns regarding the lack of clarity about processes for making complaints about mental health complaints bodies themselves or the outcomes of formal complaints (Emma Spinks, sub. 573; Matthew Fitzpatrick, sub. 936). For example:

The NSW Minister for Health and the Director of Mental Health informed me that they have no jurisdiction over the NSW HCCC [Health Care Complaints Commission]. (Name withheld, sub. 564, p. 2)

Moreover, bringing complaints is challenging, and negative perceptions that inhibit people from approaching the complaints system in the first place are common (for example, Matthew Fitzpatrick, sub. 936; NSW in Mental Health Carers NSW Inc, sub. 1231, att. 1; Victoria Legal Aid, sub. 500, att. 1). While there are third parties such as advocates and Community Visitor schemes that assist individuals in making complaints or accessing other advocacy services (NSW Ombudsman 2016; Office of the Public Advocate (Victoria) 2019; VIC DHHS 2016a), these are limited and resources constrained.

Looking forward, the mental health complaints system is likely to face greater demand. Over the five years to 2018-19, the number of complaints and enquiries received by Victoria's Mental Health Complaints Commissioner has grown by 10% a year on average (Mental Health Complaints Commissioner 2019a, p. 14). Comparable complaints bodies are experiencing similar growth (for example, HaDSCO 2019; HCCC 2019; NHPOPC 2019). Most complaints are multi-issue (Mental Health Complaints Commissioner 2019a, pp. 16-17).

Towards a simpler, transparent and fair complaints system

Consumers should have access to a simple and transparent complaints system that manages complaints fairly and allows them to ‘tell their story’. Not only is this vital for meeting justice objectives for individual consumers, but also for ensuring that it is an effective mechanism for systemically improving mental healthcare. Additionally, a fair and transparent complaints system affords natural justice to the parties against whom a complaint is made.

Several past reviews into aspects of the complaints system are relevant to this Inquiry. For example, the Productivity Commission (2014) examined Australia’s consumer complaints arrangements and found that disadvantaged Australians (which includes many people living with mental ill-health) are more susceptible to, and less equipped to deal with, legal disputes, and that a greater focus on the consumer was needed. More recently, a Senate inquiry into complaints handling by the Australian Health Practitioner Regulation Agency (Ahpra) heard concerns from health practitioners that echoed those raised in this Inquiry. In some instances, the process for dealing with notifications (that is, complaints involving health practitioners registered with National Boards under the National Registration and Accreditation Scheme) appeared to lack transparency, independence, timeliness and sensitivity (SCARC 2016b, 2017).

Work is being done by complaints bodies to improve complainant experiences. For example, following the Senate inquiries into the performance of Ahpra, Ahpra introduced a new role dedicated to considering and improving the experience of both notifiers and health practitioners — the National Engagement Advisor. Further, the National Health Practitioner Ombudsman and Privacy Commissioner works with Ahpra to continuously improve the notifications experience. It uses its complaints data to identify systemic issues and make recommendations or suggestions for improvement (for example, NHPOPC 2019, p. 26).

However, more could be done. As a first step towards developing a complaints system that meets objectives such as simplicity, transparency and fairness for mental health consumers, the Australian Government should request the Australian Commission on Safety and Quality in Health Care develop better practice guidelines on complaints management for complaints bodies handling mental healthcare complaints. It is noteworthy, for example, that about 57% of the complaints investigated by the National Health Practitioner Ombudsman and Privacy Commissioner in 2018-19 were resolved when it provided the complainant with a better explanation of the decision or action that they had concerns about (Richelle McCausland, National Health Practitioner Ombudsman and Privacy Commissioner, per. comm. 12 June 2020). These guidelines should be co-designed with mental health consumers and include standards and best-practice communication protocols. While comparable resources exist for healthcare services (ACSQHC 2004, 2005), these do not currently exist for the complaints bodies themselves.

Participants suggested various structural reforms to the health complaints system, including establishing a Federal Health Ombudsman or Australian Mental Health Ombudsman (SleeplessNoMore (Eyrie Pty Ltd), sub. 100; Sjon Kraan, sub. 667), and a Mental Health Complaints Commissioner in all states (Being, sub. 918, p. 7). Others sought stronger legal mechanisms, including for people who have experienced negligent mental health treatment (Mental Health Carers NSW Inc, sub. 1231, att. 1, p. 22) and for whistle-blowers (Law Council of Australia, sub. 492; Maurice Blackburn Lawyers, sub. 239; SleeplessNoMore (Eyrie Pty Ltd), sub. 100; and Supportive Residents and Carers Action Group Inc., sub. 11).

It is not practicable for the Productivity Commission to recommend reforms that are specific to mental health without taking into account the broader consequences on other functions performed by complaints bodies that service the health sector or other policy sectors. In some instances, health and mental health services are intertwined, especially regarding the treatment of comorbidities. In other instances, for example, health practitioners who treat people with mental ill-health also treat other health conditions. More generally, both complainants and practitioners have experienced similar frustrations with Ahpra complaints notification and management processes, feeling it was ‘not fair or impartial, and lacked transparency and adequate updates’ (Biggar, Lobigs and Fletcher 2020, p. 7).

To avoid unintended consequences, these broader issues would need to be taken into account in developing effective and efficient reforms.

The Australian, State and Territory Governments should instigate a national, independent review of Australia’s system for handling consumer complaints that relate to mental health issues. In undertaking a review of mental health complaints, given the fact that mental health sits within the health sector, and its complaints mechanisms more broadly, governments may wish to consider if there should be a broader approach to dispute resolution and the role of existing dispute bodies. A similar type of review was recently undertaken for the financial system external dispute resolution and complaints framework (Australian Government Treasury 2017).

ACTION 22.5 — SIMPLIFYING COMPLAINTS PROCESSES

All consumers should have access to a simpler and more transparent complaints system that is fair, effective and efficient and provides for systemic improvements to the mental health system overall.

Start now

The Australian Government should request the Australian Commission on Safety and Quality in Health Care to develop better practice guidelines for bodies handling mental healthcare complaints.

The Australian, State and Territory Governments should instigate a national, independent review of Australia's system for handling consumer complaints that relate to the use of mental healthcare services and supports.

22.7 Building an evaluation culture

In chapter 24, we find that evaluation and research activities are not doing enough to drive continuous improvement in mental health policies, programs and services. There is scant routine evaluation across the system and where evaluations are undertaken, they do not always lead to practical knowledge and evidence. Moreover, where evidence to improve practice is developed, it is not well communicated or implemented. This section considers the arrangements that are necessary to build a strong evaluation culture that will lift system effectiveness and efficiency.

A national body to lead evaluation

A national body should lead Australia's mental health and suicide prevention system in building an evaluation culture. This role would include having evaluations of policies and programs of national significance undertaken. Several reasons support this approach.

- Formally tasking a body to lead evaluations ascribes accountability to the role which, unlike monitoring and reporting, no institution currently performs. This would help overcome disincentives for governments to fund independent evaluations.
- Continuously scanning all relevant policies and programs would enable the body to identify priority areas for evaluation nationally.
- A national body would be able to engender analytical consistency and robustness. This would facilitate comparing program outcomes across multiple jurisdictions and enhance knowledge transfers more generally.
- Its corporate knowledge about interventions that are most effective and efficient (or not) would be a resource for stakeholders in all jurisdictions.

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- It would be well placed to build linkages between policy practitioners and researchers by undertaking policy-relevant research to support strategic decision making and working with stakeholders to fill key information gaps identified in the course of evaluations.

More specifically, the national body would be responsible for:

- promoting a culture of evidence-based policy and program development across all areas of the mental health and suicide prevention system
- developing a work program independently, but in close consultation with stakeholders
- commissioning transparent and robust program evaluations
- developing evaluation capacity and capabilities based on internationally recognised best practice approaches
- adopting and promoting rigorous evaluation quality control processes
- providing independent advice on evaluation as an input to program design
- communicating and translating findings and evidence to enable practical improvements of policies and programs
- sponsoring associated research and evaluation activities
- building and maintaining partnerships with stakeholders, particularly consumers and carers, research institutes, government departments, state and territory mental health commissions (or equivalence), and mental health service planners and providers.

Expanding the NMHC's functions to include program evaluations

Broadly defined, the 'system' that supports mental health includes not only mental health and suicide prevention programs, but numerous other programs that intersect with mental health outcomes, including in non-health sectors. Further, a robust culture of program evaluation would benefit from expert input at all stages. It begins with program design, where consideration is given to the data that should be collected and made available to enable proper evaluation later on and continues through program implementation to conclude with a final evaluation following decommissioning.

While a new body could be created for this function, the Productivity Commission considers it expedient to extend the functions of an existing body. In particular, the NMHC should be authorised to perform this role. The NMHC already has a mandate to work across all areas that impact mental health including education, housing, employment, human services and social support (National Mental Health Commission, sub. 118). This is important given that mental health involves expenditure in non-health sectors. In addition, the cost of expanding the NMHC's role would be lower than establishing a new body. It already has well developed relationships with a wide range of stakeholders. Further, there are synergies with the NMHC's existing monitoring and reporting functions. Monitoring, evaluation and research complement and support each other in driving continuous improvements (chapter 24).

While the NMHC is already authorised to perform aspects of the recommended evaluation function (box 22.8), it does not have a clear mandate for conducting independent and transparent program evaluations. Nor does it have a cross-jurisdictional purview — a necessity given the scale of mental health-related activity across both tiers of government. An expansion of its functions would require matching funding.

Box 22.8 Current functions of the National Mental Health Commission

The National Mental Health Commission (NMHC) is an executive agency of the Australian Government located within the health portfolio. It is a non-corporate Commonwealth entity for the purposes of the *Public Governance, Performance and Accountability Act 2013* (Cth). Its foundational objectives, set by the Prime Minister of the day, positioned the NMHC as the independent governance pillar of the mental health system. The objectives are to:

- plan more effectively for the future mental health needs of the community
- create greater accountability and transparency in the mental health system
- give mental health prominence at a national level (Gillard 2011).

The NMHC (sub. 118, p. 1) summarised its purpose as having a national remit:

... to provide insight, advice and evidence in ways to continuously improve Australia's mental health and suicide prevention system and act as a catalyst for change to achieve system improvements. The Commission also has a mandate to work across all areas that impact on mental health, including education, housing, employment, human services and social support.

Formally, the NMHC's current functions are to:

- develop, collate and analyse data and information to ensure a cross sectoral perspective is taken to mental health policy development and reform
- build and maintain effective working relationships with stakeholders in Australia and internationally to inform the work of the Commission
- provide independent and impartial advice to Government to improve mental health services and support within the Australian community
- manage, administer and publicly release evidence-based information in order to promote mental health and wellbeing
- review, analyse and promote research and best practice to support better treatment outcomes across the mental health sector
- promote a person-centred approach to mental healthcare that engages and values the participation of people with lived experience, their families, carers and communities; and
- undertake other relevant tasks as the Minister may require from time to time. (Order dated 27 September 2018 in Australian Government Notices Gazette C2018G00764).

Need for greater independence for evaluations

As with any body tasked with assessing performance, independence is vital. A body that is separate from policy and program funding, design and implementation would promote

greater independence and objectivity. It would also promote transparency by publishing its findings where privacy constraints do not exist.

In considering the level of independence that the NMHC should have, it is important to first identify any risks to it effectively delivering on its statutory responsibilities. In reviewing the NMHC, Deloitte (2017, p. 17) argued that its current institutional form as an executive agency enabled it to provide reporting and policy advice to Government that was free from direction ‘other than the confines of scope and government policy’. In its view, the NMHC had a sufficient degree of independence from the Department of Health because:

- there is no requirement for the Department of Health to approve NMHC deliverables
- the NMHC’s Chief Executive Officer and Commissioners are appointed by the Minister (not the Department’s Secretary) and are not Australian Public Sector employees
- the accountable authority, which is the Chief Executive Officer, reports to the Minister.

However, these protections are inadequate for the new role. The NMHC would need to be able to provide independent advice on evaluation as an input to program design, carry out those evaluations and then publish its findings, including recommended improvements. Fulfilling these responsibilities presents the difficulty of commenting on the merits or otherwise of government policies while upholding stakeholder confidence about its independence and objectivity.

There are good reasons to position the NMHC outside of political influence and process (Mental Health Australia, sub. 544, p. 12). High-quality evaluations drive change best when all parties involved in that change view them as independent, including both tiers of government. Moreover, independence needs to endure beyond the goodwill and intentions of current office holders and staff.

Accordingly, a level of professional independence that goes beyond merely a lack of direct veto power by the Department of Health is vital. At times, the NMHC would need to evaluate programs that are championed by key stakeholders. Here, it could face a situation where its public reporting of outcomes was contrary to that of key stakeholders (such as a department) or, potentially, political office holders (such as a minister).

Thus, the NMHC would need to clearly view itself as independent and not under any obligation to the Department. Moreover, to maintain the credibility of its work, stakeholders would also need to perceive the NMHC as independent. In particular, the design of its governance arrangements would need to assuage any concerns from State and Territory Governments about the NMHC acting primarily as an arm of the Australian Government.

The case for a statutory authority

For some time, various commentators have recognised the need for the NMHC to evolve and play a stronger role. Mendoza et al. (2013, p. 49), for example, argued that for the NMHC to be effective, it must become:

... a more genuinely independent body, with statutory powers of inquiry and reporting functions to the Australian Parliament. A revamped Commission must have both the statutory powers and resources necessary to develop, monitor and independently report on national mental health policy, programs and outcomes in Australia.

Notwithstanding, some have argued against statutory independence. Deloitte (2017, pp. 24–25) contended that the strong rationale required by Government was not evident and that the current arrangements offered sufficient independence. In its view, strengthening the NMHC's capacity and capability, and clarifying the roles and responsibilities of its Commissioners would address stakeholder perceptions about insufficient independence. However, their conclusion assumed no change to the NMHC's functions.

In our view, it is not credible that the NMHC could build an evaluation culture across Australia's mental health and suicide prevention system, which includes evaluating nationally significant policies and programs itself, without statutory independence. Statutory powers are appropriate for bodies that scrutinise public sector activities (Australian Government Department of Finance 2018). They are generally necessary where there is a need for enabling legislation to specify the powers and functions of the body, its level of independence and its accountability to Parliament.

The NMHC should be given statutory authority to enable it to effectively fulfil the recommended evaluation role which, among other things, would require it to publish rigorous analyses and evaluations of mental health policies and programs. Together with its existing monitoring and reporting roles, these functions would enable the NMHC to develop policy positions and provide advice to governments across the full gamut of mental health services and supports.

This role is analogous to the policy capability of other Commonwealth statutory agencies, including regulatory bodies such as the Australian Competition and Consumer Commission and the Australian Securities and Investments Commission. Statutory powers would also facilitate building an analytical culture within the NMHC that would be at arm's length from policy makers and practitioners. Moreover, greater independence would create a more stable operating environment over the long term for it to perform its role, irrespective of changes in personnel within the Department of Health, the Ministers' office and the NMHC itself.

As a statutory authority, its prescribed functions would enable the NMHC to clearly differentiate itself from other bodies that operate in the mental health sector. Some participants raised issues about a lack of clarity in this regard (ACT Government, sub. 210; Mental Health Council of Tasmania, sub. 314). Two issues are relevant: data and advocacy.

As a statutory authority, the NMHC:

- would continue to work closely with other bodies (such as the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and the Australian Commission on Safety and Quality in Health Care) to minimise duplication in monitoring and reporting

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- should not advocate, defend or publicly canvass the merits of government or opposition policies, including policies of previous governments — these are activities of peak bodies, including Mental Health Australia and Suicide Prevention Australia. Rather, the NMHC would position itself as an ‘honest broker’ in providing evidence-based advice to ministers and informing the wider community of ‘what’s working and what’s not’. Such arrangements would maximise the NMHC’s influence.

The NMHC to be an interjurisdictional body

There is wide stakeholder support for the NMHC to become an independent statutory authority with an interjurisdictional role whose responsibilities include strategic national evaluation, monitoring and reporting.²⁵² Establishing the NMHC as an interjurisdictional body would enable it to operate effectively across a system that spans both tiers of government. In particular, it would create an authorising environment that would enable it to work more closely with State and Territory Governments, which deliver and/or commission the bulk of clinical and psychosocial services, and a range of other services that directly affect mental health outcomes in sectors such as housing, justice and education. Close cooperation should include the timely exchange of data to support robust evaluations and assistance with interpreting and contextualising that data.

Interjurisdictional bodies are not new. A variety exist under intergovernmental agreements in Commonwealth statutes, or in state and territory legislation.²⁵³ The nature of their interjurisdictional interactions varies according to prescribed activities and processes. For example, the *Australian Institute of Health and Welfare Act 1987* (Cth) (section 7) requires the Australian Government minister to consult with each State health minister before giving a direction that relates to the health-related functions of the Australian Institute of Health and Welfare.

However, performing an interjurisdictional role does not obviate the responsibility for all governments to be first and foremost responsible for ensuring their stock of policies and programs remain fit for purpose. New evidence, rising public expectations and changes in the broader policy environment can cause programs that were once best practice to become ineffective, inefficient or inequitable. Therefore, it is incumbent on governments to build evaluation into program planning, to maintain oversight through effective monitoring and reporting regimes, and to periodically conduct assessment of programs. To this end, some

²⁵² Advocacy for Inclusion (sub. 935); Consumers Health Forum of Australia (sub. 646); headspace – National Youth Mental Health Foundation (sub. 947); Mental Health Victoria (sub. 942); MindSpot (sub. 666); National, State and Territory Mental Health Commissions (sub. 731); Queenslanders with Disability Network (sub. 662); Royal Australian and New Zealand College of Psychiatrists (sub. 1200); SA Mental Health Commission (sub. 691); Transforming Australia’s Mental Health Service Systems (sub. 919); and WayAhead – Mental Health Association NSW (sub. 704).

²⁵³ Examples include the National Blood Authority, National Health Funding Body, the Australian Commission on Safety and Quality in Health Care, the Independent Hospital Pricing Authority and the Australian Health Practitioner Regulation Agency.

State and Territory Governments have charged their mental health commissions with evaluation responsibilities.

It is within this context that the NMHC's ability to build and maintain co-operative partnerships with all jurisdictions would be critical for its effectiveness in leading improved performance of the mental health system over the long term. This would involve, among other things, consulting closely with jurisdictions to discern where and when it could best value add, and being mindful of its relative strengths and weaknesses. On the one hand, evaluation of State programs by a national body risks an approach that fails to fully recognise or account for service and consumer requirements that are unique to individual States and Territories. On the other hand, being independent of the development and implementation of programs would afford it considerable objectivity and perspective. Notwithstanding, it is difficult to conceive circumstances that would warrant the NMHC unilaterally duplicating the work of state and territory mental health commissions.

As a precursor to the design of the NMHC's statutory arrangements, the Australian, State and Territory Government health ministers should endorse the NMHC to take on a broad-ranging evaluation role. This support should include a statement agreeing to a set of principles for undertaking the evaluation role (discussed below).

Relationship with State and Territory Government mental health commissions

In many States and Territories, mental health commissions or equivalents provide an oversight role of the mental health system, or on aspects of it (section 22.1). Their work is informed by dedicated mental health advisory councils in New South Wales, Queensland, South Australia, and Western Australia, which may include issues relating to alcohol and other drugs. Mental health advisory councils also assist ACT Health and the Mental Health Complaints Commissioner in Victoria. Although there are no dedicated mental health advisory councils in the Northern Territory and Tasmania, there are general health advisory committees.

In addition to mental health commissions, there are multiple institutions that evaluate aspects of state and territory mental health systems, however, these tend to be reactive or ad hoc, with varying levels of independence. Auditors General occasionally conduct performance audits and reviews of specific mental health programs. Royal Commissions can be established to inquire into system-wide failures.

In response to the Draft Report, the National, State and Territory Mental Health Commissions (sub. 731, p. 1) warned against the NMHC duplicating work performed by state and territory mental health commissions. In particular, the Mental Health Commission of New South Wales (sub. 948, p. 12) noted that one of its statutory functions is:

... to review and evaluate, and report and advise on, the mental health and well-being of the people of New South Wales including conducting systemic reviews of services and programs provided to people who have a mental illness and other issues affecting people who have a mental illness. (*Mental Health Commission Act 2012* (NSW), section 12(1)(c))

To avoid unnecessary duplication, the NMHC needs to maintain links with an array of institutions in all jurisdictions beyond just mental health commissions.

Key to maximising the NMHC's value add is for it to focus on evaluating aspects of the system that are of national significance or that relate to multiple jurisdictions. The NMHC should be able to publicly justify its work program, which includes being accountable for the effective and efficient use of public resources for defined purposes, as required of it now. While this approach does not rule out the NMHC evaluating individual State or Territory programs, ideally such a decision would be made in close consultation with jurisdictions and/or their mental health commissions.

A broader question relates to the leadership roles that State and Territory mental health commissions (and equivalents) should play at the interface of government and the mental health service sector. As noted in section 22.2, effective leadership is central for realising systemic change. The reforms recommended in this report are wide ranging and complex. Without aligned effort across multiple agencies, dysfunction, duplication and gaps will continue to compromise the system's effectiveness and efficiency.

Participants suggested ways in which mental health commissions could strengthen system governance. They recognised that not all jurisdictions have a mental health commission and, among existing ones, there is much variation (section 22.1). Nevertheless, it was commonly agreed that they should play a stronger and more collaborative role in system governance.

- State and Territory Mental Health Commissions (sub. 731, p. 1) jointly agreed that:
 - existing state and territory commissions be retained and all States and Territories should establish mental health commissions (or equivalents)
 - consideration be given to having some common roles and responsibilities, including local monitoring and reporting
 - all mental health commissions should work more closely together to help develop a clear and consistent picture of mental health services development and reform.
- Transforming Australia's Mental Health Services Systems (sub. 919, p. 15) suggested that State mental health commissions should collaborate with a strengthened NMHC 'to provide expert leadership'.
- The SA Mental Health Commission (sub. 691, attach. 2, p. 10) went as far as proposing that every state and territory should establish independent statutory mental health commissions that work closely with the NMHC, or that the NMHC should expand into each jurisdiction to eventually replace existing mental health commissions.

A stronger network of mental health commissions would better serve the interests of consumers and carers. It would support more effective, efficient and integrated decision making and implementation over the long term. In addition to collaborating with the NMHC as they do now, their governance role at the State and Territory level should include:

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- maturing the capability of jurisdictions to pursue continuous policy and program improvement by providing evidence-based advice and a multi-sectoral perspective, which may also require capabilities for monitoring and evaluation activities
 - fostering genuine accountability for policy commitments, strategy implementation and mental health outcomes.

To this end, each State and Territory Government should have a mental health commission (or equivalents) that can fulfil these roles. This may require them to strengthen or expand an existing body, or establish a new body, as the case may be. However, we are not suggesting a particular organisational form as some mental health commissions play other roles and, in any case, various governmental arrangements would suit. Rather, to ensure mental health commissions can effectively fulfil their essential system governance role, we recommend that State and Territory Governments should adopt the following operating principles:

- enduring, that is, expected to continue indefinitely
- appropriately resourced to match their roles and responsibilities
- independent of, but integral to, government mental health policy making
- authorised to take a cross-sectoral view
- authorised to request and receive information and data from other government departments and bodies.

ACTION 22.6 — STRENGTHENING THE MENTAL HEALTH CAPABILITY

All States and Territories should have the capability to have innovative and accountable mental health services.

Start now

Where a body does not exist, State and Territory Governments should each establish a body (such as a mental health commission) that is responsible for promoting continuous policy and program improvement, and fostering genuine accountability for their mental health reform commitments. States and Territories should adopt the following principles to ensure that the relevant bodies operate effectively:

- enduring, that is, expected to continue indefinitely
 - appropriately resourced to match their roles and responsibilities
 - independent of, but integral to, government mental health policy making
 - authorised to take a cross-sectoral view
 - authorised to request and receive information and data from other government departments and bodies.
-

Powers to compel information

As a national monitoring and reporting agency, the NMHC requires consistent and timely access to appropriate information. While the NMHC works with governments, agencies and others to access the information needed to fulfil its current functions, on occasions this approach has not been successful (Consumers Health Forum of Australia, sub. 646; National Mental Health Commission, sub. 118). Circumstances that limit the NMHC's reporting function include that:

- information collected by agencies is not made public
- information is collected by agencies for public release, but is not released in time for the NMHC to use
- information collected by agencies does not support the NMHC's reporting needs
- agencies are either not able or willing to supply information.

Tasking the NMHC with an evaluation role would increase its existing challenges with accessing information. In addition to its current monitoring and reporting functions, the recommended evaluation role would require the NMHC to:

- evaluate and report on mental health and suicide prevention system outcomes and impacts
- evaluate and report on the strategies and plans that contribute to system outcomes
- engage broadly with multi-jurisdictional, cross-portfolio and non-government stakeholders to support a national approach to evaluation
- develop new information collection and evaluation processes to support outcome and impact evaluations
- rely more heavily on non-publicly released information.

Some of these potential challenges with accessing information to support the recommended evaluation role could be overcome by negotiating a co-operative and mutually supportive arrangements for information sharing.

Notwithstanding, the NMHC should be given legislative powers to make reasonable requests for information from Australian, State and Territory Government agencies when required to fulfil its statutory functions. These powers would be necessary where standard practices for obtaining information are not successful. As an example, the *Productivity Commission Act 1998* (Cth) provides powers to compulsorily obtain information relevant to its functions. Participants such as the Consumers Health Forum of Australia (sub. 646) and the Royal Australian and New Zealand College of Psychiatrists (sub. 1200) supported such powers for the NMHC.

Governance arrangements

The following outlines particular governance arrangements for the NMHC to operate effectively as an interjurisdictional statutory authority.

Board

The NMHC should be governed by a Board, to mitigate any risk (real or perceived) that the NMHC becomes unduly aligned with the interests of any one jurisdiction, especially the Commonwealth. As such, accountable authority should shift from the Chief Executive Officer to the Board. In addition, the Board should be granted full powers to act in the interests of the NMHC in fulfilling its statutory obligations, including powers to appoint and remove a chief executive officer.

The NMHC board should be skill-based, rather than representational, to ensure that it has the depth of capabilities to adequately support its role as the accountable authority. Board effectiveness depends on obtaining the right mix of skills, experience and attitude to successfully acquit board responsibilities. Consistent with its independent remit, the NMHC board should establish a nominations committee to ensure that it maintains an adequate mix of relevant skills, pursues best-practice board renewal and complies with standard government diversity objectives.

To this end, the inclusion of at least one non-executive director with lived experience would enhance board effectiveness. Although mental health is intrinsically a diverse area and individual experiences would differ greatly, their first-hand experience would complement those of other board members. More particularly, their expert knowledge is an inherent characteristic that would help to ensure board effectiveness. For the same reasons, reserving a board position for an Aboriginal and Torres Strait Islander person is similarly important and consistent with the Gayaa Dhuwi (Proud Spirit) Declaration (box 22.2).

Transparency and reporting

It would be important for legislators to balance the powers recommended for the NMHC with transparent processes for consulting with those responsible for the design and performance of Australia's mental health and suicide prevention system.

The intent is for governments to view the NMHC as a change agent for promoting effective and efficient policy that improves mental health and social and emotional wellbeing outcomes for all Australians. In order to elicit full stakeholder cooperation, broad consultation and strong engagement should remain a hallmark of NMHC operations, including in developing its work plan. In this regard, some participants highlighted stakeholders potentially at risk of being overlooked, including the Commonwealth Ombudsman and the Office of the Commonwealth Ombudsman as the National Preventive Mechanism Coordinator (Advocacy for Inclusion, sub. 935).

To this end, the NMHC should:

- develop a consultation process and consult with, at a minimum, the Australian Government's Department of Health, the Department of Social Services and the National Indigenous Australians Agency, State and Territory Government health/mental health departments and mental health commissions, consumer and carer peak bodies, non-government organisations and the private sector
- in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.
- as part of its annual planning cycle, prepare a rolling 3-year schedule of evaluations of mental health policies and programs, and policies and programs that have strong links to mental health outcomes. This would ensure stakeholders, including all governments, have clear visibility of its intentions and work to minimise duplicative effort
- prepare an annual report that, among standard requirements, reports on its forward program of evaluation activities as well as those commenced and completed.

Principles for conducting program evaluations

The Australian, State and Territory Governments should agree to a set of principles by which the NMHC would undertake its evaluation function. At a minimum, these principles should be based on those listed in box 22.9 to ensure that evaluations are robust, reliable and relevant. These principles should be set and agreed by the Australian, State and Territory Government health ministers in consultation with relevant stakeholders. As discussed in section 24.3, in developing these principles, the Council should ensure they reflect the importance of:

- shifting towards evaluations that focus on measuring the attributable impact of programs (through methods that incorporate control groups), rather than purely monitoring program outcomes
- promoting processes that enable lessons from program implementation to be determined and disseminated before programs reach their impact evaluation stage.

Evaluations of programs involving Aboriginal and Torres Strait Islander people

The Australian Government has asked the Productivity Commission to develop a whole-of-government Indigenous Evaluation Strategy. A draft Strategy was released in June 2020, and was informed by engagement with Aboriginal and Torres Strait Islander people, organisations and communities, government organisations, service providers, evaluators, academics and other interested parties.

Box 22.9 Principles for program evaluations by the NMHC

- Consumer and carer participation and engagement — consumer and carers should be involved in undertaking evaluations, sharing their knowledge, experience, perspectives and priorities.
- Independence — evaluators should have some degree of independence from policy makers and program managers, to ensure evaluations are objective and unbiased.
- Ethical conduct — evaluation commissioners and evaluators should behave in an ethical manner, following ethical guidelines for evaluation.
- Robust, evidence-based and impact-focused — robust evaluation methodologies and analytical methods should be used to understand the effects of programs, and inform program design and implementation. Evaluations should be impact-focused, testing the causal link between programs and their impact on communities.
- Transparency and accountability — evaluations should be made public on completion. There should also be transparency and accountability about how policy makers and program funders/managers respond to evaluation findings.
- Relevant and integrated — evaluations should support learning, evidence-based decision making, improvements in programs and service delivery, and inform policy decisions. Evaluation should not be viewed merely as a compliance activity.

The objective of the Strategy is to improve the lives of Aboriginal and Torres Strait Islander people by having policy and program decisions informed by high quality and relevant evaluation evidence. The draft Strategy sets out principles to guide what agencies and evaluators should do when they are planning, conducting, reporting and using evaluation, as well as outlining approaches to setting evaluation priorities, sharing and translating knowledge, building evaluation capability, and monitoring evaluations undertaken under the Strategy.

The Indigenous Evaluation Strategy will apply to all Australian Government agencies with responsibility for designing and/or implementing policies and programs affecting Aboriginal and Torres Strait Islander people. This will include the NMHC. It will cover Indigenous-specific policies and programs as well as mainstream policies and programs that affect Aboriginal and Torres Strait Islander people.

The Productivity Commission released the draft Strategy for public comment and plan to submit the final Strategy to the Australian Government in October 2020 (PC 2020). When finalised and endorsed by the Australian Government, the NMHC should adopt the Strategy when leading evaluations of programs that involve Aboriginal and Torres Strait Islander people.

In addition, the NMHC should follow the Gayaa Dhuwi (Proud Spirit) Declaration, which provides specific guidance on evaluations of mental health policies and programs that affect Aboriginal and Torres Strait Islander people (section 22.1). This approach is consistent with commitments under the Fifth Plan. For such evaluations, theme 3 of the Declaration requires that: Aboriginal and Torres Strait Islander people should lead the development of evaluation frameworks; and all parts of the Australian mental health system should use Aboriginal and

Torres Strait Islander values-based social and emotional wellbeing and mental health outcomes measures.

ACTION 22.7 — BUILDING A STRONGER EVALUATION CULTURE

A robust culture of program evaluation should inform the allocation of public funds across the mental health system to ensure that they are deployed efficiently and effectively.

Start now

The National Mental Health Commission (NMHC) should have statutory authority and lead the evaluation of mental health and suicide prevention programs funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

- The NMHC should be an interjurisdictional body. All health ministers should endorse the NMHC to take on a broad-ranging evaluation role.
- The NMHC should be governed by a skills-based Board. It should be granted full powers to act in the interests of the NMHC in fulfilling its statutory functions, including powers to appoint and remove a Chief Executive Officer.
- The NMHC should have legislative provisions to make requests for information from Australian, State and Territory Government agencies in order to fulfil its statutory functions.
- The NMHC should not advocate, defend or publicly canvass the merits of governments' or oppositions' policies.

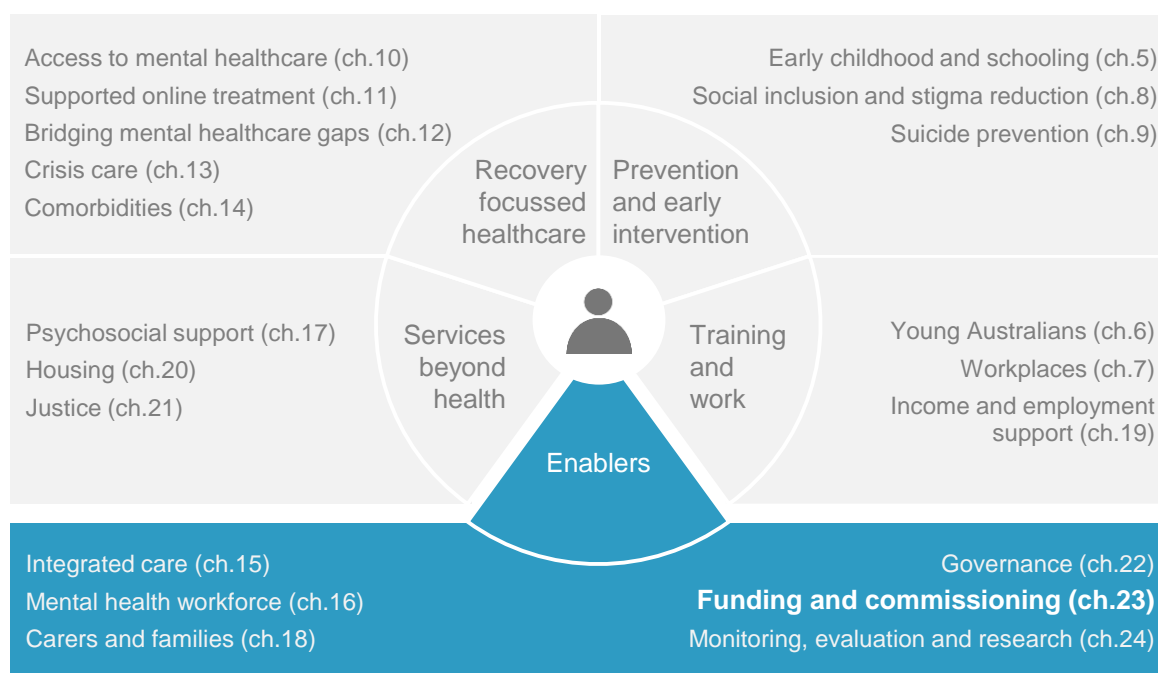
As part of its annual planning cycle, the NMHC should prepare and publish a rolling 3-year schedule of program evaluations. It should, in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.

The Australian, State and Territory Governments should agree to a set of principles by which the NMHC would undertake its evaluation function and for the mental health sector more broadly. These principles, which should be developed in consultation with relevant stakeholders, should reflect the importance of:

- shifting towards evaluations that focus on measuring the attributable impact of programs (through methods that incorporate control groups), rather than monitoring program outcomes
- promoting processes that enable lessons from program implementation to be determined and disseminated before programs reach their impact evaluation stage.

The Gayaa Dhuwi (Proud Spirit) Declaration should guide any evaluation by the NMHC of programs affecting Aboriginal and Torres Strait Islander people.

23 Funding and commissioning



Reforms to funding and commissioning arrangements matter because ...

- The gaps in mental health services described throughout this report are partly a reflection of inadequate levels of funding allocated to mental health services in some regions of Australia. But they are also a consequence of distortionary funding arrangements and unclear government responsibilities.
- Cooperation and coordination between the Australian Government's Primary Health Networks and State and Territory Governments' Local Hospital Networks is very patchy, which undermines accountability for delivering improved consumer outcomes.
- Primary mental healthcare funding arrangements:
 - do not fully reflect differences in needs between regions
 - incentivise an overreliance on Medicare Benefits Schedule-rebated care, which is not suited to all consumers' needs
 - rely too heavily on centralised decision-making, when regional decision-making would be more appropriate.
- Local Hospital Network funding arrangements permit inefficiency in community ambulatory mental healthcare services and incentivise relative overreliance on hospital-based care.
- Private health insurance and life insurance regulations prohibit insurers from investing in the mental health of their consumers.

RECOMMENDATION 23 — FUNDING ARRANGEMENTS TO SUPPORT EFFICIENT AND EQUITABLE SERVICE PROVISION

Mental health planning and funding arrangements should be reformed to remove existing distortions, clarify government responsibilities and support regional decision making.

As a priority:

- Governments should strengthen cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) by requiring comprehensive joint regional planning and formalised consumer and carer involvement.
 - The National Mental Health Commission should independently monitor and report on compliance by PHNs and LHNs against their commitments. (Action 23.1)
- The Australian Government should support State and Territory Governments that choose to establish regional commissioning authorities (RCAs) to administer mental health funding as an alternative to PHN-LHN groupings. (Action 23.4)

Additional reforms to clarify government roles that should be considered:

- State and Territory Governments should take on sole responsibility for psychosocial supports outside of the National Disability Insurance Scheme. (Action 23.2)
- All Governments should develop a National Mental Health and Suicide Prevention Agreement to clarify responsibilities and the new role of the National Mental Health Commission. It should also specify additional mental health and psychosocial support funding contributions by each level of government. (Action 23.3)

Additional reforms to funding arrangements that should be considered:

- The Australian Government Department of Health should reform the way that it allocates funding to PHNs (or RCAs) to support greater regional equity and remove incentives to engage in cost shifting. (Action 23.5)
- The Australian Government Department of Health should:
 - provide guidance on the evidence base that underpins different types of interventions and require PHNs (and RCAs) to demonstrate that they have commissioned evidence-based services that meet their catchment's needs
 - permit regional commissioning bodies to redirect to alternative services funding hypothecated to particular providers, if these providers are shown to not be meeting the service needs identified in regional plans
 - position Aboriginal Community Controlled Health Services as the preferred providers of services to Aboriginal and Torres Strait Islander people. (Action 23.6)
- The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification and develop an interim (simplified) model to allow State and Territory Governments to use activity-based funding for community ambulatory mental healthcare. (Action 23.7)
- The Australian Government Department of Health should establish a Mental Health Innovation Fund to trial new system organisation and payment models. (Action 23.8)
- The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare activities, and permit life insurers to fund mental health treatments for their insurance clients on a discretionary basis. (Actions 23.9, 23.10)

There are gaps and overlaps (but mostly gaps) in the delivery of mental health services. Most notable are the ‘missing middle’ (the shortfall in clinical and non-clinical community-based mental health services for people with moderate to severe mental illness) and the ‘low intensity gap’ (the shortfall of low intensity services that increases demands on less appropriate Medicare Benefits Schedule (MBS) rebated care) (chapters 12 and 17; appendix G).

These service gaps have emerged, in part, because the funding allocated to mental health services in some regions of Australia is insufficient to meet the needs of consumers of mental health services and their families and carers (chapters 12, 13, 15, 17 and 18). But it is also a consequence of the way that the existing funding is administered and used. Distortionary funding arrangements and unclear government responsibilities beset the planning, funding and delivery of mental health services.

- Australian Government and State and Territory Government responsibilities for clinical mental healthcare, psychosocial supports, suicide prevention services, and mental health carer supports are neither clear nor consistently implemented — either in intergovernmental agreements or ‘on the ground’ (appendix G).
- Mechanisms for funding mental health services create incentives to direct consumers toward hospital-based care and MBS-rebated care ahead of other forms of mental health services, permit low productivity among services such as community ambulatory mental healthcare, and prevent private insurers from investing in the mental health of their consumers (appendix G).

Hence, while more funding is needed in some areas, reforms are also needed to the way that funds are allocated and services are delivered to ensure that the available funding is put to best use. To this end, this chapter proposes reforms to funding and commissioning arrangements that aim to improve outcomes for consumers via two approaches:

- Decisions about allocating funding should primarily be made at the *regional* level by regional decision-makers that undertake rigorous assessments of their region’s needs to guide their decision making (this reflects the principle of subsidiarity (appendix G)). Both levels of government should support these regional decision-makers and hold them accountable for their decisions. And funding flows between levels of government and from governments to regional decision-makers should target consumer outcomes rather than provider-centric considerations. That is, funding to regional decision-makers should not incentivise them to favour some services over others.
- Australian Government and State and Territory Government investments in mental health should be *integrated*. There should be no ambiguity about which level of government (or its regional body) is responsible for providing a particular type of service or servicing a particular group of consumers or carers. And services that are separately funded by different levels of government ought to be seamlessly connected.

These approaches should not be controversial. They already underpin Priority Area One of the Fifth National Mental Health and Suicide Prevention Plan (the ‘Fifth Plan’) — the national strategy to impose a coherent regional architecture on an otherwise fragmented

system (COAG Health Council 2017a). Moreover, they are consistent with the recent commitment by all governments to create a mental health system that is ‘simple, unified and integrated’ (COAG Health Council 2019, p. 4).

What we are recommending is a stronger and more comprehensive set of reforms to give effect to these approaches.

- Sections 23.1 to 23.3 recommend structural reforms to funding and commissioning arrangements. The Inquiry draft report proposed two options for reforms to funding and commissioning, termed ‘Renovate’ and ‘Rebuild’. Following further analysis and stakeholder feedback (appendix G), we recommend an approach that incorporates elements of both these options. This approach has two parts:
 - Addressing the flaws in the current approach to strengthen cooperation between Australian Government-funded Primary Health Networks (PHNs) and State and Territory Government-funded Local Hospital Networks (LHNs) (hereafter ‘PHN–LHN groupings’) and clarify responsibility for psychosocial supports outside of the National Disability Insurance Scheme (NDIS) (sections 23.1 and 23.2). (This is a strengthening of the approach outlined in the Fifth Plan.)
 - Transitioning, on a State/Territory-specific basis, to an alternative approach whereby State and Territory Governments establish Regional Commissioning Authorities (RCAs) to pool and administer PHN and LHN mental health funds, if this is preferred by a particular State or Territory Government or if PHN–LHN cooperation fails to deliver sufficient improvement in mental health outcomes in a particular State or Territory (section 23.3).
- Section 23.4 proposes complementary reforms to how governments fund regional commissioning bodies (defined in this report to mean either PHNs or RCAs) and LHNs to reduce distortionary incentives and promote more efficient use of funds. The Australian Government should integrate the accounting of the funding it provides to regional commissioning bodies with the funding it administers via MBS rebates for mental healthcare, and distribute funding more equitably among regions. State and Territory Governments should use activity-based funding for community ambulatory mental healthcare services to increase their productivity. And regional commissioning bodies should trial and evaluate innovative new funding models with the support of an Australian Government-funded ‘Mental Health Innovation Fund’. These reforms could be pursued independently of the structural reforms outlined in sections 23.1 to 23.3.
- Section 23.5 proposes reforms to leverage insurance funds by removing restrictions that prevent private health insurers and life insurers from investing in the mental health of their consumers. Again, these reforms could be pursued independently of other reforms outlined in this chapter.

23.1 Strengthening the Primary Health Network–Local Hospital Network nexus

Under current government policy (as outlined in the Fifth Plan) PHN–LHN groupings are tasked with coordinating Australian Government and State and Territory Government funding for clinical mental healthcare and psychosocial supports outside of the NDIS and integrating the services funded by each level of government (appendix G). Governments should undertake reforms to support the PHN–LHN nexus, either on an ongoing basis or until they establish Regional Commissioning Authorities (RCAs; section 23.3) to administer the funding currently held by PHNs and LHNs.

PHN–LHN cooperation

Effective cooperation between PHNs and LHNs is essential for them to fulfil their mandate. Ideally, each PHN–LHN grouping would act as though it were a single entity holding a single pool of mental health funds that could be held singularly accountable for mental health service commissioning in its region. But financial incentives impede cooperation between PHNs and LHNs and undermine accountability for consumer outcomes (appendix G), so effective cooperation is unlikely to emerge without reform.

In principle, joint regional planning — the approach that the Fifth Plan takes to drive cooperation — seems the most likely approach to succeed, but there should be more stringent requirements on PHN–LHN groupings and an increased monitoring role by the National Mental Health Commission (NMHC).

Joint regional planning as a foundation for addressing service gaps

Joint regional planning is the process by which PHN–LHN groupings determine the mental health service needs of their region (taking into consideration the supply of services funded through other means — such as MBS-rebated services) and decide how they should allocate the resources they jointly have available to best meet these needs. The plans that result from these processes are an essential first step in addressing the gaps in provision of mental health services and thereby improving outcomes for consumers.

Joint regional planning should be the primary basis on which governments drive PHN–LHN cooperation. Joint regional plans should:

- clarify roles and responsibilities within each PHN–LHN grouping (including for integrating services)
- enable governments to hold PHNs and LHNs accountable for their subsequent commissioning and service delivery
- be developed with consumer and carer input.

However, the current guidelines for developing joint regional plans are not sufficiently stringent to effectively drive any of these outcomes, because: they do not prescribe what joint regional plans must contain; there is no clear way to determine that joint regional plans have been followed; and the deadline for producing plans has been delayed (appendix G). The Australian, State and Territory Governments should revise these guidelines to include the following of joint regional plans:

- A requirement that each PHN–LHN grouping reports, annually, a ‘gap analysis’ comparing services on the ground (whether provided/commissioned by the grouping or funded through other means) with National Mental Health Service Planning Framework (NMHSPF) benchmarks. The Australian Institute of Health and Welfare (AIHW) should supply data about current service provision to the PHN–LHN groupings and assist them with using the NMHSPF to produce these analyses. PHN–LHN groupings should develop and maintain capacity to use the NMHSPF in order to undertake gap analyses, having regard for the NMHSPF assumptions and limitations as they apply to their region. This is discussed further in chapter 24.
- A requirement that PHN–LHN groupings prepare and update annually, using a standard form template, a schedule detailing the mix of services that the PHN and LHN(s) would commission or provide over the following 3-year period (box 23.1). The AIHW should assist with developing this template to ensure it is congruent with current data collections.
- Guidance on minimum standards of service availability across all service types, as recommended by the PHN Cooperative (sub. 850).
- A requirement to clearly lay out how consumer, family and carer input was sought and whether any aspects of the plan conflict with this input.
- A requirement that joint regional plans be made publicly available (this is currently the case and should remain so).

Box 23.1 Planning horizon

Current guidelines require joint regional plans to cover a period of at least five years (Integrated Regional Planning Working Group 2018b). This requirement encourages PHNs and LHNs to take a longer term view when faced with immediate resource allocation decisions.

However, it is not feasible for PHN–LHN groupings to produce plans with the level of detail recommended by this Inquiry over an entire 5-year horizon. For one thing, PHNs know the quantum of mental health funds the Australian Government Department of Health will provide them only three years prior. As such, details about the mix of services that PHNs and LHNs plan to commission/provide should have a horizon of three years and be updated annually with an additional years’ data.

The NMHC — the primary entity responsible for monitoring PHN–LHN cooperation, as discussed later — should ensure that each joint regional plan and rolling 3-year schedule meet the new requirements and, where necessary, request further information or detail from PHN–LHN groupings.

Including psychosocial supports in joint regional planning

Existing requirements for joint regional plans are focused too narrowly on clinical services. The Fifth Plan predates PHN commissioning of psychosocial supports, and guidelines for joint regional planning are vague on the expectations of PHN–LHN groupings in regards to psychosocial supports (appendix G). But joint regional planning for psychosocial supports remains essential:

- to clarify roles — initially, responsibility for psychosocial supports for people outside of the NDIS would remain shared across governments (State and Territory Governments should, over time, take on sole responsibility for psychosocial supports outside of the NDIS, as discussed later)
- to manage, in detail, the transfer of PHN psychosocial support commissioning to State and Territory Governments
- to ensure that the psychosocial supports that consumers receive, including those delivered by the NDIS, are effectively ‘joined-up’ with the clinical mental healthcare that they receive.

Hence, the revised guidelines for joint regional planning should ensure that PHN–LHN groupings treat — in their joint regional planning — psychosocial supports outside of the NDIS in a similar way to the more rigorous approach they would be required to take with clinical mental healthcare. Further, guidelines should require PHN–LHN groupings to coordinate the clinical mental healthcare they commission with the psychosocial supports delivered by the NDIS.

Strengthening independent oversight

Independent and stronger oversight of PHN–LHN cooperation is needed, as current processes lack the independence and rigour necessary to critically assess the performance of PHN–LHN cooperation (appendix G). Providing statutory independence for the NMHC and recasting it as an interjurisdictional body is recommended (recommendation 22), with the NMHC then leveraging this status to be ‘frank and fearless’ in its assessments. But other changes are necessary.

Specifically, the NMHC should report separately on each PHN–LHN grouping. Its current reporting emphasises national-level conclusions, which provides a view of the general extent of PHN–LHN cooperation. But the purpose of monitoring and reporting on PHN–LHN cooperation should be to distinguish effective from ineffective performance, as this would allow governments to take remedial action for those groupings that are not cooperating effectively (including by establishing RCAs (section 23.3)).

Reporting by the NMHC should be based on objective measures of PHN–LHN cooperation (discussed next), as a complement to its current reporting, which is largely based on subjective assessment.

Improved monitoring of PHN–LHN outputs

The NMHC’s reporting on PHN–LHN cooperation should include an assessment of how PHN–LHN groupings are engaging with consumers and carers, allocating their respective funds and integrating their services.

Monitoring ongoing consumer and carer engagement

The NMHC should report on the extent of consumer and carer engagement with PHN–LHN groupings. To feed into this, each PHN–LHN grouping should be required to:

- develop and commit to a Consumer and Carer Engagement Framework that specifies their approach to engaging with consumers and carers, and a set of verifiable measures that indicate whether such engagement has taken place (for example, the number of times a consumer and carer reference group met annually)
- report annually to the NMHC on their performance against their Consumer and Carer Engagement Framework.

Comparing actual services against commitments

The NMHC should report on the mix of services that PHN–LHN groupings are commissioning/providing, including a transparent comparison against joint regional plan commitments. To enable this, the AIHW should supply the NMHC with data about services on the ground in each PHN–LHN region, that the NMHC can then compare with each PHN–LHN grouping’s commitments (as outlined in the standard form template).

The NMHC could also report each PHN–LHN grouping’s gap analysis against NMHSPF benchmarks for comparative purposes, but this is less critical as this information ought to already be in the public domain (chapter 24).

Improved outcomes monitoring

The *outcomes* of PHN–LHN cooperation — the extent to which PHNs and LHNs improve the mental health of the populations they serve — are what ultimately matter. Services only matter if they deliver the outcomes that consumers require. To this end, the NMHC’s reporting on PHN–LHN cooperation should include reporting of joint key performance indicators (KPIs) at the PHN–LHN grouping level. Although innate differences limit the usefulness of across the board comparisons between regions, within-region changes in KPIs and comparisons between regions with comparable populations and geographies would facilitate greater accountability and system improvements.

We are not proposing a list of KPIs that should be reported on. Further work is needed to determine which data could usefully be leveraged. Although the performance indicators in the Fifth Plan provide a good starting point from a conceptual standpoint, none are currently reported at the PHN–LHN grouping level (table 23.1). Our recommendation that AIHW report data at the PHN or LHN level (recommendation 24) would facilitate the reporting of

some of these at the PHN–LHN grouping level. The NMHC should work with the providers of the other data sources to determine whether they can be reported at the PHN–LHN level and, if not, how this could be achieved.

Table 23.1 Fifth National Mental Health and Suicide Prevention Plan performance indicators

Indicators relevant to Priority Area One

<i>Indicator</i>	<i>Frequency and mode of collection</i>	<i>Lowest geographic level currently reported</i>
The proportion of adults with very high levels of psychological stress	Collection via the ABS National Health Survey every three years	Available at State/Territory level, possible available at lower geographic level
The proportion of people with a mental illness reporting participation with family, social and community groups.	Collection via the ABS General Social Survey every four years	Possibly available at State/Territory level
The proportion of mental health consumers and carers who report a positive experience of care.	Variable (chapter 24)	Variable (chapter 24)
The proportion of episodes of mental healthcare where significant improvement was identified between admission and review or discharge.	Annual collection via the National Outcomes and Casemix Classification	Within scope of recommendation 24 that it should be reported at the PHN–LHN grouping level
The proportion of people who receive clinical mental healthcare from a general practitioner, private psychiatrist, private hospital or public specialised mental health service.	Annual collection via various sources	Within scope of recommendation 24 that it should be reported at the PHN–LHN grouping level
The proportion of discharges from an acute admitted specialised mental health unit for which there was a follow-up by a community mental health service within 7 days.	Annual collection via State and Territory Government mental healthcare services; follow-up by non-government services not captured	Within scope of recommendation 24 that it should be reported at the PHN–LHN grouping level
The number of suicides per 100 000 Australians.	Annual collection via ABS Causes of Death	Available at State/Territory level
Proportion of presentations to hospital for which there was a follow-up in the community within an appropriate period.	Under development	Likely at State/Territory level, lower levels of geography may not be feasible

Source: Productivity Commission analysis based on COAG Health Council (2017a).

The NMHC should also consider what other KPIs it should report as indicators of the effectiveness of PHN–LHN cooperation in addressing service gaps for consumers. For example, when considered in the context of the service mix commissioned/provided by a PHN–LHN grouping, reductions in the number of mental health-related emergency department presentations and hospital admissions (currently reported by the AIHW) could indicate better integration of PHN and LHN community-based services.

ACTION 23.1 — IMPROVING PHN–LHN COOPERATION

Start now

The Australian, State and Territory Government health ministers should significantly strengthen the guidance on joint regional planning for Primary Health Network (PHN)–Local Hospital Network (LHN) groupings to require each to:

- undertake gap analyses of current service provision against National Mental Health Service Planning Framework benchmarks (action 24.8)
- specify the mix of mental health services that they will commission/provide over the next 3 years and update this annually
- include all commissioned psychosocial supports outside of the National Disability Insurance Scheme within the scope of joint regional plans, and require joint regional plans to coordinate clinical mental healthcare with National Disability Insurance Scheme psychosocial supports
- set out how they consulted with consumers and carers in the development of the plan, whether any aspects of their plan conflict with the input of consumers and carers, and justify why this is the case.

Governments should require each PHN–LHN grouping to develop a ‘Consumer and Carer Engagement Framework’ that specifies an organised approach to engaging with consumers and carers and a set of benchmarks against which to report the extent of that engagement.

The National Mental Health Commission (NMHC) should develop a set of key performance indicators that capture the extent to which PHN–LHN cooperation is driving improved outcomes for consumers and carers, and seek to improve these indicators over time.

Start later

Governments should require PHN–LHN groupings to develop joint regional plans that comply with the revised guidelines and ensure that PHN–LHN groupings are adequately resourced to do so. The NMHC should ensure that joint regional plans are compliant.

The NMHC should report annually on the performance of each PHN–LHN grouping. Its reporting should comprise:

- a comparison of actual services commissioned/provided against joint regional plan commitments
- a description of the PHN–LHN grouping’s Consumer and Carer Engagement Framework and the extent of compliance with it
- reporting of key performance indicators at the PHN–LHN grouping level
- observations about the effectiveness of each PHN–LHN grouping.

The Australian Institute of Health and Welfare should provide data and analysis to the NMHC as required to facilitate this work.

The requirements on each PHN–LHN grouping should transfer to Regional Commissioning Authorities in States/Territories where they are established.

Responsibility for psychosocial supports

Clear responsibility for psychosocial supports outside of the NDIS is needed. Currently, both the Australian Government and State and Territory Governments provide psychosocial supports to those not eligible under the NDIS, with blurred division between the types of supports that each level of government offers (chapter 17). This has resulted in unclear responsibilities, leading to gaps and overlaps in service provision and inefficient service delivery (chapter 17). Responsibilities are clear for consumers that receive NDIS psychosocial supports, although there is a need for PHN–LHN joint regional planning to ensure that these services are integrated with clinical mental healthcare, as previously discussed.

One level of government should be solely responsible for providing psychosocial supports outside of the NDIS. Many Inquiry participants supported this principle.²⁵⁴ With both levels of government supplying such comparable services, it appears unlikely that joint regional planning or other cooperative processes could satisfactorily delineate responsibilities. In addition, we have recommended significantly expanding funding for non-NDIS psychosocial supports (chapter 17), meaning that accountability problems that are not fixed now would intensify.

Which level of government should take sole responsibility?

State and Territory Governments should take on sole responsibility for psychosocial supports outside of the NDIS — that is, the Australian Government should step back from making decisions about commissioning and region- or provider-specific funding allocations for non-NDIS psychosocial supports (although the broad public benefits of psychosocial supports for people with mental illness warrants ongoing funding by the Australian Government). We considered several criteria to reach this conclusion:

- *The ability to integrate psychosocial supports with clinical mental healthcare and other services.* Neither level of government is clearly better placed by this criterion. The Australian Government could readily integrate non-NDIS psychosocial supports with primary mental healthcare by devolving responsibility for them to the PHNs. It has already done this for its existing non-NDIS psychosocial supports (the National Psychosocial Support Measure and Transition and the Continuity of Support arrangements (chapter 17)). Meanwhile, State and Territory Governments provide clinical treatment for consumers with the most severe mental illness (who are likely to require higher levels of psychosocial support) and could better integrate psychosocial supports with the range of non-health services that they supply. For example, housing services (supported housing services (chapter 20) combine housing services with

²⁵⁴ Consumers Health Forum (sub. 646); Mental Health Coalition of South Australia (sub. 794); Mental Health Victoria (sub. 942); UnitingSA (sub. 807); Uniting Victoria and Tasmania (sub. 931); WA Association for Mental Health (sub. 1112).

psychosocial supports), Individual Placement and Support employment supports (chapter 19) and services for people in the justice system (chapter 21).

- *Continuity in service provision in the event that a State or Territory Government transitions to RCAs (section 23.3).* State and Territory Governments are most suited to commissioning psychosocial supports by this criterion, as they would take on psychosocial support commissioning (via RCAs) if RCAs were established.
- *Participant views.* Many consumers and psychosocial support providers supported the recommendation in the Inquiry draft report that State and Territory Governments take sole responsibility for psychosocial supports.²⁵⁵ In contrast, there was no support for PHN involvement, except from the PHN Cooperative itself (sub. 850).

That said, it is more important that responsibility is placed with a single level of government than which level of government this is. Our view is that governments should agree that State and Territory Governments should be solely responsible for providing psychosocial supports outside of the NDIS. But if this cannot be agreed, then governments should instead agree to the Australian Government taking on this responsibility and tasking the PHNs with commissioning all psychosocial supports outside of the NDIS.

Governance of the transfer of responsibility

The transfer of responsibility for psychosocial supports outside of the NDIS to State and Territory Governments should not occur before mid-2022.²⁵⁶ The immediate priority should be to continue managing the NDIS transition, including continuity of support for people who are not eligible for the NDIS (chapter 17). Transferring responsibility concurrent to this risks causing further disruption.

However, Governments should decide on an appropriate date for the formal transfer to occur and include this decision (as well as the funding commitments by all governments) in the National Mental Health and Suicide Prevention Agreement (section 23.3). PHNs, LHNs, and State and Territory Governments should each manage the process ‘on the ground’ via comprehensive joint regional planning processes.

This process should also not inhibit the pursuit of longer-term funding cycles for psychosocial supports (chapter 17 recommends that contracts with psychosocial support providers should be for a minimum of five years).

²⁵⁵ Consumers Health Forum (sub. 646); Mental Health Carers NSW Inc. (sub. 1231); Mental Health Victoria (sub. 942); UnitingSA (sub. 807); Uniting Victoria and Tasmania (sub. 931); and the WA Association for Mental Health (sub. 1112).

²⁵⁶ This would provide for a minimum of one year without disruption following the expected end (June 2021) of the PHN National Psychosocial Support Transition measure (which is targeted at recipients of pre-NDIS Australian Government psychosocial support programs who have yet to have their eligibility for the NDIS determined) and aligns with the end of the psychosocial support funding currently committed to PHNs under the Continuity of Support measure (June 2022) (chapter 17).

ACTION 23.2 — RESPONSIBILITY FOR PSYCHOSOCIAL SUPPORTS

Start later

State and Territory Governments should take sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, supported by additional Australian Government funding. The Australian, State and Territory Governments should codify this transition in the National Mental Health and Suicide Prevention Agreement (Action 23.3). Primary Health Networks and Local Hospital Networks should manage the transition ‘on the ground’ through joint regional planning in States/Territories that have not created Regional Commissioning Authorities. To ensure continuity of support during the National Disability Insurance Scheme transition, the formal transfer of responsibility should not occur prior to mid-2022.

If the Australian, State and Territory Governments cannot agree to the State and Territory Governments taking on sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, then they should instead agree to the Australian Government taking on this responsibility and tasking the Primary Health Networks with commissioning all psychosocial supports outside of the National Disability Insurance Scheme.

23.2 A National Mental Health and Suicide Prevention Agreement

The reforms outlined in section 23.1 would require the agreement of both levels of government, as would the broader recasting of the NMHC as an interjurisdictional statutory authority (recommendation 22), and the need to clarify government roles and responsibilities for; mental healthcare; psychosocial supports; mental health carer supports and suicide prevention services (chapters 9 and 18; appendix G). There would also be a need for additional Australian Government financial transfers to State and Territory Governments to support the transfer of responsibility for psychosocial supports to State and Territory Governments and to assist with filling the sizeable gaps in State and Territory Government provision of clinical mental healthcare and psychosocial supports (chapters 12, 13 and 17).

Administering these reforms and funding flows via a single intergovernmental agreement is preferable to a patchwork approach of making modifications to existing agreements or negotiating a range of smaller new agreements (appendix G). Hence, Australian, State and Territory Governments should develop an intergovernmental agreement — the National Mental Health and Suicide Prevention Agreement (NMHSPA) — to fulfil this purpose.

Scope of the Agreement

The NMHSPA would serve three key purposes: clarifying roles for mental healthcare, psychosocial supports, mental health carer supports and suicide prevention; authorising Australian Government transfers to State and Territory Governments to support provision of these services; and establishing arrangements for monitoring, reporting, and evaluation.

Government roles and responsibilities

The NMHSPA should clarify existing Australian Government and State and Territory Government roles and responsibilities for mental healthcare, psychosocial supports, mental health carer supports and suicide prevention; and govern transitions to new roles and responsibilities. This requires a different approach in each sector.

- **Mental healthcare and suicide prevention:** the NMHSPA should outline the roles and responsibilities of each level of government as closely as practicable and task PHN–LHN groupings with precisely delineating Australian Government and State and Territory Government responsibilities to reflect this on a region-by-region basis, as reflected in their joint regional plans.
- **Psychosocial supports:** the NMHSPA should outline the transition to State and Territory Governments taking on sole responsibility for psychosocial supports outside of the NDIS.
- **Mental health carer supports:** the NMHSPA should outline responsibilities as set out in chapter 18.

These arrangements would be superseded in those States/Territories that transition to RCAs, because those States/Territories (via their RCAs) would take on the responsibilities that would otherwise lie with the Australian Government.

Intergovernmental transfers

The NMHSPA should govern additional Australian Government transfers to support expansions in State and Territory Government expenditure on mental healthcare and psychosocial supports (chapters 12, 13 and 17). At a minimum, this should include funding to cover the transfer of responsibility for psychosocial supports from the Australian Government to State and Territory Governments. But, given the substantial increases in State and Territory Government expenditure that are required, there is scope for the NMHSPA to cover a much larger transfer of funds. Again, there are differences by sector.

- **Mental healthcare:** State and Territory Government expenditure would need to grow by about \$829 million per annum to meet existing gaps in service provision (recommendations 12 and 13).²⁵⁷ Some share of the growth in this funding could come via growth in National Health Reform Agreement (NHRA) payments, although scope

²⁵⁷ This comprises \$403 million to fill gaps in community ambulatory mental healthcare and \$426 million to fill gaps in bed-based care.

for this is uncertain and likely to be limited (appendix G). While the share of these additional costs borne by each level of government would be the outcome of negotiations, it is likely that additional Australian Government funding provided under the NMHSPA would be necessary and desirable given the Australian Government's access to more efficient tax bases (with the exception of State/Territory land taxes and municipal rates) and greater scope to raise additional tax revenues (PC 2011).

- **Psychosocial supports:** State and Territory Government expenditure would need to grow by \$373–1 085 million per annum to meet existing gaps in service provision (recommendation 17). Again, while negotiations between the Australian Government and State and Territory Governments would determine how these additional costs would be shared, it is likely that additional Australian Government funding provided under the NMHSPA would be necessary to fill this gap.

Arrangements for additional funding to State and Territory Governments provided under the NMHSPA should be carefully designed to ensure that it is used as intended. The NMHSPA should specify additional own-source funding commitments by State and Territory Governments, as well as the Australian Government transfers, to ensure that any Australian Government funding is additional and does not replace existing State and Territory Government contributions. Moreover, safeguards would likely be needed to ensure that this funding is funnelled toward the areas of greatest need as identified in the regional gap analyses.

Role of the National Mental Health Commission and Australian Institute of Health and Welfare

The NMHSPA should clarify the new role of the NMHC as an interjurisdictional evaluation body (recommendation 22) and its expanded remit in monitoring and reporting on PHN–LHN cooperation. The next National Mental Health and Suicide Prevention Plan (chapter 22) would provide scope to outline the specifics of this role in more detail.

The NMHSPA should also outline the role of the AIHW in facilitating and performing gap analyses using the NMHSPF (chapter 24).

Transition to Regional Commissioning Authorities

All governments should agree under the NMHSPA that any State/Territory could, at any time, transition some or all of its PHN–LHN groupings to RCAs (section 23.3).

Governments should also agree via the NMHSPA that, if the NMHC's reporting indicates that PHN–LHN cooperation is weak in a given State/Territory, then that State/Territory should transition to RCAs. Indicators of weak cooperation would include failure by PHN–LHN groupings in that State/Territory to:

- address gaps indicated by gap analyses with the NMHSPF
- commission/provide services in accordance with their joint regional plan commitments

-
- engage effectively with consumers and carers
 - improve outcomes for consumers and carers, as indicated by outcome measures.

This would help to mitigate any policy inertia preventing a State/Territory with poorly cooperating PHNs and LHNs from transitioning to RCAs.

Governance and collaboration

The Australian, State and Territory Government health ministers should be responsible for developing the NMHSPA. They should ensure that consumers and carers are key partners in its development. The agreement would constitute a major shift in government policy that aims to improve the lives of people with mental ill-health, and their carers, families and community groups. Accordingly, governments should ensure early consultation with people with lived experience to determine the most effective approach to co-design the NMHSPA. Further, they should ensure that the co-design process is properly resourced and managed to effect real change. There is now a considerable body of information about best practice co-design, including resources prepared by peak bodies that represent consumers and carers (for example, Private Mental Health Consumer Carer Network (Australia) (now Lived Experience Australia), sub. 547).

ACTION 23.3 — NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT

Governments should agree to and clarify responsibilities for mental health service delivery, funding, monitoring, reporting and evaluation.

Start now

The Australian, State and Territory Governments should develop a National Mental Health and Suicide Prevention Agreement that:

- sets out the shared intention of the Australian, State and Territory Governments to work in partnership to improve mental health and suicide prevention outcomes for all Australians
- governs the transfer of psychosocial support responsibility outside of the NDIS and associated Australian Government funding to State and Territory Governments
- clarifies the responsibilities of each level of government for providing mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services
- specifies minimum funding commitments by both levels of government and governs the transfer of Australian Government funding to State and Territory Governments to support expansion of mental healthcare and psychosocial supports
- declares the role of the National Mental Health Commission as an interjurisdictional evaluation body and its role in monitoring Primary Health Network–Local Hospital Network cooperation
- commits all governments to establishing Regional Commissioning Authorities if cooperation between Primary Health Networks and Local Hospital Networks does not drive sufficiently improved outcomes
- sets out clear and transparent performance reporting requirements.

The Australian, State and Territory Government health ministers should be responsible for developing and implementing the National Mental Health and Suicide Prevention Agreement. Governments consult thoroughly with consumers and carers to inform the development of the agreement.

23.3 Transition to Regional Commissioning Authorities

The reforms outlined above should go some way toward increasing the scope for cooperation between PHNs and LHNs by resolving the confusion and discontinuities brought about by the federal split in responsibility for mental health service commissioning. However, if funding incentives (appendix G) that undermine such cooperation and inhibit delivery of improved outcomes for consumers remain, the Australian Government should remove itself from the commissioning process and transfer the funds with which it commissions services to State and Territory Governments. State and Territory Governments should, in turn, establish RCAs that would pool mental health funds from both levels of government and commission services in their jurisdiction. The principal advantage of RCAs over PHN–LHN

groupings is that RCAs would better clarify responsibility for mental health service commissioning, thereby reducing gaps in service provision to consumers.

Transition to RCAs should occur on a State/Territory-specific basis, at the relevant State/Territory Government's discretion, and at the timing of the relevant State/Territory Government's choosing (the Australian Government should agree to this). The success of PHN–LHN cooperation is likely to vary across Australia, meaning that establishing RCAs may be an appropriate policy response in some States/Territories and not others (appendix G). Moreover, State and Territory Governments would be well-placed (especially with the benefit of enhanced reporting on PHN–LHN cooperation by the NMHC and AIHW) to determine if and when they should establish RCAs. The overwhelming majority of the funds that RCAs would hold are currently administered by State and Territory Governments,²⁵⁸ and by agreeing to establish RCAs, State and Territory Governments would be accepting additional responsibility and accountability.

This section considers the scope, structure and governance of RCAs, noting that the finer details about these issues should also be determined on a State/Territory-specific basis.

For which services should Regional Commissioning Authorities be responsible?

The Inquiry draft report proposed that RCAs should be responsible for commissioning:

- mental healthcare and suicide prevention that PHNs currently commission from the Mental Health Flexible Funding Pool
- mental healthcare and suicide prevention provided by LHNs and commissioned by LHNs or State and Territory Government health departments, with the exception of justice and forensic mental healthcare
- psychosocial supports and mental health carer supports commissioned by State and Territory Governments, noting that we have recommended that all psychosocial supports outside of the NDIS ought be commissioned by State and Territory Governments (section 23.1).

We have not changed our view that these services should fall within the scope of RCAs. But should additional services should be brought within the scope of RCAs?

Chapter 14 concludes that policy, planning, and delivery of mental health and alcohol and other drug services should be integrated. This would mean that RCAs should include in their remit not just mental health commissioning, but also PHN and State/Territory Government health department alcohol and other drug commissioning responsibilities.

²⁵⁸ In 2017–18, PHN funds for services in-scope of RCAs totalled \$0.6 billion, whereas State and Territory Government administered funds (inclusive of Australian Government transfers under the National Health Reform Agreement) for services in-scope of RCAs totalled 6 billion (AIHW 2020c; unpublished data from the Department of Health).

There is also a strong case for the funding of an RCA to fall in proportion with the cost of mental health-related emergency department (ED) presentations and hospital admissions in general or paediatric wards (about 42% of all mental health-related admissions to public hospitals in 2017-18 (AIHW 2020f)) in its region. Reflecting the cost of these hospital-based services through reductions to RCA budgets would create an incentive for RCAs to minimise avoidable ED presentations and hospital admissions by commissioning more appropriate services in the community. As regards EDs, the Western Australian experience may provide some evidence that not having ED costs reflected in community mental healthcare funding can lead to increased demands on EDs from people who would be more appropriately treated in community mental health facilities (box 23.2).

It should be noted that reflecting, in the relevant RCA's funding, the costs of mental health-related ED presentations and hospital admissions in general or paediatric wards does not imply that the RCA is commissioning (or has any control over) these services. State and Territory Government health departments should remain responsible for commissioning all services in EDs and general and paediatric wards, as these are not mental health-specific facilities (hence, there would be no additional separation of mental and physical health services in these facilities *from a consumer perspective*).

However, where feasible, the recurrent costs of providing mental health-related services in these facilities should be 'billed' to the corresponding RCA. State and Territory Governments should have flexibility in how they manage this process, as different data management systems and budget processes would lend themselves to different ways of putting this into practice. It suffices to note here that this ought to be feasible in most cases, as ED presentations and hospital-based care are typically funded via activity-based funding, which would usually allow for the recurrent costs of providing mental health-related and non-mental health-related care in general facilities to be apportioned. It is unlikely to be feasible in smaller rural and regional hospitals, where all services are generally block funded and costs are more difficult to apportion as mental health-related and non-mental health-related.

RCAs would also be well placed to fund consultation-liaison psychiatry, as these services are typically provided by clinicians who work within psychiatric wards. Providing this funding on an activity basis seems impractical at this time, as existing data collections do not usually indicate whether consultation-liaison psychiatric care has been provided (IHPA 2019). It would, however, be feasible for RCAs to block fund psychiatric wards to provide consultation-liaison services to other wards.

Box 23.2 **Emergency department funding — the Western Australian experience**

The Western Australian Mental Health Commission's funding is not adjusted for the cost of mental health presentations at EDs, although it directly commissions mental health observation areas that operate alongside EDs in two hospitals (OAGWA 2019). Since the Western Australian Mental Health Commission took on mental health commissioning responsibilities, emergency department (ED) presentations per capita have grown substantially faster in Western Australia than in Australia as a whole (figure a). And this issue is particular to mental health-related presentations, as the share of all presentations that are mental health-related has grown more sharply in Western Australia than in Australia as a whole (figure b).

Recent reviews have noted that the services commissioned by the Western Australian Mental Health Commission do not reduce the demands on EDs. The Western Australian Auditor General (OAGWA 2019, p. 26) noted:

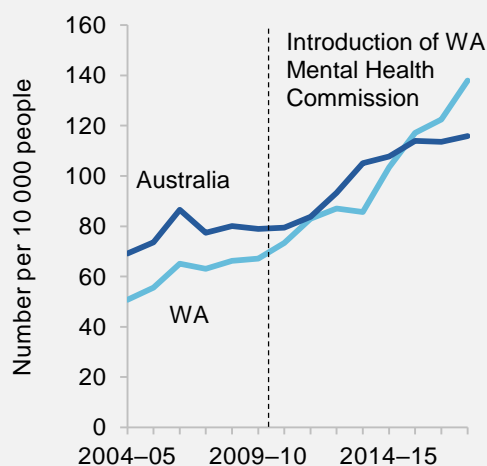
The [Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025] set out a mix of services to allow people to escalate the intensity of care as their mental health deteriorates. However, continuing gaps in the range of community-based services make it difficult for people to do this, and result in them seeking care through EDs. This is often not the most appropriate care setting for them, and increases the pressure and cost in EDs.

And Chapman et al. (2019, p. 28) noted:

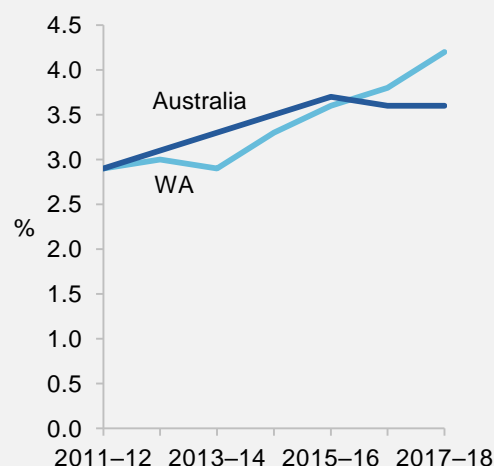
The reform direction of the [Western Australian Mental Health Commission] has been provision of standalone nonclinical and community based services for those with lower acuity illness. This group account for only 10 per cent of acute admissions, and it would be expected that this approach will have minimal impact on ED and hospital use.

Mental health related emergency department presentations

a. Annual mental health-related emergency department presentations



b. Share of emergency department presentations that are mental health-related



Source: AIHW (2019j).

Establishment of Regional Commissioning Authorities

Organisational form

RCAs should be established as separate entities at arms' length from ministerial control, although their boards should be accountable to a State/Territory Government cabinet minister. They should be separate from LHNs to prevent conflicts of interest (as RCAs would commission services from LHNs) and sufficiently separate from State/Territory Government health departments to prevent a hospital-centric bias from having disproportionate influence (appendix G). And independence would reduce political influence over their decision-making (appendix G).

Box 23.3 contains our recommended corporate governance arrangements for RCAs.

Integration with the broader health system

By design, RCAs would allow for seamless integration of the services currently commissioned or provided by PHNs and LHNs to the benefit of consumers and carers. The services that they commission should — from a consumer and carer perspective — be seamlessly integrated with the mental health and physical health services supplied in the broader health system.²⁵⁹ This should occur via regional planning and clearly defined interfaces with State and Territory Government health departments, LHNs and PHNs.

Regional planning

Like PHN–LHN groupings, RCAs should engage in regional planning to guide their commissioning decisions. This regional planning should be holistic — including RCA-commissioned mental health services and mental health services not commissioned by RCAs, such as MBS-rebated mental healthcare and mental health-related ED presentations and hospital admissions in general or paediatric wards. As we recommend for PHN–LHN joint regional planning, RCA regional planning should include a gap analysis using the NMHSPF and a process to rectify those gaps over time, subject to any funding limitations.

²⁵⁹ Some participants did not favour creating RCAs on the grounds that they considered this would silo the provision of mental and physical health services. These criticisms are not well grounded as they conflate separated *commissioning* of services with separated *delivery* of services (appendix G).

**Box 23.3 Recommended corporate governance arrangements for
Regional Commissioning Authorities****Governing boards**

Boards should be granted full powers to act in the interests of their Regional Commission Authorities (RCAs) in fulfilling their statutory functions, including powers to appoint and remove a Chief Executive Officer.

They should be skill-based, not representational. Board effectiveness depends on obtaining the right mix of skills, experience and attitude to successfully acquit board responsibilities. A particular strategic challenge that is likely to face RCA boards is overseeing a strategic plan that can adapt as the organisation changes in response to an evolving operating environment. To the extent that Australia's mental health system needs to change to address long-standing issues, boards will need to have a strategic mindset. For example, RCA boards will likely face opportunities that will be presented by new and emerging technologies, an ageing and more diverse population, higher expectations about recovery outcomes from consumers and more intense scrutiny of the performance of publicly-funded mental health entities such as RCAs. Reserving board positions for representational reasons would, all other things being equal, constrain the ability of RCA boards to meet these challenges.

One exception is that the inclusion of at least one director with lived experience would enhance board effectiveness. Although mental health is intrinsically a diverse area and individual experiences differ greatly, their first-hand experience would complement that of other board members, and help ensure RCA board effectiveness.

To avoid creating a conflict of interest (real or perceived), representatives of Local Hospital Networks (LHNs) should not be appointed to RCA boards. RCAs would typically direct significant resources to commission services from LHNs. On this issue, it is less clear whether a similar conflict of interest would necessarily attach to a representative of a Primary Health Network.

Advisory councils

RCA boards should be supported by advice from advisory councils. To be effective, RCA boards would need to consider the varied needs of a diverse range of stakeholders, including: consumers and carers (including culturally and linguistically diverse groups), all three tiers of government and government agencies, providers (public, non-government (including Aboriginal Community Controlled Health Services) and private), academia and the research community, the wider community and potentially other RCAs. A broad range of views and a diversity of input from such councils would enhance board effectiveness. In contrast to board membership, representatives from LHNs or Primary Health Networks could be included on RCA advisory councils. Indeed, there may be significant value in regularly canvassing their views and experiences.

To enable this, the Australian Government should ensure that data on utilisation of MBS-rebated mental health services is provided to RCAs promptly (ideally in real-time), and the relevant State/Territory Government should ensure that RCAs similarly have prompt data about mental health-related ED presentations and mental health-related hospital admissions in general or paediatric wards.

Regional planning should also incorporate the diverse views on regional priorities for mental health service delivery. Most obviously, this would come from RCAs' advisory councils (box 23.3). LHNs should also be afforded a special role in regional planning, as discussed below.

Role of State and Territory Government health departments

Establishing an effective relationship and split in responsibilities between RCAs and their State/Territory Government health department would be critical. State/Territory Governments establishing RCAs should, at the outset, decide on and codify the respective roles of their health department and RCA(s) and how they will work together. The Western Australian experience suggests that RCAs should be made fully responsible for all aspects of mental health service commissioning (box 23.4), but there ought to be options for how RCAs commission mental healthcare from LHNs.

- RCAs could commission mental healthcare directly from LHNs. This ought to be the default arrangement. RCAs and their health department could opt to streamline their contracts with the LHNs so as to minimise the burden to LHNs of having 'two masters'.
- RCAs could commission LHN-provided mental healthcare from their health department, which would then subcontract with LHNs. This should not amount to the RCA passing responsibility for the commissioning back to their health department — rather, the health department would merely act as an intermediary.

Box 23.4 Roles and responsibilities — the Western Australian experience

In Western Australia, responsibility for LHN-provided clinical mental healthcare is effectively split between the Mental Health Commission and the Department of Health. These services are, in the main, funded by the Mental Health Commission, but monitoring of safety and quality is performed mostly by the Department of Health. A recent review was highly critical of these arrangements, finding that they created an arrangement of 'two "system managers" with no single point of accountability or authority' (Chapman et al. 2019, p. 2).

This suggests that the same organisation that funds LHN-provided clinical mental healthcare ought to also monitor the safety and quality of these services. In our context, it would be logical for RCAs to perform both roles.

Source: Chapman et al. (2019).

Role of Local Hospital Networks

The service provision role of LHNs would be largely unchanged if a State or Territory were to transition to RCAs, as LHNs would remain providers of hospital-based and community ambulatory mental healthcare.

However, the role of LHNs in planning mental health services and their accountabilities would change.

-
- LHNs should be afforded a special advisory role in RCA regional planning. Some balance in the influence that LHNs have over how RCAs allocate funds is needed. Granting veto power to LHNs risks creating a conflict of interest. (For this reason, LHN representatives should not be appointed to RCA boards (box 23.3), and nor should their endorsement of RCA plans be a mandatory requirement.) But LHNs should have some input into how RCAs allocate funds as they would be both the most significant service providers that RCAs contract with and the de facto ‘providers of last resort’ as managers of public hospitals. RCAs should consult thoroughly with LHNs in the development of plans and should seek their endorsement of completed plans.
 - LHNs would be accountable to RCAs for their performance, whether directly via direct contracts or indirectly via streamlined contracts with their health department (as outlined previously).

LHNs would also need to ensure that the health department-commissioned services and the RCA-commissioned services that they supply are integrated from the consumer’s perspective.

Role of Primary Health Networks

If a State or Territory were to transition to RCAs, the mental health role for that State/Territory’s PHNs should mirror the role that PHNs play in the broader health system (unless RCAs task them with a larger role, as discussed below). Most significantly, they should work to integrate GPs and other physical healthcare providers with MBS-rebated and RCA-commissioned mental healthcare. To maximise the scope for this, each RCA should establish formal links with the PHNs that operate in its region.

RCAs should have the option to fund PHNs to commission some services on their behalf if circumstances suggest that this would produce better outcomes for consumers and carers. While this may sound like a backward step to some, the incentives under such an arrangement would be far better aligned than under the current arrangements.

Monitoring and reporting

As much as practicable, States/Territories transitioning to RCAs should leverage the approaches to monitoring and reporting already in place. Chapter 24 makes broad recommendations about improvements to monitoring and reporting, including improved monitoring and reporting at the regional level (recommendation 24) which should continue to apply if a State or Territory transitions to RCAs.

Likewise, the recommended architecture around supporting, monitoring, and reporting on PHN–LHN cooperation should transfer over to RCAs as much as practicable (action 23.1). While the original impetus for the architecture would largely vanish if RCAs were established, there is merit to retaining this as strong oversight of RCA activity.

ACTION 23.4 — TRANSITION TO REGIONAL COMMISSIONING AUTHORITIES

Start now

The Australian Government should, at any time, permit any State/Territory Government to establish Regional Commissioning Authorities (RCAs) to commission mental healthcare, alcohol and drug services, psychosocial and mental health carer supports outside of the NDIS, and place-based suicide prevention services. State and Territory Governments should establish RCAs if there is not sufficient cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) in their jurisdiction to drive improved mental health outcomes.

As part of this transition, the Australian Government and the relevant State/Territory Government should agree to:

- establish RCAs as separate entities at arm's length from ministerial control
- transfer PHN Mental Health Care Flexible Funding Pool and PHN alcohol and drug funding to the corresponding RCA.

The requirements on PHN–LHN groupings to undertake joint regional planning and the National Mental Health Commission monitoring of PHN–LHN cooperation (Action 23.2) should apply to RCAs.

23.4 Reforms to funding arrangements

Regardless of the extent of the reforms that are made to strengthen the PHN–LHN nexus or establish RCAs in its place, all governments should also seek to reform the ways in which they allocate funding to regional commissioning bodies and LHNs, regulate how this funding must be used, and support the development of new funding models. This section proposes reforms to funding arrangements that would:

- promote more equitable access to primary mental healthcare
- reduce incentives for regional commissioning bodies to shift costs to the MBS and provide them with greater scope to pursue innovative funding models that blend MBS rebates with contributions from the Mental Health Care Flexible Funding Pool.
- increase PHN (or RCA) flexibility to use new payment models and commission services that best meet their regions' needs
- increase the productivity of community ambulatory mental healthcare services
- support trials and evaluations of new funding models and ways of organising services.

Primary Health Network funding arrangements

Primary mental healthcare funding arrangements — MBS rebates for psychiatrists and allied mental health professionals and services commissioned by PHNs from the Mental Health Care Flexible Funding Pool²⁶⁰ — suffer from several shortcomings:

- Total primary mental healthcare funding (MBS rebates for psychiatrists and allied mental health professionals plus services commissioned by PHNs from the Mental Health Care Flexible Funding Pool) is somewhat inequitably allocated between regions (appendix G).
- PHNs face incentives to shift costs to MBS-rebated services, as these services are funded from outside PHN budgets and substitute for PHN-commissioned care (appendix G). This means that service offerings are driven less by what consumers need and more by the design of the dominant MBS program.

We are recommending a new process for determining the size of the PHN Mental Health Care Flexible Funding Pool and how it is allocated among PHNs to address both of these issues. This same process should be used to determine Australian Government contributions to RCAs where applicable, and its desirable properties would apply to RCAs.²⁶¹ It would also allow restrictions that prevent PHNs (and would prevent RCAs) from co-funding MBS-rebated mental health services (appendix G) to be removed, which would grant PHNs/RCAs greater flexibility to engage with MBS-rebated practitioners.

Our recommended process is as follows:

- The Australian Government Department of Health should determine the share of total primary mental healthcare funding that each PHN/RCA region *ought* to receive. This determination should support regional equity — the principle that consumers should have access to a similar standard of primary mental healthcare regardless of where they live (appendix G). To inform the determination, the Department of Health should develop an evidence-based weighting scheme that accounts for factors that influence differences in cost of provision (such as remoteness) and the demand for services (such as the prevalence of mental illness among the population) between PHN/RCA regions.²⁶² The weighting scheme, and the underpinning analysis, should be made publicly available.
- The Australian Government Department of Health should apply this determination to allocate total primary mental healthcare funds among PHN/RCA regions. A region's share

²⁶⁰ PHNs receive funding via the Mental Health Care Flexible Funding Pool (totalling \$506 million in 2018-19) to commission mental healthcare (unpublished data from the Australian Government Department of Health). PHN funding to commission psychosocial supports is provided separately (chapter 17).

²⁶¹ The funding process would be more effective if applied to RCAs, as it would negate incentives of all commissioning bodies to shift costs to the MBS. When applied to PHN funding, it is not able to negate incentives for LHNs and State and Territory Government health departments to shift costs to the MBS (appendix G).

²⁶² While a relevant factor when determining regional differences in funding need, the new weighting scheme should *not* account for the proportion Aboriginal or Torres Strait Islander people in a population. We are recommending that funding for Aboriginal and Torres Strait Islander mental health services remain hypothecated within the PHN Mental Health Care Flexible Funding Pool, so the funding for these services should be determined separately.

of the Mental Health Care Flexible Funding Pool should be determined as that region's allocation of total primary mental healthcare funds, less the MBS rebates for psychiatrists and allied mental health professionals billed in that region. To guarantee PHNs/RCA's three years of funding certainty, there should be a lag of three years between when MBS rebates for psychiatrists and allied mental health professionals are billed and the consequent Mental Health Care Flexible Funding Pool allocation is provided to the PHN/RCA.

Appendix G provides a detailed explanation of the recommended process. This process would:

- promote regional equity, as the *share* of total primary mental healthcare funding that each PHN/RCA catchment receives would be determined on the basis of need
- reduce PHNs'/RCA's' incentives to shift costs to MBS-rebated services, as each dollar billed to the MBS for mental healthcare would result in a one dollar reduction to the corresponding PHN's/RCA's Mental Health Care Flexible Funding Pool allocation in three years' time
- maintain three years of funding certainty for PHNs/RCA's during both the transition phase and once the new process has been established.

Once this new process has been established, the regulations under the *Health Insurance Act 1973* (Cth) that prevent PHNs (and would prevent RCA's) from shifting costs to MBS-rebated mental health services would become somewhat redundant (appendix G). As they hamper PHNs' scope to pursue more innovative funding models that could better meet consumer needs (appendix G), there would be a strong case for removing them. One proviso would be to ensure that PHN/RCA-commissioned services could only be permitted to receive co-funding from MBS-rebates with the PHN's/RCA's consent. Without this, there is a heightened risk of fraudulent 'double dipping' by providers.

Introducing additional flexibility would enable other potentially desirable funding arrangements. In States/Territories that do not establish RCA's, the rules would not permit State and Territory Governments (including LHNs) to provide co-funding to MBS-subsidised clinicians unless an exemption is in place. These restrictions have both positive and negative impacts. On the one hand, it would be desirable for a State/Territory Government to co-fund MBS-rebated clinicians if this were to reduce avoidable hospitalisations. On the other, allowing this in all instances would allow State and Territory Government services to shift costs to the MBS.

A sensible solution would be to allow State/Territory Government co-funding of MBS-rebated mental healthcare on the condition that it is governed by an agreement with the relevant PHN. The PHN would bear the cost of the MBS rebate, and so could be relied upon to judiciously determine whether the action should be allowed.

Other situations are more complex. MBS-rebated out-of-hours GP services (which are not billed under mental health-specific codes) may be particularly useful at preventing mental health-related presentations at EDs (chapter 13), and so State and Territory Governments may

wish to co-fund MBS items for them. But PHNs would not bear the cost of these MBS items, and so should not be automatically relied on to determine whether a State/Territory Government should be able to co-fund the service in question. A pragmatic solution would be to allow State/Territory Governments to co-fund these services with the agreement of the PHN, with the Australian Government (which *would* bear the additional costs) issuing guidance to PHNs on the circumstances under which they should allow or disallow these requests.

ACTION 23.5 — PRIMARY MENTAL HEALTHCARE FUNDING ARRANGEMENTS

Start now

The Australian Government Department of Health should reform the methodology that it uses to determine the size of the Primary Health Network (PHN) Mental Health Care Flexible Funding Pool and how it is allocated between regional commissioning bodies to allow for greater geographic equity in primary mental healthcare funding and to reduce funding biases that favour MBS-rebated care.

Once this has occurred, the Australian Government Minister for Health should issue a direction in relation to the *Health Insurance Act 1973* (Cth) to allow regional commissioning bodies to co-fund MBS-rebated mental health services, and allow other Australian, State and Territory Government agencies to co-fund MBS-rebated mental health services with the consent of the corresponding regional commissioning body.

The Minister for Health should also issue a direction in relation to the Health Insurance Act to allow State and Territory Government agencies to co-fund MBS-rebated out-of-hours GP services with the agreement of the corresponding PHN. The Australian Government should direct PHNs to approve these requests if there is a reasonable prospect that additional out of hours GP services would yield reductions in mental health related emergency department presentations.

Controls on Primary Health Network funding

A consistent and transparent approach should underpin the level of flexibility that PHNs have in deciding how to allocate the Primary Mental Health Care Flexible Funding among providers. Where applicable, these same reforms should apply to the equivalent component of Australian Government funding to RCAs.

Funding hypothecated to particular providers

At present, PHNs receive neither the support they need nor the flexibility to commission the mental health services that best meet the needs of their region. For example, the Australian Government Department of Health binds PHN commissioning of all existing headspace centres by requiring that about one third of the Mental Health Care Flexible Funding Pool be devoted to headspace centres. The arguments in favour of this type of hypothecation are not compelling (appendix G). Meanwhile, the Department of Health otherwise provides too

little guidance on PHN commissioning — specifically, there is insufficient guidance on the types of evidence-based services that PHNs ought to commission (appendix G).

A middle ground is needed that recognises and draws on the relative strengths of the Australian Government Department of Health to identify standards of service delivery and the PHNs/RCAs to deliver services to meet local need. Specifically:

- PHNs generally have (and RCAs generally would have) superior knowledge and contextual understanding of the particular needs of their region, the performance of existing services in their region, and the suitability of prospective new providers
- the Department of Health has greater scope to draw on and assemble higher level expertise about which types of service models are the most effective for different cohorts of people.

This suggests that the Australian Government Department of Health should *not* hypothecate PHN/RCA funding to particular providers (such as headspace centres). PHNs/RCAs are best placed to decide whether a particular type of service addresses the needs identified in their regional gap analysis. Many participants agreed with a draft recommendation to this effect.²⁶³

However, we acknowledge that continuity of support is desirable. For this reason, we recommend that:

- existing service providers to which funding has been hypothecated, such as headspace centres, continue to be funded while each PHN–LHN grouping/RCA estimates the need for specific services, including those tailored to particular demographic groups, as part of its joint regional planning process
- once the planning process is complete, each service provider to which funding has been hypothecated should transparently demonstrate to the PHN–LHN grouping/RCA how they can meet the need for services (or a component of the need) within the region as identified in the regional plan
- if the existing service provider does not subsequently perform this role to an adequate standard, the PHN/RCA should engage with it and headspace National to seek to rectify the issues or, if the PHN/RCA considers that this engagement is unsuccessful, seek to redirect the funding to another provider of the relevant services.²⁶⁴

The Australian Government Department of Health should develop and provide guidance to PHNs/RCAs about the evidence base that underpins different types of interventions and require PHNs/RCAs to demonstrate that they have commissioned evidence-based services.

²⁶³ ACEM (sub. 926); ACPA (sub. 727); Bipolar Australia (sub. 781); CHF (sub. 646); Consortium of Australian Psychiatrists and Psychologists (sub. 882); Martin Whitely (sub. 1198); Mental Health Commission of New South Wales (sub. 948); National Rural Health Alliance (sub. 1192); PHN Cooperative (sub. 850); Samaritans Foundation (sub. 785).

²⁶⁴ In this context, ‘service providers to which funding has been hypothecated’ does not refer to service providers that provide Aboriginal and Torres Strait Islander mental health services. Funding to Aboriginal and Torres Strait Islander mental health services is discussed next.

This point was well made by Transforming Australia's Mental Health Service Systems (sub. 919, p. 16):

We do believe that there needs to be good advice, and at times clear guidelines, based on the current evidence for the design of models of care, including specific interventions and service delivery vehicles, and adherence to fidelity ... Good commissioning in mental health needs high level expertise, and 31 PHNs are unlikely to have that capacity.

This guidance should be updated over time as more services are evaluated. It should draw on:

- the recommended evaluation of MBS-rebated psychological therapies (recommendation 12)
- the evaluations led by the NMHC, in its recommended evaluation role (recommendation 22)
- evaluations funded via the recommended Mental Health Innovation Fund (action 23.8)
- input from the National Centres of Excellence (such as the Orygen National Centre of Excellence in Youth Mental Health) established by the Australian Government for the purpose of providing advice on the evidence base that underpins different types of service provision and interventions.

Aboriginal and Torres Strait Islander mental health services funding arrangements

About 8% of the Mental Health Care Flexible Funding Pool is hypothecated to mental health services for Aboriginal and Torres Strait Islander people. This hypothecation is different from that which applies to headspace centres. In the headspace case, funding is hypothecated to a particular provider, whereas in this case funding is hypothecated to ensure that PHNs commission services for Aboriginal and Torres Strait Islander people.

The question that arises in this context is whether the competitive procurement processes that PHNs use are appropriate for Aboriginal and Torres Strait Islander mental health services. PHNs are required to engage with Aboriginal and Torres Strait Islander communities and Aboriginal Community Controlled Health Services (DoH 2016b), but are free to contract any organisation to provide Aboriginal and Torres Strait Islander mental health services, whether an Aboriginal Community Controlled Health Service or not (DoH 2019a).

Our view is that Aboriginal Community Controlled Health Services should be made preferred providers of Aboriginal and Torres Strait Islander mental health services, on the grounds that competitive procurement processes are not effective in this context (appendix G). This is consistent with recommendation 9, which applies to suicide prevention activities. In practice, this means that the Australian Government Department of Health should direct PHNs to allocate funds for Aboriginal and Torres Strait Islander mental health and suicide prevention to Aboriginal Community Controlled Health Services unless they can clearly demonstrate that alternative providers could produce better results in terms of access to culturally capable services and service outcomes. This same condition should apply to RCAs.

ACTION 23.6 — CONTROLS ON REGIONAL COMMISSIONING

Start now

The Australian Government Department of Health should reform the controls that it places on the services that regional commissioning bodies (currently PHNs) can commission from the Mental Health Care Flexible Funding Pool.

- It should provide guidance to regional commissioning bodies about the evidence base that underpins different types of interventions, and require regional commissioning bodies to demonstrate that they have commissioned evidence-based services that meet their catchment's needs.
- It should permit regional commissioning bodies to redirect funding hypothecated to headspace centres and other particular providers to alternative services, subject to these services demonstrably not meeting the service needs identified in regional plans. This does not include funding hypothecated for the purpose of ensuring that regional commissioning bodies commission services to Aboriginal and Torres Strait Islander people.
- It should require regional commissioning bodies to treat Aboriginal Community Controlled Health Services as preferred providers of Aboriginal and Torres Strait Islander mental health services.

Local Hospital Network funding arrangements

Reform is also needed to LHN funding arrangements, for two reasons. First, productivity is poor in community ambulatory mental healthcare services (chapter 12). Second, the existing arrangements incentivise LHNs to prioritise hospital-based mental healthcare ahead of community ambulatory mental healthcare (appendix G).

The national model for funding LHNs — as used by the Independent Hospital Pricing Authority (IHPA) — comprises activity-based funding (ABF) for hospital-based mental healthcare and block funding for community ambulatory and residential mental healthcare (section 23.3). Some reform is underway on this front — IHPA is developing a new ABF classification system (the ‘Australian Mental Health Care Classification’ (AMHCC)) that would change the basis on which ABF works for hospital-based mental healthcare *and* extend ABF to community ambulatory mental healthcare (discussed later).

In principle, there are many ways that LHNs could be remunerated for providing mental healthcare. But payment models for mental healthcare are underdeveloped relative to physical healthcare, meaning that more research is needed before these can be contemplated. While the next subsection plots a path to the development of new payment models, this subsection focusses on those that will be feasible in the near term — block funding, ABF, and variants thereof. Its conclusions apply regardless of whether health departments or RCAs fund LHNs.

The aims of payment model reform

Incentivising greater productivity in community ambulatory mental healthcare services is the most pressing aim of payment model reform. Across Australia, only about 29% of clinical staff time at community ambulatory mental healthcare services was spent on consumer-related activities (20% with consumers present and 9% without) in 2017-18. This falls well short of National Mental Health Service Planning Framework benchmark rate of 67% (chapter 12).

While excessive paperwork may be part of the problem (chapter 12), payment model reform could help. Existing block funding arrangements do little to incentivise productivity as the funding provided is independent of the amount of care provided. This provides a rationale for a payment model for community ambulatory mental healthcare that rewards greater activity — ABF, or some variant thereof. (The practicalities of this are discussed later.)

Another aim is to rebalance hospital-based mental healthcare and community ambulatory and residential mental healthcare. Current arrangements incentivise LHNs to preference hospital-based care ahead of community ambulatory and residential mental healthcare, although these effects may be weak (appendix G). There are two (potentially complementary) approaches that could improve LHN incentives in this regard — using block funding for all settings or using ABF for all settings.

The first approach would mean returning to block funding for hospital-based mental healthcare. This would remove incentives for LHNs to draw activity into hospitals. But we do not favour shifting from ABF to block funding for hospital-based mental healthcare, for two reasons.

- ABF for hospital-based mental healthcare creates both desirable and perverse incentives for LHNs (albeit with scant empirical evidence to support either having a substantial impact; box 23.5), but there is scope to mitigate the perverse incentives by altering ABF to penalise LHNs for unplanned mental health-related readmissions (this is discussed later).
- ABF for hospital-based mental healthcare facilitates improved data collection and cost benchmarking, allowing for greater transparency.

The second approach would involve using ABF for community ambulatory and residential mental healthcare. With this in place, LHNs would receive payments that reflect the cost of service provision regardless of the setting in which they treat people. This would also reduce their incentive to draw activity into hospitals.

Hence, *in principle*, there is a strong case for State and Territory Government health departments (or RCAs — section 23.4) using an ABF payment model (or some variant thereof) to remunerate their LHNs for providing hospital-based mental healthcare, community ambulatory mental healthcare and residential mental healthcare.

Box 23.5 Impacts of activity-based funding on hospital-based mental healthcare

Activity-based funding (ABF) generates incentives for hospitals to reduce the unit cost of each hospital admission. Local Hospital Networks receive a payment for each person they treat at a public hospital, and hence benefit by treating those people at lower costs. This can be primarily achieved through reductions in the length of hospital stays, as this is the primary cost driver for mental health-related admissions (IHPA 2020a).

Shorter hospital stays can have both positive and negative consequences, and there is scant empirical evidence to support either. On the one hand, shorter stays are less costly and, when adequate treatment and services are available in the community, consistent with achieving good outcomes for consumers (chapter 13). And shorter stays ought to reduce delayed discharge (chapter 13). The introduction of ABF to public hospitals in Australia did result in a reduction in unit costs of admissions (Ettelt et al. 2006), but mental health-specific effects are less clear. Across Australia, the average length of acute inpatient stays declined from 14.1 days in 2013-14 (when ABF was first applied to inpatient mental healthcare at a national level) to 13.1 days in 2017-18, but these declines had already been underway since at least 2010-11. Moreover, there were sharper than average declines in Victoria, and Queensland had the lowest average length of stay of any State/Territory in most years between 2010-11 and 2017-18 despite neither of these States using ABF for hospital-based care (appendix G; AIHW 2020d).

On the other hand, ABF could incentivise hospitals to prematurely discharge and then readmit consumers. A meta-analysis of the impacts of hospital ABF ‘suggested a possible increase in readmission [to hospital] with ABF’ (Palmer et al. 2014). However, data on 28 day readmission rates to acute mental healthcare services in Australia are not sufficiently comparable over time to draw any conclusions about the impacts of ABF (AIHW 2020d), and studies do not consistently find a relationship between length of stay and readmissions for mental healthcare (Hyland et al. 2008).

Practical difficulties with activity-based funding

In practice, implementing ABF for mental healthcare — especially community ambulatory mental healthcare — has proved challenging.

First, ABF requires a ‘casemix classification’ — a system that groups episodes of care into classes for which the average costs of treatment are similar. Classifications are usually based on ‘diagnosis-related groups’, but diagnosis has less ability to predict treatment costs for mental healthcare than for other services (IHPA 2015). A further problem is defining what marks the beginning and end of an episode of care. For inpatient care, an episode generally runs from admission to discharge, but there is no such obvious marker for community ambulatory mental healthcare.

A poor classification (one for which there is high cost variability within classes) generates perverse incentives and/or undermines the viability of ABF. Where cost variations within a class are predictable, it creates incentives for LHNs to preference consumers with simpler to treat illnesses ahead of consumers with illnesses that are more complex to treat (Jacobs et al. 2019; QMHC, sub. 712). Unpredictable within-class cost variability does not generate these perverse incentives, but can hamper the viability of ABF. Several participants

submitted that this is a particular issue for mental healthcare. Allan Fels (sub. 303, p. 2) argued that:

Whilst there is a good case for activity based funding for many medical procedures with predictable average costs, the unpredictability and variability of mental health costs make an ABF system highly problematic for mental illness.

And Transforming Australia's Mental Health Service Systems (sub. 919, p. 6) said:

ABF may work in hospital settings where there is a single disorder in focus, such as a myocardial infarction or an appendicitis needing surgery, where the treatment is well defined and there is low variability in outcomes, compared to mental health, where the diagnosis is a minor component of variance and a wide range of interventions are required, whether clinical, psychosocial, relational, and/or attending to neglected physical health care, beyond the narrow direct health intervention of medication etc.

Second, the classification and the prices associated with each class should ideally reflect the costs of providing best practice care. If these are determined on the basis of historical data, then existing shortfalls in quality of care risk being perpetuated (Transforming Australia's Mental Health Service Systems, sub. 919).

That said, it would be unwise to require a classification to be of too high a standard before ABF can be contemplated. The alternative — block funding — does not incentivise LHNs to provide best practice care nor to treat more people with more complex needs (the risks of a poor ABF classification). And ABF ought to incentivise higher productivity even when supported by a suboptimal classification.

Efforts to establish activity-based funding

The AMHCC, the national mental healthcare case mix classification that IHPA is currently developing, provides a basis on which to apply ABF to community ambulatory mental healthcare (and a way to apply ABF to hospital-based mental healthcare without relying on diagnosis-related groups) (box 23.6). While IHPA's eventual use of the AMHCC would be to determine Australian Government transfers to State and Territory Governments under the NHRA (appendix G), State and Territory Government health departments could also use ABF underpinned by the AMHCC to fund LHNs to deliver community ambulatory mental healthcare.

However, there are concerns about the AMHCC. The first relates to reliability of the relatively new 'phase of care' variable used to separate classes. An IHPA-commissioned study of the 'inter-rater reliability' of the variable (the degree to which different clinicians would assign the same phase of care in identical situations) concluded that the variable had 'poor to fair' reliability (Coombs 2017).

Box 23.6 **Structure of the Australian Mental Health Care Classification**

The Australian Mental Health Care Classification is a mental health-specific case mix classification developed by the Independent Hospital Pricing Authority. It has separate structures for admitted and community ambulatory settings.

- The admitted setting structure uses four ‘splitting variables’ — phase of care, age group, mental health legal status, and patient complexity as measured by the Health of the Nation Outcome Scales. These create 45 classes of admitted patients, each intended to have its own price per episode of care.
- The community ambulatory setting structure also uses four ‘splitting variables’ — phase of care, age group, the Health of the Nation Outcome Scale, and the Abbreviated Life Skills Profile, which measures how successfully people with schizophrenia or with a chronic mental illness live in the community. These create 46 classes of community patients, each intended to have its own price per episode of care.

The Australian Mental Health Care Classification does not cover residential mental healthcare services.

Source: IHPA (2018).

The second concern relates to the integrity of the ‘costing study’ that IHPA commissioned to inform the development of the AMHCC. In his capacity as a professor at the University of Queensland, Professor Philip Burgess (a senior clinical advisor of IHPA’s Mental Health Working Group) (pers. comm., 2 September 2019) advised us that the study did not adequately isolate the treatment costs of individual consumers to produce comparable data across jurisdictions. His overarching view is that the AMHCC is not fit-for-purpose at this time.

The third relates to the AMHCC being developed on the basis of existing standards of care, rather than evidence-based practice. This is standard practice in the development of ABF classifications. In this regard, Transforming Australia’s Mental Health Service Systems (sub. 919, p. 6) said:

There is no consensus even within the IHPA Mental Health advisory networks, as to the definition or description of these phases, as deliberations continue as to whether ABF for episodes and phases should pertain to traditional episodes or phases of care, e.g. prolonged in-patient or maintenance care, and whether they should encourage contemporary evidence based good practice: that is whether there should be incentives to provide less life disruptive and more cost effective contemporary, recovery oriented, proxies for these phases in the community.

State and Territory Governments appear uncommitted to the AMHCC. IHPA had intended to use it to ‘shadow price’ NHRA mental healthcare transfers in 2020-21, but was forced to abandon this for community ambulatory mental healthcare services as only the Queensland Government provided the necessary costing data to allow shadow prices to be determined (IHPA 2020a).²⁶⁵ And they have previously urged caution in its use. In 2018, Queensland Health submitted to IHPA that ‘it may be several years before the AMHCC is sufficiently robust for funding purposes’ (Queensland Health 2018b, p. 8), and the Victorian Department

²⁶⁵ The shadow pricing exercise is expected to proceed for admitted care, but the Northern Territory and Tasmania did not provide costing data to inform pricing for these services either.

of Health and Human Services urged a cautious approach to implementing the AMHCC involving several further years of testing (VIC DHHS 2018a). Moreover, the Victorian Government has embarked on developing its own ABF classification for hospital-based and community ambulatory mental healthcare (Victorian Government, sub. 1228).

We are not in a position to make determine whether the AMHCC is fit-for-purpose. However, there is sufficient concern among informed parties to warrant consideration of whether it needs revision. Our view is that IHPA should immediately launch a review of the classification to determine:

- whether the structure of the AMHCC and the variables within it should be refined or changed (especially the ‘phase of care’ variable)
- if the ‘phase of care’ variable is retained, how it could be refined to improve inter-rater reliability
- whether there are aspects of the alternative mental health ABF classification that the Victorian Government is developing that should be adopted by the national model
- if a new costing study is required
- a revised timeframe for implementing the classification.

Developing a simpler payment model

If the recommended review proceeds, it may delay the introduction of the AMHCC or suggest that a fundamental reconsideration of ABF for community ambulatory mental healthcare is necessary. Given the issues outlined above, it would not be ideal for community ambulatory mental healthcare services to remain block funded during this time.

The question arises as to whether there is a simpler payment model that could improve the productivity of community ambulatory mental healthcare services. An obvious approach is to draw on the fee-for-service payment model (chapter 12) and fund community ambulatory mental healthcare services on the basis of time spent treating people. Such a funding model would be activity-based, like conventional ABF, but the funded unit of activity would be, say, an *hour* of care rather than an *episode* of care.

Victoria is using a similar model to fund its contribution to community ambulatory mental healthcare services. The Victorian Department of Health and Human Services funds clinical community care at 18 LHNs on the basis of ‘community service hours’ (VIC DHHS 2019a). There may be value in further refining this funding model to establish, for example, different prices for hours spent with consumers present, hours spent on consumer-related activities for which consumers are not present, and hours spent in and out of office.

This payment model has several advantages over block funding.

- It would incentivise services to devote more time to consumer-related activities (although this would appear to have had limited success for Victorian community ambulatory mental healthcare services (chapter 12)).

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- It would be unlikely to incentivise treating consumers with simpler to treat illnesses ahead of consumers with illnesses that are more complex to treat (a concern about poorly designed ABF systems), as the variation in the cost of providing an *hour* of care ought to be greatly lower than that of providing an *episode* of care.
 - While it could theoretically incentivise ‘over-servicing’ by community ambulatory mental healthcare services, this ought to be of little concern given the shortages of these services (chapter 12).
 - It would nullify incentives for LHNs to preference hospital-based care ahead of community-based care.

How should such a model be developed? One option is to task IHPA with developing a national model. IHPA is well placed to do so and could liaise with the Victorian Government about the aspects of its current model that have been more or less successful. However, under standard IHPA processes (which are to develop payment models to determine Australian Government transfers to State and Territory Governments), this risks it becoming a drawn-out process. IHPA’s development of the AMHCC has been underway since 2012.

Hence, it may be preferable for IHPA to develop a national model to be used *only* as a means for State and Territory Government health departments to fund their LHNs (i.e. not for the purposes of determining Australian Government transfers to State and Territory Governments, which would remain block funded). This would allow model development to be expedited.

Another option would be for State and Territory Governments to each determine their own payment models. While this risks some duplication between State/Territory Governments, it has merit. State and Territory Government health departments would likely need to adapt a national model to meet their particular needs anyway (as they often do with other ABF classifications). And the costs of developing the recommended model ought not to be restrictively high. Even if IHPA is not actively involved in the development of the model, it could facilitate communication between jurisdictions to reduce duplication of effort.

In summary, IHPA should review the AMHCC and the Australian Government should direct IHPA to negotiate with State and Territory Governments to determine how best to implement a fee-for-service model for community ambulatory mental healthcare in the interim period. This could become an ongoing alternative to ABF depending on the findings of IHPA’s review.

Adjustments for unplanned readmissions

As noted in box 23.5, ABF for hospital-based care can incentivise LHNs to prematurely discharge consumers.

IHPA is currently developing adjustments to its ABF classifications that would penalise LHNs for ‘avoidable hospital readmissions’, thereby reducing incentives for premature discharge (and other aspects of poor quality care that lead to hospital readmissions) (IHPA 2020b). Thus far, mental health-related hospital readmissions are effectively outside

the scope of this work insofar as none of the conditions that would constitute an avoidable readmission relate to mental health (ACSQHC 2019a).

Extending these adjustments to mental healthcare would reduce incentives for LHNs to prematurely discharge consumers. But how ought this be done? We consider it reasonable to consider *all* unplanned hospital readmissions for mental health reasons within a reasonable timeframe following a mental health-related separation to be avoidable for the purposes of ABF. However, determination of an appropriate timeframe and any exemptions should be subject to a clinical review. The Australian Commission on Safety and Quality in Healthcare (which maintains the list of conditions considered to constitute an avoidable readmission) should undertake such a review.

ACTION 23.7 — ACTIVITY-BASED FUNDING

Start now

The Independent Hospital Pricing Authority (IHPA) should review the Australian Mental Health Care Classification to determine:

- whether its structure and splitting variables should be refined or changed (especially the ‘phase of care’ variable)
- if the ‘phase of care’ variable is retained, how it can be refined to improve inter-rater reliability
- if a new costing study is required
- a revised timeframe for implementing the classification.

As an interim measure, IHPA should work with State and Territory Governments to develop a simpler activity-based payment model for community ambulatory mental healthcare services based on hours of care provided. State and Territory Governments should use this payment model to fund community ambulatory mental healthcare services. It should not be used to determine Australian Government National Health Reform Agreement transfers if this would significantly delay its development.

The Australian Commission on Safety and Quality in Healthcare and IHPA should seek to incorporate mental health-related avoidable hospital readmissions into broader activity-based funding reforms.

Toward new payment models

So far, this chapter has recommended granting PHNs the ability to blend MBS rebates with co-funding from the PHN Mental Health Care Flexible Funding Pool and extending an activity-based payment model to community ambulatory mental healthcare. While these are important reforms that should be pursued as soon as practical, they are not the endpoint of improvements to mental healthcare payment models.

Unfortunately, there has been relatively little research in Australian and abroad about more sophisticated ways of paying providers of mental health services.²⁶⁶ It is worth considering ways to foster the development of new models.

What *might* work better?

Recent years have witnessed a shift from funding physical healthcare providers on the basis of individual episodes of care toward a smaller number of payments that cover all care provided over a given timeframe, known as *capitation* or *bundled* payments. When well-administered, these payments can incentivise providers to minimise the costs of achieving good clinical and functional outcomes for consumers, usually by better coordinating care and shifting care to lower cost settings.

For example, rather than receiving a payment each time they provide an episode of care to an individual (as is the case under ABF), LHNs could instead receive a quarterly payment for each individual within their care and have flexibility to provide care in the most appropriate setting. This would strongly incentivise the LHN to *prevent* avoidable hospitalisations, whereas the ABF approach can *encourage* hospitalisations (appendix G; NSW Government, sub. 551).

Other innovative approaches include outcome-based payment models, where providers are partially remunerated on the basis of improvements in measureable outcomes. Aftercare (sub. 835) and the Queensland Mental Health Commission (sub. 712) and suggested that these payment models should be considered where applicable.

However, these newer payment models have shortcomings. Capitation can encourage ‘underservicing’ (PC 2017d). And it can be complex to administer. The LHN example above would require a more sophisticated casemix classification than an ABF classification, as it would need to adequately predict the efficient cost of providing treatment over a forthcoming time period (as opposed to just the current episode of care). Likewise, outcome-based approaches are feasible only in instances where (desirable) outcomes are measurable and can be attributed to the intervention being funded. For instance, mainstream employment support programs are funded on an outcomes basis (chapter 19), because the desired outcome (employment of more than 8 hours per week) is easy to measure and clearly attributable to the program at hand. But suitable outcome measures are more difficult to identify for mental healthcare and psychosocial supports.

²⁶⁶ For example, a recent literature survey of 23 studies of the impacts of bundled payment models did not include any studies of bundled payments for mental healthcare (Struijs et al. 2020), and a recent literature survey of 70 studies of the impacts of ‘accountable care organisations’ (a way of organising healthcare delivery wherein a cluster of organisations is funded on a capitation or similar basis to provide all healthcare for an enrolled population) included only one study that specifically considered mental health services (Peiris, News and Nallaiah 2018).

Hence, across-the-board shifts to these kinds of payment models is premature. Instead, policy should focus on encouraging and learning from regional innovations.

Rigidities in the existing system

Are there barriers that prevent regional decision makers (PHNs, LHNs, or — in the future — RCAs) from pursuing innovative payment models for mental health services? If so, what can be done about them?

The MBS is a barrier to payment model reform. While it is currently the most suitable way to fund most primary mental healthcare (notwithstanding that MBS-rebated psychological therapy should be subject to a rigorous evaluation (recommendation 12)), it does not permit much experimentation with new ways of funding or providing care. Several stakeholders raised the possibility of ‘cashing out’ MBS rebates — delisting items from the MBS and instead administering funding via regional commissioning (Deakin Health Economics, Institute for Health Transformation, sub. 156; Grattan Institute, sub. 816; Joanne Enticott, Anton Isaacs, Sebastian Rosenberg, Frances Shawyer, Brett Inder and Graham Meadows, sub. 836; RANZCP, sub. 385).²⁶⁷ And the Western Sydney PHN has previously proposed primary mental healthcare funding arrangements that would involve a partial cash-out of MBS payments (WentWest 2015).

In our view, universally cashing out MBS rebates for psychiatry and allied mental health is not advisable. These services are generally administered at much lower cost when funded via the MBS (chapter 12). Moreover, requiring all PHNs to commission MBS-equivalent services would involve a large expansion to their responsibilities and infrastructure. Currently, PHN-commissioned services treat about 190 000 consumers per year, whereas about 1.2 million consumers receive MBS-rebated allied mental healthcare and 400 000 consumers receive MBS-rebated psychiatry each year (DoH 2019e).

Otherwise, there is ample flexibility to allow for payment model experimentation. There are no restrictions on the types of payment models that PHNs may use when commissioning services from the Mental Health Flexible Funding Pool, and action 23.5 would only add to the flexibility available to PHNs. As regards LHN-provided care, there is scope under the NHRA for the Australian Government to convert an existing ABF funding stream to block funding should a State/Territory Government indicate that it wishes to trial an innovative funding model (IHPA 2019). At present, this model is being used for the Victorian Government’s ‘HealthLinks: Chronic Care’ program, which uses a capitation funding model to provide integrated support to consumers with chronic and complex health needs (VIC DHHS 2017) (Unfortunately, consumers admitted to hospital for mental health reasons are not eligible for the model.)

²⁶⁷ Some of these participants suggested doing so on the grounds that MBS funding is poorly targeted (to the benefit of wealthier people living in urban areas). We propose managing these shortcomings through changes to the way that the PHN Mental Health Care Flexible Funding Pool is allocated (action 23.5).

Trials and evaluations are needed

Just because PHNs, RCAs or State/Territory Governments *could* pursue new payment models does not mean that they *will* do so, that these models will be suitably evaluated, or that the learnings of these evaluations that result will be shared across Australia.

Only carefully designed and evaluated trials will give an indication of which new approaches will work. But trialling and evaluating a new way of doing things is costly and risky for all parties (most notably consumers, whose care may be disrupted). A concern is that PHNs, State/Territory Governments and/or RCAs will be unwilling to take on these risks when they could wait for a counterpart to do so. This suggests that the Australian Government should provide additional funding to support trials, on the proviso that they are independently evaluated to a high standard and the findings published.

There is precedent for the Australian Government playing such a role within the mental health sector.

- the Australian Government Department of Health has designated several PHNs as ‘Mental Health Reform Lead Sites’ and contributed funding for evaluations of new initiatives in regional planning and service integration, stepped care, low-intensity services, services for youth with severe mental illness, and clinical care coordination for adults with severe and complex mental illness (University of Melbourne 2019). The evaluations of these trials are ongoing.
- The Australian Government committed funding to support the ‘National Mental Health Integration Program’, a series of ambitious trials that ran from 1999 to 2003 in Inner Urban East Melbourne, Illawarra, and Far West NSW and considered ways to fund and integrate private and public psychiatric care. These trials were evaluated (Eagar et al. 2005).

There is also precedent in the broader health system. The Australian Government has recently established a ‘Health Innovation Fund’. Under this arrangement, New South Wales and Western Australia received \$50 million in 2018-19 toward ‘delivery of new projects that support health prevention and the better use of health data’ (COAG 2018c, p. 2). These States are required to report performance data and provide an evaluation of these projects to the Australian Government.

To this end, the Australian Government should establish a Mental Health Innovation Fund to support high quality trials and evaluations by PHNs, LHNs and State/Territory Governments (or, potentially, RCAs). PHN–LHN groupings or RCAs, with the support of State/Territory Governments, would submit proposals for new payment or system organisation models to the Australian Government. If approved, the Australian Government would provide funding to support the evaluation component of the new model.

The Inquiry draft report’s proposal for a Mental Health Innovation Fund was supported by several PHNs (COORDINARE, sub. 1194; Murrumbidgee PHN, sub. 1199; PHN Cooperative, sub. 850), the Consumers Health Forum (sub. 646), and Transforming Australia’s Mental Health Service Systems (sub. 919). We have since given further thought

to the governance and scope of the Mental Health Innovation Fund so as to maximise its potential and minimise any risks.

- The Mental Health Innovation Fund should cover only the additional administrative costs of running and evaluating the trials. In particular, it should not provide additional funding for mental health services.
- Proposals that integrate psychosocial supports and mental healthcare should be considered (a suggestion of Uniting Vic.Tas, sub. 931).
- If PHN–LHN groupings propose new models to integrate PHN-funded and LHN-provided care, their respective responsibilities must be clearly specified.
- The Australian Government should consider the past performance of PHN–LHN groupings or RCAs when deciding whether to approve the projects.
- The Australian Government should permit MBS rebates for allied mental healthcare and/or psychiatry to be cashed out for trial purposes, but *only* if a suitably detailed proposal for redirecting this funding is provided and the PHN–LHN groupings or RCA commits to not removing access to services for consumers currently receiving MBS-rebated care or to maintaining access to the MBS for consumers who choose to continue receiving MBS-rebated care.
- The Australian Government should consider granting exemptions to section 19.2 of the Health Insurance Act as necessary if proposals involve co-funding MBS-rebated GP consultations. As well as supporting a GP’s role in mental healthcare, this would allow for models that attempt to better integrate physical healthcare (a suggestion of the Canberra Mental Health Forum, sub. 687).

ACTION 23.8 — MENTAL HEALTH INNOVATION FUND

Start later

The Australian Government should establish a Mental Health Innovation Fund to trial innovative service delivery, system organisation and payment models. The Mental Health Innovation Fund should allow Primary Health Network – Local Hospital Network groupings and Regional Commissioning Authorities to apply for funding to trial new models under the proviso that the models are independently evaluated and the findings are published.

23.5 Leveraging private insurance to better use

Private health insurance

Private health insurance (PHI) is a significant component of Australia's mental health system. In 2016-17, private health insurers paid approximately \$50 million in benefits for hospital-based mental health treatment, equivalent to about 20% of mental health-related hospital costs.

Longstanding regulation has dictated that the roles of PHI in Australia are to subsidise private hospital care (which also attracts MBS rebates for clinician fees) and to fund services outside of hospitals that are not eligible for MBS rebates (box 23.8). It is outside the scope of this Inquiry to analyse this policy. As such, we have not formed a view on whether it would be desirable to substantially change the scope of PHI. Nor have we examined the appropriateness of the subsidies and tax breaks that consumers receive for taking out PHI, or the issue of public hospitals treating private patients. These issues are not specific to mental healthcare and would warrant more thorough consideration than is possible here.

Box 23.8 **Private health insurance in Australia**

There are two forms of private health insurance in Australia — hospital cover and extras/ancillary cover.

Hospital cover

Hospital insurance subsidises the cost of care in private hospitals (or the cost of care when admitted as a private patient in a public hospital). The Medicare Benefits Schedule provides rebates for clinicians fees for these services, so the insurer's role is to fund (not necessarily in full) additional expenses such as accommodation and theatre fees and clinician gap payments. There are four tiers of hospital cover on offer (gold, silver, bronze and basic) that each cover different suites of treatments.

Extras/ancillary cover

Extras/ancillary insurance covers out-of-hospital treatments that are not eligible for Medicare Benefits Schedule rebates (including psychology).

Regulatory environment

The private health insurance market is tightly regulated.

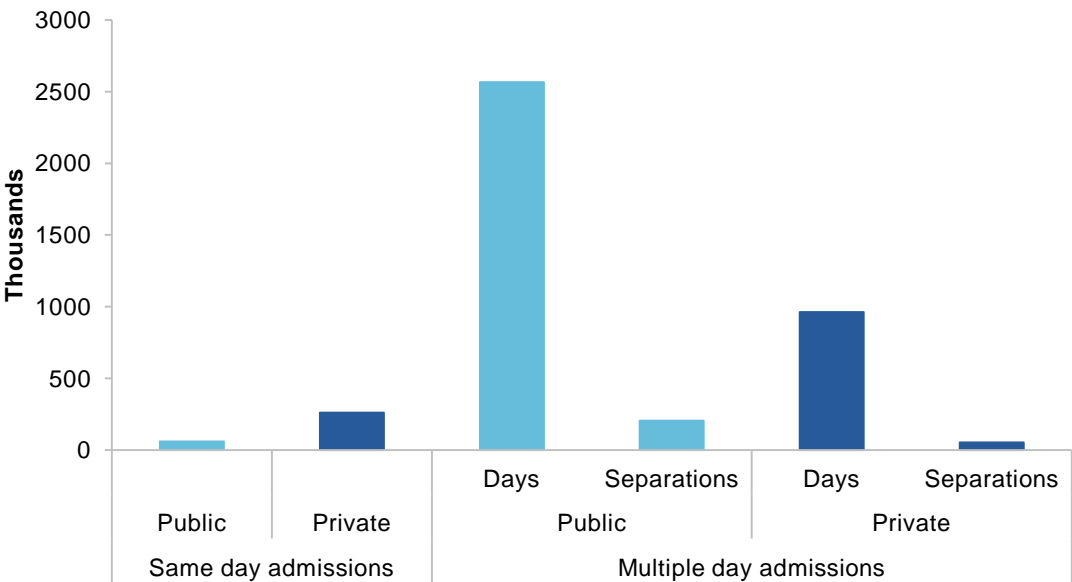
- All private health insurance is 'community rated', meaning that insurers:
 - are not permitted to discriminate against prospective insureds (they cannot prevent people with pre-existing medical conditions or people that are statistically more likely to make claims from taking up insurance)
 - must charge a uniform price for each of their products. An exception operates through the Lifetime Health Cover loading scheme, which applies surcharges to people that first take out hospital insurance when aged over 30 years (to incentivise people aged under 30 years, who typically make fewer claims, to take out private health insurance).
- The risk equalisation scheme complements community rating by re-distributing money from insurers paying less than average in benefits to those paying greater than average in benefits. This ensures that insurers that face a riskier demographic profile (for instance, those that market to older people) are not disadvantaged by community rating.

Role of private health insurance in mental healthcare

Public and private hospital roles differ. In 2017-18, private hospitals provided 81% of mental health-related same day admissions, 21% of multiple day admissions and 27% of days of care among those multiple day admissions (figure 23.1). Private Healthcare Australia (sub. 222) noted that schizophrenia and other acute psychiatric disorders are predominantly treated in public hospitals, while anxiety and eating disorders are primarily treated in the private hospitals.

Figure 23.1 Public and private hospital admissions and days of care^{a,b}

Number of mental health-related public and private hospital admissions and days of care, 2017-18



^a Public hospital same day admissions are counted by separations, while private hospital same day admissions are counted by days of care. ^b Counts of separations for multiple day admissions indicate the number of multiple-day episodes of care completed. For example, if a person is admitted for a three day period, this will be recorded as three days of care and one separation.

Source: AIHW (2020g, 2020f).

Should insurers be permitted to fund more community-based care?

As indicated above, it is outside the scope of this Inquiry to consider whether private health insurers should be permitted (or required) to develop products that would fund comprehensive primary mental healthcare. That said, we consider that the private health insurance regulatory framework should recognise and leverage the fact that private health insurers face strong incentives to prevent avoidable hospitalisations among their insureds.

- Regulations should permit private health insurers, on a discretionary basis, to fund services outside of hospitals that could prevent their hospital cover holders from requiring hospitalisation. This does not suggest an expansion of PHI into new products

that cover additional care outside of hospital whenever demanded by a consumer — a concern raised by the Doctors Reform Society (sub. 746). Such considerations are beyond the scope of this Inquiry. Rather, it suggests that private health insurers should not be prevented from *choosing* to fund community-based care when consumers want it.

- Regulations should require private health insurers to fund hospital services to the extent agreed in the insurance contract whenever it is clinically necessary.

The current regulations are designed to permit some preventative care, but are not aligned toward doing so for mental healthcare. The restrictions in place prevent private health insurers from funding services outside of hospitals that are eligible for MBS rebates (irrespective of whether the rebate is claimed or not). There are exceptions for some services:

- Those that are designated as ‘hospital substitutes’ (under the *Private Health Insurance (Health Insurance Business) Rules 2018* (Cth), s.10). As Bupa (sub. 485, p. 10) notes:

This list has been extremely helpful in encouraging innovative models of care, which Bupa has seen in the Oncology specialty. Many funds now offer cancer treatment at home as an option for consumers. However, the items that can be provided as Hospital-Substitute under the MBS has not ‘kept-pace’ with the evolution of alternative models of care.

There are no mental health-related items currently designed as hospital substitutes.

- Those that form part of a ‘chronic disease management program’. This allows private health insurers to fund MBS-eligible allied mental health professionals, including psychologists and ‘mental health workers’. That said, Bupa (sub. 485, p. 10) criticised the chronic disease management program exemption as too prescriptive:

It is our experience that [the chronic disease management rule] is drafted in a manner which prevents us from doing all we can to assist our customers. We believe [the chronic disease management rule] does not promote best practice evidence, which would support a wider variety of providers (such as mental health nurses) in the provision of chronic condition prevention and management.

Some private health insurers aim to prevent hospitalisations by providing services outside of hospitals that are not eligible for MBS-rebates (and, hence, are not restricted). For example, Australian Unity offers the ‘MindStep’ program, a 6-week telephone-based program of cognitive behavioural therapy for insureds who have previously been admitted to hospital with depression and anxiety. Average days in hospital and readmissions fell for people enrolled in the program, leading to a reduction in average claim costs of \$7800 per person per year for those enrolled in the program. Australian Unity saved \$4 million in the program’s first year (Potter 2017).

Options for reform

Private Healthcare Australia and Bupa both argued for greater flexibility in the existing regulations. Private Healthcare Australia (sub. 222, p. 21) proposed amendments to the *Private Health Insurance Act 2007* (Cth) to remove the restrictions on health funds insuring out-of-hospital care for forms of care ‘that have been demonstrated to deliver patients

improved choice and outcomes’, via a formal schedule of exceptions rather than a general removal of the rule. Similarly, Bupa (sub. 485), proposed that additional MBS-funded mental health services be deemed ‘hospital substitutes’ (therefore permitting PHI co-funding). It would appear that these approaches could produce similar results, and hence we do not have a preference between them.

In addition, Bupa (sub. 485, p. 11) suggested that the chronic disease management rules should be amended to remove the requirement that chronic disease programs fund allied mental health professionals.

We believe this is unnecessarily restrictive and we support a change to the rule that would allow [us] to decide which providers (for example nurses and social workers) we want to fund to provide chronic disease prevention and management services to our customers.

Some efforts at reform are currently underway. In 2018, the Private Health Ministerial Advisory Committee convened a Mental Health subgroup of the Improved Models of Care Working Group to consider, among other things:

[I]dentification of the most clinically appropriate and efficient settings for the delivery of mental health services, including consideration of:

- home based care;
- community based care; and
- other non-admitted day programs. (DoH 2018b)

The Private Health Ministerial Advisory Committee was unable to provide the Productivity Commission with a copy of the subgroup’s report. However, the minutes of a subsequent meeting of the Improved Models of Care Working Group reveal that the report found that existing regulations did not prevent alternative models of care from being adopted, but that uptake of alternative models of care is low and existing regulation may be discouraging them (DoH 2018c).

Many participants supported the Inquiry draft report’s recommendation that this work be extended to become a larger and more public review of the current regulatory framework for mental health-related private health insurance. Among them were private health insurers (Bupa, sub. 1191; Medibank, sub. 700; PHA, sub. 815), consumer groups (Bipolar Australia, sub. 781; CHF, sub. 646) and a provider group (PACFA, sub. 883). It remains our view that a more substantial and transparent review is necessary.

ACTION 23.9 — PRIVATE HEALTH INSURANCE AND FUNDING OF COMMUNITY-BASED HEALTHCARE

Start now

The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions.

Life insurance

Life insurers, which provide income protection insurance products, are currently not permitted to fund mental healthcare for their consumers.

The incentives that life insurers face are similar to those of private health insurers. They have a strong interest in preventing mental ill-health among their consumers, lest it lead to insurance claims in the event that they become unable to work. For these reasons, we recommended in the Inquiry draft report that life insurers be permitted to fund mental healthcare on a discretionary basis. Life insurers strongly supported this recommendation (Life Insurance Industry, sub. 821; SuperFriend, sub. 873; TAL Life Limited, sub. 643).

Some participants had reservations. Doron Samuelli (sub. 720) argued that:

- there is limited evidence underpinning the impact of access to mental healthcare on claim volumes. Hence, if life insurers were to fund mental healthcare, this would increase their costs and put upward pressure on premiums
- the arrangements would effectively allow life insurers to enter the PHI market, creating confusion over treatment liability.

Requiring that funding of mental healthcare be on a *discretionary* basis ought to nullify these concerns. The proposal is not that life insurers be permitted to offer mental healthcare insurance products — merely that they should have the *option* of funding mental healthcare treatment. If doing so is not in their financial interest (i.e. if the expected cost of the treatment exceeds the expected reduction in claims), then they are unlikely to fund those treatments. Likewise, there would be no confusion over treatment liability, as life insurers would have no liability in this regard.

A third concern is that such arrangements would create ethical conflicts, as clinicians funded by life insurers could be incentivised to inappropriately recommend that a person return to work (Beyond Blue, sub. 877; Doron Samuelli, sub. 720). We acknowledge these concerns, but consider that appropriate regulation and ethical convictions on the part of clinicians (as well as regulatory oversight by the Australian Securities and Investments Commission) should be sufficient to manage such issues. For example, the life insurance industry code of conduct could be amended to prevent life insurers making incentive payments to clinicians to return

consumers to work or otherwise pressuring clinicians to engage in such behaviour. The Life Insurance Industry (sub. 821) itself suggested that any funding of mental healthcare should be with consumer's consent and choice of clinician.

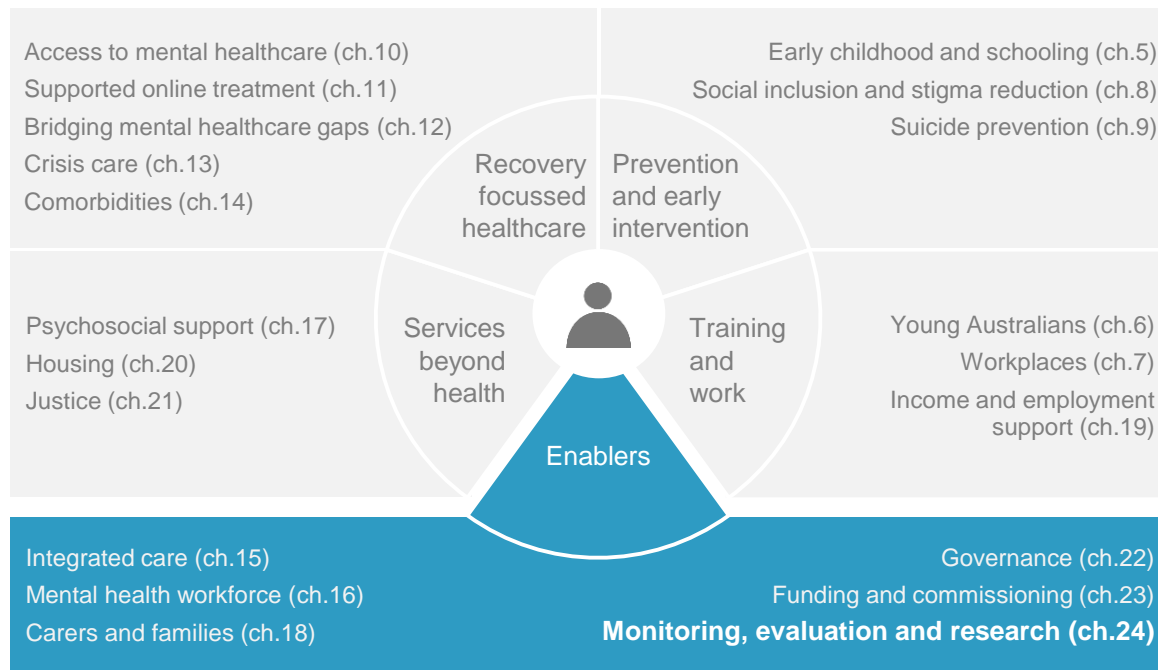
Some life insurers suggested that the arrangements should be extended to consumers of 'total and permanent disability' products as well as 'income protection' products (Life Insurance Industry, sub. 821; SuperFriend, sub. 873). We agree, as the same arguments made above apply to all life insurance consumers.

ACTION 23.10 — LIFE INSURANCE AND FUNDING OF MENTAL HEALTHCARE

Start now

The Australian Government should permit life insurers to fund mental health treatments for their income protections and total and permanent disability insureds on a discretionary basis. The Australian Securities and Investments Commission should work with the life insurance industry on the preconditions necessary for this to occur.

24 Monitoring, evaluation and research



Monitoring, evaluation and research matter because ...

- While the mental health system collects substantial amounts of data, this is rarely used to inform decisions made by consumers and carers. There are only limited evaluations to inform governments, service commissioners and providers how they are tracking on outcomes. And for some key indicators, data either does not exist or is out of date.
- Using data collections to their full potential is key to creating a person-centred mental health system. Collecting better data on service effectiveness and building a culture of service evaluation would shed light on what is working well for people and what is cost effective.
- Monitoring, evaluation and research, underpinned by data, are essential to ensure accountability, improve policies and services; and ultimately achieve the outcomes valued by the people who use the mental health system.

RECOMMENDATION 24 — DRIVE CONTINUOUS IMPROVEMENT AND PROMOTE ACCOUNTABILITY

A robust information and evidence base is needed to improve programs, policies, and outcomes for people with mental illness and carers. This requires that governments support data collection and use, transparent monitoring and reporting, program evaluations and practical research.

As a priority:

- The Australian, State and Territory Governments should agree on a set of targets and timeframes that specify key mental health and suicide prevention outcomes.
 - These targets should be co-designed with consumers and carers and include both quantitative and qualitative evidence and data.
 - Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce should be included in discussions about any targets that may affect Aboriginal and Torres Strait Islander people (Action 24.4).
- The Australian, State and Territory Governments should require monitoring and reporting at the service provider level that is focused on consumer and carer outcomes (Action 24.5).
- The Australian Institute of Health and Welfare should publish data on mental health services at a national, State and Territory, and regional level that is aligned with the National Mental Health Service Planning Framework (NMHSPF); and gap analyses against NMHSPF benchmarks. Each regional commissioning body should report a regional-level gap analysis in their joint regional plan (Action 24.8).

Additional actions that should be considered:

- The Australian Government should fund regular national surveys of mental health and wellbeing (Action 24.2) and the establishment of a national clinical trials network in mental health and suicide prevention (Action 24.12).
- The National Mental Health Commission should include outcomes, activities and reforms from all relevant health and non-health portfolios in its national monitoring and reporting (Action 24.10).
- The Australian, State and Territory Governments should:
 - develop a strategy to improve the usability of data collections (Action 24.1) and ensure prioritised data and information gaps are addressed, including data on non-government organisations that provide mental health services (Action 24.3).
 - develop standardised and outcome-focused reporting requirements for service providers and report all data relating to the performance of services at a regional level (Actions 24.6, 24.7).
 - enhance and make all parts of the NMHSPF publicly available (Action 24.9).
 - require funding applications for mental health programs to include an assessment of their expected cost-effectiveness and require all new programs to have been trialled as pilots, before they can be scaled up (Action 24.11).

A robust evidence base is necessary for improving outcomes for consumers and carers, and for using taxpayers money effectively and efficiently.

... information on [the prevalence of mental disorders, the costs of mental ill-health, treatment outcomes and service quality] is crucial if policy makers are to commit greater resources to mental health care, to prioritise areas of greatest need, and make sensible decisions about effective and efficient care for mental ill-health. A better information infrastructure will be the foundation of stronger mental health systems. (OECD 2014, p. 19)

Australia's National Mental Health Plans have prioritised data development and information management since Australian, State and Territory Government health ministers endorsed the first plan in 1992. Decision makers rely on a range of data and information to develop and fund mental health and suicide prevention policies, programs and services.

However, many Inquiry participants and past reviews highlighted the limitations of the current arrangements (AIHW, sub. 370; CHF, sub. 496; Mendoza et al. 2013; NMHC 2014b; NMHC, sub. 118). Inadequate data and information to guide decision making and promote accountability generate significant costs. They can lead to expenditure on ineffective and costly interventions, which reduce public confidence in the mental health system, and to unnecessary data collection (AHMC 2009a, 2009b).

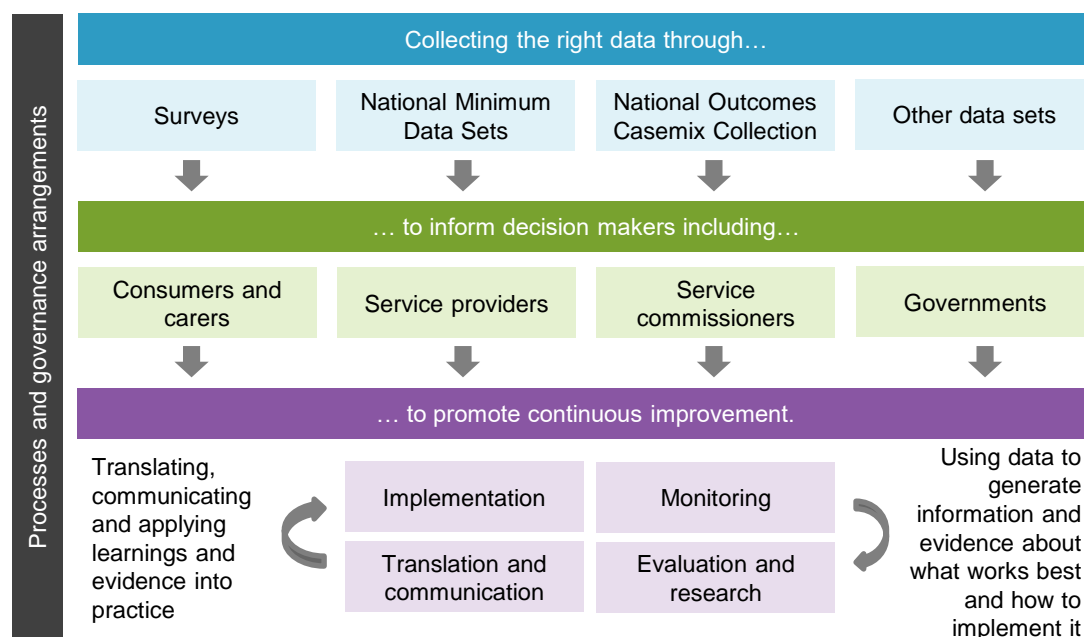
The Productivity Commission also experienced significant data and information limitations during the course of this Inquiry, which restricted the type and level of analysis that could be undertaken in some cases. In particular, data on mental health outcomes and activity in non-health areas (such as justice) was limited, as highlighted in other chapters (section 24.1).

Currently, there is no policy framework to guide monitoring, evaluation and research in mental health and related sectors. Consequently, some aspects are overlooked. For example, the Queensland Mental Health Commission (sub. 228) observed that while a lot of monitoring activity occurs in mental health, less attention is paid to evaluations and other initiatives that would address data issues and information gaps.

The Productivity Commission proposes a framework of improved processes and institutional arrangements to generate the right *information* to drive continuous improvement, and promote accountability through better monitoring, evaluation and research (figure 24.1). It is based on a set of principles identified by the Productivity Commission (box 24.1).

The recommended actions in this chapter are intended to complement the forthcoming *Indigenous Evaluation Strategy*, which will set out a whole-of-government framework for Australian Government agencies when evaluating policies and programs affecting Aboriginal and Torres Strait Islander people (PC 2020). The draft strategy was released on 3 June 2020 and outlined a principles-based framework — the over-arching principle was about centring Aboriginal and Torres Strait Islander people, perspectives, priorities and knowledges. This strategy will be relevant to mental health and suicide prevention programs for Aboriginal and Torres Strait Islander people, and will be particularly important given the lack of quality evaluations of those programs (AH&MRC, sub. 206; NMHC, sub. 118). The strategy is expected to be finalised in October 2020.

Figure 24.1 **Framework for monitoring, evaluation and research**



Source: Adapted from Productivity Commission (2016).

Box 24.1 **Principles to guide monitoring, evaluation and research**

The Productivity Commission's framework for monitoring, evaluation and research (figure 24.1) is based on the following principles:

- fit-for-purpose — data collected should inform decision making at all levels of the mental health system, including by consumers and carers, governments, service planners and commissioners and providers
- maintains social licence — data collection and use should meet public expectations
- supports continuous improvement — information from monitoring, evaluation and research should support continuous improvement of mental health outcomes
- independent — bodies tasked with monitoring, evaluation and research should be independent of areas responsible for policy, program development and implementation
- transparent — monitoring, evaluation and research should be made publicly available through appropriate, ethical and collaborative consent processes
- person-centred — monitoring, evaluation and research should aim to improve outcomes for people with mental ill-health and their carers. Monitoring should include measures of consumer reported experiences and outcomes
- culturally capable — bodies undertaking monitoring, evaluation and research should consider different cultural needs that may affect approaches and aim to address them
- generating a net value — resources should only be allocated to monitoring, evaluation and research if the benefits outweigh the costs.

The Productivity Commission has applied this framework to analyse issues and propose reforms to:

- data collection and use (section 24.1)
- monitoring and reporting (section 24.2)
- evaluation (section 24.3)
- research (section 24.4).

24.1 Data collection and use

To undertake effective monitoring, evaluation and research, the right data needs to be collected. This involves investing in data that is of high quality. This section describes the existing data landscape, highlights areas where data is underutilised and gaps exist, and identifies and recommends reforms to address these issues.

Maintaining a social licence

Maintaining a social licence is a critical consideration for data collection and use (PC 2017a; CHF, sub. 646). Social licence can be defined as a community's tacit acceptance or approval of data use. It requires organisations (including governments, companies and research institutions) to meet public expectations about data being used to create value for the community, and for the public to have trust in those institutions, their processes and their people.

This is important for both principled and pragmatic reasons, as individuals are more willing to share their data when they trust how it is being used and feel they have some control over it (PC 2017a). Public institutions are obliged to operate consistently with the public trust placed in them, which includes ensuring that data use is managed fairly and respectfully. Pragmatically, data use initiatives will likely fail if the community does not understand or believe they generate benefits. When community expectations are not met or are breached, individuals may withdraw their consent for their data to be used.

To maintain a social licence, fundamental values or standards should be embedded to guide data collection, sharing and use (PC 2017a, box 24.2). These fundamental standards include embedding: a sense of shared control; a right to choose to participate, where possible, in the benefits of data collection and use (such as better service delivery, or personal benefits); and a belief that accountability and integrity is upheld by data collectors and users.

Embedding these fundamental standards is central to realising the full value of data, particularly in mental health where stigma and discrimination are concerns. People with mental illness may be reluctant to share their data, due to fears they could be identified and discriminated against, for example, when seeking insurance (chapter 8). Further, specific considerations to maintaining a social licence may be required in some instances. For example, a lack of trust in institutions can be more evident among Aboriginal and Torres Strait Islander

people, due to historical and political context. Collection and use of Aboriginal and Torres Strait Islander people's data would need to recognise and respect this.

... the accumulation of many generations of Aboriginal and Torres Strait Islander peoples' experiences of colonial and post-colonial interventions have coloured our relationship with data. We have an abiding concern, shaped by historical legacies of distrust, in knowing what data are collected and how this information is used, both with and without our consent. (NACCHO, sub. 1226, p. 21)

Box 24.2 Fundamental standards to maintaining a social licence for data collection and use

- *Shared value*: value derived from data should be shared among stakeholders (private sector, public sector, researchers, not-for-profits, community groups, and individual consumers), where privacy or consent issues do not prevent it.
- *Control*: individuals should be informed about who holds their data and how it is used, and be able to exercise control over this, subject to the context in which the data is being used.
- *Trust*: embedding genuine safeguards into data frameworks to assure people their data is being used safely.
- *Genuine accountability*: data management in Australia should build trust and confidence in the system by being transparent, promoting responsible data stewardship, and safeguarding privacy and data security.

Source: Productivity Commission (2017a).

Data landscape

At the national level, the amount of data collected in mental health is large relative to other areas of health and welfare (AIHW, sub. 370; table 24.1).

Supporting these collections is a long standing governance structure for information development in mental health that does not necessarily exist for some other areas of health. The Australian, State and Territory Governments established the Mental Health Information Strategy Standing Committee to advise the Australian, State and Territory health ministers on mental health information and data issues (box 24.3).

The Mental Health Information Strategy Standing Committee has led recent developments in the national data landscape, including:

- Your Experience of Service National Best Endeavours Data Set (NBEDS) — which includes data on consumer- and carer-rated experiences of care in public sector specialised mental health services in New South Wales, Victoria and Queensland
- Seclusion and Restraint NBEDS — which aims to monitor restrictive practices in hospitals and mental health units.

Table 24.1 Major data collections in mental health

National population surveys	
ABS National Survey of Mental Health and Wellbeing (1997, 2007)	Prevalence of selected mental disorders, demographics, medication, comorbidity, employment and education characteristics of people aged 16–85 years
ABS National Health Survey (pre-2000, 2004-05, 2007-08, 2011-12, 2014-15, 2017-18)	Psychological distress, various mental health conditions, demographics, medications, comorbidity, employment and education characteristics of people aged 15 years and older
Low prevalence (psychosis disorder) surveys (1998, 2010)	Prevalence of psychosis for people aged 16–64 years seen by public sector mental health services, their personal, social and living circumstances, service use by people with psychotic illness and effect of illness (including on functioning)
Child and adolescent surveys (1998 and 2014)	Prevalence of selected mental disorders, severity, effect on schooling, service use of people aged 4–17 years
National Minimum Data Sets	
Mental health establishments	Expenditure and activity (for example, bed and staff numbers) for public sector specialised mental health services
Admitted patient care	Same day and overnight admitted mental healthcare
Residential mental healthcare	Care in residential mental health services. non-government organisation services receiving government funding is optional
Community mental healthcare	Community ambulatory mental healthcare services
Primary mental healthcare	Activity and outcomes data of primary mental healthcare services commissioned by primary health networks
National Outcomes and Casemix Collection	
National Outcomes and Casemix Collection	Consumer outcomes data from state and territory public sector specialised mental health services
Other datasets	
Medicare Benefits Schedule and Pharmaceutical Benefits Scheme	Administrative payments data
National Health Workforce Dataset	Registration and survey data collected through the registration process for registered health practitioners
Your Experience of Service survey	National consumer and carer experience surveys implemented in New South Wales, Victoria and Queensland
Mental health non-government organisation establishments NBEDS ^a	Non-government organisations involved in providing mental healthcare services, including data on the number of organisations and number of full-time equivalent staff
Mental health seclusion and restraint non-admitted patient NBEDS	Seclusion and restraint events at the hospital level for public sector specialised mental health hospital acute service units, including short stay mental health units

^a NBEDS is a dataset for which there is a commitment to provide data nationally on a best endeavours basis, but not formally mandated for national collection (AIHW 2019m).

These datasets can — and should — be used to inform service improvement and promote accountability. For example, the Victorian Mental Illness Awareness Council (2019) recently used this data to rank Victorian hospitals on seclusion rates to inform the public and hold hospitals accountable.

However, the mental health sector has been criticised as being ‘data rich but information poor’ (Rosenberg and Salvador-Carulla 2017, p. 38). Much more can be done to improve the

collection and use of mental health data to inform decision making and improve outcomes for consumers and carers. In the absence of high-quality and informative data, many decisions about service and program priorities are being made without evidence of either clinical or cost effectiveness, nor robust consideration of alternatives.

Box 24.3 The Mental Health Information Strategy Standing Committee

The Mental Health Information Strategy Standing Committee provides expert technical advice and, where required, recommends policy for consideration by the Australian, State and Territory health ministers.

The Mental Health Information Strategy Standing Committee brings together jurisdictional mental health data representatives and key stakeholders including consumers, carers, clinicians, peak bodies and key organisations. It provides a national collaborative forum for the development and implementation of national initiatives in mental health information, national monitoring, reporting and benchmarking of mental health publications and resources. It facilitates communication and collaboration regarding mental health information with government, private sector and non-government agencies. It also leads the development of national data collections.

Source: AIHW (2020b).

Optimising data collection to get more information

Data collection can be costly and burdensome

Establishing and maintaining data collections can be complex and costly for governments and those required to collect data. Governments allocate resources to support data collection, which include investments in new data infrastructure and ongoing maintenance of data collections. For example, the Australian Government (2012) allocated \$240.3 million to build and operate the information technology system required to collect and analyse data to monitor consumer outcomes and performance under the National Disability Insurance Scheme (NDIS). Moreover, additional resources and systems are required to ensure datasets are translated into useful information.

Data collection is a complex exercise, and one which requires additional resources and systems at the level of both funded services but also for the funder, who needs mechanisms for collecting de-identified data from commissioned services, as well as systems for secure storage, analysis and interpretation. These are non-trivial undertakings and if implemented poorly can result not only in unreliable data, but also a considerable waste in effort. (MindSpot, sub. 178, p. 7)

Forming nationally consistent datasets can add additional complexity as data must be collected from a ‘disparate state-based assortment of mental health services’ (Holloway, Alam and Griffiths 2012, p. 23). In addition, State and Territory Governments often use data definitions and structures that are not consistent with each other, adding to the time and resources required to achieve nationally consistent collections.

For many service providers, the costs of data collection can also be significant. The Victorian Council of Social Service (sub. 478, p. 20) reported that ‘overly burdensome reporting and regulation ... [is] costing organisations valuable time that could be used for frontline service delivery’. This is particularly the case for non-government organisations (NGOs), which often receive funding from various government agencies with different reporting requirements (chapter 17).

Further, service providers often view data collection as a lower priority relative to service delivery, especially if funding does not extend to data collection. While this is understandable, overlooking data collection is a very short-term view. It ignores the value of data in informing improvements in service delivery and outcomes for consumers, and is inconsistent with the pursuit of innovative, person-centred service delivery.

The most effective programs and services find ways to embed data collection into their delivery models and provide timely information back to data collectors and/or service users. One example is the Link-Me trial, which ensured data collection allowed for a randomised control trial evaluation to be undertaken (Le et al. 2019). Governments can facilitate data collection by standardising reporting requirements, which reduces the burden on service providers (section 24.2).

Data is underutilised

There are concerns that few quality insights have been gathered from mental health data to date (Rosenberg and Salvador-Carulla 2017). The National Mental Health Commission (NMHC) (sub. 118, p. 32) reported that ‘[m]ore can be done to improve the collection and value of mental health data’. The Department of General Practice at the University of Melbourne (2019, p. 1) stated that ‘Australia lags behind other developed countries in the collection, storage and use of patient centred healthcare data’. Service providers also questioned the value of their time spent collecting and submitting data.

[Health Services Union] members report doing ‘hours of paperwork’ ... However, they also report a sense of the data ‘going nowhere’ and of ‘systems that do not talk to each other’ so the real benefits of that information, those that can support the delivery of efficient, holistic and individualised care, are not realised. (Health Services Union, sub. 237, p. 12).

To illustrate, a review by the Office of the Auditor General Western Australia found that the Western Australian Mental Health Commission and the Western Australian Department of Health did not use data effectively to manage service delivery and reform. Although they knew the volume of mental healthcare being provided, they did not know how many people accessed care, or if they were using services as intended (OAGWA 2019). This was because they were tracking the number of times a service was delivered, not who was using a service. The review found that by:

Focusing on each discrete activity in the mental health system, rather than how people use services ... the MHC [Mental Health Commission] lack[ed] some of the information needed to effectively quantify demand, prioritise investment and demonstrate its expected benefits. (OAGWA 2019, p. 10)

Inquiry participants provided other examples of underutilised datasets in response to an information request (box 24.4). Although no particular dataset stood out, the feedback is evidence of a widespread problem.

There are three key reasons why datasets are being underutilised.

First, datasets are underutilised because of restrictions on access and use (Murrumbidgee Primary Health Network, sub. 1199; WentWest Limited, sub. 445). For example, the NMHC (sub. 118) and the Australian Institute of Health and Welfare (AIHW) (sub. 370) remarked that although data on individuals with psychosocial disability who access the NDIS is collected, it is currently not available for reporting on. The Victorian Government (sub. 483) stated that there are opportunities to improve data sharing between the Australian, State and Territory Governments to better inform service delivery. Service commissioners can also face barriers to accessing timely data that could be used to inform regional assessment and planning (Murrumbidgee Primary Health Network, sub. 1199). Further, restrictions can limit research opportunities, and the ability for consumers to make informed decisions and exercise choice (WentWest Limited, sub. 445).

More specifically, access issues can be caused by privacy legislation, health legislation and a ‘culture [in health] that prioritised the protection of data, rather than promoting its use to improve program design and service delivery’ (PC 2017a, p. 538). For example, under the *Privacy Act 1988* (Cth), health information is considered a particularly sensitive type of personal information and there are additional requirements for its protection (PC 2017a). However, a risk averse culture that avoids sharing and releasing data can be an even greater barrier to data access. Parts of the public sector remain reluctant to share data (even when genuine legislative barriers do not exist) due to fear that data would be misused or misinterpreted (PC 2017a).

Second, the low quality of data can limit its potential use (MHCT, sub. 314; Suicide Prevention Australia, sub. 1189). Data can be considered low quality and unsuitable for further analysis if it is unreliable, incomplete, inaccurate or inconsistent. For example, Suicide Prevention Australia (sub. 1189) reported that data collected on suicidal ideation and behaviour presentations in emergency departments varies significantly in its completeness and quality. In their view, this data cannot be reliably used to inform suicide prevention policy and services because of non-standardised definitions and classifications.

Box 24.4 Examples of underutilised datasets

The Independent Private Psychiatrists Group (sub. 473, p. 2) highlighted the poor use of outcomes data collected.

Outcome measures have been collected in both the public and the private mental health sectors for around 15 years. Unfortunately, no significant use has been made of that outcome measurement data, since its inception. Useful data are available in those databases, and is available to both the Commonwealth and State and Territory governments, which could guide the type of service systems that need to be developed and implemented.

The Australian Institute of Family Studies (sub. 753, p. 14) said existing longitudinal datasets can support mental health research, but are underutilised.

... there are a number of longitudinal datasets that are used to examine issues related to mental health, including [the Longitudinal Study of Australian Children, Building a New Life in Australia], the Australian Longitudinal Study on Women's Health, [Ten to Men: The Australian Longitudinal Study on Male Health and the Household, Income and Labour Dynamics in Australia survey]. Overall, these data assets are under-utilised in relation to mental health research for numerous reasons, including:

- limited funding and resources to maximise use of the data, including promotion and user support (e.g. data-user workshops)
- a lack of 'discoverability' of the data and absence of centralised infrastructure
- limited utility; for example, due to a lack of data linkage.

Grow Australia (sub. 847, p. 19) said that a lot of data is publicly available at the national level, but underutilised, because reporting is too high-level and is not analysed effectively.

... the reality is that there are significant amounts of data which are publicly available but unused (not analysed) or which can be extracted from existing data sets if the right questions are asked of the data custodians (and of course sometimes this involves additional costs). Yet while the data are available, much national reporting currently does not go into the level of granularity which is available through effective analysis and hence the magnitude of the impact and prevalence of behaviours, barriers and activities for particular age groups (e.g. children and young people) or specific at risk groups (e.g. LGBTIQ) can be masked and diluted by population-wide approaches.

Participants stated that there are developed private sector datasets that could be better utilised.

Medicare subsidised psychology sessions have not been fully evaluated to date because outcome monitoring has not been mandated and there is no public dataset. One dataset that taps into private psychology outcomes is NovoPsych's longitudinal data (over 150,000 patients). This provides an opportunity to undertake an evaluation of this [program] right now. NovoPsych is yet to statistically evaluate broad outcomes but would be happy to do so with a partner. (NovoPsych Pty Ltd, sub. 645, p. 4)

Before new outcome measures and quantitative monitoring programs are suggested, we would strongly support the idea of actually using the data that is already available. We note as a starting point, that there is still no exact number for consumers treated in the public system in Australia. On the contrary, there is an exact number of Australians being treated by the private sector which is well known and has been documented for years. (Independent Private Psychiatrists Group, sub. 742, p. 17)

Third, some datasets, on their own, provide insufficient information to be useful for informing decision making. Participants highlighted that many do not provide valuable insights and information (One Door Mental Health, sub. 856; QMHC, sub. 228). For example, the Queensland Mental Health Commission (sub. 228, p. 12) stated:

... it is often difficult to gain meaning from the data that enables a clear understanding of the outcomes and impacts of policies, programs and investments. Measuring outputs or comparing

health expenditure alone provides no insight into achieving the best outcomes for people or providing the evidence-base for a future course of action.

Data linkage

A significant weakness of the existing evidence base is that many datasets sit in isolation from one another. On their own, they provide limited insights on how policies, programs and services can be designed and enhanced to meet consumer and carer needs, and improve outcomes. The AIHW(sub. 370, p. 4) stated:

... the mental health sector's information activities necessarily reflect Australia's federated model of funding and delivery of the health and welfare sectors, and is fragmented. Consequently, there is no single 'unified information system' with consistent definitions and structure which policymakers and researchers can use to assess whether programs and support services are 'making a difference' and effectively supporting Australians living with mental ill health or experiencing mental health issues.

Data linkage techniques can improve data use by extracting more information from existing datasets. By matching records on the same individuals contained in different datasets, richer insights can be gathered (PC 2017a). For example, the Australian Government's Multi-Agency Data Integration Project provides insights into the employment status of sub-groups of people with mental illness who use Medicare Benefits Schedule (MBS)-rebated mental health services. It demonstrated that individuals with low education, who were unemployed and living in regional areas, were less likely to be prescribed talking-based therapies and more likely to be prescribed medication (NMHC, sub. 118).

Reviews of the mental health system have consistently highlighted the significant potential for data linkage to improve data analysis (KPMG and Mental Health Australia 2018; NMHC 2014b; Nous Group 2018c). Many participants also highlighted its potential (AIHW, sub. 370; MHCT, sub. 314; NSW Government, sub. 551). Broadly, better use of data linkage in mental health could enable assessment of:

- consumer and carer outcomes that are realised over a long period of time
- the relationship over time between the use of services in one sector (such as psychosocial supports) and outcomes in another sector (such as health)
- the social determinants and predictors of mental illness or self-harm
- an individual's access to services and pathways of care as their condition and circumstances change.

The extent to which datasets should be linked depends on the evaluation or research questions being asked. If the aim is to evaluate the outcomes of specific interventions, then only data relevant to the intervention's intended outcomes may need to be linked. For example, linking correctional and health data could help evaluate programs that aim to help ex-prisoners with mental health problems transition back into the community (VAADA and Justice Health Unit 2019).

On the other hand, if the aim is to address broader questions around social determinants and consumer pathways of care, multiple datasets may be required (KPMG and Mental Health Australia 2018). Many participants argued linking health service data with non-health data such as education, housing, employment, social security, employment, justice and NDIS data is essential (for example, Melbourne Disability Institute, sub. 144; NSW Government, sub. 551; PHNs, sub. 377).

However, there are impediments to data linkage that should be reduced or removed, subject to maintaining appropriate protections for individuals.

First, legislative and cultural barriers exist. The complex legislative environment governing the management of personal information and a risk averse culture among data custodians and ethics approval committees can impede greater use of data linkage (PC 2017a). Legislation especially restricts data linkages in health (PC 2017a). For example, MBS and Pharmaceutical Benefits Scheme data is not allowed to be linked routinely. The NMHC (sub. 118) observed that access to the Multi-Agency Data Integration Project is often granted on a project-by-project basis, which can limit access to routine and ongoing analysis. Further, where analysis through data linkage projects occur, results are often not shared or made public, preventing wider learning.

Second, technical complexities can impede data linkage. The AIHW (sub. 370, p. 7) said ‘limitations inherent to administrative datasets can make data extraction, linkage and merging of different mental health datasets challenging in the absence of a nationally agreed linkage methodology’. Further, the Victorian Government (2019a, p. 27) said that ‘changes in sampling methods, methodologies and gaps in data collection reduces [the Victorian Government’s] ability to link data [in mental health]’. The Murrumbidgee Primary Health Network (sub. 1199, p. 10) stated that:

... critical changes to the Primary Mental Healthcare Minimum Data Set are required in order to link service data across a person’s entire mental health service journey within the Primary Mental Healthcare Minimum Data Set. Currently, individual data is linked to an episode of care that is oriented around the service provider. Therefore, the data of the same individual accessing a subsequent service is not connected.

Notwithstanding, there is scope to improve the use of mental health data by improving its access and quality, and through linking separate datasets. As a result, the Australian, State and Territory Governments should develop a strategy to improve data usability in mental health. The strategy should consider potential data linkage projects and identify datasets that are underutilised because of restrictions imposed on access and use, or because they are of low quality and unsuitable for further analysis (for example, due to inconsistent definitions and classifications). Subsequently, projects to improve data usability should be prioritised, barriers to implementing projects should be identified and solutions to address them should be developed.

ACTION 24.1 — A STRATEGY TO IMPROVE DATA USABILITY

There is significant mental health data currently collected — but much of it is underutilised.

Start now

The Australian, State and Territory Governments should develop a strategy to improve data usability in mental health and suicide prevention including identifying:

- data linkage projects between Australian, State and Territory Government datasets
- datasets that are underutilised due to access barriers, in particular, access barriers faced by State and Territory Governments and regional commissioning bodies
- datasets that are underutilised due to low data quality, including inconsistent definitions and classifications.

This strategy should identify high-priority projects in consultation with relevant stakeholders, assess the barriers to implementing such projects and develop solutions to address them.

Addressing data gaps

Many participants identified data gaps as impeding efforts to improve system performance (for example, AIHW, sub. 370; NMHC, sub. 118; MHCN, sub. 245). Data gaps limit opportunities to inform policy, program, service decisions and consumer decisions. Their existence is well understood by all governments:

Better data is required to understand the mental health needs and subsequent outcomes for Australians from all walks of life, from all parts of Australia and across their life span ... Previous National Mental Health Plans have supported significant investment in measurement and reporting and provided data on many of these issues, but gaps remain. (COAG Health Council 2017a, p. 17)

The data gaps that are most limiting relate to:

- prevalence and service utilisation data that is outdated
- mental health services provided by NGOs and MBS-rebated providers (psychologists and psychiatrists)
- particular demographic groups
- non-health sectors.

Prevalence and service utilisation data is outdated

The main source of population level data is outdated. The ABS *National Survey of Mental Health and Wellbeing* was last collected in 2007. Although the Australian Government recently announced that it will re-establish the survey (NMHC 2019a), the time gap from the 2007 survey is too wide to provide any guidance on the effectiveness of existing

interventions or the need for new measures in particular populations or regions. The Australian Government should ensure the survey is conducted *routinely*, no less than every 10 years. In addition, the survey design should enable consistent comparisons over time. The re-established survey is expected to form a part of the \$90 million *International Health and Mental Health Study*, consisting of four surveys on: mental health and wellbeing, health characteristics and chronic health conditions, nutrition and physical activity and various other health measures (AHHA 2019). However, the Australian Government has not committed to undertake these surveys routinely.

Routine national surveys are important because they enable data to be collected on people who do not access mental health services. The 2007 survey found that 65% of people with mental illness did not access a health service for that problem. As such, the survey is essential for planning and monitoring purposes by governments and service providers alike.

Decision making in relation to mental health would benefit by receiving a range of population level data that is much broader than the performance of, and access to specified mental health services. Mental health services only provide service to a very small proportion of the people in the population with poor mental health, and it is important that strategic decision-making is also informed by an understanding of who is not accessing these services, as well as who is. (Anglicare Victoria, sub. 312, p. 25)

A range of participants supported routine national surveys (for example, CHF, sub. 646; ACCI, sub. 1202; SAMHC, sub. 691).

Fundamentally, a national survey on mental health and wellbeing should provide data that is person-centred, outcomes-focused and used to drive improvements. It should allow for:

- the monitoring of changes in prevalence and effects of mental health conditions
- analyses to help decision makers understand patterns of use for mental health and other support services, and their effect on individual outcomes over time.

It should adequately represent demographic groups. Some demographic groups have diverse needs and may be more vulnerable to mental illness. For example, people who identify as LGBTIQ are more at risk of mental illness and self-harm, but there is a paucity of data collected on this community (Mental Health Australia, sub. 864; Senate Select Committee on Health 2015). People from culturally and linguistically diverse backgrounds can face a number of barriers — for example, in some cultures, cultural norms or taboos about mental illness can make people less willing to seek help or have it known that they are experiencing mental illness (chapters 2 and 8). Current framing of data collection may mean mental illness is under-reported for these groups. It is desirable to track mental health outcomes for particular demographic groups to improve program planning and for evaluation purposes.

The ABS should consider methods to improve response rates of people with mental illness, and to ensure demographic groups are adequately represented. This could include the ABS conducting more targeted surveys or oversampling certain demographic groups. A criticism of the previous survey was the low response rate, which may bias survey samples and undermine the validity of results. At the national level, the response rate in 2007 was 60%

(ABS 2007), which was lower than the *National Health Survey* response rate of 76% (ABS 2019d). The majority of people who refused to participate stated that they were ‘too busy’ or ‘not interested’. Others refused because the content was ‘too personal’ (ABS 2009). Internationally, investigations into low response rates for mental health surveys found people with high levels of mental distress had increased rates of non-response (Torvik, Rognmo and Tambs 2011). Increased rates of non-response may reflect difficulties in locating people, social anxiety and lack of willingness to participate.

The survey should also consider opportunities for linkage with other datasets. As mentioned above, data linkage can provide more comprehensive information from existing datasets, particularly in mental health. A higher response rate would also assist with data linkage.

ACTION 24.2 — ROUTINE NATIONAL SURVEYS OF MENTAL HEALTH

Mental health data at a national level needs to be systematically updated over time.

Start later

The Australian Government should support the Australian Bureau of Statistics to conduct a National Survey of Mental Health and Wellbeing no less than every 10 years. Its design should enable:

- consistent comparisons over time
- monitoring changes in prevalence and effects of mental health conditions
- analyses to understand patterns of use for mental health and other support services, and their effect on individual outcomes over time.

The survey design should ensure that it adequately represents demographic groups who may have diverse needs and involve consumers and carers in its design. Opportunities for linking the survey data with other datasets should be considered.

Mental health services

At the national level, the development of data collections has largely been based on Leginski et al. (1989), including for mental health national minimum datasets and key performance indicators developed for Primary Health Networks (PHNs) (AIHW 2004; DoH 2016c; box 24.5). To enable adequate performance monitoring of mental health services, the Leginski framework states data collection should determine: *who* receives *what* from *whom* at what *cost* and with what *effect*? The Leginski framework is widely applied in practice. For example, the New Zealand Government used it to develop its *National Mental Health Information Strategy* (New Zealand Ministry of Health 2005).

Box 24.5 **The Leginski framework for monitoring in mental health**

The Leginski framework posits that the performance areas a manager needs to know about are: who receives what from whom at what cost and with what effect?

- **Who receives?** 'Who' refers to the clients served by the organisation. Data collected would include demographic and clinical characteristics of mental health consumers.
- **What services?** 'What' refers to details of the mental health services delivered. Details include volume and type of service, usually split along the dimensions of staffing, types of client, services, products and costs.
- **From whom?** 'Whom' refers to service characteristics and details of the staff, for example, professional training, demographic characteristics and salary. The 'whom' should apply to the full organisation and not only those directly involved in providing the services.
- **At what cost?** 'Cost' refers to expenditures of the mental health service. Note that cost is primarily driven by two other areas: what services are delivered and by whom.
- **With what effects?** 'Effects' refer to the outcomes or benefits of the service. It is frequently assessed in terms of either an improvement in the client's condition or a prevention of deterioration and requires data such as severity of symptoms and continuity of care.

Source: Leginski et al. (1989); New Zealand Ministry of Health (2005).

Despite much data being collected in the mental healthcare system, there remain gaps against what is considered adequate under the Leginski framework. For some key areas of service provision, there is very little or no nationally consistent data collected (figure 24.2). These gaps prevent stakeholders from assembling a comprehensive view and analysing the sector's inputs, activity, outputs and outcomes. In particular, there are significant gaps in data collected by MBS-rebated service providers and NGOs.

MBS-rebated service providers

A lack of data on outcomes for people using MBS-rebated mental health services was a key issue raised by consumers, peak bodies and service providers (box 24.6). MBS-rebated providers (psychologists and psychiatrists) deliver mental healthcare to a large proportion of people seeking support (chapter 12). While MBS data provides some information on activity, data on what services are provided and associated outcomes (from both the provider and service user perspectives) are limited. It would be desirable for services to be funded only if their effectiveness could be evaluated, preferably through outcomes data. The lack of outcomes data and evaluation for MBS-rebated mental health services — which cost the government approximately \$1.2 billion per year (AIHW 2019e) — is concerning.

Figure 24.2 Data gaps in areas of mental health service provision^{a,b,c,d,e,f}

	NGOs	GPs	MBS-rebated providers	PHNs	Specialised community care	Public hospital care	Private hospital care
Who receives Consumer information							
What services Interventions							
From whom Workforce							
At what cost Government expenditure							
To what effect Outcomes or experiences							

Nationally consistent data
 Data available but needs improvement
 Partial data available
 Data in initial development
 No data

a A 'No data' label shows that no ongoing, nationally consistent, consolidated collection of data exists. **b** Although there is no data on NGO consumer outcomes, data on consumer experiences is 'in initial development'. **c** For GPs and MBS-rebated providers, consumer information on demographics (such as age and gender) is nationally consistent, but no data is collected on diagnoses. MBS-rebated providers are office-based specialists (such as psychologists and psychiatrists). **d** Although PHN data on consumer experiences is only partially available, data on consumer outcomes is 'available, but needs improvement' — PHNs are mandated to collect outcomes data. **e** Specialised community care includes public community and residential mental health services only. For specialised community care data, data on consumer experiences is partially available, but data on consumer outcomes is 'nationally consistent'. **f** Public and private hospital care includes admitted mental health services only (excludes emergency departments). Outcomes data is 'nationally consistent', or 'available, but needs improvement', for public hospital care and private hospital care, respectively, but data on consumer experiences is only partially available.

Source: Productivity Commission analysis based on Mental Health Information Strategy Standing Committee unpublished data.

In undertaking the MBS Review, the Mental Health Reference Group recommended outcomes measurement be built into the MBS and the Better Access program in particular (MBS Review Mental Health Reference Group 2018). Chapter 12 discusses the potential benefits of embedding feedback-informed practice, involving routine outcomes monitoring.

Box 24.6 Participant views on the lack of outcomes data

Inquiry participants raised concerns that data regarding MBS-rebated mental health services is focused on activity, but not outcomes.

... currently the only data to inform planning of MBS funded psychology services relate to activities, not outcomes ... Unfortunately, due to the limited administrative requirements for receiving funding for services from the MBS, data are only collected about activity rather than outcomes ... As a consequence, decision-makers and funders are unable to make high quality, strategic decisions and, consequently, may be funding inefficient and ineffective services. (ACPA, sub. 359, pp. 32-34)

... the collection of output data still dominates most mental health service level data, particularly in the public mental health sector. State/territory mental health services and Primary Health Networks have adopted what has been described as an 'audit society' ... that focuses more on the achievement of targets and key performance indicators than the quality of care delivered and clinical outcomes. There is also no requirement for psychiatrists, GPs, psychologists or other allied health professionals to report on outcomes for services delivered under Medicare. (APS, sub. 543, p. 36)

As with primary care more generally, there is little or no collection or analysis of patient-level data on the diagnosis, treatment, and outcomes of Medicare-funded mental health services. (Grattan Institute, sub. 816, p. 6)

... the Australian Government spent \$1.2 billion on benefits for Medicare-subsidized (MBS) mental health-specific services ... Unfortunately, the data obtained from MBS funded mental health services relate to activities, not outcomes [Medicare Benefits Schedule, 2019]. As a consequence, little is known about the consumers using such services, their diagnoses, symptom severity, level of disability or impairment, social and environmental difficulties, or other information which helps inform treatment planning. In addition, little is known about the actual clinical outcomes of MBS subsidized services on consumers' mental health and impairment. (MindSpot, sub. 178, p. 4).

NGO support services

The NGO sector has grown strongly and delivers a range of community support services to people with mental illness, including psychosocial supports (chapter 17). Expenditure on specialised mental health services grants to NGOs increased ten-fold (in real terms) over the past 25 years — from \$43 million in 1992-93 to \$438 million in 2017-18 (AIHW 2020c).

However, there is little data collected on NGO activity and performance. Multiple Inquiry participants highlighted this as a data gap (for example, AIHW, sub. 370; DoH, sub. 556; MHCC, sub. 214).

... a clear data gap currently exists in the activity of non-government organisations in providing mental health services, which are not included in national data collections. (DoH, sub. 556, p. 51)

The Australian, State and Territory Governments have begun work to address data gaps in the NGO sector, but substantial gaps remain (Schess et al. 2018). In 2011, the AIHW commenced the Mental Health Non-Government Organisation Establishments national minimum dataset project to collect nationally consistent data on NGOs (DoHA 2013a). Collection was due to rollout nationally in 2015, but only Queensland and Western Australia implemented it — effectively reducing it to a National Best Endeavours Data Set (NBEDS). The national rollout was disrupted by the NDIS, which led to uncertainty about the number of NGOs transferring to disability services and concerns about implementing new reporting

requirements on NGOs while they transitioned to the NDIS. The Mental Health Coordinating Council (Sydney transcript, p. 180) said that limited resources and competing priorities have since prevented some jurisdictions from implementing the dataset.

Ensuring adequate data on mental health-related NGO services is important for two key reasons. First, NGOs account for an important and growing part of the mental health system. Second, collection of NGO data is required for undertaking accurate gap analyses and service planning (section 24.2). Without adequate data on NGO services, it is impossible to monitor, effectively evaluate and research, or plan for mental healthcare provided by NGOs. Gaps in the provision of important services such as psychosocial supports cannot be estimated, let alone filled. The NGO sector does itself a disservice by not ensuring the governments that fund it have quality information on its activities and consumer outcomes.

Although the Mental Health Non-Government Organisation Establishments NBEDS is a good start, it is too output (rather than outcome) focused.

... it would be very helpful for the Commission to recommend that all States and Territories participate in the ... [Mental Health Non-Government Organisation Establishments NBEDS] ... because at the moment there's only two states that are collecting that data and it makes it difficult to tell the national story about what the CMO [community managed organisations] sector are delivering if we don't have national data. Now, there's some I guess again weaknesses in what would be collected because it would be largely output data but at least it's a start. (Mental Health Coordinating Council, Sydney transcript, p. 178)

NGOs may also require ongoing guidance to ensure high quality (and useful) data is collected. For example, in Western Australia (where an online portal is used to collect NGO data) a user guide was developed to enhance reporting consistencies and the Western Australian Mental Health Commission maintains a helpdesk to assist NGOs assess their data before submitting (MHCC 2018, 2019). The aim of providing this support is twofold: to improve consistency and quality of data, and to streamline the reporting process to minimise reporting burden.

The Australian, State and Territory Governments should ensure that a national dataset on mental health-related NGO services is established in all states and territories. The data should allow for analyses on how NGOs improve outcomes for consumers and enable accurate gap analysis and service planning. The Mental Health Non-Government Organisation Establishments NBEDS should be considered, however, it may need further development — for example, it could be more outcomes-focused. The AIHW should be tasked and funded to lead this, to ensure nationally consistent data is collected where appropriate.

Demographic groups

There is limited data for demographic groups of interest. For example, there is limited data on the degree to which Aboriginal and Torres Strait Islander people access mental health services and the extent to which their outcomes improve (NMHC 2014b). The AIHW highlighted the lack of data for specific demographic groups as an issue.

Information on the mental health support needs and subsequent support provided to a number of specific sections of Australian society: Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse people, Lesbian Gay Bisexual Transgender and Intersex (LGBTI) people, people with experience of suicide, refugees and victims of traumatic crime is not currently available for national reporting purposes. (AIHW, sub. 370, p. 6)

Data that is collected on demographic groups needs to improve. For example, the quality statement for the National Community Mental Health Care Database notes that data on Indigenous status should be interpreted with caution due to the varying quality of Indigenous identification — Indigenous status is missing for 7% of contacts in the dataset (AIHW 2017).

Acknowledging that data gaps exist in mental health, the Australian, State and Territory Governments have tasked the Mental Health Information Strategy Standing Committee with updating the National Mental Health Information Priorities (COAG Health Council 2017a). This should provide strategic priorities for information development over a decade. Work on this is currently underway, with a draft version completed for consultation. The Productivity Commission has consulted with the Mental Health Information Strategy Standing Committee regarding this, and understands data gaps identified as priorities largely align with data gaps identified in this Inquiry. This includes data regarding MBS-rebated providers, NGOs and certain demographic groups, such as people from culturally and linguistically diverse backgrounds and people identifying as LGBTIQ.

However, the National Mental Health Information Priorities is a statement of common intent, rather than a binding prescription for Australian, State and Territory Governments. This means there is a need for greater accountability. To help ensure this, the Australian, State and Territory Governments should commit to developing and adequately funding strategies to address identified data gaps and information priorities in the statement on National Mental Health Information Priorities. In addition, the NMHC should publicly report on progress made against the statement on National Mental Health Information Priorities. The first progress report should be conducted five years after the statement's release and a second 10 years after the statement's release.

ACTION 24.3 — ADDRESSING DATA GAPS

High-quality and fit-for-purpose data should be collected to inform decision making and improve service delivery, and outcomes for people with lived experience and carers.

Start now

- The Australian, State and Territory Governments should complete Action 24 in the Fifth National Mental Health and Suicide Prevention Plan to update the statement on National Mental Health Information Priorities (NMHIP).
- The Australian, State and Territory Governments should develop and adequately fund strategies to address identified data gaps and information priorities in the statement on NMHIP. This should include consultation on how best to:
 - collect the data in a way that imposes the least regulatory burden to ensure data is high-quality and fit-for-purpose
 - publish the data in ways that are useful to policy makers, service providers, and importantly, consumers and the public.
- The Australian, State and Territory Governments should ensure a nationally consistent dataset is established in all States and Territories of non-government organisations that provide mental health services. In doing so, they should:
 - ensure data collection focuses on outcomes for people that are valued by them (not just outputs and activity)
 - ensure data collection informs service planning at the regional level
 - adequately fund and provide ongoing support to non-government organisations to collect this data, to ensure the data is of high quality
 - task and adequately fund the Australian Institute of Health and Welfare to lead and coordinate the implementation nationally.

Start later

- The National Mental Health Commission should publicly report on the progress made against the statement on NMHIP, five and ten years after its release. The National Mental Health Commission should highlight which data gaps and information priorities were addressed, which were not and why.

Non-health sectors

There is a dearth of information on mental health outcomes and activity in non-health areas, as highlighted in many chapters of this report, in particular the following.

- Chapter 5 found that large volumes of data is collected by schools on their students, but it remains difficult to assess which of the many varieties of interventions improve children's and young people's mental health and wellbeing.

-
- Chapter 6 reports the absence of a regular, national data collection on the mental health of tertiary students in Australia, with most research into student mental health having been in the form of optional self-reported surveys, mostly of university students.
 - Chapter 9 establishes that data recording suicide attempts and ideation are incomplete. And, although data recording suicide deaths are reasonably well reported, it lacks information about individual characteristics, such as physical and mental health history, employment and family circumstances. There is also no consistent reporting of state and territory suicide prevention expenditure and activity.
 - Chapter 21 highlights that limited data is available on the prevalence of mental illness across all stages of the criminal justice system for many states and territories.

This section focused largely on national, state and territory data collection. However, data is also important at the commissioning and service provider level. For example, regional commissioning bodies (PHNs or RCAs) would require data to inform their service planning analysis. Organisations delivering services require data to monitor and assess their performance, highlighting areas where improvements are needed. The next section discusses this, with a focus on collecting and using data for monitoring and reporting purposes.

24.2 Monitoring and reporting

Monitoring is essential to improve policies, programs, services and ultimately outcomes. In mental health, the focus needs to be on tracking progress against intended outcomes and the relative performance of different services (Mendoza et al. 2013). In turn, monitoring and reporting activities serve to drive better outcomes through improved transparency and accountability. They act as a catalyst for change by highlighting where there is slow progress or poor performance (Nous Group 2018c).

The need for better monitoring and reporting of system performance has long been acknowledged by governments (Nous Group 2018b). However, commentators noted that current monitoring activities are sub-optimal, providing little information about the state of mental health and mental illness in Australia (Mendoza et al. 2013). This section examines existing monitoring and reporting arrangements, proposes reforms to rationalise and strengthen these arrangements, improve transparency and drive improvements for people experiencing mental ill-health and their carers.

Current arrangements

Roles and responsibilities

There are many organisations that contribute to the monitoring and reporting landscape for mental health and suicide prevention (Nous Group 2018b). This includes both Australian and State and Territory Government agencies (box 24.7).

Box 24.7 **Government agencies that undertake monitoring and reporting in mental health and suicide prevention**

At the national level, several Australian Government agencies undertake monitoring and reporting in mental health and suicide prevention.

- The National Mental Health Commission plays a lead role in monitoring and reporting, and has a mandate to work across all areas that affect mental health. This includes sectors that influence the social determinants of mental health, such as education, housing, employment, human services and social support (NMHC 2017, sub. 118). Under the *National Mental Health Strategy*, the Council of Australian Governments (2017a) tasked the National Mental Health Commission with monitoring and reporting on the implementation of the Fifth Plan, including annual progress in implementing agreed actions and key performance indicators.
- The Australian Institute of Health and Welfare (AIHW) monitors and reports nationally on public mental health services (AIHW 2019e). It produces annual reports which provide an overview of key statistics and related information in mental health (AIHW 2018b). In particular, it monitors key performance indicators for state and territory mental health services, and trends in Medicare Benefits Schedule and Pharmaceutical Benefits Scheme activity. AIHW's reporting is constrained by the availability of comparable national data, as most data is sourced from national minimum datasets.
- The Steering Committee for the Review of Government Service Provision reports annually on the Australian, State and Territory Governments' management of mental health through the *Report on Government Services* (SCRGSP 2020b). This focuses on state and territory specialised mental health services and mental health services subsidised under the Medicare Benefits Schedule. These metrics cover aspects of equity, efficiency and effectiveness.
- The Australian Commission on Safety and Quality in Health Care reports on the variation of some mental health activity (based on Medicare Benefit Schedule, Pharmaceutical Benefits Scheme and admitted patient care data) through its *Australian Atlas of Healthcare Variation* reports (ACSQHC 2018a). This data is made available by local geographical level (Statistical Area Level 3^a), remoteness and socioeconomic status.

State and Territory Governments undertake their own monitoring and reporting activities, although differences exist between jurisdictions. Most jurisdictions use their own frameworks to monitor progress against strategies and service activity. For example, the Western Australian Mental Health Commission monitors and reports on population outcomes and key indicators using data from the ABS, AIHW and Western Australian Department of Health, and its own data (WAMHC 2018a). In Tasmania, monitoring and reporting is limited to national minimum data reporting requirements (TAS DHHS 2015).

^a Statistical Area Level 3 is a geographical area with a population between 30 000 and 130 000 people.

Coverage of monitoring

The National Mental Health Performance Framework (NMHPF) sets out the broad architecture for monitoring in mental health (AIHW 2019l). It was developed in 2005 to facilitate a culture of continuous quality improvement in mental health service delivery (figure 24.3). In addition to monitoring the performance of mental health services for consumers and carers (tier 1), the NMHPF highlights the importance of monitoring the social determinants of mental health and broader effects of illness on functioning (tiers 2 and 3).

Figure 24.3 **National Mental Health Performance Framework, 2020**

Health service performance (tier 1)				
Accessible People can obtain healthcare at the right place and right time, taking account of different population needs and the affordability of care	Appropriate Service is a person centred, culturally appropriate, rights-based, trauma-informed and recovery oriented. Consumers and carers are treated with dignity and confidentiality and encouraged to participate in choices related to their care, including reporting positive experiences through PROMs and PREMs		Continuity of care Ability to provide uninterrupted and integrated care or services across programs, practitioners and levels over time. Coordination mechanisms work for mental health consumers, carers and healthcare providers. Care and support is holistic and includes psychosocial and physical dimensions	
Effectiveness Care, intervention or action achieves the desired outcome from both the clinical and mental health consumer and carer perspective, as reflected in patient-reported outcomes. Care is based on evidence-based standards	Efficiency and sustainability The right care is delivered at minimum cost and human and physical capital and technology are maintained and renewed while innovation occurs to improve efficiency and respond to emerging needs. Members of the work force receive appropriate support and report positive experiences		Safety The avoidance of, or reduction to, acceptable limits of actual or potential harm (physical or psychological) from healthcare or the environment in which healthcare is delivered. Includes aspects of the safety of care delivered to consumers (including patient-reported incidents and restrictive practices) as well as safety of carers and workforce	
Determinants of health (tier 2)				
Environmental Factors Physical, chemical and biological factors such as water, food and soil quality	Health Behaviours Attitudes, beliefs, knowledge and behaviours such as patterns of eating, physical activity, smoking and alcohol consumption	Personal biomedical factors Genetic-related susceptibility to disease and other factors such as blood pressure, cholesterol levels and body weight	Personal history Factors such as experience of trauma	Socioeconomic Factors Income, employment, housing, education and social inequalities
Health status and outcomes (tier 3)				
Deaths Age- or condition-specific mortality rates	Health conditions Prevalence of disease, disorder, injury or trauma or other health-related states	Human Function Alterations to body, structure or function (impairment), activities (activity limitation) and restrictions in participation	Wellbeing Measures of physical, mental, social and emotional wellbeing of individuals	

Source: AIHW (2019I).

Despite the large amount of monitoring and reporting activity, there are gaps in coverage (Nous Group 2018b). While the NMHPF advocates monitoring for all three tiers, in practice, monitoring and reporting largely focuses on the performance of mental health services (tier 1). Currently, much of the data and information development in mental health aims only to refine these indicators (NMHPSC 2013). Further, key performance indicators under tier 1 are reported annually, but indicators under other tiers are not reported at all. It is also important to note that all key performance indicators under tier 1 relate to state and territory funded services only — there are none yet for MBS-rebated services and other services provided by the private sector (AIHW 2020a).

As such, there is scope to extend the coverage of monitoring activities to cover social determinants and the effect of mental ill-health on other outcomes related to people's functional capacity and recovery (Mental Health Australia, sub. 538), such as the effect of illness on a person's ability to engage and participate in certain activities.

Rationalising national reporting

Inquiry participants called for some rationalisation of monitoring and reporting activity.

Consideration could be given to rationalising the multitude of mental health-related reporting activities in the interests of creating a simpler, authoritative system. (AIHW, sub. 370, p. 8)

There would be significant benefit to clarifying the different roles of reporting agencies (AIHW, ABS, ROGS, National Mental Health Commission) to reduce duplication and to streamline and enhance the overall reporting and analysis. It is recommended that a single national multilayer reporting and monitoring framework be developed which clarifies and incorporates the different agencies roles. (ACT Government, sub. 210, p. 36)

However, there are sound reasons for tasking different agencies with particular monitoring responsibilities. In part, due to the sheer scale and associated complexities of what can and could be monitored (as illustrated by the NMHPF).

Notwithstanding, there should be greater clarity about roles and responsibilities, namely that:

- the NMHC should lead monitoring and reporting of the performance of the mental health *system* (all areas that affect mental health including employment and social services), including progress made against reforms (under plans and strategies)
- the AIHW should lead monitoring and reporting on the performance of mental health *services* (such as those provided by NGOs, GPs and MBS-rebated providers).

The NMHC, AIHW and other Australian Government agencies (principally, the Steering Committee for the Review of Government Service Provision and the ABS) should minimise unnecessary duplication of effort in monitoring and reporting. Reforms to strengthen the roles and responsibilities above are discussed in the next section.

Strengthening monitoring and reporting

Throughout this Inquiry, participants emphasised the importance of a person-centred, outcomes-focused approach to monitoring and reporting (Mental Health Australia, sub. 407; Mental Health Commission of New South Wales, sub. 486; NMHC, sub. 949; RASA, sub. 420). This approach places the individual at the centre, underlining that the overall objective of mental health policy is to improve outcomes and wellbeing for people with mental ill-health. There has been a shift towards person-centred, outcomes-focused monitoring and reporting in health and other areas, such as the disability sector. Examples include the Victorian Government's *Victorian Public Health and Wellbeing Outcomes Framework* (VIC DHHS 2016b) and the National Disability Agency's performance framework (PC 2019b).

However, in mental health, a person-centred, outcomes-focused approach to monitoring and reporting has not been achieved in practice. For example, the NMHC (sub. 949, p. 26) stated 'there is still much to do to move the routine monitoring and reporting focus towards consumer and carer outcomes and include social determinants through a cross-portfolio remit'. Given the importance of social determinants and the effects of mental ill-health on a person's functioning, a lack of monitoring and reporting on personal factors, such as employment, physical health and income, is a significant shortcoming.

Further, where mental health-related data is collected, and could contribute to person-centred, outcomes-focused monitoring and reporting, it is unclear to what extent it is used. For example, chapter 5 highlights that, in schools data is inconsistently collected and reported, but there is no consistent evaluation of outcomes. This could be in part because mental health is not seen as a key area of responsibility of non-health portfolios. This shortcoming reveals the lack of focus by these portfolios on outcomes for the people whom they are serving. There is considerable scope to strengthen monitoring activities in areas beyond health.

A person-centred, outcomes-focused approach

To achieve a person-centred, outcome-focused approach to monitoring and reporting in mental health, a national agency should lead and coordinate it, and have the remit to do so. The Productivity Commission recommends that the NMHC should undertake this role. Although the NMHC already has a mandate to work across all sectors that relate to mental health, it should give greater emphasis to the social determinants of mental health (such as socioeconomic status), the effect of mental ill-health on people's functional capacity (such as ability to participate in education and work) and outcomes for people receiving mental health treatment and support services.

The NMHC's monitoring and reporting role across health and non-health sectors would be better supported through a whole-of-government mental health strategy (action 22.1). Further, giving the NMHC statutory independence (action 22.7) would likely strengthen its monitoring capability. And while the primary motivation of this is to support recommended

evaluation responsibilities, placing it at arm's length from policy makers and practitioners is likely to better support its monitoring and reporting effectiveness as well.

The NMHC's Contributing Life Framework offers a broad set of outcomes that captures the type of lives people with mental illness wish to attain and provides a promising framework to determine outcomes that could be monitored (box 24.8). The framework was developed in consultation with users of mental health services and their carers, and identifies areas that are important to individuals' abilities to lead a 'contributing life' (DoHA 2013a). Inquiry participants also highlighted the importance of this.

Consumers can, and want to make meaningful contributions to their communities through social and economic participation. Being able to return to a 'contributing life' is a recovery goal for many people who experience mental ill health. (ACT Mental Health Consumer Network, sub. 297, p. 3)

The National Mental Health Commission's concept of a 'contributing life' is insightful in describing what a good life looks like and is based on extensive consultation with people with lived experience. (MHCSA and LELAN, sub. 360, p. 8)

Box 24.8 The Contributing Life Framework

The Contributing Life Framework offers a whole-of-life perspective on mental health. It states that measuring success must centre upon people's quality of life and the related determinants such as access to housing, education and meaningful employment, and leading a life free from discrimination. The National Mental Health Commission consulted with consumers and carers in developing the framework, which underpins its monitoring and reporting work. As such, it describes what it means to live a contributing life:

... a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty (NMHC 2013, p. 13).

There are five elements of the contributing life framework: thriving, not just surviving; maintaining connections with family, friends, community and culture; ensuring effective care, support and treatment; something meaningful to do; and feeling safe, stable and secure.

Source: NMHC (2013).

The NMHC should monitor progress against outcomes derived from the Contributing Life Framework. This would represent a shift from the current health-centric monitoring under the NMHPF (figure 24.3) toward monitoring of outcomes that are meaningful to consumers.

To operationalise this new approach, indicators for measuring progress against outcomes would need to be chosen. Often a set of indicators is necessary as no single indicator can capture changes in an outcome area. A set of criteria would need to be applied to select effective indicators (PC 2018). An example of indicators to track progress against the Contributing Life Framework outcomes and suicide prevention were identified, based on analysis undertaken throughout this Inquiry (table 24.2).

Table 24.2 Indicator examples to measure progress against outcomes

Thriving, not just surviving

- Life expectancy gap from premature death among people with mental illness (action 14.1)^a
- Rates of substance use and smoking among people with mental illness (ABS National Survey of Mental Health and Wellbeing, Cat. no. 4326.0; ABS National Health Survey, Cat. no. 4364.0)
- Rates of obesity, diabetes, hypertension and elevated cholesterol among people with mental illness (ABS National Survey of Mental Health and Wellbeing, Cat. no. 4326.0; ABS National Health Survey, Cat. no. 4364.0)
- Proportion of consumers who received information on physical health and substance use^b
- Prevalence of mental illness and age of onset^c, prevalence and distribution (by geography) of psychological distress (ABS National Health Survey, Cat. no. 4364.0)
- Proportion of mental health carers who feel weary, angry, worried or depressed due to caring role (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)

Ensuring effective care, support and treatment

- Number of people receiving low intensity treatments (the clinical subset of low-intensity treatments as discussed in chapter 12) (AIHW 2020e; MindSpot 2019)^d
- Proportion of MBS-rebated psychological therapy that is bulk-billed^e
- Number of people for whom mental health medications are dispensed by age and region, compared to number of people referred for non-pharmacological treatments by age and region^f
- Proportion of PHN services that are using assessment and referral practices based on Initial Assessment and Referral (chapter 10)^c
- Proportion of PHN–LHN groupings that have developed joint regional plans and among these, the extent of compliance with their plans (action 23.1)^a
- Proportion of consumers who experienced reduced clinical symptoms, and are satisfied with care^g
- Proportion of clinical staff time in community ambulatory mental healthcare services spent on consumer-related activities (chapter 12) (AIHW 2020h, table FAC.42; AIHW, unpublished data)^h
- Proportion of preschool children who have undergone a comprehensive development assessment, including social and emotional developmentⁱ
- Rates of utilisation of workplace Employee Assistance Programs mental health services^j
- Proportion of people in correctional facilities with a mental health condition (AIHW 2019r)^k, relative to expenditure on mental health services in correctional facilities^c
- Proportion of mental health-related emergency department presentations seen on time (AIHW 2019j)
- Rate of readmission to hospital (within 28 days of discharge) (AIHW 2020a)
- Carer Experience Survey collection rates and results to measure carer-inclusive practice (action 18.1)^a
- Proportion of mental health carers with unmet need for support (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)

Engaged in meaningful activity

- Proportion of schools achieving wellbeing outcomes (actions 5.3 and 5.7)^a
- Proportion of children with mental ill-health disengaged from schooling (attendance under 30%)^c
- Proportion of teachers completing personal development programs on child social and emotional development and wellbeing (action 5.4)^a
- Number of people claiming mental health-related worker's compensation and average time off work for each claim (Safe Work Australia 2020)
- Usage of counselling services for mental health conditions by university students^c
- Labour force engagement by people with mental illness (ABS National Health Survey, Cat. no. 4364.0)

(continued next page)

Table 24.2 (continued)

Proportion of income support recipients with a mental health condition earning an income, participating in employment support programs, or leaving the payment for employment^l

Proportion of mental health carers who are not working, but would like to (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)

Level of consumer and carer participation in the design of policies and programs, to be determined in collaboration with consumers and carers^c

Maintaining connections with family, friends, community and culture

Proportion of people with lived experience of mental illness experiencing high levels of social exclusion and disadvantage (Housing, Income and Labour Dynamics in Australia (HILDA) survey data)

Experiences of stigma among people with mental illness, including interactions with health workers^m

Experiences of loneliness among people with and without mental illness (HILDA survey data)

Attitudes among the general population towards people with severe mental illness^m

Number of people participating in clubhouses, day drop-ins and recreation services^c

Connection to culture, country, spirituality and community^m

Proportion of mental health carers who have strained relationships with family or are losing touch with friends due to caring role (ABS Survey of Disability, Ageing and Carers, Cat. no. 4430.0)

Feeling safe, stable and secure

Proportion of people with mental illness in unsuitable housing (AMHOCN 2019b)

Estimated gap in supported housing places (chapter 20) (ABS Australian Demographic Statistics, Cat. no. 3101.0; AIHW 2020h; Siskind et al. 2012)^h

Proportion of people who are discharged into homelessness (AIHW 2019q)

Gap in Housing First-type places (chapter 20)^c

Rate (per 100 000 people) of mental health-related incidents that involved a police response^c

Number of people diverted to appropriate mental healthcare through court diversion programsⁿ

Rate (per 100 000 people) of mental health orders madeⁿ; proportion of cases before mental health tribunals where the individual: attended^o; had legal representation^o; or received non-legal advocacy^c

Proportion of separations, episodes of care and service contacts, where the mental health legal status was reported as involuntary (AIHW 2019i)

Preventing suicide

Number of ambulance and police attendances for self-harm and suicidal ideation^p

Number of hospital attendances of self-harm and suicidal ideation^p

Rates of follow-up after suicide attempt/self-harm^q

Number of deaths by suicide per 100 000 people (ABS Causes of Death, Cat. no. 3303.0)

^a Data would be collected under referenced actions. ^b Data is collected by New South Wales' Your Experience of Service survey (NSW Health 2018b). ^c Data is not routinely collected or publicly reported. ^d Data can be sourced from other providers such as PORTS and Beyond Blue. ^e MBS data, unpublished. ^f Data is collected for prescriptions of medication listed on the PBS and referrals to MBS-rebated psychological services. ^g Data collected through use of PROMs and PREMs. ^h Must be derived from the source datasets (as done in relevant chapters). ⁱ Data is collected and reported in some states, and for some demographic groups (such as Aboriginal and Torres Strait Islander children). ^j Data can be sourced from EAP service providers such as Converge International (chapter 7). ^k Reliable data for some jurisdictions is not available, due to small sample sizes. ^l Department of Education, Skills and Employment and Department of Social Services data, unpublished. ^m Data could be collected through specific surveys such as Reavley et al. (2020) and Yap and Yu (2016a, 2016b), or the National Mental Health and Wellbeing survey (action 24.2). ⁿ Data is routinely collected in New South Wales (NSW MHC 2018, 2020). ^o Data is reported in state and territory mental health tribunal annual reports. ^p Data is being processed by Turning Point for the AIHW. ^q Data linkage of state and territory mental health and patient administration systems (chapter 9).

Source: Productivity Commission analysis.

Although the indicators in table 24.2 provide an example of how monitoring against outcomes could be done in practice, there should be broader consultation with consumers and carers, stakeholders, sector experts and service providers collecting data to inform a final set of indicators.

In doing so, the NMHC should consult with Aboriginal and Torres Strait Islander people to determine what social and emotional wellbeing outcomes and indicators could be monitored. The Aboriginal Medical Services Alliance NT (sub. 434, p. 15) stated ‘there are currently no national [key performance indicators] to measure [social and emotional wellbeing]’ for Aboriginal and Torres Strait Islander people. An established model of social and emotional wellbeing outlines domains or outcomes that are important to Aboriginal and Torres Strait Islander people (chapter 8). The NMHC may need to undertake additional monitoring under this model.

Scope to broaden reporting on mental health-related expenditure

Monitoring expenditure on interventions is necessary for assessing their efficiency relative to alternative allocations. This information is critical for decision makers seeking to improve mental health outcomes by reallocating resources.

There is scope to expand routine reporting of expenditure on mental health, to include sectors outside of health. The NMHC (sub. 118, p. 31) stated:

At present, the [National Mental Health] Commission’s role in monitoring and reporting on mental health reform is somewhat limited due to the fact that mental health activity (and expenditure) is spread across multiple government agencies and the private sector (including individual co-payments), and data on inputs, outputs and outcomes is not always readily available ... Currently, available data sits outside the health portfolio, limiting the ability for the Commission as well as other agencies to influence the data that is reported publicly.

Routine reporting of Australian, State and Territory Government expenditure on mental health across all sectors (health and non-health) would be beneficial for several reasons. First, it would enable more complete monitoring and reporting of governments’ response to mental ill-health. For example, the NMHC (sub. 118, p. 32) considered ‘it would be desirable to report expenditure beyond the health portfolio such as in housing, justice, and education’ to obtain a more ‘accurate view of expenditure’. Second, it would better support whole-of-government planning and service integration insofar as portfolios would have better visibility of mental health expenditure in other portfolio areas. This could enable more integrated and holistic service delivery for consumers. Third, it would enhance accountability by increasing transparency over the use of public resources. Finally, this data could be used to inform priority setting of evaluations (section 24.3).

The NMHC should consult with stakeholders and sector experts to determine which additional sectors could be in scope for routine reporting of mental health expenditure. This would include the AIHW, which currently curates, analyses and reports on mental health-related expenditure data, including non-health data, such as, specialist homelessness

services (AIHW, sub. 370). Additional sectors that could be considered for inclusion in routine reporting include social and human services, education and training, employment and justice. Although these sectors are closely linked with mental ill-health (as discussed throughout this report), in some instances they are not reported on. For example, routine data on mental health expenditure in correctional facilities is not reported (chapter 21). It may also be informative to report on private sector expenditure, such as out-of-pocket expenses.

Cooperation between multiple government portfolios is necessary to collect appropriate data, and pre-conditions should be formalised to encourage such cooperation. Options used elsewhere in government to encourage data sharing between multiple portfolios include: memoranda of understanding, letters of exchange and ministerial agreements (PC 2017a). Further, new data legislation — which will be known as the *Data Availability and Transparency Act* when it passes Parliament — will formalise data sharing at the Australian Government level and facilitate increased sharing with the states and territories.²⁶⁸ In addition, chapter 22 recommends the NMHC be given legislative powers to make reasonable requests for data from Australian, State and Territory Governments (action 22.7), if necessary.

Reporting on the progress of mental health reforms

Reporting on reform progress is important to track whether commitments made in mental health plans and strategies are being met (COAG Health Council 2017a). This includes monitoring progress against action items and outcomes for consumers and carers that the reforms aim to achieve. For example, the NMHC reports annually on progress in implementing the Fifth National Mental Health and Suicide Prevention Plan and performance against its indicator set.

In addition, this Inquiry has made recommendations that may require the NMHC to undertake additional monitoring and reporting of reforms. For example, chapter 23 requires the NMHC to take a more active role in monitoring cooperation between PHNs and Local Hospital Networks (LHNs), to identify PHN–LHN groupings that appear not to be cooperating effectively (action 23.1).

This an important component in national monitoring and reporting, and the NMHC should continue to expand its role in monitoring progress against mental health reforms under the National Mental Health Strategy (action 22.1).

²⁶⁸ The Australian Government planned to introduce the *Data Availability and Transparency Bill* in the first half of 2020, but this has been delayed due to the COVID-19 pandemic.

Establishing targets for key mental health outcomes

Once governments commit to monitoring and measuring outcomes, the question emerges as to whether they should set specific targets. Targets are a well-established accountability tool. They go beyond measuring dimensions of service performance and into setting ‘the desired standard of performance to be achieved on a given performance indicator’ (AHMC 2009b, p. 86).

There are various advantages in setting targets. At a system level, they can send a clear signal about priorities for system participants and galvanise energy around those priorities (Kelman and Friedman 2009). However, there can be disadvantages. They may excessively narrow the focus of system participants to the goals being measured — only what is measured gets noticed. As a consequence, important aspects of system performance get missed, particularly if system actors shift their effort towards the measured parts (Kelman and Friedman 2009). ‘Gaming’ may be another downside, where efforts are made to improve the *statistic* being measured without improving the underlying quality of service that is meant to drive that statistic (Kelman and Friedman 2009).

Australia has generally not adopted targets as a means of spurring mental health and suicide prevention reform, with one recent exception. The Prime Minister set a target of zero suicides in Australia, albeit without a date for achievement (Morrison 2019). The Australian, State and Territory Governments have considered targets, but never adopted them. They prioritised setting targets within the first year of the Fourth National Mental Health Plan (AHMC 2009b), but this did not happen. In 2013, the Australian, State and Territory Governments sought advice from its Expert Reference Group (2013, p. 3) on a set of ‘ambitious and achievable national, whole of life, outcome-based indicators and targets for mental health that will be understood by the community and drive systemic change’. The Expert Reference Group (2013) proposed 10 targets, but Governments did not formally agree to them. A subsequent attempt by the NMHC (2014b) to secure agreement from all Governments on a revised set of targets was not successful.

Internationally, there are many targets in mental health — most commonly related to suicide prevention. Experience suggests that targets can play an important role in progressing system priorities, particularly if they are visible to frontline service delivery staff (New Zealand Government Inquiry into Mental Health and Addiction 2018; Scottish Executive 2002; WHO 2013b Global target 3.2).

Many participants believe that well designed and implemented targets could help improve Australia’s mental health system.²⁶⁹ This involves ensuring that:

- targets reflect sensible and achievable aspirations (Briscoe 2004)

²⁶⁹ Advocacy for Inclusion (sub. 935); Australian Medical Association (sub. 387); Australasian College for Emergency Medicine (sub. 926); Community Services Industry Alliance (sub. 915); Consumers Health Forum of Australia (sub. 646); Dieticians Association of Australia (sub. 766); Drummond Street Services (sub. 718); Grow Australia (sub. 847); Melbourne Children’s Campus (sub. 927); Mental Health Australia (sub. 407); Mental Health Carers NSW (sub. 1231); Mental Health Commission of New South

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- actions demonstrably link to achieving targets (Department of Finance 2015b)
 - there is a meaningful baseline for setting targets (AHMC 2009b)
 - those responsible for achieving targets are clearly identified and committed (House of Commons Library 2010)
 - there is transparency, monitoring and reporting (ANAO 2019).

However, focusing exclusively on quantitative targets can lead to a decline in outcomes that are not easily measured, or to increased effort that improves metrics but not service quality. Kelman and Friedman (2009) suggest various approaches to pre-empting and mitigating unintended responses. In particular, targets based on qualitative evidence, not just quantitative evidence, should be used, and any response to a target needs to be moderated to avoid bias towards achieving that target at the expense of other unmeasured outcomes. For example, it is important to temper responses to newly-introduced targets. Putting a spotlight on areas of poor performance in a system can elicit strong public responses, especially where swift change is unlikely. Mental Health Victoria (sub. 479, att. 1, p. 15) suggested:

... governments and political parties are reluctant to set targets, probably because they are afraid of what happens when they are not met. But without targets, plans ... remain aspirational documents full of well-meaning but unfulfilled intent.

The Australian, State and Territory Governments should agree on a set of realistic targets that specify key mental health and suicide prevention outcomes that Australia should be able to achieve over a defined period of time with sustained effort. To ensure these targets are relevant and fit-for-purpose, they should develop a process for setting them that, among other things, involves co-design with consumers and carers, and includes both quantitative and qualitative evidence and data. There could be consideration of targets that have been proposed by previous reports, including those proposed by the Expert Reference Group (2013) and from this Inquiry (Action 14.1).

The Australian, State and Territory Governments should engage Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce in discussions about any targets that may affect Aboriginal and Torres Strait Islander people. Following this collaborative process, they should publish the targets and an explanation of how they were set and will be monitored and reported.

Wales (sub. 948); Mental Health Coordinating Council (sub. 920); Mental Health Victoria (sub. 942); Mental Health Victoria and Victorian Healthcare Association (sub. 1184); Mind Australia Limited, Neami National, Wellways and SANE Australia (sub. 1212); National Mental Health Commission (sub. 949); South Australian Mental Health Commission (sub. 691); Stefanie Roth (sub. 841); SuperFriend (sub. 873); Victoria Legal Aid (sub. 818).

ACTION 24.4 — ESTABLISH TARGETS FOR KEY MENTAL HEALTH OUTCOMES

Accountability for mental health outcomes should include measurement against predetermined performance targets.

Start now

The Australian, State and Territory Governments should agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.

- To ensure these targets are relevant and fit-for-purpose, they should develop a process for setting them that, among other things, involves co-design with consumers and carers and includes both quantitative and qualitative evidence and data.
- They should engage Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce in discussions about any targets that may affect Aboriginal and Torres Strait Islander people.

Following this collaborative process, the Australian, State and Territory Governments should publish the targets and an explanation of how they were set and they will be monitored and reported.

Service-provider level reporting can enhance service quality

Benchmarking analyses

Monitoring and reporting can lead to improvements in service quality through benchmarking analyses. Benchmarking analyses should aim to drive a quality improvement cycle by enabling services to access regular reports on performance relative to similar services. Benchmarking can be defined as:

... the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture. (AHMAC and MHSC 2009, p. 4)

Examples of benchmarking initiatives have emerged in mental health, but it is far from ‘the norm’. For example, the Australian Government Department of Health funds a program called MedicineInsight, which gathers GP data across Australia to inform quality improvements and population mental health outcomes (NPS MedicineWise, sub. 175). The program’s findings are made available to policy makers, health systems and professionals. However, not all GPs participate in the program, with data collected from only 650 GPs. Further, a review of the Australian Mental Health Outcomes Classification Network found that it had improved outcomes measurement, but it had not yet lived up to its initial vision of supporting benchmarking activity (DoH 2011).

Some State Governments have implemented systemic approaches to benchmarking, where central health authorities exist to facilitate and coordinate state-wide benchmarking. For example, the System Information and Analytics Branch in the New South Wales Department of Health has a primary role to support data and information needs of the state's health system (NSW Health 2017). The branch includes an Information for Mental Health unit that coordinates and facilitates benchmarking of mental health services within the state and provides data to inform policy making by LHNs and the State Government (AHMAC and MHSC 2009; NSW Health 2018a).

Nationally, clinical quality registries (CQRs) provide another model to facilitate and coordinate benchmarking analyses (box 24.9). CQRs systematically monitor quality by routinely collecting, analysing and reporting health-related information (ACSQHC 2014). The information is used to identify benchmarks, significant outcome variance and inform improvements in healthcare quality. They can be managed by one or multiple organisations, and can operate in physical locations or virtually. Currently, CQRs exist for some forms of healthcare (such as joint replacement), but there are no CQRs in mental health. The Australian Government's *Draft National Clinical Quality Registry Strategy* listed mental health as a 'clinical domain priority' for national CQRs development (DoH 2019c).

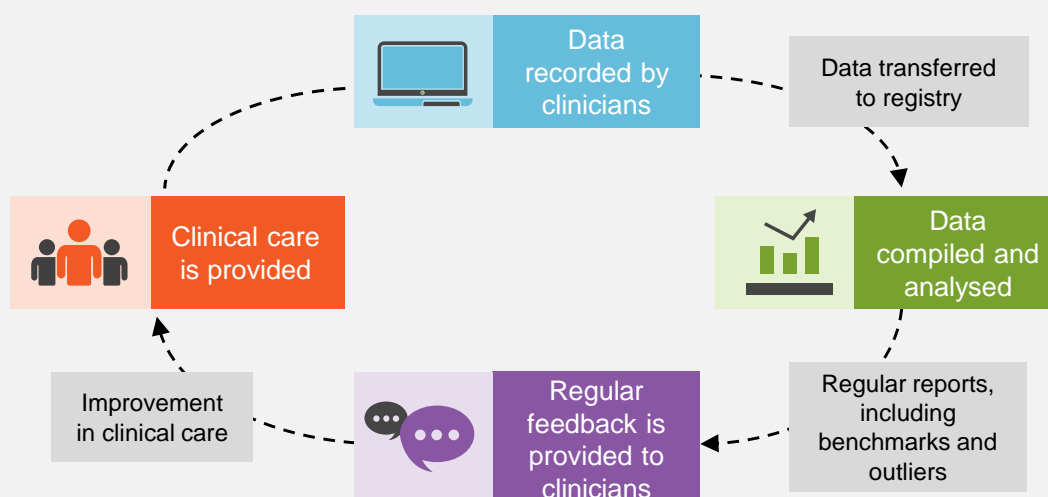
There is an economic case for Australian CQRs. An evaluation of five well-established CQRs (prostate cancer, trauma, intensive care, dialysis and transplantation, and joint replacement) found that each led to a significant net positive return on investment, with the benefit-to-cost ratios ranging from 2:1 to 7:1 (ACSQHC 2016a). The Consortium of Australian Psychiatrists and Psychologists (sub. 260) highlighted some overseas examples of mental health CQRs contributing to evidence-based decision making. For example, the Swedish National Quality Registry for Psychosis Care evaluated outcomes based on a nationwide patient registry and identified a reduction in psychiatric beds had likely caused a higher mortality rate amongst patient being treated for severe mental illness.

Benchmarking analyses in mental health can have positive effects on service providers and support quality improvements in services. The National Mental Health Benchmarking Project found benchmarking had helped service providers identify areas for improvement in their business and clinical processes (AHMAC and MHSC 2009). In particular, service providers were better able to use indicators to guide and evaluate service improvement activities, and gain access to a developed knowledge base. A key benefit from the benchmarking project was that it led to a collaborative environment that supported information sharing and learnings from peers.

However, barriers to implementation need to be addressed before the benefits of national benchmarking can be realised. A key issue is data quality (AHMAC and MHSC 2009). In particular, variation in the completeness of provider data (due to variable compliance with data entry) and comparability of data (due to varying protocols, processes and definitions) challenge broader implementation of benchmarking analysis. The evaluation of CQRs also found that issues such as low coverage, inadequate reporting and inadequate collection of information about patient outcomes limits the effectiveness of some CQRs (ACSQHC 2016a).

Box 24.9 Clinical quality registries in Australia

Clinical quality registries (CQRs) systematically measure and monitor the quality (appropriateness and effectiveness) of healthcare, within specific clinical domains (for example, musculoskeletal disorders or strokes). CQRs routinely collect, analyse and report health-related information, including longitudinal data (ACSQHC 2014) (example below).



Information collected from CQRs can be used to inform improvements in healthcare quality and safety within those domains. In addition to improved consumer outcomes, the use of CQRs can improve compliance with evidence-based guidelines and standards and informs the development of new guidelines and standards (ACSQHC 2014).

To date, there is no overarching Australian strategy to guide and optimise the contribution of CQRs to improved outcomes for consumers and ensure that returns on investment are maximised. However, a national strategy is in development (DoH 2019c). Moreover, there are no CQRs in mental health in Australia. The Australian Commission on Safety and Quality in Healthcare now recognises mental health, especially schizophrenia and major affective disorder, as a prioritised domain (ACSQHC 2016b).

Service providers and Inquiry participants called for the Australian Government to facilitate and coordinate some form of national benchmarking. For example, there was support from service providers to make the National Outcomes and Casemix Collection data available at an organisational level to facilitate benchmarking (DoH 2011). The Australian Psychological Society (sub. 543, p. 36) said that:

... [the society] and its members are committed to being accountable for their work under Medicare and accordingly have submitted to the Department of Health a proposal for an easy-to-use, secure online point-of-service data collection system that could support the delivery of psychological services under Medicare.

The Australian, State and Territory Governments should actively address barriers to implementing national benchmarking, and fund the facilitation and coordination of it. National benchmarking at the service provider level would improve service quality and outcomes for consumers and carers. Although some States (such as New South Wales) have implemented systemic approaches to benchmarking mental health services, it is largely underutilised across Australia. The Australian, State and Territory Governments should consider different models for facilitating and coordinating benchmarking analyses, including through CQRs, or by establishing a central authority to undertake the role (such as in New South Wales). Different funding arrangements should also be considered, including cost sharing models with service providers. Barriers to implementing national benchmarking should be identified and addressed.

Publishing data at a service provider level

Publishing data at the service provider level can also improve service delivery, particularly if it focuses on safety and quality (ACSQHC 2019c). In this chapter, the service provider level refers to mental health service *organisations* (for example, clinics, centres, hospitals, psychosocial support services, counselling centres), rather than *individual* clinicians. The benefits would largely be realised through:

- informing consumer choice (consumers are provided more information, enabling them to seek out better performing providers)
- self-improvement by providers (through comparison with their peers).

Although much of the literature shows this level of public reporting rarely influences consumer choice, there is evidence that it encourages healthcare providers to engage in self-improvement activity, largely because of the peer-pressure effect (ACSQHC 2019c; PC 2017b). For example, a systematic review undertaken by the United States' Agency for Healthcare Research and Quality found that public reporting is more likely to result in improvements in quality, if the clinician or hospital is operating in a competitive market (ACSQHC 2019c).

Despite evidence that public reporting at the service provider level can improve service quality, its use in Australia is limited, particularly in mental health. A notable exception is the recently established National Seclusion and Restraint NBEDS, which provides seclusion rate data across Australia by hospital (AIHW 2019i). The Australian Government developed the *MyHospitals* website in 2010, to provide accessible and user friendly information about the performance of Australian hospitals (ACSQHC 2019c), however, it does not report any mental health-related indicators. The Productivity Commission has previously found that there was scope to significantly improve the *MyHospitals* website and recommended improvements (PC 2017b).

The limited availability of mental health data at a service provider level severely impedes self-improvement among providers, and consumer choice. While the Fourth National Mental Health Plan aimed to address this by establishing transparent web-based reporting to compare similar services around Australia (AHMC 2009b), and the Fifth Plan implies that this is important, such data remains unavailable.²⁷⁰

Public reporting of mental health services occurs at the service provider level in other countries. For example, England makes performance data accessible online in formats that enable consumers, families, carers and clinicians to compare the performance of service providers (providing psychological therapies) across domains such as recovery rates and outcome improvement rates (box 24.10). Clarke et al. (2018) found that publishing this data improved transparency, enabled identification of sources of local variability in mental health outcomes and facilitated improvements in service provision. While some provider level data is also publicly available for those providing services in the community, including NGOs (NHS 2020a), it is typically limited to information on access.

In Australia, there are concerns that the mental health sector is not yet ‘ready’ for public reporting and benchmarking analysis (discussed above) at the service provider level. There are claims that this level of reporting could lead to mistrust of relevant providers, that consumers might be confused (because data provides a static snapshot of performance at a given point in time that may not always reflect current performance) or that providers might ‘game’ the system, misreport or distort data to create a good impression, or focus attention on some performance measures at the expense of others (Trauer 2011).²⁷¹ Some providers want to delay the publication of information on their performance and limit scope for consumer-choice driven quality improvements. For example, NovoPsych Pty Ltd (sub. 645, p. 3) said that ‘[i]n due course standardized approaches to publishing outcome data for public consumption could be developed, providing more transparency when mental health consumers are making health care choices’, but any movement towards this needs to be ‘[led] from *within* the profession, with an emphasis on self-directed quality improvement’.

²⁷⁰ Actions to provide such data under the Fourth National Mental Health Plan were suspended following the creation of the National Health Performance Authority, which was expected to undertake quarterly public reporting of every LHN (and the hospitals within it), private hospitals and Medicare Locals (COAG 2011). However, the National Health Performance Authority was abolished in 2016, with its functions transferred to the AIHW (AIHW 2016). And although the same goal for making data available was not explicitly included in the Fifth Plan, Action 25 of the Fifth Plan implies it should be, stating ‘Governments will ensure service delivery systems monitor the safety and quality of their services and make information on service quality performance publicly available’ (COAG Health Council 2017b, p. 28).

²⁷¹ Publication of provider level data initially met with a number of concerns in England. England’s NHS providers considered that publishing such data would adversely impact public trust and professional morale (Adab et al. 2002).

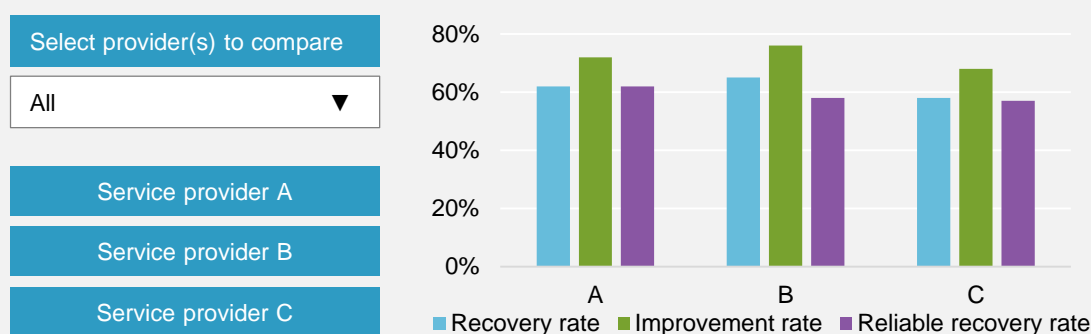
Box 24.10 England's National Health Service monitoring and reporting

In England, data is gathered from across the National Health Service (NHS) into one place so professionals and the public can easily compare the performance of healthcare and other support services over a range of measures.

The NHS website allows users to compare information for many NHS service providers. Indicator information may cover the quality and safety of a hospital, as well as information about facilities provided, such as the cost and availability of car parking.

The NHS website publishes data on the performance of organisations providing psychological therapies in England under the Improving Access to Psychological Therapies program.

An adapted example of the web interface is provided below.



Source: National Health Service (2016, 2020b).

The development of service-provider level public reporting requirements should certainly involve consultation with both the relevant service providers and consumers to understand the benefits of provider level data for improving service quality and consumer choice. To delay this reporting until service providers feel comfortable with it, however, would be reinforcing the misconception that the (largely publicly subsidised) service providers are more important than the consumers whom they are supposed to be helping. Inquiry participants were supportive of more transparent public reporting, which provides consumers and carers greater visibility over services (CHF, sub. 646; Mental Health Australia, sub. 864).

Transparent provision of data at the service provider level is an essential element of a person-centred mental health system — information that would enable consumers and carers to make informed decisions on care and support options. The public reporting of activity, outcomes and performance data for hospitals, specialists and allied health professionals would be especially informative in this regard (PC 2017b). As a result, the Australian, State and Territory Governments should strengthen and expand commitments to public reporting at the service provider level.

ACTION 24.5 — MONITORING AND REPORTING AT THE SERVICE PROVIDER LEVEL

The Australian, State and Territory Governments should require monitoring and reporting at the service provider level that is focused on consumer and carer outcomes, to encourage improvements in service quality, improve transparency and accountability, and inform consumer choice.

Start now

- The Australian, State and Territory Governments should fund the facilitation and coordination of benchmarking analyses. In doing so, different models of facilitation and coordination should be considered, such as through a national clinical quality registry in mental health or by tasking a central authority. Different funding arrangements should also be considered, including cost sharing models with service providers. Australian, State and Territory Governments should identify and address any implementation barriers.
- The Australian, State and Territory Governments should require all publicly funded mental health service providers (clinical and non-clinical) to commit to public reporting at the service provider level. This would support consumers and carers to exercise choice, and encourage performance improvement by service providers. Lessons from overseas examples should be drawn on, for example, the National Health Service website that is used to inform consumers and carers in England.

Enhancing regional monitoring

Performance monitoring at the regional level

Although data is often available at a state or territory level, it is less available at the finer geographic area at which service decisions are made for the communities where consumers and carers live.

Governments have been working to improve data availability at local and regional levels. Action 1 in the Fifth National Mental Health and Suicide Prevention Plan calls for better integrated planning and service delivery at the regional level, including making data available to inform regional-level planning (COAG Health Council 2017a). To deliver on this, the AIHW is currently working to improve data availability at a more local level (by Statistical Area Level 3 and PHN regions). This has been completed for some mental health datasets already, including residential and community mental healthcare data (AIHW 2019h, 2019k). The AIHW is also developing a single ‘portal’ for a range of datasets (possibly including Medicare, the Pharmaceutical Benefits Scheme and hospital and community mental health services) to support local mental health planning activities (Integrated Regional Planning Working Group 2018a).

The *Atlas of Healthcare Variation* reports provide some information by local geographical Statistical Area Level 3, however data is limited to information on access to mental health treatments and reporting is inconsistent between annual reports (ACSQHC 2018a).²⁷²

At the very least, data must be available and reported at a level that is useful, given regional boundaries of PHNs, LHNs or Regional Commissioning Authorities (RCAs) if established (chapter 23). Which regional boundary should be used depends on the data collection in question and its uses. For example, state and territory data collections should be available at the LHN level, whereas primary mental healthcare data should be available at the PHN level.

Regional-level data is important for two key reasons. First, regional reporting would hold regional commissioning bodies (PHNs or RCAs) accountable to the public. For example, data at the PHN and LHN level is needed to strengthen monitoring and reporting, and evaluation of PHN–LHN groupings (action 23.1). The PHN Advisory Panel (2018, p. 9), which includes several PHN members, supported increased transparency:

All Panel members agreed that enhanced visibility of the performance of PHNs would be well received, as currently there is limited information publicly available to those outside the PHNs and the Department, despite significant amounts of data being collected by PHNs.

Second, reporting (and collecting data) at regional levels allows for more informed service planning and commissioning by regional commissioning bodies (PHNs or RCAs). For example, the Primary Health Networks Cooperative (sub. 377, p. 13) stated:

There are rich information datasets at the national and state levels. However, this unfortunately is not consistently the case at regional and local levels, making planning and commissioning processes challenging.

The opaqueness of PHN activities and PHN-commissioned services presents a significant data gap that inhibits integrated planning and service delivery at the regional level.

Reporting data at regional levels also enables planners and researchers to compare experiences across regions with similar demographics and social determinants. This creates opportunities for regional commissioning bodies (PHNs or RCAs) to learn from those that are performing well, and to improve outcomes in their own regions.

In a country the size of Australia, state by state comparisons are of limited value. It may be far more useful to compare, say, the Barwon and Hunter regions than to compare Western Australia with Tasmania. (Rosenberg and Salvador-Carulla 2017, p. 50)

²⁷² The 2015 release includes data on GP mental health treatment plans, and dispensing of antidepressant and antipsychotic medicines. However, this data was not included in the 2017 release, and only data on antipsychotic medicines dispensed was included in the 2018 release.

There is an opportunity to strengthen monitoring and reporting at a regional level. The Australian Government should release data collected on and by PHNs for annual publication by the AIHW. The Australian, State and Territory Governments should authorise the AIHW to report all data relating to the performance of mental health services, that it currently reports, at a regional level (as defined by PHN and LHN regional boundaries) in addition to existing reporting at state, territory and national levels. Reporting at regional levels already occurs in health more broadly (for example, the *Healthy Community Indicators* at a PHN level), and for some mental health datasets, including residential and community mental healthcare data (AIHW 2019h, 2019k).

In addition, the AIHW should ensure this data is readily accessible to the public, including a historical time series, to maximise its usefulness for planning and research. The Australian Government should provide AIHW with additional resources to establish service performance reporting at the regional level and to make this data publicly accessible.

ACTION 24.6 — REPORTING SERVICE PERFORMANCE DATA BY REGION

Transparency at a regional level is required to make sure mental health services are meeting local needs.

Start now

- The Australian Government should release data collected on and by Primary Health Networks for annual publication by the Australian Institute of Health and Welfare (AIHW).
- The Australian, State and Territory Governments should authorise the AIHW to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by Primary Health Network and Local Hospital Network regional boundaries, as well as at a State and Territory and national level.
 - The AIHW should ensure that this data is readily accessible to the public, including as historical time series, to maximise its use for planning and research.
 - The Australian Government should continue to provide AIHW with additional resources to establish service performance reporting at the regional level and to make this data accessible to commissioning bodies and the public.

Standardising reporting requirements

Australian, State and Territory Governments should provide national guidance to standardise reporting requirements across regions. This would reduce administrative burdens for service providers and facilitate comparisons on a consistent basis for planning and research purposes.

PHNs have developed their own reporting requirements to monitor services delivered by providers that they commission. This includes ensuring adequate reporting requirements are built into contracts. Although the Australian Government Department of Health discusses

the importance of monitoring and evaluation to commissioning in the *PHN Commissioning Framework* (DoH 2016a), the framework does not provide a standardised approach for reporting, allowing PHNs flexibility to determine their own reporting needs.

As a result, individual approaches have emerged, imposing a sizable administrative burden on some service providers that operate across multiple PHN regions. This can be especially challenging for NGOs providing psychosocial supports across the country (chapter 17), as highlighted by Jesuit Social Services (sub. 441, p. 20):

... each PHN has different reporting and evaluation requirements, which places a sizable administrative burden on specialist programs such as Support After Suicide. Establishing consistent reporting requirements across different PHNs would help ensure greater efficiency, particularly for service providers with limited resources.

Further, without standardised reporting, it is difficult to systematically compare service performance across regions. This has negative effects on transparency (and accountability) and reduces opportunities for commissioning agencies (PHNs or RCAs) to learn from one another and improve.

Any standardised approach needs to be outcome-focused and needs to allow some flexibility for how outcomes are achieved at a regional level. PHNs are independent organisations, commissioning mental health services to meet the needs of people in their regions, with an aim to improve consumer and carer outcomes. The needs of people in one PHN region can differ significantly from the needs of people in another region. As a result, any standardised approach needs to recognise this, and allow for some regional flexibility on how outcomes are achieved by PHNs. However, at the same time, undue reporting burdens should not be imposed on service providers.

There is scope for both the Australian Government, and State and Territory Governments to consult with regional commissioning bodies (PHNs or RCAs), to develop standardised, outcome-focused monitoring and reporting requirements for the service providers they commission services from. This should ensure undue regulatory burden is not imposed on service providers and facilitate inter-regional comparisons. The Australian, State and Territory Governments should provide guidance and support to all regional commissioning bodies (PHNs or RCAs) to implement this, and monitor and report on compliance.

ACTION 24.7 — STANDARDISED REGIONAL REPORTING REQUIREMENTS

Service providers operating in multiple regions should face consistent outcome-focused reporting requirements across those regions.

Start now

The Australian, State and Territory Governments should develop, in consultation with regional commissioning bodies, standardised and outcome-focused reporting requirements for service providers. This should ensure undue regulatory burden is not imposed on service providers and facilitate inter-regional comparisons. The Australian, State and Territory Governments should provide guidance and support to regional commissioning bodies to implement this, and monitor and report on compliance.

Gap analyses using the National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (NMHSPF; box 24.11) and its accompanying Planning Support Tool can be used to generate ‘benchmarks for optimal service delivery across the full spectrum of mental health services in Australia’ (University of Queensland 2019, pp. 5, 30).

Box 24.11 The National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (NMHSPF) was developed by the Australian, State and Territory Governments as an action arising from the Fourth National Mental Health Plan. The NMHSPF and its accompanying Planning Support Tool allow users to estimate need and expected demand for mental healthcare and the level and mix of mental health services required for a given population. These estimates can be used to guide strategic planning and future investment in the mental health system at the national, State/Territory and regional level.

The NMHSPF has been used across Australia as a nationally consistent tool for service planning.

The Commonwealth and the states and territories have demonstrated a commitment to the refinement and application of the NMHSPF through the Fifth Plan. The department encourages PHNs and LHNs to use the NMHSPF in their regional planning. (DoH, sub. 556, pp. 42)

For example, in both Tasmania and the Northern Territory — which each have only one primary health network — the State Health Department and the primary health network are collaborating to develop joint regional plans based on the NMHSPF (NT Government 2019; Tasmanian Government, sub. 1242). Both Western Australia and South Australia have used the NMHSPF as a key input into their longer-term strategic mental health plans (chapter 12). And we have used the NMHSPF to estimate service gaps presented in this report — for community ambulatory mental healthcare services (chapter 12), bed-based services (chapter 13), psychosocial support services (chapter 17), housing (chapter 20), and carers (chapter 18).

Comparisons of services ‘on the ground’ with NMHSPF benchmarks (known as ‘gap analyses’) could serve both to guide resource allocation decisions and to hold governments, PHNs, LHNs, and (potentially) RCAs to account for their resource allocation decisions. The Fifth National Mental Health and Suicide Prevention Plan prioritised the first of these functions — it required PHNs and LHNs to use the NMHSPF to guide their joint regional planning. It also required governments to support PHNs and LHNs in their planning and facilitate ongoing improvement of the NMHSPF (COAG Health Council 2017a). However, there have been few efforts to use the NMHSPF to drive accountability. Gap analyses could reveal whether governments, PHNs and LHNs (or RCAs) are allocating adequate funding to particular types of mental health services.

Producing gap analyses requires: access to (and competency with) the NMHSPF; and data about what services are being provided to allow a comparison with the NMHSPF benchmarks.

Access to the NMHSPF is currently limited to PHNs, LHNs and government agencies (Australian Government Department of Health, sub. 556) (although the Productivity Commission recommends that it be made publicly available — action 24.9). Inquiry participants stated that some PHNs and LHNs are still building capability with the NMHSPF.

Much of the relevant data about mental health services on the ground is already collected, but some (such as data on services provided by PHNs) is not published, and some (such as data on psychosocial supports) is not collected systematically. As well, much of the available data does not align with the NMHSPF. To address this:

... the AIHW and the University of Queensland are undertaking work to map data from existing national mental health data collections to the NMHSPF outputs, and enable reporting of these results at the PHN, LHN and SA3 level. Mapping of Medical Benefits Schedule funded services to NMHSPF outputs has already been completed and made available to licensed users. (University of Queensland 2016, p. 6)

Once this work is complete, the AIHW should publish annually data from all relevant sources in a way that aligns with the NMHSPF. This data should be published at a national level, a state and territory level, and a regional (PHN) level. Publishing this data would make it available for use by all governments, by PHN–LHN groupings/RCAs and by service providers, and would improve the transparency of both service provision and gap analyses.

Regional gap analyses

Region-level gap analyses (conducted at the PHN–LHN grouping/RCA level) should form part of the broader joint regional planning process. They should be undertaken each year and published within regional plans. This is consistent with the focus of the Fifth National Mental Health and Suicide Prevention Plan on joint regional planning backed by the NMHSPF (COAG Health Council 2017a) and with the Productivity Commission’s support for regional planning (chapter 23).

Each PHN–LHN grouping should be provided with support to undertake gap analyses.

- The AIHW should ensure timely provision of data about services on the ground to PHN–LHN groupings/RCA in a format that aligns with the NMHSPF.
- The AIHW should assist PHN–LHN groupings/RCA that have not developed the capacity to use the NMHSPF to generate NMHSPF outputs.
- The AIHW should verify all completed gap analyses.

Governments should provide additional resourcing to the AIHW to support its expanded role. However, PHN–LHN groupings/RCA that require the AIHW to generate NMHSPF outputs should fund the AIHW to do so from their own budgets. Governments should expect PHN–LHN groupings to acquire and maintain expertise with using the NMHSPF, and resourcing arrangements should reflect this.

State/Territory gap analyses

Timely and consistent gap analyses must also be available to inform government policy development and decision making at a state, territory or national level, and promote transparency. The Productivity Commission recommends that the AIHW undertakes and publishes this analysis for all jurisdictions, including:

- benchmarking of service levels for all types of mental health services included in the NMHSPF (including primary care, community ambulatory care, and bed-based services), at both a state and territory, and national level
- gap analyses, based on a comparison of these benchmarks, with services that are currently provided (where this data is available), at both a state and territory, and national level.

Empowering (and funding) the AIHW to publish gap analyses covering the whole mental health sector for each state and territory, and for Australia as a whole would increase accountability at both levels of government, and provide a necessary basis on which governments could take action to address service gaps and undertake strategic mental health planning.

In addition, for community ambulatory services, all State and Territory Governments should give permission for the AIHW to publish data each year on the amount of time that clinical staff spend on consumer-related activities (with and without the consumer present). This data is crucial to understanding the level of these services that consumers are receiving, and what additional resources are needed to ensure that all consumers receive adequate services (chapter 12). The AIHW already collects this data from the states and territories each year, but it is not published (although all State and Territory Governments, except the ACT, gave permission for the Productivity Commission to publish the data as part of this Inquiry — chapter 12). The AIHW should publish this data side-by-side with its state and territory level resource gap analyses, to make clear that both the ‘resource gap’ and the ‘productivity gap’ need to be addressed for consumers to get adequate services.

ACTION 24.8 — GAP ANALYSES USING THE NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK

Start now

As work to map data from existing national mental health data collections with National Mental Health Service Planning Framework (NMHSPF) outputs is completed, the Australian Institute of Health and Welfare (AIHW) should annually publish all relevant data on mental health services in a format that aligns with the NMHSPF at a national, State/Territory, and regional level.

Each Primary Health Network–Local Hospital Network grouping or regional commissioning authority should annually report, in their joint regional plan, a gap analysis using the NMHSPF.

The Australian Government, and all State and Territory Governments, should give the AIHW permission to annually publish, at both a national and State/Territory level:

- independent estimates of NMHSPF benchmarks of all mental health services, including psychosocial support services, included in the NMHSPF, at both a national and State/Territory level
- gap analyses based on a comparison of these benchmarks with services that are currently provided (where this data is available)
- data on the amount of time that clinical staff in community ambulatory mental health services are spending on consumer-related activities (with and without the consumer present).

The National Mental Health Service Planning Framework should be improved

While the National Mental Health Service Planning Framework (NMHSPF) is already widely used, it needs improvement. For example, it does not currently cover forensic mental health services (chapter 21). And while it accounts for differences in age distributions when estimating population needs, the NMHSPF leaves it to jurisdictions or local PHN/LHN planners to account for other differences that may affect population needs, specifically the resource estimates for Aboriginal and Torres Strait Islander people and for populations in regional and remote areas.

The benchmarks from the NMHSPF are sensitive to certain assumptions in the model, which are more optimistic than the actual rates ‘on-the-ground’. Chapter 12 highlights this issue in discussing how much time community ambulatory staff spend on consumer-related activities, which is significantly less than the targets used in the NMHSPF. Benchmarks for acute beds rely on assumptions about occupancy rates and readmission rates that are similarly optimistic.

The NMHSPF does not deal well with substitution between types of care. When considering the required level of one service, the NMHSPF assumes that all other services are at their

required levels. For example, if a State Government decided to provide more non-acute beds in the community than recommended by the NMHSPF, this would not change the number of sub-acute beds in *hospitals* that would (according to the NMHSPF) be needed to meet population needs. The Consortium of Australian Psychiatrists and Psychologists (sub. 882) argued that Australia needs more hospital beds than suggested by the NMHSPF, and raised concerns with assumptions related to how demand for hospital services are affected by the provision of services in the community, and to the optimal split between community and hospital non-acute beds.

Participants have also questioned whether the NMHSPF is flexible enough to account for large temporary shocks to population mental health — such as natural disasters or recessions. This flexibility is particularly important for the COVID-19 pandemic, with the threat of infection, social distancing rules and the consequent economic downturn and job losses all expected to adversely affect people’s mental health.

Work is underway to improve the NMHSPF.

The Australian Department of Health (in conjunction with State and Territory Governments) has commissioned the University of Queensland to undertake a program of work to further develop and refine the NMHSPF. Priorities for development include revising the epidemiology of the NMHSPF to incorporate the latest evidence and refining the care profiles of the NMHSPF to better account for the needs of key populations including Aboriginal and Torres Strait Islander populations and people living in rural and remote areas (Australian Government Department of Health, pers. comm., 24 March 2020).

We support these efforts to make the NMHSPF more accurate and useful.

Greater transparency is needed

The NMHSPF (and the Planning Support Tool) are not publicly accessible, although some documentation is published (NMHSPF 2017). This limits ‘external scrutiny of regional service planning’ (NMHC, sub. 118, p. 30).

The Australian Government Department of Health (sub. 556, p. 42) told us that:

Over 200 users from PHNs, LHNs and state and territory government health agencies have been trained and given access to use the NMHSPF. In 2019, NMHSPF licence arrangements will be expanded to allow access for a broader range of users with a legitimate government role in planning and resourcing of mental health services.

But access is not available to academics, clinicians and other stakeholders for whom the NMHSPF would be valuable. The Consortium of Australian Psychiatrists and Psychologists (sub. 882, p. 18) submitted that:

Because the bases of the assumptions underlying NMHSPF’s modelling of Australia’s bed numbers aren’t publicly available, it isn’t possible to readily engage in a fact-based debate about them.

Greater transparency would allow much needed scrutiny over the assumption and mechanics of the model, and increase trust in the NMHSPF's output. To this end, we are recommending that the NMHSPF and the Planning Support Tool are made publicly available, along with all supporting documentation.

ACTION 24.9 — INCREASING THE TRANSPARENCY OF THE NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK

The key planning tool used for mental health — the National Mental Health Service Planning Framework (NMHSPF) — should be transparent to facilitate its improvement.

Start now

The Australian, State and Territory Governments should enhance and make all parts of the NMHSPF publicly available, including the Planning Support Tool and all supporting documentation.

Start later

Over time, the NMHSPF should:

- be able to account for substitution between types of care
- be expanded to include forensic mental health services
- be made more flexible so that it can account for large but temporary 'shocks' to population mental health, such as natural disasters, epidemics or recessions.

24.3 Evaluation

Monitoring and reporting alone may not be enough to drive improvements in policy, programs and services, but they can underpin evaluation. For example, in some cases, monitoring can inform evaluation and research priorities by revealing weaknesses or problem areas, but by itself, cannot provide reliable information on the effectiveness and efficiency of interventions. The Mental Health Commission of New South Wales (sub. 486, p. 13) said that 'robust monitoring of investment and person, community and service outcomes, needs to be matched by robust evaluation systems'.

Evaluation is the systematic process of collecting and analysing information to enable an assessment of an activity, project, policy or program (PC 2019a). Good evaluations generate valuable information and contribute to a wide range of initiatives and objectives (HM Treasury 2011). In particular, they can: provide reliable information on the effectiveness and efficiency of programs; inform the development of new programs and improve existing ones; and promote accountability by enhancing transparency. Evaluation can improve the effectiveness and efficiency of governments' multi-billion dollar investments in mental health, securing better outcomes for people using services and programs, and their carers.

Current arrangements

Apart from some notable exceptions, program evaluations in mental health across Australia are, for the most part, ad hoc, uncoordinated and lacking in objective evidence.

Some State Governments have developed their own evaluation capability. Notably, the Western Australian Mental Health Commission established a Performance, Monitoring and Evaluation team to manage datasets and undertake system evaluations (WAMHC 2016a). In addition, it employed a full-time evaluation officer to support the State's *Suicide Prevention 2020* strategy (Western Australian Mental Health Commission, sub. 259). The role includes coordinating external evaluations and evaluating projects, as well as the overall strategy.

However, participants noted that Australia generally has a lack of routine program evaluation and evidence gathering to inform funding allocations and program improvements in mental health. The Mental Health Commission of New South Wales (sub. 486, p. 13) observed that:

There is limited insight into costs, benefits and quality of services across the whole care economy. This lack of information is a challenge to informing decisions to strengthen prevention, early intervention and care in a community setting, and for evaluating the financial and human benefits.

And where evaluations are undertaken, it is not clear if they are used to improve programs.

There are significant concerns that, when service evaluation raises issues regarding the efficacy of that service, this has not necessarily resulted in changes in funding or changes in the service model to ensure high quality, high value service delivery. (ACPA, sub. 359, p. 34)

There are multiple reasons for the lack of program evaluations. First, levels of program funding may be insufficient (Borzycki 2005). Evaluation is resource intensive, which Anglicare Victoria (sub. 312, p. 27) noted makes it hard to obtain sufficient funding:

... despite the obvious benefits for system-wide learning ... It remains the case that when negotiating costs with funding bodies, including governments, evaluation is often the first casualty.

In addition, there are weak incentives for program funders and managers to prioritise evaluations. For large, long-standing programs in particular (such as Better Access), the incentives may be weakened by potential political risks. Such programs may be seen as an accepted part of service delivery, with strong opposition to any proposed changes that might flow from evaluations (Anthony Jorm, sub. 45). In other situations, programs end because of changes in political priorities, creating no incentive or funding to evaluate the de-funded program, even when there are opportunities to extract key lessons for future program design.

Moreover, the benefits of some mental health programs are likely to be realised in other sectors (or portfolios), possibly many years later. The AIHW (sub. 370, p. 5) noted this:

Some outcomes are not observed or cannot be observed while a program is operating as they require generational change. Early childhood education is a good example — some of main benefits of early childhood education are not apparent until participants are teenagers.

Benefits that are largely realised in the long term and in other sectors (or portfolios) dull incentives to evaluate programs in the short to medium term (Knapp and Iemmi 2016).

Inquiry participants were also concerned that current approaches to program evaluations:

- lack transparency, accountability and independence (RANZCP, sub. 385)
- are not shared more broadly within government to support improvement (Mental Health Commission of New South Wales, sub. 486)
- do not provide meaningful findings due to funding constraints (One Door Mental Health, sub. 108)
- are not prioritised — there is a lack of funding for formal evaluation of programs or services and external evaluations are not always funded as part of service agreements (Northern Territory Mental Health Coalition, sub. 430).

The NMHC should lead evaluations nationally

While the lack of evaluation could be addressed at a state, territory and regional level, this is only a partial solution. It would unlikely lead to nationally consistent datasets, which would limit consistent comparisons across states and territories, and between regions. It would also make it harder to learn about ‘what works, and what does not work’ on a national scale.

On the other hand, assigning responsibility for program evaluations to a national body could address many shortcomings by ensuring consistency in data, evaluations and learning. Although Inquiry participants did not call for the establishment of a national evaluation body, they did highlight the need for a more structured approach to evaluation (APS, sub. 543; Anthony Jorm, sub. 45). Suicide Prevention Australia (sub. 523, pp. 9–10) highlighted the importance of ‘working toward nationally consistent and reportable evaluation practice’ across the system.

For these reasons, chapter 22 recommends that a national body — the NMHC — be tasked with leading evaluations of mental health and suicide prevention programs. This includes programs funded by Australian, State and Territory Governments, and programs in non-health sectors that have strong links with mental health outcomes. Chapter 22 discusses the recommended role of the NMHC in more detail, but broadly, the NMHC is expected to evaluate aspects of the system that are of national significance or that relate to multiple jurisdictions. This would involve close consultation with jurisdictions to discern where and when the NMHC could best add value.

Expanding the NMHC’s functions to include evaluation would also complement and strengthen its role in monitoring and reporting. As mentioned above, monitoring can underpin good evaluation — it can reveal weaknesses in areas of the mental health system that need further investigation, identifying areas where evaluation should be prioritised. The NMHC (sub. 949, p. 26) stated that a ‘monitoring, evaluation and reporting function’ would mean

‘ongoing and continuous monitoring is reinforced, in addition to the periodic evaluations and the scheduled reporting’.

ACTION 24.10 — STRENGTHENING MONITORING AND REPORTING

Monitoring and reporting should be more focused on consumer and carer outcomes, and broadened beyond health portfolios.

Start now

- The National Mental Health Commission (NMHC) should lead monitoring and reporting on mental health and suicide prevention outcomes, activities and reforms across portfolios. This includes monitoring and reporting on:
 - outcomes derived from the Contributing Life Framework for people with mental illness, their carers and suicidal behaviour annually
 - mental health and suicide prevention expenditure (including in non-health sectors), with the NMHC to determine frequency of reporting
 - the progress of mental health reforms (including strategies and plans) annually.
- The NMHC should consult with stakeholders, including consumers and carers, Aboriginal and Torres Strait Islander people and sector experts in finalising a set of indicators to monitor and report on progress against outcomes derived from the Contributing Life Framework.
- The NMHC should consult with stakeholders and sector experts to identify mental health related expenditure in non-health sectors, such as justice and education, that could be routinely reported on.
- The NMHC should continue to monitor and report on progress against mental health reforms under the National Mental Health Strategy.
- The NMHC’s monitoring and reporting activities should inform and support its recommended evaluation function (Action 22.7).

Evaluations that reveal program effectiveness

Evaluations should support learning, evidence-based decision making, improvements in programs and service delivery, and inform policy decisions. However, some approaches to program design, implementation and data collection limit the extent to which evaluations can support these aims. For example, if a program evaluation does not measure the effect of a program, then it cannot conclude whether the program has improved consumer and carer outcomes.

Shifting towards impact evaluations

Where evaluations of mental health programs have been undertaken, they have tended to be ‘monitoring evaluations’. That is, they simply report on how program use and occasionally outcomes vary between participant demographic groups (for example, by age or gender). For example, an evaluation of a program might show that, on average, the mental health of participants in a program improved by 10%, with a higher improvement for women. However, was this improvement due to the program or ‘something else’?

Evaluations of mental health programs are most useful when they reveal the effectiveness or the ‘impact’ of a program. Often, this is best achieved by establishing a control group — a group of individuals who did not participate in the program, but have similar characteristics to those participating in the program. Having a control group is important to establish a ‘base’ to judge the program, providing information on how a program affects outcomes, rather than just an observation of changes in outcomes. For example, the lack of a control group, amongst other aspects, meant that an evaluation of the Better Access program was unable to properly assess program impact (Anthony Jorm, sub. 45). In contrast, a randomised control trial of Mindspot’s web-based, help-seeking navigation tool *Link*, compared quality-adjusted life years²⁷³ gained by the intervention group with a control group (Le et al. 2019; Deakin Health Economics Institute for Health Transformation, sub. 156).

Notwithstanding these comparisons, there will be instances where it is not feasible (or is potentially unethical) to include a control group. In such situations, evaluations need to be planned and implemented using alternative approaches — such as careful measurement of changes in mental health over time, controlling for any other factors that change during the evaluation period.

Evaluating program implementation and progress

Evaluations can also be undertaken earlier on, before programs reach an impact evaluation stage. In particular, there are two types that are considered below.

First, program evaluations can be conducted as a program is being rolled out, to monitor implementation progress and inform improvements. For example, the Department of Industry, Innovation and Science’s *Evaluation Strategy* includes: ‘post-commencement’ evaluations to identify any issues related to initial implementation, design and delivery of the program; and monitoring evaluations to consider the program’s progress in improving short- and medium-term outcomes (DIIS 2017).

This is important to ensure lessons learned can be used for ongoing improvements in program implementation and consumer outcomes, and to inform the development of new or similar programs. To do otherwise wastes accrued knowledge. For example, interim

²⁷³ Quality-adjusted life year is a measure of disease burden. It is used in economic evaluation to assess the value of medical interventions. One quality-adjusted life year equates to one year in perfect health.

evaluations may identify valuable lessons regarding barriers or challenges to implementation and possible ways to address them, without waiting for the final impact evaluation.

Second, program evaluations can be undertaken to estimate the impact of evaluations *before* they reach an impact evaluation stage. Research shows that early measurable indicators, that are reliable proxies for likely long-term outcomes of an intervention, can be extremely useful in early evaluations. For example, Athey et al. (2019) found that long-term effects of programs on labour market outcomes can be predicted accurately by combining several short-term treatment outcomes into a ‘surrogate index’.

These types of evaluations can be useful in mental health, given many programs are, for a variety of reasons, defunded before their impact can be evaluated. Inquiry participants highlighted that a number of programs have been stopped due to changes in funding arrangements (Ken Barnard, sub. 924, att. 1; Sharon Blake, sub. 584; Northern Territory Mental Health Coalition, sub. 430). For example, the introduction of the NDIS led to the transfer of funding from several mental health programs to the scheme (chapter 17). Programs can also stop due to changes in government and political priorities (ConNetica 2013). Programs aiming to improve long-term outcomes may not transcend election cycles, and be defunded before outcomes are realised (and evaluated).

For the reasons above, Australian, State and Territory Governments should ensure that evaluation principles (action 22.7) reflect the importance of:

- shifting towards evaluations that focus on measuring the attributable *impact* of programs (through methods that incorporate control groups), rather than *monitoring* program outcomes
- promoting processes that enable lessons from program implementation to be determined and disseminated before programs reach their impact evaluation stage.

Evaluate first, rollout later

Some of Australia’s large scale mental health programs have been rolled out nationally, with very little information on which to gauge their likely value and little planning for how to subsequently determine this. Jorm (sub. 45, p. 5) stated ‘[i]t would have been preferable for Better Access and headspace to be trialled on a smaller regional scale with comparisons made with control regions, before a decision was made on national rollout’.

Rolling out programs before trialling and evaluating them can lead to governments funding programs that are not the most effective or efficient way to improve outcomes for consumers and carers. This may arise, for example, where proposed programs have a sound rationale, but may face practical barriers to ‘work’ in practice (such as a lack of appropriately skilled staff). Similarly, a program may work overseas and improve consumer outcomes, but may not work locally without adaption to meet cultural needs or local circumstances. Ensuring programs are trialled and evaluated before they are rolled out nationally provides information on how to improve consumer outcomes in practice.

Further, such an approach would avoid governments becoming unintentionally ‘locked’ into funding unproven programs. If a program is rolled out nationally and then subsequently found to not deliver the intended outcomes, it can be difficult for governments to revert to exploring alternatives.

In some cases, pilot trials are evaluated to have positive impacts, but similar results are not observed when the program is scaled up (ACOSS, sub. 1208). This may occur if the program is not implemented in the same way as the pilot trial. There may be, for example, differences in workforce skills and experiences, or in the characteristics of participants.

There are various strategies to minimise this risk. First, a pilot trial could be progressively scaled up (rather than fully scaled up), as further evaluation and learning comes to light. Second, a particular level of workforce skills and experience (that is aligned with the pilot trial) should be required for the scaled up program. Finally, evaluations of pilot trials should inform eligibility requirements for program participants, to ensure participants in a scaled up program are part of the appropriate target group.

The Australian, State and Territory Governments should fund trials of newly proposed programs and associated evaluations before any program is scaled up — this should be a pre-requisite. Pilot trials are not only a practical way of informing better designed policies and programs, but also a strategy to help governments manage risks and responses to new problems and an avenue for innovation in program design (PC 2017d). There are some examples of pilot trials being used, for example, in suicide prevention (chapter 9), although, concerns have been raised about the implementation of these trials, including that they have been slow and uncoordinated.

Cost-effectiveness evaluations

Cost-effectiveness evaluations are necessary to support government decision making on which interventions are most efficient to fund. While multiple evaluation approaches exist, each with their own strengths and limitations, cost-effectiveness evaluations are widely recognised as a useful approach for measuring and comparing the value for money of different health interventions (NICE 2018).

Cost-effectiveness analysis uses an outcome measure (for example, a life year saved, a death averted, or a year free of symptoms) and assesses the cost per unit of achieving it — comparing the cost of different methods to achieve the same outcome.²⁷⁴ Assessing the cost-effectiveness of interventions can help decision makers ensure the maximum benefits are achieved from limited budgets. Common types of health economics analysis, including different forms of cost-effectiveness evaluations are summarised in the United Kingdom’s National Institute for Health and Care Excellence (NICE) (2014) guidelines manual.

²⁷⁴ Although results, including comparative results between programs, can depend on the exact outcome measure used.

Cost-effectiveness is different to clinical effectiveness. An intervention may be effective at a clinical level (for example, leading to significant benefits per individual treated), but may have low cost effectiveness if it has a high cost per individual. In this situation, implementing the high-cost intervention may lead to consumers getting less — and less effective — mental health treatment in aggregate compared to them being able to access a range of alternative, more cost-effective interventions. Cost-effectiveness evaluations are key to ensuring that consumers receive the best possible mental healthcare, recognising that health budgets will always be finite. Measuring cost-effectiveness should be a standard element of research into mental health interventions. Allocating funds to cost-effective mental health programs and interventions avoids unnecessary expenditure.

In the United Kingdom, NICE uses cost-effectiveness evaluations to inform its decision making about what mental health interventions, services or programs to recommend (box 24.11). NICE have developed guidelines that provide evidence-based recommendations for health and social care, with several guidelines for mental health and behavioural conditions (NICE 2019).

Economic evaluation plays a significant role in the development of NICE guidelines for evidence-based treatments. Its aim is to ensure that NICE guidelines do not introduce ‘cost pressure[s] into the health and social care system unless ... [it] is convinced of the benefits and cost effectiveness of the recommendations’ (NICE 2014, p. 122).

Some participants were concerned that requiring cost-effectiveness evaluations would not be practicable or would be too narrow in their focus. For example, headspace – National Youth Mental Health Foundation (sub. 947) stated that such evaluations can be very complex, and based on many assumptions, which may not be evident until after the program is funded and implemented. Submissions also highlighted that cost-effectiveness evaluations may not consider program benefits that may be realised in the longer term, or in other government portfolios. For example, program costs may be borne by health departments, but costs-savings may be realised by justice agencies (SAMHC, sub. 691, att. 2).

However, NICE’s incorporation of cost-effectiveness into its guidelines shows that it is largely practicable. Further, whether or not cost-effectiveness evaluations include long-term outcomes, or benefits realised in other government portfolios, would depend on the intended outcomes of a program. NICE states that the time horizon for a cost-effectiveness evaluation should be long enough to fully reflect costs or outcomes of programs and take a holistic view, including any cost savings realised by a government agency that did not fund the program (NICE 2014).

The Australian, State and Territory Governments should require all funding applications for mental health programs or interventions to include an assessment of the expected cost effectiveness of the proposed program or intervention. This should inform decision making on how funding should be allocated. To ensure a consistent approach for cost-effectiveness evaluations, the Australian Government, in consultation with State and Territory Governments, should develop a set of general principles and reference cases, as is the case in England.

Box 24.11 **The United Kingdom's National Institute for Health and Care Excellence and its evidence-based recommendations**

The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care in England. Decisions on how NICE guidance applies in other UK countries is determined by their respective governments. NICE uses the best available evidence to develop recommendations to improve health and social care. Its guidance includes the development of NICE guidelines, which cover clinical, social care, public health and medicines practice. These guidelines are developed for a range of stakeholders, including practitioners, local authorities and service commissioners. Although practitioners are expected to take NICE guidelines fully into account, they are not mandatory.

Multiple NICE guidelines have been developed for mental health and suicide prevention including guidelines for: depression in children and young people, generalised anxiety disorder and panic disorder in adults, common mental health problems and preventing suicide in community and custodial settings. Gyani et al. (2013) found consumers receiving NICE-recommended treatments for depression were more likely to recover compared to those who did not receive NICE-recommended treatments.

The development committee considers the cost-effectiveness of programs and interventions when developing NICE guidelines. This occurs in two stages. First, a literature review is undertaken. If existing economic evidence is inadequate or inconclusive, then a second stage of analysis may be undertaken, whereby economic modelling is conducted. This includes adapting existing economic models or building new models. In general, the committee requires more robust evidence for programs or interventions that have a substantial effect on resources.

The NICE guideline development team are expected to follow a set of general principles and reference cases if economic modelling is required (NICE 2014). This helps ensure a consistent approach for cost-effectiveness evaluation. Reference cases specify the evaluation methods that should be considered, and can differ, depending on whether the intervention focus on health, non-health or social care outcomes. An example is provided below.

<i>Element of assessment</i>	<i>Interventions with health outcomes</i>	<i>Interventions with health and non-health outcomes</i>	<i>Interventions with a social care focus</i>
Perspective on costs	Health and social services	Public sector, societal perspective, other (for example, employer)	
Perspective on outcomes	All direct health effects (including for carers)	All health effects, non-health effects may also be included	Effects on people for whom services are delivered (including for carers)
Type of analysis	Cost-utility analysis	Cost-utility, cost-effectiveness, cost-consequences, cost-benefit, or cost-minimisation analysis	
Time horizon	Long enough to reflect all important differences in costs or outcomes between the programs or interventions compared		
Measuring health effects	Quality-adjusted life years: the EQ-5D is the preferred measure of health-related quality of life		
Measure of non-health effects	na	Decided on a case-by-case basis	Capability or social care-related quality of life measures

Source: Gyani (2013); National Institute for Health and Care Excellence (2014, 2019).

ACTION 24.11 — REQUIRING COST-EFFECTIVENESS CONSIDERATION AND PILOT TRIALS OF NEW PROGRAMS

New programs should be cost effective and trialled before being scaled up.

Start later

- As part of their commissioning processes, governments should require all funding applications for mental health programs or interventions to include an assessment of the expected cost-effectiveness of the proposed program or intervention. Allocation of funding should only be considered for programs or interventions that are expected, on the basis of evidence provided in the funding request, to be cost effective. The Australian Government, in consultation with State and Territory Governments, should develop a set of general principles and reference cases to ensure a consistent approach.
- All new mental health programs or interventions should be first trialled as pilot programs, before they can be progressively scaled up. Only pilot trials with positive impact evaluations that have been shown to improve outcomes in practice should be scaled up.

24.4 Research

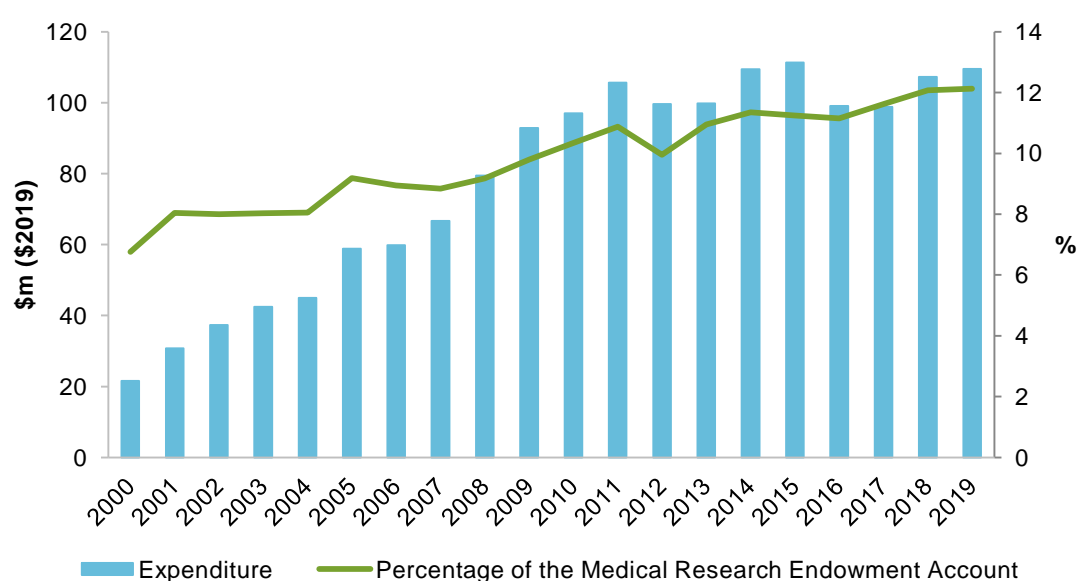
Research plays an important role in improving the lives of, and outcomes for people with lived experience and their carers. It is an essential component of a well-functioning mental health system because it generates reliable information on which to base decisions and policies. Importantly, it can shed light on the importance of causal mechanisms, such as: what contributes to mental ill-health, what are its effects and why interventions do or do not support recovery. It can provide information on what works *best* for consumers and carers in terms of the most effective interventions and models of service delivery. While evaluations may inform efforts to improve program effectiveness, research increases the stock of knowledge for devising *new* policies, programs or services to improve outcomes for people with mental illness and their carers (Mind Australia and CHP 2011).

Roles, responsibilities and funding

Mental health research in Australia is carried out by multiple agents, including academics, clinicians and governments. It is funded by the Australian, State and Territory Governments, philanthropy, the private sector and universities. Governments have set up a number of bodies to administer mental health research funding (KPMG 2018a). The National Health and Medical Research Council (NHMRC), followed by the Australian Research Council and the Australian Government are the main funding bodies for mental health research in Australia — based on the number of publications citing the funder (Pollitt et al. 2016).

Reliable estimates of the total amount of research funding in mental health are unavailable due to the variety of funding sources and differences in reporting. But data from the NHMRC shows it allocated an average of about \$103 million per annum (2019 dollars) over the decade to 2019 towards mental health research — with the amount and share (as a proportion of the NHMRC’s Medical Research Endowment Account) increasing over time (figure 24.4). The Australian Research Council provided an average of \$15.2 million per annum (about \$17.4 million in 2019 dollars) between 2010 and 2014 (NMHC 2014c).

Figure 24.4 NHMRC expenditure on mental health research^{a,b}
2000 to 2019



^a The Productivity Commission has inflated NHMRC expenditure to 2019 dollars. ^b Percentage of the Medical Research Endowment Account is based on actual NHMRC expenditure figures.

Source: Productivity Commission analysis based on NHMRC unpublished data.

Compared to other areas of health and given its contribution to Australians’ total burden of disease, mental health has received relatively less funding from the NHMRC. For example, funding for research in cancer was between 2.2 to 2.5 times larger than for mental health, over the past five years to 2018 (NHMRC 2019c). In contrast, the share of the total burden of disease for cancer (18%) is only 1.5 times larger than that for mental health and substance use disorders (12%) (AIHW 2019b).

However, there are reasons why comparing the share of research funding to burden of disease is not an ideal indicator for a target amount of research funding. For example, funding amounts needed depend on the type of research undertaken, which can differ between areas of health research (Chinnery et al. 2018). Although several submissions (for example, Future Generation, sub. 1118; APS, sub. 543; PRCBHM – University of Newcastle and Society for Mental Health Research, sub. 759) stated that more funding

should be allocated to mental health research, it is difficult to evaluate and conclude if this is the case, and if so, how much more is needed.

Notwithstanding, the Australian Government has allocated more funding to mental health research in recent years. For example, in the 2018-19 budget, the Australian Government announced \$125 million over 10 years to the *Million Minds Mental Health Research Mission* (through the Medical Research Future Fund), which will be administered by the NHMRC (2019a). Further, in the 2017-18 budget, the Australian Government announced \$15 million to support mental health research (Australian Government 2017a), and in June 2017, there was \$12 million for Suicide Prevention Australia to establish a National Suicide Prevention Research Fund (Suicide Prevention Australia 2017).

Supporting practical mental health research

Australia's performance in mental health research is well-regarded. International rankings place Australia in the top five, internationally, in terms of both quantity and quality of research publications (Christensen et al. 2011).

However, there are concerns it is not performing as well as it could to improve outcomes for people with lived experience. There are two main reasons.

First, mental health research has been criticised for being misaligned with both national strategic priorities and current 'real world' problems. For example, the intent of mental health policy in the past decade has largely shifted to prevention and promotion, and whole-of-life support, but research in these areas appear to be under-represented (NMHC 2014c). Christensen et al. (2013) found that mental health research funding and publication output has remained largely unchanged, despite significant policy reforms. This has created crucial gaps in the evidence base, particularly for interventions that address 'real world' problems (NMHC 2014c).

Inquiry participants highlighted many areas requiring further research (box 24.12). A particular concern is that some mental health treatments have little evidence of their effectiveness (Dalton et al. 2017). Where treatments have been tested and found to work effectively, differing implementation models have led to varying outcomes, compared to the intervention design itself (Skvarc et al. 2018). For example, an intervention may have different effects depending on whether it was delivered by a GP, psychologist, mental health nurse or peer worker. Further, the physical health outcomes of some mental health medications (such as atypical antipsychotics) have been raised as a concern (DUSC 2013; Nasrallah 2008). And, given the very high prevalence of mental illness among transgender people (chapter 2), the lack of research evidence on the longer term mental health outcomes associated with common medical interventions for these people (Nobili, Glazebrook and Arcelus 2018; White Hughto and Reisner 2016) should be addressed.

Recent national and international crises, such as the bushfires during the summer of 2019-20 and the COVID-19 pandemic, have highlighted the need for more research on the effects of

community crises on mental health. For example, the longer term effect of social isolation on mental health, resulting from COVID-19 lockdowns, are unknown, and the evidence base about mental health risks, and how to manage them under pandemic conditions is limited (Holmes et al. 2020). Information on how such crises can affect mental health would better equip the mental health system to respond, including by providing guidance on how much additional capacity is needed, and identifying how particular cultural needs might best be addressed and where the additional capacity should be focused.

Box 24.12 Participant views on the lack of research about what works

Inquiry participants highlighted various gaps in existing mental health research:

What we particularly lack is research on how to reduce the big risk factors for mental disorders, which are adverse childhood experiences. (Anthony Jorm, sub. 45, p. 4)

The truth is we do not have a great deal of data on the impacts of mental ill-health in Australia and there is a lack of research conducted into the impact of many mental illnesses. (One Door Mental Health, sub. 108, p. 3)

[there is a] lack of detailed research on the outcomes delivered by community mental health services. (Mind Australia, sub. 380, p. 20)

Given the absence of research in personalised approaches to mental healthcare for anxiety disorders, we also have limited knowledge of how to deliver the right care to the right child at the right time. (Centre for Emotional Health, sub. 384, p. 4)

... there is a need to research best practice community support models to accompany and guide increased investment in this part of the mental health sector. There is currently a paucity of research in this area, and future investment should be evidence informed and based on contemporary trauma-informed and recovery-based approaches. (WAAMH, sub. 416, p. 9)

Rather than piecemeal information on costs of outcomes we need a broader holistic understanding. How do each of the social determinants of health interact and affect individuals? How do we identify earliest practical intervention for an individual? How do we best help those who need guidance to bounce back or to manage? What system is best to provide financial support? Work is good for one's health but is a sense of wellbeing a workplace responsibility? Where does the workplace fit in? We need more research. (Carolyn Davis, sub. 192, p. 19)

There is limited research in the area of effective programs for Aboriginal and Torres Strait Islanders both mental illness, social disadvantage and who are at-risk or have offended. A strong evaluation process within these services is necessary to better understand what works among this population. (APS, sub. 853, p. 29)

These research ‘gaps’ have arisen, in part, because there are few national mechanisms for prioritising and overseeing mental health research, to ensure it is aligned with policy priorities and challenges faced in practice (NMHC 2014c; State of Victoria 2019) — a ‘top-down’ approach to prioritising research. Most research funded is investigator-initiated (or ‘bottom-up’), meaning researchers (or investigators) propose what research they wish to undertake in their areas of interest. Although targeted calls for research in mental health have been made in recent years, most research undertaken is investigator-initiated.

Further, people with lived experience of mental illness and carers are often insufficiently involved in research. Historically, there have been no mechanisms to involve consumers systematically in prioritising research and across all stages of research (NMHC 2014c). The Royal Commission into Victoria’s Mental Health System found that including people with

lived experience in academic institutions is ‘far from systemic’ and that there is a risk that it can become tokenistic (State of Victoria 2019, p. 410).

Second, commentators have said research generates little evidence that is translated into practice or disseminated widely. The NMHC found that ‘planners and providers of services do not always take account of research and evaluation findings’ (NMHC 2014c, p. 138). An Australian study on the quality of mental healthcare found only 26% of consumers received an evidence-based intervention (Harris et al. 2015). VicHealth and Partners (sub. 131, p. 8) highlighted the lack of evidence-based practice:

Evidence-based prevention programs do exist, but many are poorly utilised. Priority should initially be given to increasing the reach and adoption of those strategies that have been developed locally and evaluated rigorously, especially those that have positive results from randomised controlled trials and economic analyses.

There are several reasons why research evidence is not being translated into practice or diffusing across the sector. For example, research may not be relevant to the needs of policy makers and practitioners, or not presented in a user-friendly format (DoHA 2013b). This is critical for staff who may have little time to read research findings, or assess and determine their relevance to their service settings.

Both these issues are evident in health more broadly. The McKeon Review found that Australian health and medical research is not ‘sufficiently driven by a nationally coordinated set of priorities’ with no ‘nationally agreed mechanism for facilitating this’ (DoHA 2013b, p. 103). Additionally, the review found there was a weak link between research and health policy, and the delivery of healthcare services.

The Australian, State and Territory Governments have recognised these shortcomings and are supporting initiatives to address them. The Fifth National Mental Health and Suicide Prevention Plan’s Action 28 requires the NMHC to lead the development of a national mental health research strategy to improve treatment outcomes (COAG Health Council 2017a). The NMHC has established a steering committee of consumers and carers, government representatives, research funding bodies and prominent researchers, with the strategy to be completed by the end of 2020 (NMHC 2019b). Through its recommended evaluation function (action 22.7), the NMHC would be well-informed about evidence gaps in the sector, and could sponsor relevant research in the future.

Further, the Australian Government’s *Million Minds Mental Health Research Mission* (mentioned above) seeks to ‘support research that addresses key national mental health priorities’ (DoH 2020c). This includes research into the causes of mental illness, the best early interventions, and prevention and treatment strategies. It applies a ‘top-down’ approach to funding research, aligning research with national priorities. The mission’s advisory panel includes consumer and carer advocates. The priorities for the first tranche of funding included: eating disorders, child and youth mental health, and Aboriginal and Torres Strait Islander mental health and suicide prevention (DoH 2020c).

Additionally, the NHMRC (2019b) recently announced funding for a special initiative in mental health — to establish a national centre for innovation in mental healthcare that will support a collaborative network. The collaborative national network is intended to undertake innovative, high quality implementation research to improve outcomes for people experiencing mental illness. It is expected to be virtual, and involve key institutions and existing networks. Similarly, the Royal Commission into Victoria’s Mental Health System recommended the establishment of a Collaborative Centre for Mental Health and Wellbeing, in its interim report, which is expected to deliver collaborative research, enable research translation and knowledge dissemination, and involve people with lived experience (State of Victoria 2019).

Establishing national research infrastructure and networks that enable coordinated and collaborative research can lead to greater alignment between research and the needs of consumers, policy makers and practitioners, and help achieve translation and dissemination of research evidence (UK Department of Health 2017). Without them, collaboration would likely occur on an ad hoc basis (around programs and grants), rather than sustained over the longer term. They can also engage researchers from different disciplines, which is particularly important in mental health. The social and environmental determinants and effects of mental ill-health warrants interdisciplinary research (State of Victoria 2019).

Inquiry participants highlighted the importance of infrastructure which enables coordinated and collaborative research (Consortium of Australian Psychiatrists and Psychologists, sub. 882; Mind Medicine Australia Limited, sub. 1106). For example, Mind Medicine Australia Limited (sub. 1106, pp. 7–8) stated that:

... a Centre of Excellence [could be established] to maximise and extend our understanding of Medicine-Assisted Psychotherapies ... [it] would focus on, among other things: ... research into the practical use of Medicine-Assisted Psychotherapies ... the development of local trials and participation in global multi-site trials ... [and] the education of health sector professionals and medical schools around Australia.

FINDING 24.1 — SUPPORT FOR PRACTICAL COORDINATED RESEARCH

Mental health and suicide prevention research in Australia has largely been misaligned with both national strategic priorities and current ‘real world’ problems, and has generated evidence that is not translated in practice or widely disseminated. As a result, mental health and suicide prevention research appears to be disconnected from policy making, program development, service models and delivery, and desired consumer outcomes.

While Governments have recognised these shortcomings and are supporting some initiatives to address them — including through steps to align mental health research with national strategic priorities and funds to establish a national centre for innovation — more can be done to ensure research is coordinated and making efficient use of research funds.

Establishing a clinical trials network

Currently, fragmentation and poor coordination of clinical trials in healthcare generally and mental health specifically are a source of duplication and other inefficiencies. There is scope to improve existing activity.

Clinical trials test the effectiveness and cost-effectiveness of interventions, often through randomised control trials. They are complex, require considerable methodological expertise and training, and large participant numbers (ACTA 2015). This can be particularly difficult in Australia, given its small and geographically dispersed population (AHRA 2019).

Trials conducted by independent researchers (as distinct from those by commercial organisations) can face inefficiencies to the extent that they rely on coordination between other clinicians and appropriate experts for larger participant numbers and network infrastructure (ACTA 2015). Clinical trials can also ‘waste’ knowledge and expertise when skills and resources are lost at the end of trials, and are not used to inform new trials.

Inquiry participants and commentators have raised concerns that clinical research in mental health can be especially inefficient. This can be due to fragmented network infrastructure and a shortage of willing participants (March et al. 2005), which increases the time that researchers spend coordinating with clinicians and other experts. Research efforts can also be duplicative, resulting in an inefficient use of resources. For example, there are concerns of duplication in suicide prevention research (Suicide Prevention Australia 2018; Black Dog Institute, sub. 306).

To address these deficiencies, clinical trials networks have been developed in other areas of healthcare. These are organised groups of clinicians and researchers who share research infrastructure, enabling them to conduct clinical trials across multiple centres dispersed geographically (ACTA 2015). Their functions include direct coordination and management of trials, data management and statistical analysis, and preserving and sharing knowledge and expertise (ACSQHC 2017a). Dozens of clinical trials networks exist in Australia to date, covering a range of health areas including breast cancer, strokes and kidney disease, and disciplines such as primary care and anaesthesia (ACTA 2015).

The Australian Commission on Safety and Quality in Health Care (2017a) found that clinical trials networks play a key role in the success of clinical trials. Networks can improve structural efficiency, enable long-term sustainability and can enhance the implementation of evidence into practice. However, it also suggested actions to further identify best-practice models of network operation, barriers and enablers to drive the implementation of trial results through networks, and opportunities for greater integration with existing data sources. Overall, it found networks returned a net benefit, estimating a \$5.80 return for every \$1 invested (ACSQHC 2017a).

Despite the benefits of clinical trial networks, there is no national network for mental health (ACTA 2015). The Australian Clinical Trials Alliance (ACTA) and the Australian Health Research Alliance highlighted the need for a clinical trials network in mental health (ACTA 2015; AHRA 2019). Bupa (sub. 485, p. 14) also called for a clinical trial network in mental health to support more comprehensive and coordinated research:

One barrier to the development of a strong evidence base in mental health care is the lack of a clinical trial network for mental health ... We propose Australia's first Mental Health Clinical Trial Network be established in partnership with [ACTA] and key mental health research institutes, key partners and stakeholders including patients with lived experience/patient advocacy bodies across Australia. The Clinical Trial Network could focus initially on young people, as this is where the major impact of mental disorders occurs and there has been extensive new clinical infrastructure assembled in recent years in which large scale clinical trials (with subsequent translation of outcomes) are now feasible.

A national clinical trials network in mental health would complement current efforts to improve the efficiency of clinical research in mental health and leverage off existing expertise. For example, NHMRC-funded Centres of Research Excellence in mental health could serve as a platform or 'nexus' for a mental health clinical trials network. Further, existing expertise in ACTA including in developing new networks and involving consumers in developing, conducting and reporting trials could provide valuable support (ACTA 2019).

Submissions were generally supportive of a national clinical trials network, but emphasised the need for research to cover all areas of the mental health system, including care provided in community settings (QAMH, sub. 714; Black Dog Institute, sub. 1207). The Productivity Commission agrees with this, but notes that clinical trials networks are not limited to clinical settings. For example, ACTA stated existing networks actively undertake research across a range of settings including acute, non-acute, primary care and community (ACTA 2015). Notwithstanding, a national clinical trials network in mental health must cover all areas of the mental health system, including care provided in the community.

The Australian Government should fund the establishment of a national clinical trials network in mental health. This would improve the efficiency of clinical trials, improve the translation of research into practice and drive better consumer and carer outcomes through higher quality care. This network should consider research across all areas of the mental health system, including care provided in community settings. In developing this network, there should be consultation with relevant bodies, including the NHMRC and ACTA.

ACTION 24.12 — A CLINICAL TRIALS NETWORK SHOULD BE ESTABLISHED

A clinical trials network can improve the community alignment and application of mental health and suicide prevention research.

Start now

The Australian Government should fund the establishment of a national clinical trials network in mental health and suicide prevention. This network should consider research across all areas of the mental health system, including care provided in community settings. In developing this network, the Australian Government should consult with bodies that work in this area including the National Health and Medical Research Council, the Australian Clinical Trials Alliance and other relevant stakeholders, including people with lived experience.

25 Pathways to a mentally healthy Australia

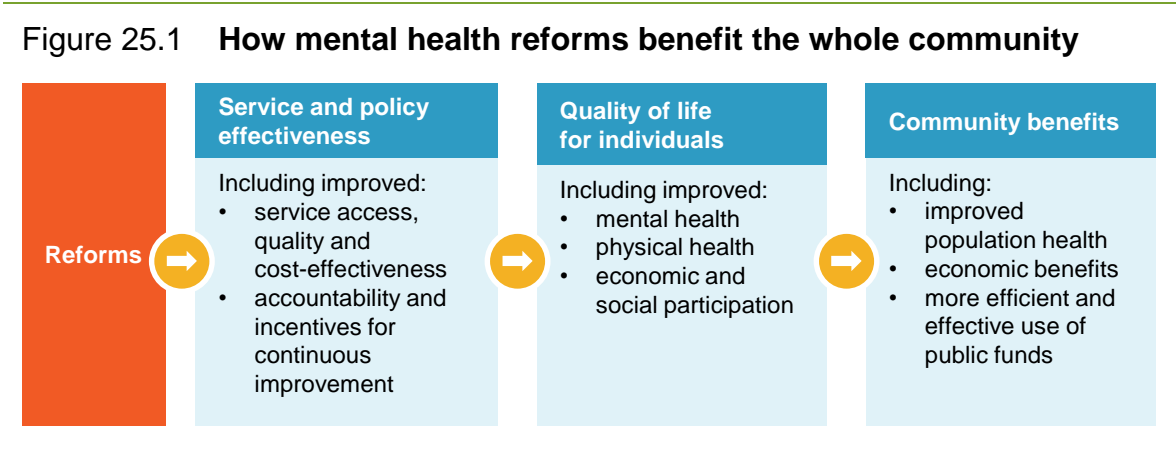
Successful reform requires ...

- There are a range of effective interventions that could significantly improve people's mental health and the quality of life for individuals, and their carers and families.
- In the long run, economic growth and savings in government expenditure would also follow from a healthier and more productive population.
- Cooperation and commitment by all levels of government, providers over services and supports to people, and workplaces, is essential for success.
- The implementation of major reforms would be strengthened by recommended changes to governance, monitoring and evaluation, and funding arrangements.
- Recommended reforms have been prioritised based on the potential benefits to quality of life, the cost-effectiveness of reforms, reform dependencies and implementation readiness.
- A number of recommended reforms are not priorities but would nevertheless significantly improve mental health outcomes. Implementation of these should be planned, taking into account any necessary underpinning reforms and resources available after priority reforms have been adopted.

25.1 The long-term benefits of mental health reform

This Inquiry report presents a comprehensive set of recommended reforms — covering healthcare, community supports and many other areas of people’s lives — that are intended to set the mental health system on a path towards a person-centred model.

If governments commit to implementing all recommended reforms included in this Inquiry report, it would take time to realise the full extent of expected benefits. Working towards a person-centred mental health system would entail changes to policy settings and improvements to services, which, in turn, would support people with mental ill-health to achieve the outcomes that matter to them, and lead to community-wide health and economic benefits (figure 25.1).



The mental health system that would result from the recommended reforms would:

- focus on prevention, drawing on the beneficial outcomes for mental health of education, employment and social participation
- improve access to evidence-based self-help resources and online services via a new national digital mental health platform
- facilitate easier access to culturally capable, joined-up and affordable services quickly in the community to prevent a deterioration in mental health
- empower those who need additional care to choose evidence-based services that are relevant to their personal and clinical recovery, and to be supported by service providers to achieve those outcomes
- consistently incorporate the views of consumers, carers, families and kinship groups
- support continuous improvement through monitoring and reporting that focuses on providing service providers and policymakers feedback on outcomes that matter to consumers, carers and families.

Mental health reform would translate into practical outcomes for people with mental ill-health, their carers and their families (figure 25.2). Recovery from mental illness and staying well requires a focus beyond healthcare, and this Inquiry has considered ways to sustain and improve the mental health of people as they interact with psychosocial support, education, justice, housing, and income and employment support systems.

Figure 25.2 What do reforms mean for people with mental ill-health, carers, families, and the broader community?

People with mild mental illness and those at-risk	People with moderate mental illness	People with severe mental illness
Timely and culturally appropriate access to group therapy and digital treatment options	Greater access to mental health services in the community	Improved access to: <ul style="list-style-type: none">• specialist mental health treatment
Early intervention, including effective social and emotional wellbeing support in early childhood education and schools	Better experiences in emergency departments and more peer- and clinician-led after-hours alternatives	<ul style="list-style-type: none">• psychosocial supports• care coordination• effective employment support• supported housing• homelessness services• bed-based treatment and care• peer workers• legal aid and advocacy services
Practical application of mental health strategies by all employers and tertiary training providers		
All mental health consumers, carers, families and kinship groups		
Less health inequality across different parts of the community	More appropriate assessment processes for income and employment support services	
Reduced stigma associated with mental illness	Family- and carer-inclusive delivery of services	
Continuous improvement of services over time	More services to support carers and families	
More consumer and carer involvement in policy and service planning	Effective suicide prevention programs	
The broader community		
A healthier population with more people reaching their potential in the community, including through social and economic participation.	Assurance that there is an effective mental health system in place if they need it	
More productive work colleagues and economy	More efficient and effective use of public funds	

Chapter 4 describes the expected benefits from individual recommendations and actions. This includes both the costs and benefits of many key reforms that the Productivity Commission was able to quantify (appendixes I, J and K) as well as other non-quantifiable benefits. This analysis contributed to the selection of reform priorities from among all of the recommended actions. The priority reforms include actions that would result in better use of existing expenditure or that can improve mental health with little additional recurrent expenditure, as well as reforms that, while more expensive, are cost effective when weighed against the potential gains in quality of life and

that should be expanded or trialled. A number of recommended reforms are not priorities but would nevertheless significantly improve mental health outcomes. Implementation of these should be planned, taking into account any necessary underpinning reforms and resources available after priority reforms have been adopted.

This chapter describes the expected long-term benefits of the reforms recommended as part of this Inquiry. Section 25.2 examines how the reforms would improve people's experiences with the mental health system. An implementation plan is outlined in section 25.3.

25.2 Looking beyond the numbers

When summed together, the net benefits of implementing the Productivity Commission's reforms would be substantial. Most of these benefits would be in terms of improvements to the health-related quality of people's lives. Reforms are estimated to add up to 84 000 quality-adjusted life years — the equivalent of \$18 billion per year for Australians (chapter 4 and appendix I). The estimated net benefits for the Australian economy are relatively modest, up to \$1.3 billion per year, as a result of increased employment and productivity — equivalent to 0.1% of GDP (Productivity Commission estimate using ABS 2019a).

The relatively small estimate for the economic benefits of reforms is not surprising. First, the analysis does not quantify the longer-term social investment benefits of reforms — that improving an individual's mental health early in their life can have life-long benefits for both the individual and those they interact with, while at the same time potentially reducing their lifetime demand on Australia's healthcare system (both physical and mental healthcare). Second, some of the recommended reforms are about addressing deep-seated cultural and societal problems — including stigma and homelessness — and ineffective governance arrangements, or inefficient funding practice. The benefits of these reforms are not readily quantified.

It is difficult to fully appreciate all the ways that the recommended reforms could affect people's lives by looking at the numbers alone. The examples that follow are fictional, but are a reflection of the many stories in submissions, comments and public hearings that the Productivity Commission has received from people with lived experience of mental illness, their carers and families, and support services throughout the Inquiry. They demonstrate how the recommended reforms could improve access to a range of supports for each individual, their carers and family. These vignettes describe the effects of reforms for people with mild, moderate or severe mental illness and with varying needs for psychosocial and other supports.

Early intervention to support young children and their families

Jessica and Matthew have two children, 3 year old Charlotte and 4 month old Oliver. Matthew has been short-tempered and irritable since Oliver's birth, and feels that he will never be a good enough father now that he has to divide his limited time between two children. Charlotte has always been a quiet child, but has become more withdrawn in recent months and rarely talks to or plays with other children.

As a result of the recommended reforms, there is enhanced screening for postnatal depression by the child health nurse when Jessica and Matthew take Oliver for his baby health check. The nurse identifies that Matthew is at high risk of postnatal depression, and suggests that he might like to talk with a counsellor (Action 5.1). After speaking with the counsellor, Matthew is relieved to learn that many new fathers feel the same way. He continues to attend counselling sessions and gradually finds it easier to cope.

Jessica and Matthew attend a parenting education program at their local child health centre (Action 5.2). They learn that children's social and emotional development is best supported through play and reprioritise their busy lives to spend more time playing with Charlotte and Oliver.

Charlotte's preschool teacher has recently participated in additional training on children's social and emotional development. She has concerns about Charlotte's withdrawn behaviour, and seeks advice from a mental health professional. With additional support from her teacher, Charlotte grows in confidence and starts to spend more time playing with her classmates (Action 5.2).

The annual costs of perinatal depression and anxiety have been estimated at \$877 million (chapter 5).

Better support for school students

Nicole is in Year 9 at high school and, until recently, was a very good student. But now she is no longer participating in class and has trouble concentrating. When her teacher asks her about this, she opens up about problems she has been having and that she has been self-harming. Nicole's teacher is concerned but does not know what to do to get help for her.

12% of girls and 4% of boys aged 12 to 17 years self-harmed in the previous 12 months (chapter 2).

As a result of the Productivity Commission's reforms, Nicole's school has a wellbeing strategy (action 5.6). As part of the strategy, the school has a wellbeing leader. Nicole's teacher seeks advice from the wellbeing leader on how to make reasonable adjustments for Nicole in the classroom (action 5.8). The wellbeing leader uses the navigation portal to put Nicole in contact with a mental health service to meet her needs (action 15.2). With Nicole's consent, the school receives information from her psychologist about the type of support Nicole would benefit from, and implements these suggested supports (action 5.8).

Other teachers reported there were children in the school dealing with issues like Nicole, so the Principal decided to have an evidence-based social and emotional wellbeing program delivered throughout the school (action 5.5). This helped the whole school community get a greater understanding of mental health and know

that effective treatment is available. It also helped Nicole and other students with mental health problems face less discrimination in school.

Nicole's teacher was also able to learn more about social and emotional development and wellbeing as part of her professional development (action 5.4), which better prepared her for these issues in the future.

Services that support people to achieve their goals

Kim is 24 years old and recently left a traumatic domestic relationship. Money is tight and she finds it hard to make ends meet for her young son and herself. She feels anxious and sometimes overwhelmed by the pressures in her life. She does not have the time or money to go to a psychologist, even though she feels she should.

Anxiety and depression contributed to Kim dropping out of university in the past but she wants to get a post-school qualification to try for a better job and improve her financial security. She is enrolled in an online vocational training course. This time, when she is unable to complete a module, the staff at the training provider are able to provide her with the support she needs to finish her qualification (recommendation 6).

Kim's GP uses the navigation portal to help her access therapy that would work best for her (action 15.2). She chooses to see a psychologist over videoconference because it is affordable and appointments fit flexibly around caring for her son, work and study commitments (action 12.2).

65% of people aged 16–25 years reported high levels of psychological distress (chapter 6).

Mentally healthy workplaces are productive workplaces

There were 23 000 nurses working in mental health in 2018 (chapter 16).

Health and welfare support workers are more likely than average to make a serious work-related mental health claim (chapter 7).

Jade is a nurse at a small regional hospital. She works closely with people recovering from mental illness. Her work is highly valued by consumers and co-workers but she often feels stressed and is not sure how much longer she will continue in this line of work.

She is dealing with the trauma and suffering of others daily, making difficult decisions about balancing people's safety and their independence, and is often exposed to verbal abuse. While the nature of the work is challenging, Jade had been able to manage the risks to her health and wellbeing in the past when she was well supported by her employer.

Jade's workplace has started having issues with staff retention, recruitment and turnover, which have contributed to a loss of skills and a reduced staff-to-patient ratio. She has less time for non-urgent tasks and feels rushed with clients and their families. There is less capacity for co-workers to provide supervision and support, and she is unable to take as much time off to recharge as she would like.

The government introduces a range of health, governance, funding and monitoring reforms recommended by the Productivity Commission. Gaps in funding for regional services start to close. Changes to the mental health workforce help Jade's hospital reduce the staff turnover (actions 16.1, 16.2 and 16.7) and make it easier to recruit new mental health nurses (action 16.4).

In addition, Jade's hospital makes workplace mental health a higher priority and takes risks to the mental health of staff as seriously as physical health and safety

risks (actions 7.1 and 7.2). Jade's employer develops a better understanding of what they can do to support staff, and jobs start being redesigned to reduce the risk of staff burn-out. Not only is there greater clarity and guidance, but additional incentives also contribute to change — initiatives that reduce the risks of workplace-related psychological injury are used to lower workers compensation scheme premiums (action 7.3).

As a result of these changes, Jade makes the decision to stay on at the hospital. Her employer has found that by committing to a mentally health workplace, the quality of care provided has improved and costs associated with staff recruitment have declined.

A comprehensive and trusted source for self-help, assessment and referral

Sam went to the GP to have his routine annual check-up, which showed he was in good physical health. While there, he mentions that work has been stressful, he is getting easily frustrated and not sleeping as well as usual. He is starting to avoid catching up with friends, something he used to look forward to. The GP practice nurse assists Sam to complete a mental health assessment using the new assessment and referral tool available on the national digital mental health platform (action 10.4). Sam and his GP then discuss the results.

The tool recommends several options that are likely to meet Sam's needs, selected from a broad range of treatment and support services. After discussing the assessment results and the service recommendations with his GP, Sam decides that self-help resources available on the national digital mental health platform would be a good option for now. These resources are free, come from a trustworthy source and can be accessed at whatever time suits him best.

At least 5 million people had a consultation with their GP about their mental health in 2018-19 (chapter 10)

Reduced barriers to treatment for mild mental health problems

2.3 million people experience a mild mental illness each year (chapter 1).

Angelo is 52 years old and recently had a serious health scare. Within a fortnight he was out of hospital but even though his physical health has improved, he does not feel like himself. He avoids unfamiliar places, finds it harder to concentrate at work and he often needs to step outside alone to calm his nerves. Angelo knows little about mental health and does not feel comfortable seeking help or talking about such things. As a result of recommended reforms, he:

learns about the benefits of clinician supported online treatment through a public information campaign, and enrolls in a service via the national digital mental health platform (actions 10.4 and 11.1)

feels comfortable enough to speak to his GP at his next check-up and the GP encourages him to keep in contact about his experience with online treatment. Angelo chooses to forward the outcomes data from the online treatment to his GP (action 11.1).

He values clinician supported online treatment because it is discreet and he can use it from home in the evening. He begins to feel better and able to participate more at work and in his community. As a result of this treatment and with a better understanding of his mental health, he has gained a level of protection against mental health problems in the future.

Better mental health can improve physical health too

Omar is 40 years old, has a psychosocial disability arising from his mental illness, and also has diabetes. He lives with his father, Nasir, but often feels lonely, especially since the death of his mother. He has not been able to work or study because of his disability, and finds it difficult to form friendships. Nasir provides Omar with significant emotional support, cooks his meals and helps him to manage his health. However, as Nasir gets older, he is finding it increasingly difficult to continue this role. Nasir regularly attends a community centre where he has friends from his country of origin and occasionally Omar accompanies him.

As a result of the recommended reforms, a psychosocial support worker starts working at the community centre and, after speaking to Nasir, begins to provide Omar with regular support (action 17.3). The psychosocial services become more effective over time as the funding cycle becomes more stable (action 17.1).

Omar slowly builds trust in the relationship with the psychosocial support worker who helps him to better manage his health and everyday activities more independently. Omar starts attending the community centre regularly and volunteers to help in the community garden. The social connections that he forms over time contribute to his mental health improving, and he becomes more proactive at managing his diabetes with the help of a diabetes educator (action 14.1). Nasir also was assisted to support Omar when the psychosocial support worker connected him with culturally capable carer support services available in his local area (action 18.2).

About 690 000 people with mental illness needed psychosocial support in 2019-20 (chapter 17).

Almost 1 million people in Australia provided regular support to someone with mental illness in 2018 (chapter 18).

Care planning and coordination before and after discharge from acute care

About 800 000 people in Australia have severe mental illness (chapter 1).

Alex has been admitted to hospital many times as a result of symptoms related to psychosis. Last time, Alex was discharged from acute inpatient care in a rush to make a bed available for someone else being admitted from the emergency department. The discharge plan did not make adequate arrangements for coordinating his mental healthcare in the community or for somewhere to live.

Alex had no place to stay; he lost his rental accommodation just before he was admitted to hospital. He gave his mother's address to the hospital but has not communicated with her for years. After being discharged from hospital, he finds temporary accommodation at a homeless shelter, runs out of the medication he was given on discharge from the hospital and soon becomes unwell again. Alex misses his follow-up appointment and the clinical team cannot contact him as he is not staying with his mother. The homeless shelter call the police when Alex starts showing unusual behaviour but, as a result of the recommended reforms, what happens for Alex this time is different.

The police have access to real-time information from mental health professionals (action 21.2). A mental health worker is available to assist the police and paramedics who attend to Alex. There is an alternative to taking Alex to the emergency department, and he is assessed by a clinician at an after-hours service while a peer worker gives him support (action 13.1).

Alex agrees to a voluntary admission to hospital so his medication can be restarted, avoiding compulsory treatment as occurred in the past. During the admission Alex is assigned a care coordinator who takes responsibility for

organising the services in his discharge plan and ensuring there is continuity of care (action 15.4). Care coordination of Alex's clinical and support needs is made easier by having a single care plan that is shared with his service providers in the community (action 15.3). Importantly, his care coordinator is able to find him housing that integrates with mental healthcare and support to maintain his housing (action 20.3).

Care that considers the needs of the whole family

Michelle is a single mother who lives with a longstanding depressive disorder and has three children under the age of 14 years. Her eldest child oversees the housework, provides emotional support to Michelle, helps the other children with their homework, and sometimes misses school as a result of these responsibilities.

As a result of the Productivity Commission's recommended reforms, Michelle's treating clinician has received additional professional training that enables her to provide care that considers the needs of Michelle's whole family (action 18.1). As a result, Michelle has been provided with access to psychosocial supports that assist her in carrying out activities of daily life made more difficult by her depression (action 17.3). This reduces the caring responsibilities of her eldest child. Michelle's children are also provided with access to support services that help them understand mental illness and connect with children in similar situations (action 18.2).

About 5% of children aged 9 to 14 years provided care to a family member with mental illness in 2014 (chapter 18).

Coordinated access to a range of supports for people with complex needs

Tom is 32 years old and lives in a regional town. He has lived with a personality disorder since his teens. There have been periods when he has been well enough to work but he has been unable to sustain employment for more than a year. Tom gets into arguments with his landlord because his irregular income means he sometimes pays his rent late and his symptoms contribute to him neglecting housekeeping. There is a private psychology clinic in town but he cannot afford the treatment he needs and the waitlist is long.

Mental illness is more prevalent among people who are unemployed (31%) compared with those in work (19%) (chapter 2).

Tom is able to have an assessment by a psychiatrist by videoconference and the psychiatrist is able to provide timely advice to Tom's GP (action 12.2). As a result of the recommended reforms, more mental healthcare options become available for people in regional areas. There are more peer workers employed locally (action 16.5), and Tom finds increased hope for recovery after receiving support from a peer worker who has lived experience of a personality disorder.

Identifying and building on Tom's strengths helps him to take more control over his life and feel more confident. His peer worker suggests he consider part-time work using the Individual Placement and Support employment support model (action 19.4). This employment support is integrated with his mental healthcare and having the two services working together helps him to gain and maintain employment. Tom also receives tenancy support services that help him maintain his private rental by negotiating with his landlord and helping him resolve late payments (action 20.1).

25.3 Reform implementation

The vignettes above describe how people would benefit from increased access to effective services. However, the implementation of reforms to individual services across the mental health system would not be sustainable without structural and cultural changes to support these reforms.

Effective implementation requires supportive organisational cultures, where the values, beliefs and attitudes of policymakers, employers, and those employed by service providers align with the aim of a person-centred mental healthcare system. But currently, too many clinicians focus on symptoms of mental ill-health, rather than the person and their environment and too many policymakers focus on commissioning healthcare rather than reducing the need for healthcare. Changes are needed to the incentives and capabilities at every level, and this in turn contributes to the cultural change within government, service providers, and the community that is needed for long-term reform.

System-level changes are vital to reform success

While the Productivity Commission's vision is for a person-centred mental health system, the service-level reforms needed to create such a system must be built on foundational reforms in areas such as governance, funding, service planning, monitoring and evaluation (chapters 22, 23 and 24). These system-level reforms would enable a significant change in culture across the mental health system, which would encourage a focus on people, their needs and preferences, and close monitoring of their progress towards the outcomes that matter to them. For example, available services would better reflect what is valued by those who use them if regional planning processes were required to incorporate the voices of consumers and carers (action 23.1).

Ways to encourage more effective service delivery

Reforms to both the collection and use of data would provide major incentives for change, and in time would drive much needed cultural change towards a recovery-oriented and person-centred mental health system.

Better data on effectiveness of services at the provider level would encourage high-performing service providers, and would empower consumers to make informed choices about their care (action 24.5). This would be a significant change to ways of working for many providers. The recommended trial to make use of patient reported outcome measures to assess the effectiveness of psychological therapy would provide timely feedback to individual clinicians about their performance (action 12.3). A focus on outcomes and feedback on performance would provide a feedback loop to mental health services that encourages continuous improvement and person-centred service delivery.

Information is critical to know what works. The recommended reforms to collect better data on service effectiveness and build a culture of service evaluation would shed light on what is working well and what is cost-effective (chapter 24). This would enable governments to better direct expenditure to achieve the desired outcomes, which makes the system more sustainable over time.

Ways to encourage a whole-of-government and whole-of-life approach to mental health policy

One of the shifts that is needed is greater inter- and intra-governmental cooperation. Non-health government agencies need to increase their policy focus on mental health. However, they currently have little incentive to do so. A new whole-of-government National Mental Health Strategy would align the collective efforts of health and non-health sectors (action 22.1). Implementation of the strategy would be facilitated by an interjurisdictional Special Purpose Mental Health Council, which would comprise Health Ministers as permanent members and other relevant Ministers on 18-month rotations (action 22.3).

These changes will be needed to support implementation of actions that aim to improve the focus on mental health in specific sectors.

- In justice, improving mental health services provided within the criminal justice system would require government agencies with responsibility for health and for correctional services to work together (action 21.4).
- In housing, to operationalise the commitment to no person with mental illness being discharged from hospital or a correctional facility into homelessness (action 20.2), both health, housing and corrections policy ministers would need to agree on how they will jointly achieve this goal.
- In school education, despite improvements over time, government policies to support the social and emotional wellbeing of school students are fragmented, complex and inconsistent (chapter 5). In part this is because there is no clear delineation over where education policy responsibilities end and where the health policy responsibilities take over. The responsibilities that schools should have over student wellbeing should be clarified in the National School Reform Agreement (recommendation 5). All schools would have greater incentive to improve student wellbeing once they have good data on how well their school is performing, and they are required to report on wellbeing outcomes, in addition to literacy and numeracy outcomes.
- In tertiary education, institutions would have a greater focus on the mental health of their students were they required to develop a student wellbeing strategy that demonstrates how they would meet their existing regulatory and legislative requirements (action 6.3).
- In workplaces, the reforms would strengthen incentives for employers to promote mentally healthy workplaces. In future, workplace health and safety legislation would ensure psychological health and safety in the workplace is given similar consideration to physical health and safety (action 7.1). This outcome is further supported by improving workers

compensation schemes so that employers who implement workplace initiatives that protect mental health would have capacity to pay lower insurance premiums (action 7.3).

- In employment support services, coordinated action would be required by health and employment Ministers to co-locate employment and mental health support as part of the Individual Placement and Support model (action 19.4). And as individual participation increases, this would have positive benefits for mental health.

In each of these cases, the accrued benefits of improved mental health outcomes would be evident in the performance reporting and expenditure of multiple levels of government and across government departments. But, most importantly, these whole-of-government and whole-of-life reforms have the potential to improve the lives of millions of Australians.

Achieving cultural change across the community

There are cultural barriers to reform that will take time to dismantle. For example, systemic discrimination and stigma affecting people with mental illness are major obstacles that governments and the community have only started to tackle. This Inquiry does not resolve these issues, but it recommends steps towards changing the perceptions of mental illness — at the community level, at the government level, for those who plan and deliver services, and for those who seek help.

To support cultural change, a range of actions are needed to embed greater mental health literacy and skills within service providers. Within health services, the Productivity Commission is recommending:

- a national mental health workforce strategy with the aim to align health workforce skills and cultural capability to consumer needs (action 16.1)
- training and professional development for GPs to incorporate person-centred approaches to practice that recognise the importance of personal recovery (action 16.3)
- training of all nurses to include a discrete unit on mental health (action 16.4)
- mental health stigma reduction programs are incorporated in the training and professional development of health professionals (actions 16.6 and 8.1)
- actions to support the growth of employment in peer workers, including educating health professionals about their role and value (action 16.5)
- embedding more family and carer workers in specialised mental healthcare services to improve the capabilities of these services to provide family- and carer-inclusive practices (action 18.1)
- access to training and support for mental health workers to provide person-centred, effective and coordinated care to people with comorbidities (action 14.1).

Beyond health services, other actions to improve and embed mental health skills include:

- supporting early childhood education and care staff to access professional development related to mental health and professional advice, when needed (action 5.2)
- development of standards for initial teacher education and professional development programs, to incorporate social and emotional development and mental health (actions 5.3 and 5.4)
- development of guidance and provision of training for tertiary education providers to help them best support student social and emotional wellbeing (actions 6.3 and 6.4)
- mental health expertise and information for police responding to mental health-related incidents (action 21.2)
- mental health training and resources for social housing workers (action 20.1) and insurers (action 8.2).

At the community level, a national stigma reduction strategy would help dispel some of the myths and misconceptions that continue to surround mental illness (chapter 8). While societies' views about mental illness have progressed, people with less prevalent conditions continue to face discrimination in health services and in the community. Attitudes about seeking help would also change over time as people become familiar with the national digital mental health platform and its self-help resources (action 10.4).

Enabling a person-centred mental health system requires the removal of barriers hindering the good work of passionate individuals. The Productivity Commission was struck during the course of this Inquiry with the level of dedication and care that so many workers in community settings have for the people they support, notwithstanding difficulties in funding and access to services. Extending the typical contact length for psychosocial services from one year to at least five years is an example of a simple reform that would remove a barrier to quality care created by the uncertainty about service and provider continuity (action 17.1). Similarly, actions to improve service navigation, such as clear information about the services available in the local area, would empower both service providers and service users (action 15.2).

Implementation timeframe

There are many improvements needed to create a person-centred mental health system. Some can be achieved in the short term, by reallocating existing resources and priorities with little or no increase in government expenditure. Others involve considerable expenditure, but can lead to a significant improvement in quality of life — either across the community or for those consumers who face the most pressing needs. Some reforms deal with specific parts of the mental health system, such as clinical assessment. Others involve the whole community, such as a national campaign to reduce stigma.

While this Inquiry presents a comprehensive reform agenda, it is a matter for governments to decide when and where to prioritise their efforts and expenditure. However, the Productivity Commission has been cognisant that providing a road map to a person-centred mental health system is an important part of what we have been tasked with on this Inquiry. To assist governments, the Productivity Commission has suggested priority reforms that should be started as soon as possible (figure 25.3).

The Productivity Commission has prioritised its recommended reforms based on the following criteria: the potential to improve lives at both the individual and community level; benefits to the economy and taxpayers; implementation readiness; and dependencies between reforms (chapter 4). Some of the reforms are relatively simple to implement, requiring little consultation or coordination. For example, the recommended changes to the Medicare Benefits Schedule (MBS) for telehealth were already introduced on a temporary basis as a response to COVID-19.

For more complex reforms, the recommended timeframes consider the benefits of a staged approach to implementation. Large-scale change will not only take time, it will inevitably face implementation challenges and errors. A staged approach allows for more meaningful consultation with consumers and carers, minimises the effects of mistakes and allows for continuous improvement. For example, a staged rollout is recommended for the Individual Placement and Support model (recommendation 19) and is suggested for the national digital mental health platform (recommendation 10).

The timing of recommendations also considers dependencies between reforms. Some reforms stand alone — for example raising the understanding and importance of mental health in the workplace. But other reforms are part of a sequence — reforms need to be started today to create the foundations for further reform tomorrow. For example, before governments can implement several of the priority reforms — to fund mental healthcare, psychosocial supports and care coordination services to meet community need — governments would need to undertake regional planning to assess shortfalls in the current supply. The recommended process for Local Hospital Networks and Primary Health Networks to develop joint regional plans would support this first stage of reform (action 23.1).

The priority reforms span across the policy responsibilities of the Australian Government, and of State and Territory Governments, as well as shared responsibilities. The Australian Government could start implementing reforms by focusing on identified priority reforms to:

- amend the Medicare Benefits Schedule for group therapy, telehealth, and family and carer consultations (actions 12.1, 12.2 and 18.1)
- develop the national digital mental health platform (action 10.4) and expand clinician-supported online treatment (action 11.1)
- require mental health professionals to discuss possible side effects of medication (action 10.2)

-
- develop an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* (Action 22.2).

These actions would improve the range and quality of services available to people and make them more accessible, especially for people with mild symptoms. And combined with evaluating and trialling policy changes to MBS-rebated psychological therapy (action 12.3), this would enable Australian Government funding to be used more effectively and reach more people across the spectrum of needs in the community.

State and Territory Governments could start implementing reforms by focusing on identified priority reforms on:

- regional planning to assess any shortfalls in the supply of psychosocial supports, mental health community ambulatory services, and care coordination services (actions 12.4, 15.4, 17.3)
- building capacity for mental health services to support and partner with families and carers (action 18.1)
- preventing unnecessary presentations to emergency departments by providing more alternatives (action 13.1)
- committing to no exits from hospital inpatient units and correctional facilities into homelessness (action 20.2).

These actions would improve mental healthcare for people with moderate or severe clinical needs. At the same time, State and Territory Governments could focus on priority reforms beyond health, which would relieve the pressure on healthcare services, including:

- collecting data on screening for perinatal mental illness (action 5.1)
- increasing support and information for police responding to mental health-related incidents (action 21.2)
- access to legal representation at mental health tribunals (action 21.8)
- expanding the Individual Placement and Support model (action 19.4).

Together, governments could start reform implementation by collaborating on:

- establishing a clear, ongoing role for consumers and carers in all aspects of system planning, design, monitoring and evaluation (action 22.4)
- improving monitoring and reporting at the service provider level (action 24.5)
- strengthening joint regional planning arrangements and establishing Regional Commissioning Authorities for those States and Territories who choose to do so (actions 23.1 and 23.4)
- developing a new whole-of-government National Mental Health Strategy (action 22.1)
- making student wellbeing a clear outcome of the education system (action 5.3)

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- suicide prevention by offering effective aftercare and renewing an Indigenous-led National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan (actions 9.1 and 9.2)
 - improving care to people with comorbidities and accountability for their physical health outcomes (action 14.1)
 - putting psychological health and safety on par with physical health and safety in the workplace and amending workers compensation schemes to provide no-liability treatment (actions 7.1 and 7.4).

These actions that clarify roles and responsibilities help align incentives in the system towards prevention, earlier intervention, and a healthier population. This set of priority reforms are complex but once they are in train, they would enable many more practical changes to follow – both actions recommended as part of this Inquiry and changes to everyday practice to align with this new policy paradigm – to create a person-centred mental health system.

As a priority, it is also recommended that governments start work to establish the National Mental Health Commission as an interjurisdictional statutory authority, with responsibility for: leading evaluation; developing the National Stigma Reduction Strategy; monitoring reform progress; and reporting on progress towards system-level targets developed in consultation with consumers, carers and the community (actions 8.1, 22.7, 23.1, 24.4 and 24.10). This would provide reform momentum by improving accountability of government to the public for the outcomes that matter to them, and encouraging continuous improvement of services.

Figure 25.3 Implementation timeframes for some key reforms

All priority reforms included and some non-priority reforms included.
Non-priority reforms marked with *

Start now	Start later
Actions to improve mental health services include:	
Establish the national digital mental health platform, with more clinician-supported online treatment (10.4, 11.1)	Evaluate online treatment services (11.1)
More group, video and telephone therapy (12.1, 12.2), and trial and evaluate changes to MBS psychological therapy	Rollout what works from trials of psychological therapy (12.3)
Create target and implementation plan to reduce gap in life expectancy for people with severe mental illness, provide more alternatives to the ED, and improve information about medication side effects (10.2, 13.1, 14.1)	Report on outcomes from the Equally Well Consensus Statement and progress in addressing the gap in life expectancy (14.1)
Regional planning to assess any shortfalls in the supply of community mental healthcare services, care coordination and psychosocial supports (12.4, 15.4, 17.3)	Increase funding to address service shortfalls (15.4, 17.4)
Improve capacity in mental health services for family- and carer-inclusive practices (18.1)	Educate health professionals about the value of peer workers (16.5)*
Actions to improve services beyond the mental health system include:	
Expand the Individual Placement and Support program	Disseminate best practice for IPS (19.4)
No exits into homelessness from hospitals and correctional facilities (20.2)	Increase funding for housing (20.3)*
Increase support for police responding to mental illness-related incidents (21.2)	Disability justice strategies (21.7)*
Legal representation at mental health tribunals (21.8)	Non-legal advocacy (21.9)*
Actions towards universal screening for perinatal mental illness (5.1)	Fund trials to improve child social and emotional wellbeing (5.7)*
Add student wellbeing to the National School Reform Agreement (5.3)	Improve schools' data, teacher training & wellbeing programs (5.4, 5.5, 5.7)*
Raise importance of workplace psychological health and safety, and workers compensation schemes fund mental healthcare regardless of liability (7.1, 7.4)	Disseminate information on workplace interventions (7.6)*
National Stigma Reduction Strategy (8.1)	Monitor interventions provided in tertiary education (6.3)*
Universal aftercare following a suicide attempt, & National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (9.1, 9.2)	Rollout what works from suicide prevention trials (9.3)*
Governance and funding reforms include:	
Whole-of-government National Mental Health Strategy, with more consumer and carer participation (22.1, 22.4)	Special Purpose Mental Health Council (22.3)*
Improved monitoring and reporting at the service provider level (24.5)	Establish Mental Health Innovation Fund to trial innovative service delivery, system organisation and payment models (23.8)*
PHN-LHN cooperation; transition to Regional Commissioning Authorities (23.1, 23.4)	Agreement on responsibilities for psychosocial supports (23.2)*
Expanded and independent role for the National Mental Health Commission (22.7)	New programs are cost effective and trialled before being scaled up (24.10)*

A Inquiry conduct

This appendix describes the stakeholder consultation process undertaken for the Inquiry.

Inquiry terms of reference

The terms of reference for the Inquiry — reproduced in the preliminary pages of this report — was received from the Treasurer on 23 November 2018. The Inquiry was advertised in *The Australian* on 5 December 2018.

Consultations

Throughout the Inquiry, the Productivity Commission held and benefited from the following consultations processes:

- 11 roundtables
 - Youth, South Australia Mental Health Commission Youth Advisory Group (20 February 2019)
 - Culturally and linguistically diverse people, South Australia Mental Health Commission (21 February 2019)
 - Hospital and community mental health services, Royal North Shore Hospital and Ryde Community Centre (27-28 February 2019)
 - Consumers and carers, and NSW Mental Health Commission (4 April 2019)
 - Consumers and carers (4 February 2020)
 - Mental health modelling (11 February 2020)
 - Workplace mental health (11 February 2020)
 - Aboriginal and Torres Strait Islander people in urban areas (13 February 2020)
 - Early childhood services (17 February 2020)
 - Education system (17 February 2020)
- 13 days of public hearings
 - Canberra (15 November 2019)
 - Melbourne (18-19 November 2019)
 - Geraldton (20 November 2019)
 - Perth (21 November 2019)

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- Sydney (25-26 November 2019)
 - Broken Hill (28 November 2019)
 - Rockhampton (2 December 2019)
 - Brisbane (3 December 2019)
 - Launceston (9 December 2019)
 - Adelaide (5 February 2020)
 - Darwin (27 February 2020)
- Hearings were advertised: in newspapers (*The Australian* on 24 October 2019, the *Midwest Times* on 13 November 2019 for the Geraldton hearing, and the *Barrier Daily Truth* on 16 November 2019 for the Broken Hill hearing); through Facebook and Twitter; through a flyer emailed to key stakeholders for distribution; and through an email to registered Inquiry participants.
 - About 300 meetings were held with individual stakeholders across Australia
 - The Productivity Commission received 1244 public submissions during the Inquiry and also provided facilities on the Inquiry website for interested stakeholders to lodge a brief comment. A total of 488 comments were received (table A.1). All public submissions and comments are available on the Inquiry website.

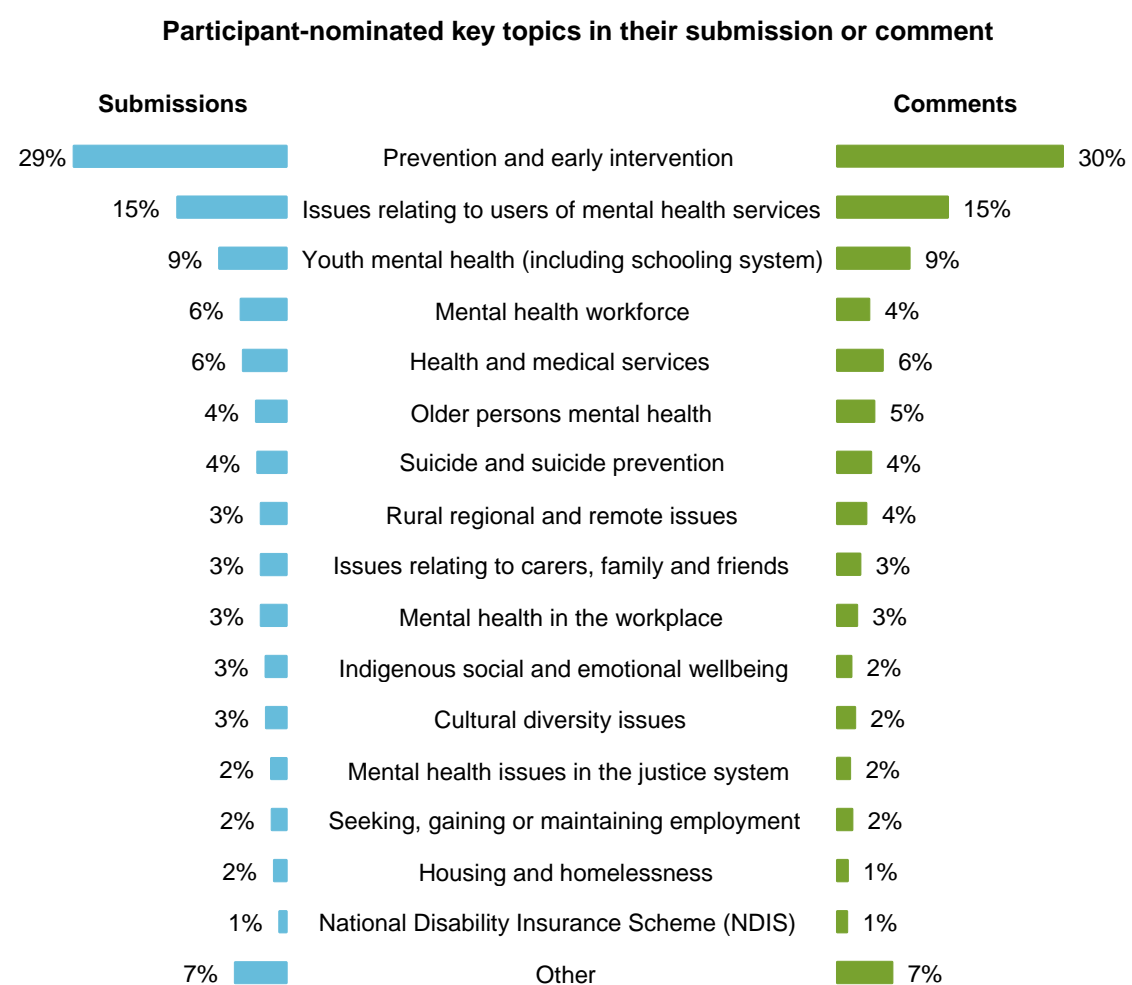
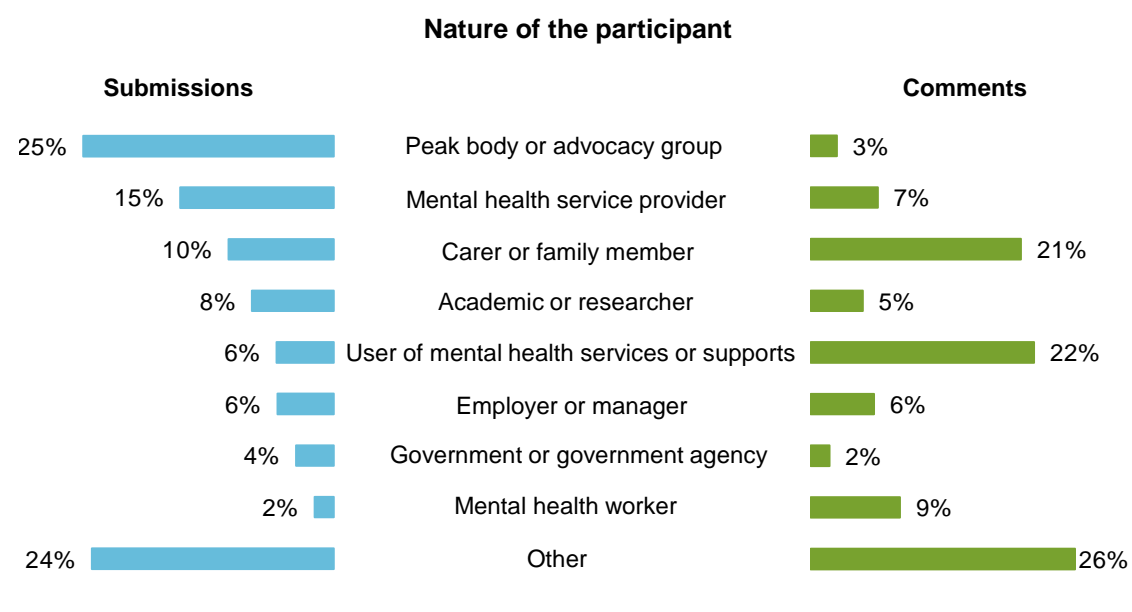
To facilitate our ongoing interaction with State and Territory Governments during the Inquiry, a State and Territory Government Consultative Group was formed for the inquiry. The group was convened via teleconference on four occasions and was used as both an avenue through which to gather together information on mental health programs and supports delivered by State and Territory Governments and an avenue through which the Productivity Commission shared updates on Inquiry developments and understanding.

A separate document on the *Inquiry website only*, lists parties who contributed to the Inquiry through meetings, roundtables, hearings and submissions or comments.

Table A.1 Number of submissions and comments received

	<i>Pre-draft</i>	<i>Post-draft</i>	<i>Total</i>
Submissions	564	680	1244
Comments	191	297	488

Figure A.1 Submissions and comments received



Data and information requests

The Commission is very appreciative of the data and information provided by: a number of Australian, State and Territory Government agencies; industry, business and employee representative organisations; and number of non-government service providers during the course of the Inquiry. Where possible, the Commission has published this data and information in detail in the Inquiry report.

This inquiry uses unit record data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey. The HILDA Project was initiated and funded by the Australian Government Department of Social Services (DSS) and is managed by the Melbourne Institute of Applied Economic and Social Research (Melbourne Institute). The findings based on HILDA data that are reported in this inquiry are those of the Productivity Commission and should not be attributed to either DSS or the Melbourne Institute.

Unit record data from the Multi-Agency Integration Project (MADIP) dataset has also been used. The project creating this dataset is a partnership among Australian Government agencies combining healthcare, education, government payments, personal income tax and population demographics over time. The findings based on MADIP data that are reported in this inquiry are those of the Productivity Commission.

The Commission also collected some data for this Inquiry by serving formal notice under section 48 of the *Productivity Commission Act 1998* (Cth). For this purpose, the Commission served a formal notice on SafeWork NSW.

Documents produced by the Inquiry

The following public documents were prepared by the Commission in this Inquiry:

- Issues paper — released 21 January 2019
- Draft Report — released 31 October 2019
- Final Report — delivered to Government on 30 June 2020 (to be publicly released within 25 parliamentary sitting days).

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