



Australian Government
Productivity Commission

The Social and Economic Benefits of Improving Mental Health

Productivity Commission
Issues Paper

January 2019

The Commission has released this issues paper to assist individuals and organisations to prepare submissions.

It contains and outlines:

- the scope of the inquiry
- the Commission's procedures
- matters about which the Commission is seeking comment and information
- how to make a submission.

The Issues Paper

The Commission has released this issues paper to assist individuals and organisations to participate in the inquiry. It contains and outlines:

- the scope of the inquiry
- matters about which we are seeking comment and information
- how to share your views on the terms of reference and the matters raised.

Participants should not feel that they are restricted to comment only on matters raised in the issues paper. We want to receive information and comment on any issues that participants consider relevant to the inquiry's terms of reference.

Key inquiry dates

Receipt of terms of reference	23 November 2018
Initial consultations	November 2018 to April 2019
Initial submissions due	5 April 2019
Release of draft report	Timing to be advised
Post draft report public hearings	Timing to be advised
Submissions on the draft report due	Timing to be advised
Consultations on the draft report	November 2019 to February 2020
Final report to Government	23 May 2020

Submissions and brief comments can be lodged

Online (preferred):	https://www.pc.gov.au/inquiries/current/mental-health/submissions
By post:	Mental Health Inquiry Productivity Commission GPO Box 1428, Canberra City, ACT 2601

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Subscribe for inquiry updates

To receive emails updating you on the inquiry consultations and releases, subscribe to the inquiry at: www.pc.gov.au/inquiries/current/mentalhealth/subscribe

The Productivity Commission

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long term interest of the Australian community.

The Commission's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

Further information on the Productivity Commission can be obtained from the Commission's website (www.pc.gov.au).

Terms of reference

Inquiry into the economic impacts of mental ill-health

I, Josh Frydenberg, Treasurer, pursuant to Parts 2 and 3 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission (the Commission) undertake an inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

Background

In 2014-15, four million Australians reported having experienced a common mental disorder.

Mental health is a key driver of economic participation and productivity in Australia, and hence has the potential to impact incomes and living standards and social engagement and connectedness. Improved population mental health could also help to reduce costs to the economy over the long term.

Australian governments devote significant resources to promoting the best possible mental health and wellbeing outcomes. This includes the delivery of acute, recovery and rehabilitation health services, trauma informed care, preventative and early intervention programs, funding non-government organisations and privately delivered services, and providing income support, education, employment, housing and justice. It is important that policy settings are sustainable, efficient and effective in achieving their goals.

Employers, not-for-profit organisations and carers also play key roles in the mental health of Australians. Many businesses are developing initiatives to support and maintain positive mental health outcomes for their employees as well as helping employees with mental ill-health continue to participate in, or return to, work.

Scope

The Commission should consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. It should make recommendations, as necessary, to improve population mental health, so as to realise economic and social participation and productivity benefits over the long term.

Without limiting related matters on which the Commission may report, the Commission should:

- examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy;

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- examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity;
 - examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups;
 - assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy;
 - draw on domestic and international policies and experience, where appropriate; and
 - develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth over the long term.

The Commission should have regard to recent and current reviews, including the 2014 Review of National Mental Health Programmes and Services undertaken by the National Mental Health Commission and the Commission's reviews into disability services and the National Disability Insurance Scheme.

Process

The Productivity Commission should undertake broad consultation, including with carers and consumers, and by holding hearings in regional Australia, inviting public submissions and releasing a draft report to the public.

The final report should be provided to the Government within 18 months.

J. FRYDENBERG
Treasurer

[Received 23 November 2018]

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1. What is this inquiry about?

Many Australians experience difficulties with their mental health. Mental illness is the single largest contributor to years lived in ill-health and is the third largest contributor (after cancer and cardiovascular conditions) to a reduction in the total years of healthy life for Australians (AIHW 2016). Almost half of all Australian adults have met the diagnostic criteria for an anxiety, mood or substance use disorder at some point in their lives, and around 20% will meet the criteria in a given year (ABS 2008). This is similar to the average experience of developed countries (OECD 2012, 2014).

Despite a plethora of past reviews and inquiries into mental health in Australia, and positive reforms in services and their delivery, many people are still not getting the support they need to maintain good mental health or recover from episodes of mental ill-health. Mental health in Australia is characterised by:

- more than 3 100 deaths from suicide in 2017, an average of almost 9 deaths per day, and a suicide rate for Indigenous Australians that is much higher than for other Australians (ABS 2018)
- for those living with a mental illness, lower average life expectancy than the general population with significant comorbidity issues — most early deaths of psychiatric patients are due to physical health conditions
- gaps in services and supports for particular demographic groups, such as youth, elderly people in aged care facilities, Indigenous Australians, individuals from culturally diverse backgrounds, and carers of people with a mental illness
- a lack of continuity in care across services and for those with episodic conditions who may need services and supports on an irregular or non-continuous basis
- a variety of programs and supports that have been successfully trialled or undertaken for small populations but have been discontinued or proved difficult to scale up for broader benefits
- significant stigma and discrimination around mental ill-health, particularly compared with physical illness.

The Productivity Commission has been asked to undertake an inquiry into the role of mental health in supporting social and economic participation, and enhancing productivity and economic growth (these terms are defined, for the purpose of this inquiry, in box 1). By examining mental health from a participation and contribution perspective, this inquiry will essentially be asking how people can be enabled to reach their potential in life, have purpose and meaning, and contribute to the lives of others. That is good for individuals and for the whole community.

Box 1 **Definition of key terms**

Mental health is a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental illness or **mental disorder** is a health problem that significantly affects how a person feels, thinks, behaves and interacts with other people. It is diagnosed according to standardised criteria.

Mental health problem refers to some combination of diminished cognitive, emotional, behavioural and social abilities, but not to the extent of meeting the criteria for a mental illness/disorder.

Mental ill-health refers to diminished mental health from either a mental illness/disorder or a mental health problem.

Social and economic participation refers to a range of ways in which people contribute to and have the resources, opportunities and capability to learn, work, engage with and have a voice in the community. Social participation can include social engagement, participation in decision making, volunteering, and working with community organisations. Economic participation can include paid employment (including self-employment), training and education.

Productivity measures how much people produce from a given amount of effort and resources. The greater their productivity, the higher their incomes and living standards will tend to be.

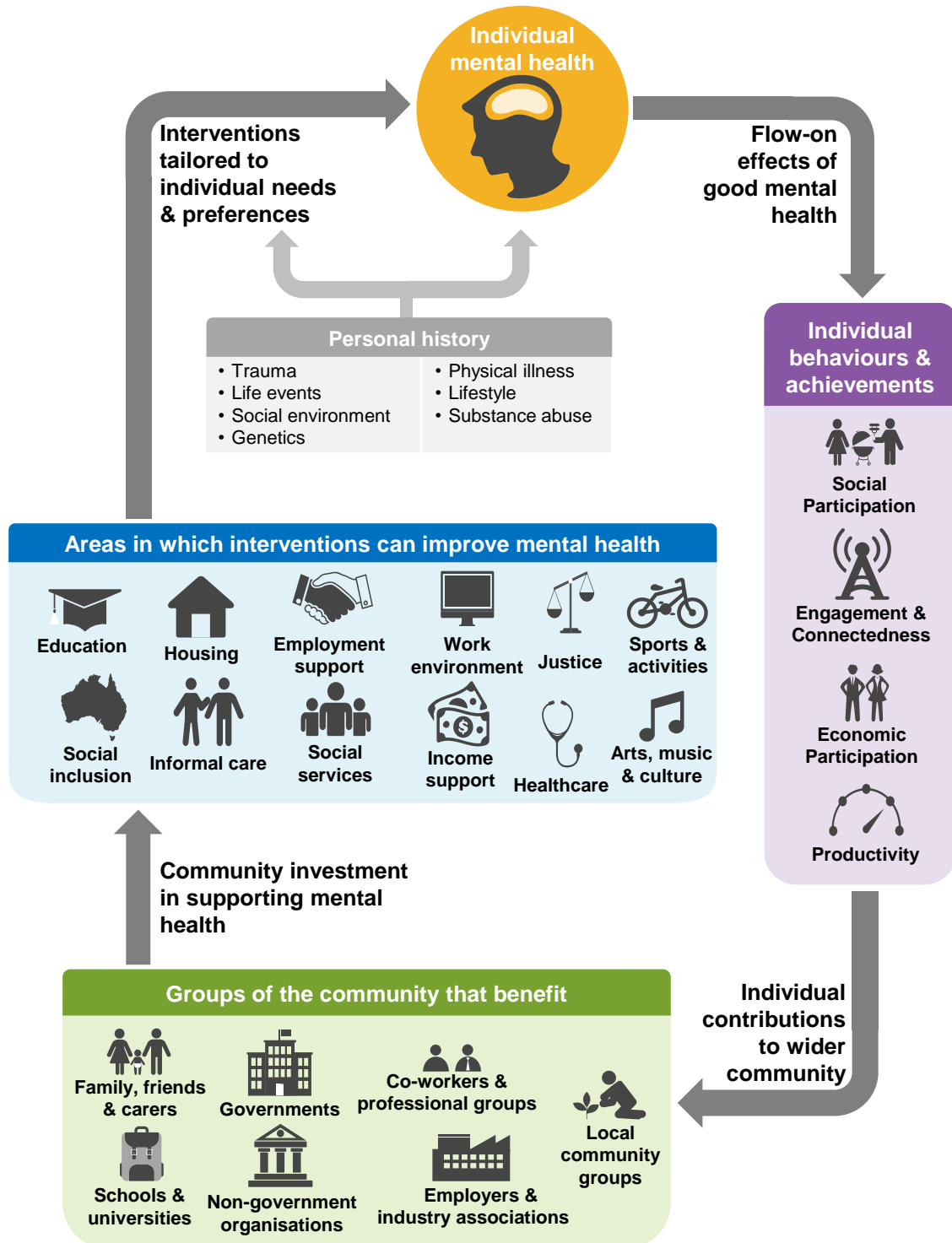
Economic growth is an increase in the total value of goods and services produced in an economy. This can be achieved, for example, by raising workforce participation and/or productivity.

Sources: AIHW (2018b); DOHA (2013); Gordon et al. (2015); PC (2013, 2016, 2017c); SCRGSP (2018); WHO (2001).

An improvement in an individual's mental health can provide flow-on benefits in terms of increased social and economic participation, engagement and connectedness, and productivity in employment (figure 1). This can in turn enhance the wellbeing of the wider community, including through more rewarding relationships for family and friends; a lower burden on informal carers; a greater contribution to society through volunteering and working in community groups; increased output for the community from a more productive workforce; and an associated expansion in national income and living standards. These raise the capacity of the community to invest in interventions to improve mental health, thereby completing a positive reinforcing loop.

The inquiry's terms of reference (provided at the front of this paper) were developed by the Australian Government in consultation with State and Territory Governments. The terms of reference ask the Commission to make recommendations to improve population mental health so as to realise higher social and economic participation and contribution benefits over the long term.

Figure 1 **Improvements in mental health can benefit both individuals and the wider community**



Inquiry scope and relationship to other reviews

This inquiry will examine what Australia is losing — year after year — by forgoing greater social and economic participation by people with mental ill-health. The inquiry will differ from past reviews by considering how reforms outside of healthcare — such as in workplaces, education, justice systems, housing and social services — can improve mental health, and hence social and economic participation. Moreover, we will be considering the role of all parties in facilitating improved mental health, including all levels of government, not-for-profit and private sector service providers, employers and professional groups.

The broad scope of this inquiry is consistent with evidence that there are many factors in addition to healthcare which should be targeted in order to improve mental health, and doing so will achieve improvements not possible by focusing solely on mental health services.

Studies on Australian samples have shown that psychological distress is associated with unemployment (Reavley et al. 2011), low income (Enticott et al. 2018; Reavley et al. 2011), low social capital (Phongsavan et al. 2006), low social connectedness and social support (Atkins et al. 2013; Levula, Harré and Wilson 2018); workplace characteristics (Considine et al. 2017); poor quality diet (Hodge et al. 2013; Nguyen, Ding and Mhrshahi 2017), limitations on physical functioning (Atkins et al. 2013; Byles et al. 2014) and physical diseases (Byles et al. 2014). There may be limits on how much change [mental health] treatment can produce where such risk factors are present and persisting. Dealing with these risk factors may require a greater emphasis on prevention (Jorm 2014) and on social factors that lie outside the domain of mental health services (Mulder, Rucklidge and Wilkinson 2017). (Jorm 2018, p. 1061)

While healthcare is within the scope of this inquiry, we will draw on the findings and recommendations of the many past health-related reviews, and how governments have responded to them, rather than duplicate past analysis and recommended reforms. To minimise duplication with reviews in other areas, this inquiry will not be assessing:

- the National Disability Insurance Scheme (NDIS) because it has been examined in other reviews by the Productivity Commission (PC 2011, 2017b, 2018b). However, we will examine the interface between the NDIS and other services for those with a mental illness, and any new developments which have significant implications for population mental health, participation and productivity (discussed further below)
- support specifically for military personnel and veterans because the Commission is currently conducting a separate inquiry on compensation and rehabilitation for veterans (PC 2018a) — although it is possible that many of our conclusions will be relevant to this group
- mental illness associated with a terminal condition, such as dementia, given that the Commission has examined end-of-life care in an inquiry on human services (PC 2017a)
- aged care accommodation choices, because the Australian Government has established a royal commission into the aged care sector (Morrison 2018; Royal Commission into Aged Care Quality and Safety 2019). However, we will examine the role of mental health in improving the social and economic participation and contribution of older people.

The inquiry will, however, have a broad scope in terms of which groups of individuals, services and organisations are covered. This is reflected in the diversity of conditions which fall within the definition of mental illness (table 1).

Moreover, this inquiry is about the mental health and wellbeing of Australia’s population generally, not only about people with a diagnosed mental illness. A person without a diagnosable mental illness could be experiencing escalating or sustained psychological distress which reduces their participation in, and contribution to, society. Conversely, a person with a history of mental illness might have a high level of mental health because they have the right treatments and supports to be able to take part in activities that are meaningful, such as work or study, providing a sense of purpose and positive self-perception.

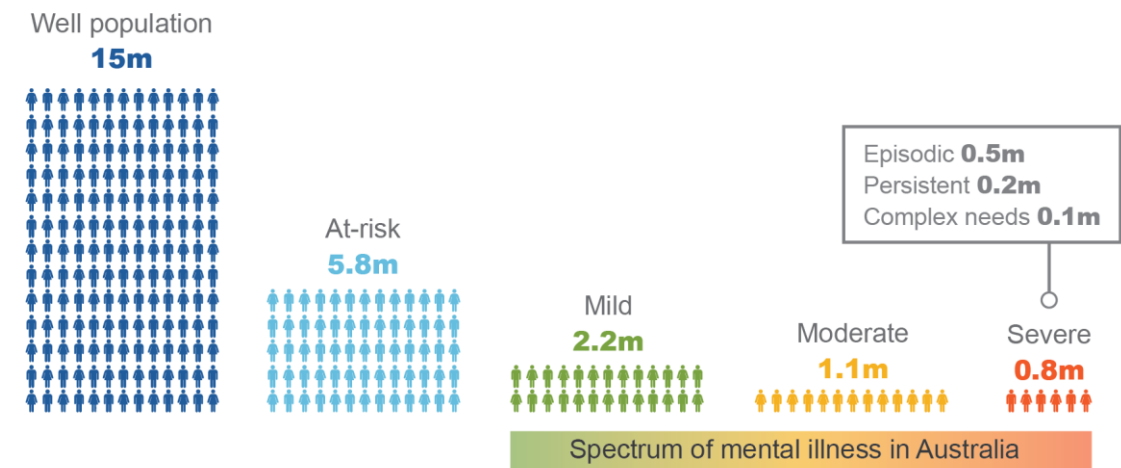
Table 1 The many different types of mental disorders		
<i>In-scope for this inquiry</i>	<i>Scope for this inquiry under consideration^a</i>	<i>Out-of-scope for this inquiry^a</i>
Psychosis Mood disorders Anxiety disorders Personality disorders Eating disorders Child behavioural disorders	Substance use disorders Autism spectrum disorders	Dementia Intellectual disability
^a Dementia and intellectual disabilities are treated as out-of-scope for this inquiry, except in those instances where they are comorbid with another mental disorder. The Productivity Commission is assessing the extent to which substance use disorders and autism spectrum disorders fall within the scope of this inquiry. Source: Adapted from APA (2013) and QCMHR (2019).		

To give the inquiry focus, we intend to give greatest consideration to where there are the largest potential improvements in population mental health, participation and contribution over the long term. From the Commission’s initial consultations, this seems likely to include:

- people with a mild or moderate mental illness (such as anxiety and depressive disorders) because they account for the vast majority of Australians with a mental disorder (figure 2)
- young people, because mental illness at a young age can affect schooling and other factors which influence opportunities over a person’s lifetime — moreover, most mental illnesses experienced in adult life have their onset in childhood or adolescence (McGorry et al. 2011)
- disadvantaged groups, such as individuals from very low socioeconomic backgrounds and people residing in remote areas because they may have more difficulty in accessing services which could improve their mental health (AIHW 2018d; Harris et al. 2010; Meadows et al. 2015)
- suicide prevention, because the years of additional life lived, and associated social and economic participation and productivity years into the future, can be significant.

We also intend to focus on measures that could improve the integration and continuity of support for particular groups, such as people with severe, persistent and complex mental illness, and which could better take into account the episodic nature of some mental illnesses.

Figure 2 **Distribution of mental health among the Australian population^a**



^a Estimated number of people (adults and children) in each group based on their mental health over the 12 months up to 31 March 2018. People were categorised as having a mental illness (mild, moderate or severe) if they had an episode of mental illness within the 12-month period. They were categorised as being at-risk if they had emerging symptoms of a mental illness within the 12-month period, or an episode of mental illness before the 12-month period, or were children of parents with a mental illness.

Source: Productivity Commission estimates based on prevalence rates published in the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a) and NMHC (2014a); and population statistics published by the ABS (*Australian Demographic Statistics*, Cat. no. 3101.0).

Inquiry process and consultation

We will be undertaking wide-ranging consultations for this inquiry. We also invite written submissions and comments on the issues to be covered by the inquiry. This issues paper is intended to assist you to lodge a submission or comment, but it is not intended to provide an exhaustive list of the issues. Submitters need not cover every issue raised in this paper and are welcome to submit material on other issues they consider directly relevant to the inquiry's terms of reference.

We welcome input from those providing services and supports to those with mental ill-health, and from employers grappling with the mental health of their workforce.

We particularly encourage participation in the inquiry from those in the community — young and elderly people, those of working age, people with lived experience, and families and carers — who are navigating through current mental health services and supports to find what is most effective for themselves or those they care for. The experiences of Indigenous

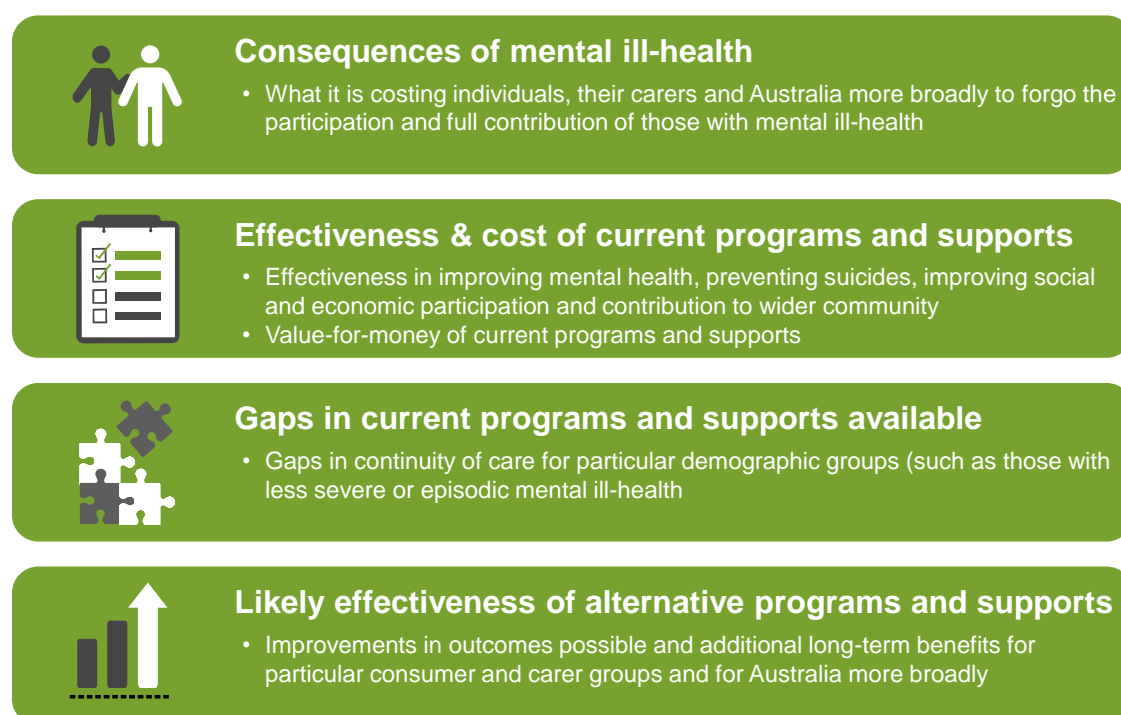
Australians, culturally and linguistically diverse groups, and people living in regional and remote areas are also important.

To facilitate input from individuals who do not have the resources to lodge a formal submission or only wish to provide input on a limited range of issues, the inquiry website includes an option for people to make a brief comment (up to 500 words).

2. Assessment approach

We will be investigating how to improve population mental health so as to realise benefits from increased social and economic participation and contribution to the wider community in both the near and long term. There are four streams of assessment that we will be undertaking in this investigation (figure 3). This includes an assessment of the consequences of mental ill-health, and the effectiveness of current and alternative programs and supports (including gaps in current programs and supports available), from the perspective of particular groups (such as consumers and their carers) as well as the community as a whole.

Figure 3 **Assessment components**












Assessing the consequences of mental ill-health

The costs of mental ill-health for both individuals and the wider community will be assessed, as well as how these costs could be reduced through changes to the way governments and others deliver programs and supports to facilitate good mental health.

The Commission will consider the types of costs summarised in figure 4. These will be assessed through a combination of qualitative and quantitative analysis, drawing on available data and cost estimates, and consultations with inquiry participants and topic experts. We welcome the views of inquiry participants on other costs that we should take into account.

Figure 4 **Costs of mental ill-health to the community^a**

Resources expended on human services	Reduction in incomes & living standards	Intangible costs
Healthcare Expenditure on diagnosis, treatment & recovery 	Lower economic participation Individuals & carers spend less time working or in education 	Lower social participation Less contact with family & friends, lower community involvement 
Other services & supports Expenditure on education, employment, housing, justice & social services 	Lost productivity People produce a lower rate of output when at work 	Pain & suffering Diminished health, reduced emotional resilience, increased distress & premature death 
Informal care Time and effort provided by family & friends to support individuals 	Cost of collecting taxes to provide services Taxes alter prices, change behaviours & lowers output 	Stigma & discrimination Reduced rights, limited choices & poor treatment by others 

^a Financial support payments (such as the disability support pension and carer payments) are not included because they are a transfer between different members of the community, rather than a cost to the community as a whole. The cost of collecting taxes to fund transfer payments, and publicly funded human services, are included because this is a cost to the whole community.

Many of the costs of mental ill-health are intangible. They include psychological distress, unpleasant side-effects of medications, social isolation, lower social participation and stigma and discrimination (Knapp, McDaid and Curran 2003). As these are difficult to value in monetary terms, we may need to assess their magnitude in other ways (such as by considering disability-adjusted life year measures).

In addition to intangible costs, there are the economic costs of:

- resources expended on supporting people with a mental ill-health, including on healthcare and other human services such as social housing, as well as support from family and other unpaid carers¹
- reduced incomes and living standards caused by lower economic participation and contribution among people with mental ill-health and their carers.

To quantify the costs of reduced economic participation and contribution of people with mental ill-health and their carers, we will draw on estimates of the extent to which mental ill-health leads to:

- a lower probability of being employed²
- a greater likelihood of being absent from work when employed (absenteeism)³
- lower productivity while at work (presenteeism).⁴

Past research has estimated that the costs to individuals and the community in high-income countries of lower participation and productivity are about double the level of healthcare expenditure on people with a mental illness (Bloom et al. 2011). Previous Australian research indicates that, for some groups of individuals (teenagers and young adults) and some types of mental illness (such as anxiety, affective and substance use disorders), participation and productivity costs could be much more than twice the cost of healthcare.⁵

There will necessarily be a time dimension to the assessment of costs because mental illness can be a life-long condition, with varying episodes of ill-health into the future, depending on what healthcare and other supports are received and when. For example, effective prevention and early intervention when people are young could reduce the mental-ill health they experience and its associated costs, for many years into the future.

¹ Diminic et al. (2017) estimated that 240 000 Australians were informal carers for an adult with mental illness in 2015. Of these, 54 000 were a primary carer who provided the most informal assistance.

² For example, Frijters, Johnston and Shields (2014) estimated that the probability of an Australian adult being employed falls by around 30 percentage points when there is a one-standard-deviation decline in their mental health.

³ Bubonya, Cobb-Clark and Wooden (2016) estimated that the rate of absences from work is, on average, about five percentage points higher among Australian workers who report being in poor mental health. PWC (2014) estimated that absenteeism due to poor mental health costs Australian employers \$4.7 billion annually.

⁴ Forbes, Barker and Turner (2010) estimated that, in Australia, poor mental health is associated with an average reduction in hourly wages (an indicator of labour productivity) of around 5% for men and 3% for women. PWC (2014) estimated that reduced productivity due to poor mental health costs Australian employers \$6.1 billion annually.

⁵ Access Economics (2009) estimated that, in 2009, mental illness among Australians aged 15-25 years led to productivity costs (\$7 459 million) which were more than five times greater than health system costs (\$1 414 million). Lee et al. (2017) estimated that, in 2007, anxiety, affective and substance use disorders among Australian adults led to productivity costs (\$11 800 million in 2013-14 dollars) which were more than twelve times greater than healthcare costs (\$974 million).

This inquiry's assessment of costs will also take account of the considerable diversity that can exist between different mental illnesses, groups of individuals, and organisations which support mental health (including governments, service providers, and businesses).

Assessing current and potential interventions to improve mental health outcomes

The inquiry will assess how effective are existing, and potential alternative, services and supports in meeting the needs and preferences of people at risk of mental ill-health, their families and carers. We will also examine (as with all Commission inquiries) how effective interventions are in improving the wellbeing of the wider Australian community.

In order to determine effectiveness, we will consider the extent to which the mental health of individuals is improved, plus the flow-on benefits of increased social participation, engagement and connectedness, and economic participation and contribution through employment. This will be informed by evaluations of specific interventions, consultations with inquiry participants and topic experts, and the Commission's judgement.

Where feasible, we will also assess the cost-effectiveness of interventions in facilitating improved mental health (that is, the cost of achieving a given improvement in mental health and its flow-on effects). The aim will be to test whether resources are being used in ways that achieve the best possible outcomes.

The inquiry will make recommendations to improve the mental health and wellbeing of particular groups and the community as a whole. The reforms that we choose to focus on will be informed by views expressed by inquiry participants and our own analysis of outcomes (effectiveness and cost) under current approaches compared to what could be achieved, given evidence from best practice in Australia and other countries.

We will comment on how the costs and benefits of our recommended reforms are likely to be distributed across different groups. This may include testing the hypothesis that interventions to facilitate improved mental health can generate a net financial return for the entity that funds them.⁶ The funder could be a government (for publicly funded human services, with the financial return being reduced public expenditure on costly healthcare) or employer (for workplace initiatives, with the financial return being greater profitability from a more productive workforce).

QUESTIONS ON ASSESSMENT APPROACH

- *What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.*
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⁶ Various quantitative studies in Australia and overseas have estimated that there would be a positive return on investments in mental health for the government or employer that funds them (for example, Knapp, McDaid and Parsonage 2011; KPMG and Mental Health Australia 2018; PWC 2014).

The following sections of this paper consider specific service areas and other interventions that can support mental health. This is followed in the final section of the paper by a discussion of the overarching policy frameworks needed to ensure that there is a systematic and coordinated approach to mental health across the many different supports, and that there are monitoring systems in place to promote ongoing improvements.

3. Contributing components to improving mental health and wellbeing

Improving mental health — and hence social and economic participation and contribution to the wider community — necessitates consideration of services and supports including, but not limited to, healthcare. Other services and supports include housing, social services, and measures provided through workplaces, education providers, and justice systems. How these components work together to wrap a support network around the individual consumer and their carers is a critical part of effective interventions.

Healthcare

The healthcare system supporting mental health covers a wide range of services, providers and settings, including:

- primary care delivered in the community by general practitioners (GPs), nursing and allied mental health providers
- more specialised mental health services provided in community settings, which could be delivered by a psychiatrist, psychologist or other allied health professional working in either private practice or a (publicly funded) specialist community mental health service
- residential mental health services, which provide overnight specialised mental health care in a domestic-like environment
- emergency departments, day clinics and admitted-patient services provided in a (public or private) hospital, which could be either a general or specialised psychiatric hospital
- pharmacies in the community, or within a publicly funded health facility, which dispense medications to people with a mental illness.

State and Territory Governments are responsible for healthcare provided by publicly funded hospitals and community and residential mental health services, with provision sometimes delegated to a non-government provider. A significant proportion of care is also provided by practitioners working in private practice.

Structural weaknesses identified in past reviews

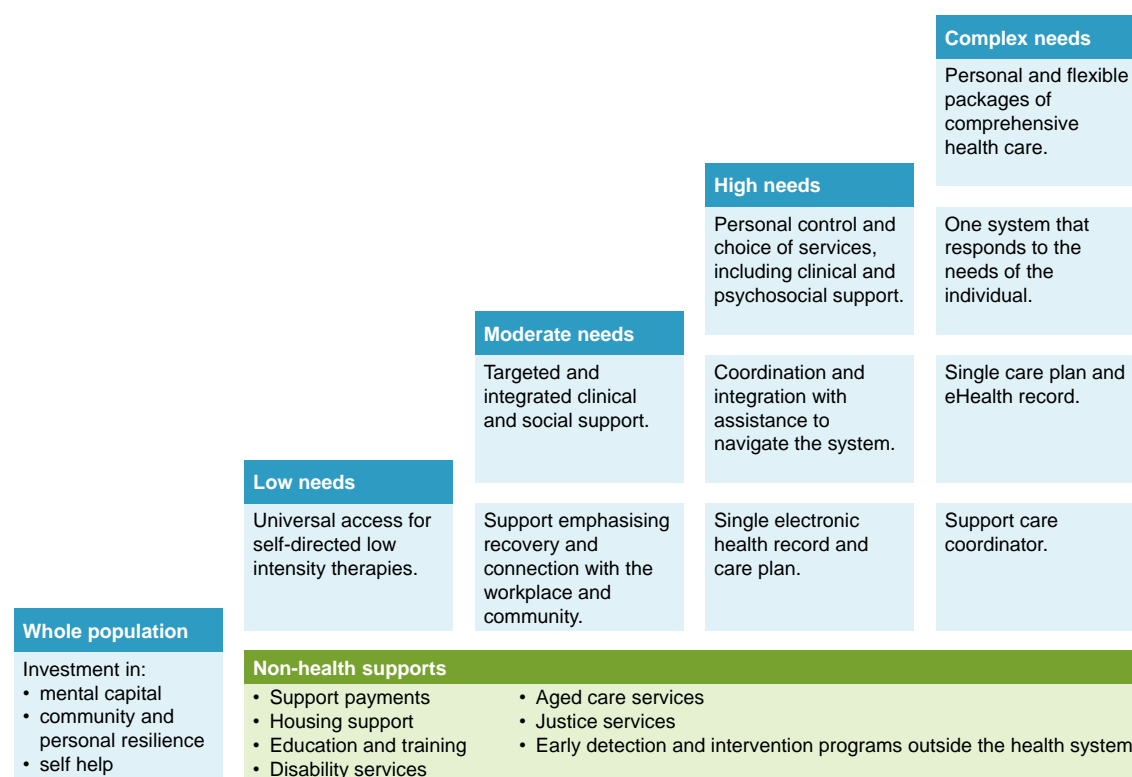
This inquiry will not be duplicating the work done in many past reviews to identify the structural weaknesses in existing models of healthcare for people with a mental illness (for example, HREOC 1993; KPMG and Mental Health Australia 2018; Medibank and Nous Group 2013a; Mendoza et al. 2013; Richmond, Sainsbury and Conoulty 1983). The problems are well known, with the most extensive review in recent years — undertaken by the National Mental Health Commission (NMHC 2014a) — highlighting issues such as:

- the concentration of resources in costly acute and crisis care (such as hospital emergency departments), despite evidence that mental health services in community settings can be more effective in preventing pain and suffering, facilitating recovery, and keeping people in the community with their families and participating in employment or education
- fragmentation and limited coordination across services, providers and settings, rather than a genuine mental health ‘system’ in the sense of being a planned, unitary whole to address the needs of the population
- services being designed with a focus on the needs of providers rather than consumers
- inequitable access to care, such as in regional and remote areas, and for disadvantaged groups.

Governments have a long history of efforts to improve outcomes but they have found it challenging to make progress on issues such as those listed above (Doggett 2018). Recognising the need for further improvement, a new wave of reforms is now underway across a wide front and more could follow after governments consider the recommendations of various recent and current reviews (for example, CARC 2018).

At a national level, the Australian Government has, in response to the recommendations of the NMHC review, been phasing in a package of reforms. This includes redirecting Commonwealth funding for primary mental health programs to a new flexible funding pool to be used by its regional primary health networks (PHNs) to plan and commission primary care, in concert with State and Territory Government local health networks and others (Department of Health 2015; NMHC 2018b). This is intended to more effectively tailor support to local circumstances and facilitate a shift to a ‘stepped model’ of care which varies according to an individual’s needs (figure 5). More generally, in 2017, governments agreed to a renewed five-year program of cross-jurisdiction coordination on a broad range of mental health policies under the auspices of the Fifth National Mental Health and Suicide Prevention Plan (NMHC 2018a).

Figure 5 **Stepped model of care**



Source: Adapted from (NMHC 2014a).

This inquiry will not generally be recommending changes in areas where reforms are currently in the early stages of being implemented or where it is too early to evaluate outcomes achieved from reforms. We do, however, welcome input from participants on any areas that have been overlooked in the current reform agenda, and views on why it has historically been challenging to address the structural weaknesses in healthcare.

QUESTIONS ON STRUCTURAL WEAKNESSES IN HEALTHCARE

- *Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?*
- *What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?*

How to address specific health concerns

You are invited to comment on what changes should be made in Australia's health sector to address specific concerns related to mental health, where you see the issue as having a major influence on wellbeing, participation and productivity. Some examples of the issues you may want to comment on are discussed below.

Mental health promotion, prevention and early intervention

An important issue for this inquiry will be how, and to what extent, can the prevalence and severity of mental ill-health be reduced through more effective mental health promotion (equipping the population to maintain good mental health), identification and prevention (such as interventions targeted at people with a high-risk of mental illness, including to prevent relapse) and early intervention (care provided soon after an episode of illness becomes evident).

For example, KPMG and Mental Health Australia (2018) found evidence to support greater provision of cognitive behaviour therapy for young people who have a parent with a diagnosed depressive order (prevention), and community-based assertive outreach for individuals experiencing initial onset of psychosis (early intervention).

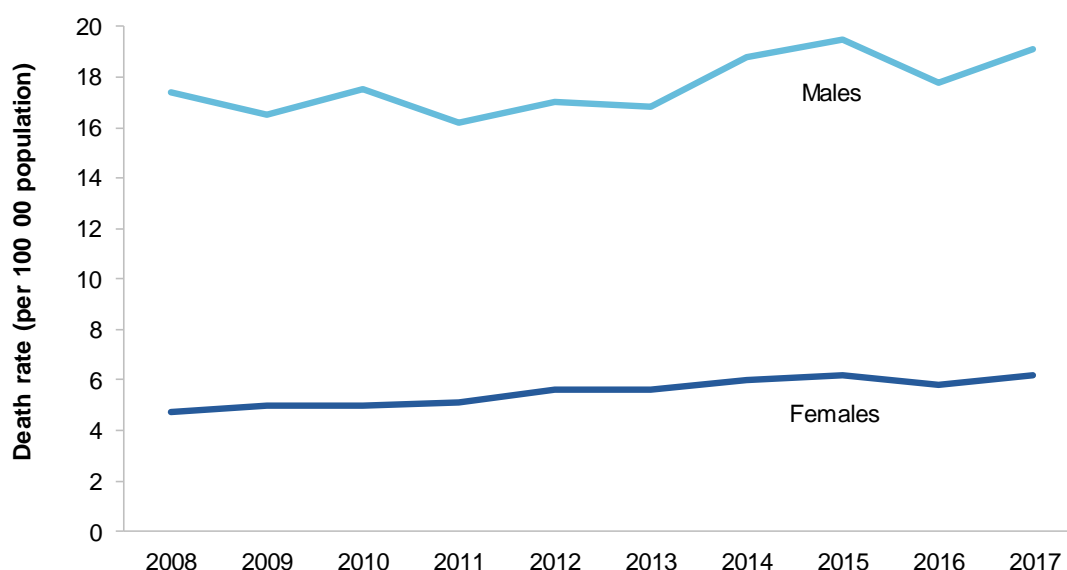
Actions taken in areas other than healthcare, such as in workplaces and through housing support, could also be viewed as forms of prevention or early intervention. These areas are discussed further below.

Suicide prevention

Suicides are not just the loss of an individual and their future, but the loss of a member of a family and community. Beyond the social costs of suicide, there can also be large financial costs to the whole community, with one estimate valuing lost economic participation; provision of coronial, police and ambulance services; and counselling support for family and friends at \$1.7 billion annually (KPMG 2013). An associated concern is the number of people who are hospitalised due to self-harm, which is more than twenty times the number who lose their life to suicide (COAG Health Council 2017b).

There has been no significant reduction in the death rate from suicide over the last decade, despite ongoing efforts to make suicide prevention policies more effective (figure 6). In light of this, governments recently made suicide prevention a focus for cross-jurisdiction coordination under the Fifth National Mental Health and Suicide Prevention Plan. This includes a commitment to develop a national implementation strategy, which will set the direction for future planning and investment, and is expected to be released in 2020 (NMHC 2018b). Moreover, individual jurisdictions have already committed to funding various trials and other interventions to prevent suicides.

Figure 6 **Death rate from suicide by gender, 2008-2017^a**



^a Aged-standardised death rate from intentional self-harm per 100 000 population. Age-standardised death rates enable the comparison of death rates over time and between populations of different age-structures. The age-standardised death rate for females and males combined ranged from 10.5 persons per 100 000 (in 2011) to 12.7 persons per 100 000 (in 2015).

Source: ABS (*Causes of Death, Australia*, Cat. no. 3303.0).

Comorbidities

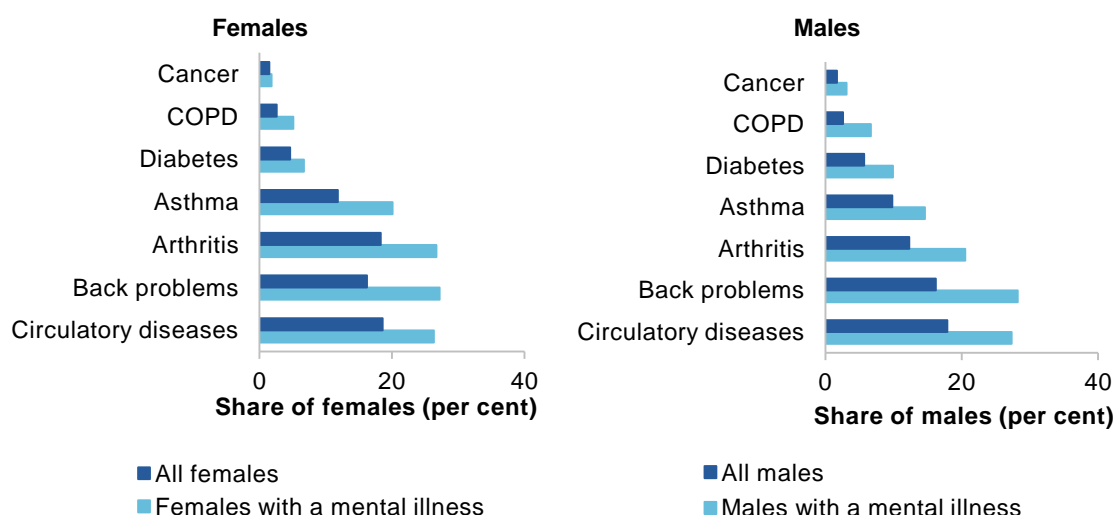
People with a mental illness have a relatively high rate of physical ailments (comorbidities), and an associated lower life expectancy, compared to the rest of the population. Around 60% of adults with a mental disorder have a physical condition, compared to less than 50% for other adults (AIHW 2012). This pattern is evident across a range of physical illnesses (figure 7).

There is evidence that almost 80% of the difference in average life expectancy between people with a mental illness and the whole population is due to deaths from physical ailments (rather than from other causes). This compares to around 14% caused by suicide (Lawrence, Hancock and Kisely 2013). The annual cost of comorbidities associated with premature death in people with a serious mental illness is, according to one estimate, \$15 billion (RANZCP 2016).

The relationship between physical and mental conditions can be a two-way causation, with physical illness making people more prone to developing a mental illness and vice-versa. Such a situation may make it more difficult to improve health outcomes for people, but also increase the benefits from doing so.

Figure 7 People with a mental disorder are more likely to have a physical illness^a

2014-15



^a COPD refers to chronic obstructive pulmonary disease.

Source: Harris et al. (2018) using data from ABS (National Health Survey, Cat. no. 4329.0).

QUESTIONS ON SPECIFIC HEALTH CONCERNS

- Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?
- Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?
- What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?
- What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?
- What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

Health workforce and informal carers

The configuration and capabilities of Australia's mental health workforce — healthcare workers who deliver mental health services and supports — reflects past models of healthcare and so may need to change in order for government reforms to be effective in improving where and how care is delivered. This will be made more challenging by ongoing problems with high worker turnover due to stress, and the difficulty of recruiting skilled workers, especially in regional and remote areas, many of which are experiencing shortages (NMHC 2018b).

Peer workers — people employed on the basis of their lived experience to support individuals experiencing a similar situation — are being used to better support people with a mental illness in their recovery. The nature of the experience and training required to allow peer workers to be most effective and the circumstances in which they can best be utilised, is the subject of ongoing work (Slade et al. 2014).

Informal carers often support a family member or friend with a mental illness by coordinating their healthcare, providing emotional support, and assisting with day-to-day living. While informal care potentially comes at a cost in terms of reduced workforce participation and productivity among informal carers, and may pose increased risks to their own mental health, in some situations informal care might be the most effective option.

QUESTIONS ON HEALTH WORKFORCE AND INFORMAL CARERS

- *Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?*
 - *What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?*
 - *What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?*
 - *What could be done to reduce stress and turnover among mental health workers?*
 - *How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?*
 - *What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?*
-

Housing, income support and social services

Governments and non-government organisations fund and deliver many basic services that support individual mental health including housing, social services and services that facilitate social participation and inclusion. You are invited to comment on the effectiveness and cost of these services and identify areas in which changes could be made to better support those with mental ill-health and reduce the lost opportunities to Australia.

Housing and homelessness

Mental ill-health is closely linked with housing problems and homelessness (Costello, Thomson and Jones 2013). In 2017-18, about one third of people (about 81 000) who accessed specialist homelessness services were experiencing mental ill-health (AIHW 2018h). About half of these people (about 39 000) were homeless upon their first presentation to these services — almost 40% higher than the number of people in this situation five years earlier.

The causes of accommodation instability and homelessness can be complex, arising from factors such as domestic violence, drug or alcohol use or mental illness. People who experience mental illness can find it difficult to obtain adequate housing or maintain their occupancy. Conversely, housing stresses such as affordability and poor housing conditions can contribute to mental ill-health.

People experience homelessness in different ways. For example, they may live in crisis shelters or be ‘sleeping rough’, either temporarily, episodically or chronically. Homelessness and instability in accommodation can contribute to the onset, or exacerbation of, mental illness or poor physical health. Homelessness among people experiencing mental illness can increase their difficulty to find and keep a job; receive training or education; participate in the community; receive (and/or reduce the effectiveness of) social supports and assistance; and return to stable housing. For some, the consequences can be devastating.

Homelessness is a significant and growing cost to the community as it can lead to greater use of crisis services, in particular, temporary accommodation, hospital stays and justice services (Zaretzky et al. 2013). Between 2012-13 and 2016-17, total government expenditure on specialist homelessness services increased around 5% a year on average, from \$634 million to \$817 million (SCRGSP 2018). However, the number of people experiencing a mental illness who received these services grew even faster, at about 12% a year, and those people tended to experience longer periods of support (AIHW 2018e).

We are interested in identifying practical ways to improve the effectiveness and efficiency of housing support for people experiencing mental ill-health. This includes approaches that aim to prevent and respond to homelessness.

QUESTIONS ON HOUSING AND HOMELESSNESS

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

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

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

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

Income support and social services

A source of income and the mastery of day-to-day tasks are essential features of a happy and fulfilling life. While many people can provide these things for themselves, some people with a disabling mental illness are not able to work and need regular non-clinical support in addition to clinical treatment. Likewise, informal carers of people with a mental illness may have their earning capacity reduced as a result of their carer responsibilities.

Income support

A variety of dedicated income support payments are available to people with mental illness and their carers. People that are substantially unable to work due to mental illness may receive a Disability Support Pension (DSP), and carers of people with mental illness that are substantially unable to work due to their caring responsibilities may receive a Carer Payment and/or Carer Allowance. The level of the DSP and Carer Payment are both just over a quarter of male average weekly earnings, while the Carer Allowance is a smaller amount (less than 20% of the DSP and Carer Payment).

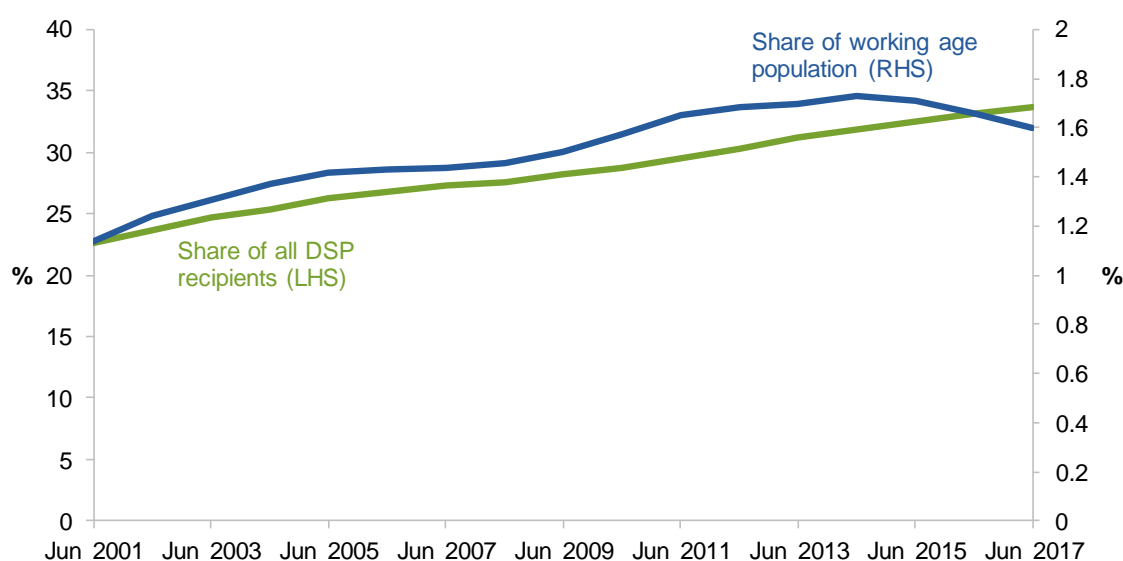
People with a mental illness, and unemployed carers, who do not qualify for any of the above mentioned payments may qualify for the general Newstart Allowance unemployment benefit.

Between 2001 and 2014, the share of DSP recipients receiving the payment due to mental illness grew from 23% to 34% and the share of the working age population receiving DSP for mental illness grew from 1.1% to 1.7% (figure 8). However, to some extent the latter

phenomenon reflects existing income support recipients moving to DSP (DSS 2013; McVicar and Wilkins 2013). In any event, by June 2017 the share of the working age population receiving DSP for mental illness declined slightly due to tightening of the mechanism for assessing work capacity in 2012 (PBO 2018).

Figure 8 Mental illness-related Disability Support Pension recipients

Share of working age population and DSP recipients receiving Disability Support Pension due to psychological or psychiatric disability



Source: Productivity Commission estimates based on based on ABS (*Australian Demography Statistics, Dec 2017*, Cat. no. 3101.1), data.gov.au (various issues of DSS Payment Demographic Data), and DSS (2013).

The 2015 McClure review of the welfare system, and the Productivity Commission's 2011 *Disability Care and Support* inquiry, recommended that the DSP be recast as a transitional payment for those assessed as having better employment prospects, supporting their efforts to work and supporting employers of DSP recipients (McClure, Aird and Sinclair 2015; PC 2011). The Australian Government did not adopt this recommendation.

In this inquiry, the Commission intends to examine if (and how) income support payments could better meet the needs of people that are unable to work due to mental illness or caring responsibilities. A key challenge is that of providing appropriate support to people whose condition (or caring responsibilities) are episodic in nature, as their capacity to work may be highly variable.

Psychosocial disability support services

The Australian and State and Territory Governments provide specialist disability support services for people with psychosocial disability.⁷ These arrangements are currently undergoing a significant transition as the NDIS rolls out.

The Commission's 2017 *NDIS Costs* study (PC 2017b) recommended that the National Disability Insurance Agency (NDIA) implement a 'psychosocial gateway' to improve access to, and use of, the supports available under the NDIS. The NDIA has subsequently developed a new 'psychosocial disability stream' in consultation with Mental Health Australia (Fletcher and Henderson 2018).

Given that the Commission has recently conducted a thorough examination of the NDIS in this dedicated study, it does not intend to substantively revisit the provision of NDIS supports to people with psychosocial disability unless significant new issues arise, or problems are identified by inquiry participants that are not already being addressed.

The Australian, State and Territory Governments have agreed to provide continuity of support to people with psychosocial disability when they received pre-NDIS supports but do not qualify for the NDIS. The Australian Government has published details about its continuity of support arrangements (DSS 2018). As the rollout of the NDIS continues, the Commission is interested in whether gaps are emerging in the Australian, State and Territory Governments' continuity of support arrangements.

QUESTIONS ON SOCIAL SERVICES

- How could non-clinical mental health support services be better coordinated with clinical mental health services?*
 - Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?*
 - What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?*
 - Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?*
 - Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment?*
 - How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?*
-

⁷ Psychosocial disabilities are disabilities that may arise from mental illness.

Facilitating social participation and inclusion

Social participation and inclusion are inextricably linked with mental health and wellbeing. Good mental health supports participation in social and community activities. Conversely, participation in social and community activities correlates with improved mental health. Social inclusion, in the context of mental health, is about how communities engage and include people living with a mental illness and whether those with a mental illness feel connected, valued, accepted, or positive about the communities in which they live. An important part of enabling social inclusion is ensuring that aspects of people's lives that are important to them — such as indigenous or cultural values — are included in the way communities engage.

Policies and programs that promote social inclusion — in areas as diverse as the arts, music, cultural activities and sports — aim to reverse the circumstances or habits that lead to social exclusion. Various issues hamper those who want to participate socially and contribute to their communities. Apart from the functional challenges imposed by mental ill-health, many face social discrimination and stigma. These added challenges limit their access to employment, health, education, social or political life. Over time, such disadvantage leads to further exclusion — a descending cycle.

Non-government organisations, such as sports clubs and community groups, can play an important role in facilitating social inclusion and reducing stigma and discrimination. There is also a role for all levels of government, including by:

- leading the development of policies to promote strong social participation
- providing public assets and amenities
- supporting non-government organisations.

QUESTIONS ON SOCIAL PARTICIPATION AND INCLUSION

- *In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?*
 - *What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?*
 - *Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?*
 - *What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?*
-

Justice and child protection

For some parts of Australia's social frameworks — such as the justice system and child protection system — mental ill-health may be a factor that raises the likelihood of people interacting with these systems, but may also necessitate particular consideration in program and support delivery. You are invited to comment on what changes could be made in Australia's justice and child protection systems that could improve mental health and have flow-on benefits to individuals' economic or social participation and contribution in the short or longer term.

Justice system

The share of people with a mental illness is much higher in prisons than in the general population. Almost half of adults entering prison report that a health professional had told them they have a mental illness (AIHW 2015). Although repeat contact with the justice system is common among prisoners, mental disorders compound it. Those with complex needs (including multiple mental disorders, as well as social and economic disadvantage) have significantly higher rates of offences, convictions and imprisonments than persons with a single or no-diagnosis, both as a juvenile and an adult. Inadequate resources in prisons, and a lack of services designed to smooth transitions back into society, have been identified by others as concerns (NMHC 2013; SCMH 2006).

The impact of cycling in and out of prison on individuals and their families is significant. The cost to the wider community is also high, including for those who are impacted by criminal acts and the cost of funding police, legal aid and prosecutors, courts, prisons and community corrections, community health and hospitals, public and community housing and Centrelink. In extreme cases, these costs could reach \$1 million a year for an individual with complex needs and high levels of institutional contact from a young age (McCausland et al. 2013).

The State and Territory Governments have introduced alternative approaches, including mental health courts and diversion programs. These specialist courts aim to break the cycle of reoffending by diverting individuals towards support and treatment, rather than by applying criminal penalties. The circumstances under which such approaches represent constructive alternatives are important in evaluating their effectiveness.

QUESTIONS ON JUSTICE

- *What mental health supports earlier in life are most effective in reducing contact with the justice system?*
 - *To what extent does inadequate identification of mental health and individual needs in different parts of the justice system increase the likelihood, and extent, of peoples' future interactions with that system?*
 - *Where are the gaps in mental health services for people in the justice system including while incarcerated?*
 - *What interventions in the justice system most effectively reduce the likelihood of re-offending, improve mental health and increase prospects for re-establishing contributing lives? What evidence is there about the long-term benefits and costs of these interventions?*
 - *What are the main barriers to lowering the over-representation of people living with a mental illness in the justice system and what strategies would best overcome them?*
 - *To what extent do inconsistent approaches across states and territories lead to inefficient, ineffective or inequitable outcomes for offenders and their families?*
-

Child safety

Mental ill-health is widespread among children and young people who are in contact with the child protection system. In particular, there are sharply elevated rates of mental illness among young people that child protection authorities have placed in out-of-home care (OOHC) and young people that have left out of home care — a consequence of factors such as trauma associated with family circumstances prior to entering care, negative experiences (such as placement instability, disrupted attachments or sexual abuse) while in care and lack of support after leaving care. The prevalence of mental illness is especially high among the 5% of children in OOHC that live in residential care facilities, rather than home-based care with relatives or foster carers (AIHW 2018a; Rahamim and Mendes 2016).

In addition to the devastating impact on the mental health and development of children, child maltreatment generates significant economic costs that are borne by both the child and by society more broadly. McCarthy et al. (2016) estimated the lifetime cost of each incident of child maltreatment in 2012-13 was almost \$180 000 on average, due to additional demand for child protection, health, justice and housing services, reduced workplace productivity, and efficiency costs associated with taxation.

The Commission is interested in ways to improve the mental health of people in contact with the child protection system, including prevention and early intervention programs targeting at-risk parents and children, and support around the mental wellbeing of young adults leaving OOHC.

QUESTIONS ON CHILD SAFETY

- *What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system?*
 - *What, if any, alternative approaches to child protection would achieve better mental health outcomes?*
-

Skills acquisition, employment and healthy workplaces

The participation and productivity of people with mental ill-health depends on the opportunities for them to acquire skills, the necessary support to find and maintain a job and a mentally healthy workplace that supports and maintains the good mental health and wellbeing of all its employees.

Education and training

Education and training play an important role in social participation, economic participation and productivity. Education can enable increased workforce participation and higher earnings, and other private and social benefits, such as improved health and reduced crime (FCDC 2012; McMahon 2004; Wolfe and Haveman 2002).

However, many people who have a mental disorder in adulthood had experienced mental ill-health earlier in their life when they were undertaking education and training. For most people, mental disorders first emerge when they are young — half of all mental disorders emerge by the time people are 14 years old and three quarters by 25 years (Kessler et al. 2005; youthbeyondblue 2018). In addition, one in seven students aged 4-17 years have experienced a mental disorder in the previous 12 months (Telethon Kids Institute 2017). There is some evidence that students experiencing mental ill-health can have poorer education outcomes than their peers, including lower educational attainment, higher drop-out rates, and poorer engagement while studying (for example, ABS 2008; Orygen 2018; Telethon Kids Institute 2017).

In recent years, there has been increased focus on the mental health and wellbeing of children and young people participating in all levels of education (early childhood education and care, school education, university and vocational education and training). There are a range of programs and services that focus on educating students, teachers and other staff, and families on mental health and wellbeing and building resilience, providing support to students experiencing mental ill-health and helping non-students to re-engage with education and training. Services are funded and/or provided by government and non-government organisations and include a mix of broad brush and targeted services. Examples include:

- *Be You*, which is funded by the Australian Government and delivered by Beyond Blue, Headspace and Early Childhood Australia and aims to promote mental health and wellbeing in early childhood education and care settings and schools (Be You 2018)
- State Government initiatives, such as the NSW Government's School-Link program, which provides early intervention programs in schools and TAFEs (School-Link 2018)
- counselling and mental health support services provided by universities (for example, University of Sydney 2018).

QUESTIONS ON EDUCATION AND TRAINING

- *What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes?*
- *Is there adequate support available for children and young people with mental ill-health to re-engage with education and training?*
- *Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?*
- *How effective are mental health-related supports and programs in Australian education and training settings in providing support to students? How effective are programs in educating staff, students and families, on mental health and wellbeing? What interventions are most effective? What evidence exists to support your assessment?*
- *Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health?*
- *What overseas practices for supporting mental health in education and training should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*

Government support to find and maintain a job

The rate of workforce participation among people with a diagnosed mental illness (62%) is considerably lower than for those without a mental illness (80%). There are strong social and economic arguments for governments to reduce this gap by supporting individuals with

a mental illness to find and maintain a job. Employment can provide them with social engagement; be important in providing a sense of self-identity, purpose and daily structure; and is associated with better mental wellbeing, including lower rates of depression and anxiety (Harvey et al. 2012). Workforce participation also reduces reliance on income support measures and increases the overall income generation capacity of the economy.

The Australian Government has primary responsibility for income support and employment services for people experiencing mental ill-health (AIHW 2018f). It funds a number of programs and services provided by both profit and non-profit organisations to assist people with mental ill-health, and their carers, to find employment and remain in the workforce. This includes the:

- Disability Employment Service (DES), which assists those with a disability, injury or health condition to find and keep a job
- Personal Helpers and Mentors (PHaMs) employment services, which focus on assisting people with a mental illness to overcome non-vocational barriers to finding or keeping a job. PHaMs will be transitioned to the NDIS from 2019-20
- Carers and Work program, which helps carers to increase their workforce participation.

State and Territory Government employment support is provided through various programs, including by funding the provision of community-based mental health support services, and social enterprises to employ people with mental and physical disabilities.

QUESTIONS ON GOVERNMENT-FUNDED EMPLOYMENT SUPPORT

- *How cost effective have the Australian Government's Disability Employment Service (DES) and Personal Helpers and Mentors service (PHaMs) been in enabling people with a mental illness to find and keep a job? Have the DES and PHaMs been targeted at the right populations?*
 - *What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job?*
 - *To what extent has the workforce participation of carers increased due to the Australian Government's Carers and Work Program?*
 - *What will the transition to the NDIS mean for those receiving employment support?*
 - *Which State or Territory Government programs have been found to be most effective in enabling people with a mental illness to find and keep a job? What evidence supports this?*
 - *How could employment outcomes for people experiencing mental ill-health be further improved?*
-

The Australian Government also provides general support to firms to employ people with a disability, injury or health condition (including mental illness). This involves the provision of wage subsidies and special workplace arrangements to enable employers to pay wages to a person with a disability, injury or health condition based on how productive they are in their job. Furthermore, there is financial assistance for employers to provide for work-related

modifications, equipment and workplace assistance to employ people with a disability, injury or health condition through an employment assistance fund.

QUESTIONS ON GENERAL EMPLOYMENT SUPPORT TO FIRMS

- *What examples are there of employers using general disability support measures (through supported wages and assistance to provide workplace modifications) to employ people with a mental illness? How could such measures be made more effective to encourage employers to employ people with a mental illness?*
 - *Are there other support measures that would be equally or more cost effective, or deliver improved outcomes?*
-

Mentally healthy workplaces

There are many actions that could potentially be taken in workplaces to improve mental health. Examples include: anti-bullying policies; improved manager and leadership training to better manage workplace changes; resilience training and stress management; promoting and supporting early help through employee assistance programs; support and training for those returning to work from a mental illness; giving workers greater flexibility and control over how, when and where their work is completed; and increasing awareness of mental illness among employees to reduce stigma and facilitate support from work colleagues.

A number of studies have estimated that such measures could deliver a net benefit not only for employees but also the businesses which implement them. For example, PWC (2014) modelled various initiatives to facilitate better mental health in Australian workplaces which it estimated would deliver an average return to employers of \$2.30 for every \$1.00 invested. Similarly, KPMG and Mental Health Australia (2018) estimated a return to Australian employers which ranged from \$1.30 to \$4.70 for every \$1.00 invested, depending on the initiative being implemented.

The aggregate gains to businesses could be significant, given that there is currently a large cost associated with mental-ill health in the workforce. Available estimates indicate that almost all of the costs borne by employers are due to people with mental-ill health being absent from work (absenteeism) or having lower productivity when at work (presenteeism). PWC (2014) estimated that absenteeism cost Australian employers \$4.7 billion annually and presenteeism a further \$6.1 billion. More recent estimates by KPMG and Mental Health Australia (2018) put these costs at \$2.6 billion and \$9.9 billion respectively. The NMHC (2014b) reported that employees with job-related stress and mental illness were absent from work for an average of almost 11 weeks a year in Australia.

The Commission welcomes comments on why employers are not investing more in workplace mental health, given the large potential benefits suggested by past modelling. It may be that the modelling does not fully reflect the:

- barriers to implementing measures to improve workplace mental health, and their cost
- factors which create uncertainty about the returns to a given employer
- limited extent to which measures which been beneficial for a small sample of businesses, or a particular type of organisation, can be applied more widely.

Small businesses could find it particularly challenging to implement measures to make their workplaces more mentally healthy, given their limited resources and smaller size over which to spread the fixed cost of any initiatives. Of interest, is the extent to which industry associations, professional groups, governments and other external parties can and should assist small, and other, businesses to reduce implementation barriers and costs.

There may also be a case to strengthen the incentives which employers face to make their workplaces more mentally healthy. For example, KPMG and Mental Health Australia (2018) recommended trialling a system to make workers' compensation insurance premiums more reflective of the mental-health risk profile of workplaces. They proposed a trial because an evidence base needs to be developed on whether there is a strong case for such a system.

While mental ill-health accounted for only 6% of all workers' compensation claims in 2014-15, they were associated with more time off work (15.3 weeks off work compared to 5.5 weeks for all claims) and higher average claim costs (\$24 500 per claim compared to \$9 000 for all claims). Moreover, the number of serious claims linked to mental ill-health in 2014-15 was similar to that recorded in 2000-01, whereas claims linked to most other causes had fallen significantly over that period. (Safe Work Australia 2018)

QUESTIONS ON MENTALLY HEALTHY WORKPLACES

- *What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?*
 - *Are employers pursuing the potential gains from increased investment in workplace mental health which have been identified in past studies? If so, which employers are doing this and how? If not, why are the potential gains not being pursued by employers?*
 - *What are some practical ways that workplaces could be more flexible for carers of people with a mental illness? What examples are there of best practice and innovation by employers?*
 - *How can workplace interventions be adapted to increase their likelihood of having a net benefit for small businesses?*
 - *What role do industry associations, professional groups, governments and other parties currently play in supporting small businesses and other employers to make their workplaces mentally healthy? What more should they do?*
 - *What differences between sectors or industries should the Commission take account of in considering the scope for employers to make their workplaces more mentally healthy?*
 - *Are existing workers' compensation schemes adequate to deal with mental health problems in the workplace? How could workers' compensation arrangements, including insurance premiums, be made more reflective of the mental-health risk profile of workplaces?*
 - *What overseas practices for supporting mental health in workplaces should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?*
-

Another factor which could influence the adoption of measures to facilitate mentally health workplaces is the regulation of workplace health and safety (WHS) by the Australian, State and Territory Governments. Such regulation sets requirements on how the wellbeing of employees is protected in workplaces. However, identifying, assessing and addressing risks to mental health in the workplace is likely to be more complex than for physical health because many of the risk factors — such as job demand and control, imbalance between effort and reward, and bullying and harassment — are not as easily identified and addressed (Harvey et al. 2014).

QUESTIONS ON REGULATION OF WORKPLACE HEALTH AND SAFETY

- *What, if any, changes do you recommend to workplace health and safety laws and regulations to improve mental health in workplaces? What evidence is there that the benefits would outweigh the costs?*
 - *What workplace characteristics increase the risk of mental ill-health among employees, and how should these risks be addressed by regulators and/or employers?*
-

4. Framework to enhance mental health and improve participation and workforce contribution

Towards coordinated care and a fully integrated system

Achieving a coordinated and integrated mental health system requires a strong policy framework and good governance. This is a responsibility shared by Commonwealth, State and Territory Governments. They have articulated their aims in the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council 2017a) as being to:

- promote the mental health and wellbeing of the Australian community and, where possible, prevent the development of mental ill-health
- reduce the impact of mental ill-health, including the effects of stigma on individuals, families and the community
- promote recovery from mental ill-health
- assure the rights of people with mental ill-health, and enable them to participate meaningfully in society.

In its review, the NMHC (2014a) recommended a system which delivers truly person-centred care, so that people with a mental illness and their carers can easily access support at the time it is needed. The NMHC also called for services for people with more severe and complex disorders to ‘wrap around the person’, cover the continuum of their needs, and be sustained and responsive to their changing needs over time. For those who needed it, different types of care would be coordinated and case managed. Underpinning this was envisaged to be a fully integrated system, with strategy, policy and funding aligned through the combined efforts of mental health consumers and governments.

The NMHC (2014a) found that people who were living with mental illness and their carers often had a poor experience of care. In part, this was because the system was fragmented and did not consider all aspects of a person’s life (that is, the ‘whole person’). Years of poor planning and service coordination had often resulted in different levels of government and different sectors of the system operating in isolation which, in turn, led to duplication, overlap and service gaps.

Key to achieving a person-centred and coordinated approach to mental health care and support is a more integrated mental health system (NMHC 2014a; Senate Select Committee on Health 2015). The Fifth Plan aims to achieve this in emphasising coordination and integration, which the COAG Health Council committed to operationalising through supporting integrated planning and service delivery at the regional level (COAG Health Council 2017a). However, these reforms are still in the early stages. Despite pockets of excellence (Mendoza et al. 2013), poor integration and coordination between health and non-health service areas remains a fundamental concern.

The policy framework, institutional arrangements, systems and processes for guiding, monitoring and evaluating public and private resources define the governance arrangements that are deployed for targeting the mental health outcomes described above. At a national level, these are expressed in the *National Mental Health Strategy*, which includes: the *National Mental Health Policy* (AHMC 1992); five *National Mental Health Plans*; and the *Mental Health Statement of Rights and Responsibilities* (Standing Council on Health 2012).

There is a wide range of both health and non-health services delivered to people living with a mental illness that are best delivered at a sub-national level. In addition to joint governance arrangements with the Commonwealth in these areas, State and Territory Governments are responsible for overseeing publicly funded services provided in their jurisdiction, including healthcare and other services that support mental health, such as schools, housing and justice.

Although good governance will not necessarily guarantee the outcomes sought by every individual who lives with a mental illness, or their carers, it goes a long way to increasing that likelihood.

QUESTIONS ON COORDINATION AND INTEGRATION

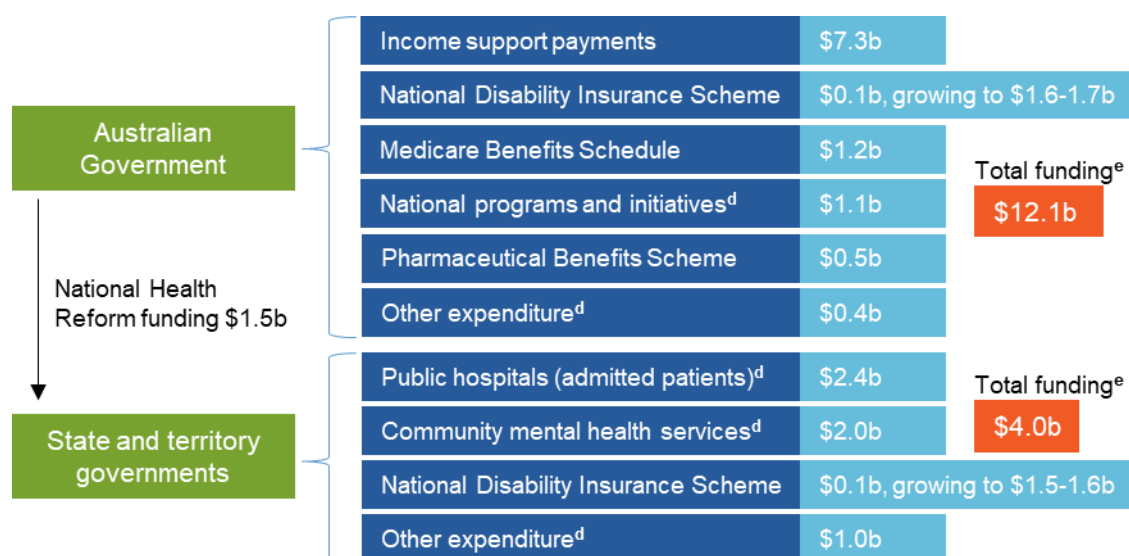
- *How effective are the governance and institutional arrangements for mental health in Australia in achieving the objectives agreed by COAG Health Council in the Fifth Plan? How can they be improved?*
 - *To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?*
 - *What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?*
 - *Is the suite of documents that comprises the National Mental Health Strategy effectively guiding mental health reform? Does it provide government and non-government stakeholders with clear and coherent policy direction? If not, what changes could be made?*
 - *Are there aspects of mental health governance where roles and responsibilities are unclear or absent? Are the mechanisms for holding government decision-makers accountable for system performance sufficiently well-defined?*
-

Funding arrangements

The costs of providing mental health services and payments are borne by governments, consumers and their families, insurers, employers and not-for-profit organisations.

In 2016-17, the Australian Government contributed at least \$12.1 billion to mental health-related services and payments, while State and Territory Governments contributed at least \$4 billion (figure 9) — an amount that has grown significantly since the early 1990s (figure 10). While both levels of government fund health services to a similar amount, the Australian Government takes sole responsibility for funding income support payments to people with mental illness-related disability and their carers. In addition, at the full rollout of the NDIS (expected in 2020), it is anticipated that governments will fund services to people with psychosocial disability in the order of \$3–3.3 billion per annum.⁸

Figure 9 Snapshot of mental health funding and expenditure^{a,b,c}
2016-17, with NDIS expenditures also projected to full rollout (expected 2020)



^a 'Other expenditure' by the Australian, State and Territory Governments is expenditure reported by AIHW (2018g) that is not listed elsewhere. ^b 'Income support payments' are Disability Support Pension, Carer Payment and Carer Allowance issued because of psychiatric/psychological disability. ^c 'Public hospitals (admitted patients)' are specialised psychiatric units or wards in public acute hospitals or public psychiatric hospitals. This understates total expenditure on admitted patients with a psychiatric diagnosis because they sometimes receive care in hospitals without a specialised psychiatric unit or ward. ^d 2015-16 figures. ^e Total funding is the total expenditure for the respective level of government with an adjustment made to account for the National Health Reform funding transfer from the Australian Government to the State and Territory Governments.

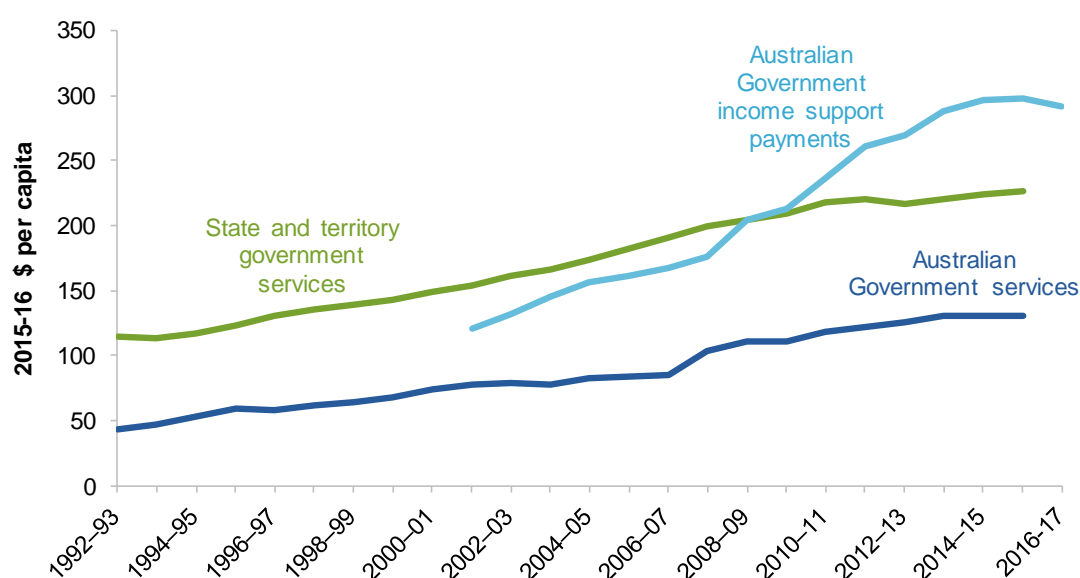
Sources: AIHW (2018g); Income support payments are Productivity Commission estimates based on data.gov.au (2016) and DSS (2017); National Disability Insurance Scheme expenditures are Productivity Commission estimates based on NDIA (2017) and PC (2017b); National Health Reform funding is a Productivity Commission estimate based on ABS (*Australian Demographic Statistics, March 2018*, Cat. no. 3101.0) and Administrator National Health Funding Pool (2017, 2018).

⁸ To some extent, this reflects a transfer of existing disability support services (figure 9) into the NDIS.

The Commonwealth and the states each fund a very different mix of services. The Commonwealth subsidises primary health services⁹ and pharmaceuticals, provides payments to the states to support their provision of public hospitals, and directly funds a wide variety of national programs across several portfolios. The states, meanwhile, primarily fund a share of community mental health services and public hospital services.

Expenditure by Australian governments on mental health services is moderate by international standards — ninth among 20 (out of 34) OECD members as a share of gross domestic product, and eighth as a share of total government health expenditure (figure 11).¹⁰

Figure 10 Mental health expenditure over time^a
Real per-capita expenditure on mental health by level of government



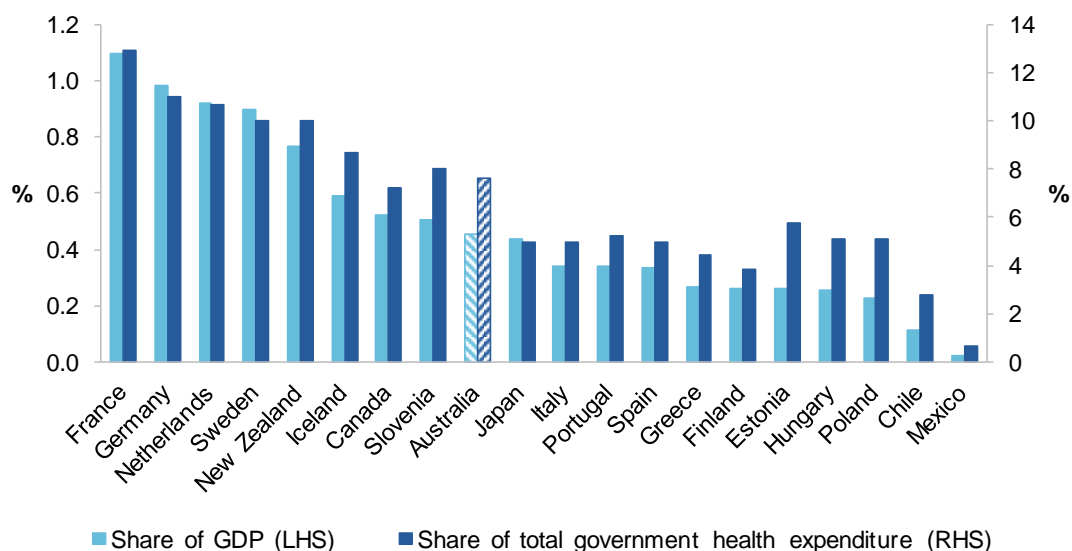
^a Expenditure is not adjusted for National Health Reform funding transfer from the Australian Government to the state and territory governments.

Source: AIHW (2018g); Australian Government income support payments are Productivity Commission estimates based on ABS (*Australian Demographic Statistics*, Mar 2018, Cat. no. 3101.0; *Consumer Price Index*, Sep 2018, Cat. no. 6401.0) and various departmental annual reports.

⁹ Figure 9 underestimates the Australian Government's contribution toward Medicare-subsidised mental health services. The estimate of \$1.2b captures only items recorded as mental health-specific services, but AIHW (2018f) indicate that over 80% of mental health-related GP encounters are not recorded as such.

¹⁰ This is based on data reported for 20 OECD members from the 34 OECD countries included in the World Health Organisation survey of 194 members.

Figure 11 Government expenditure on mental health services — international comparison
Selected OECD countries, 2011



Source: Productivity Commission estimates based on data from OECD (2018) and WHO (2013).

Consumers (and their families), carers, insurers, employers and not-for-profit organisations also bear costs of providing mental health services.

- Mental health consumers incurred expenditure of at least \$285 million (in 2016-17) on Medicare-subsidised mental health services, spent a further \$115 million (in 2015-16) on mental health services provided by state governments, and spent an estimated \$185 million (in 2010-11) on Pharmaceutical Benefits Scheme-subsidised mental health-related medications (AIHW 2018g; Medibank and Nous Group 2013b). This is in addition to expenditure on services that are not government subsidised.
- Informal carers provided an estimated \$13 billion worth of support services to people with a mental illness in 2015 (Diminic et al. 2017).
- Private health consumers contributed, through their private health insurers, about \$466 million toward mental health services provided in private hospitals in 2015-16 (AIHW 2018g).

Funding arrangements are not simply a way of paying for things — they also generate incentives for governments and service providers. This inquiry will consider if (and how) funding arrangements could:

- better incentivise service providers to deliver good outcomes
- break down silos and encourage different governments and service providers to operate in a coordinated fashion

-
- encourage governments to recognise the impacts of funding decisions on other portfolios, levels of government or over time. Of interest, for example, is whether there are sufficient incentives for investment that would yield improved mental health, even though the benefits may not be realised for some years and and/or the fiscal benefits would accrue to a different portfolio or level of government.
-

QUESTIONS ON FUNDING ARRANGEMENTS

- *What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?*
 - *Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?*
 - *How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?*
 - *Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?*
 - *How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?*
 - *What government services and payments beyond those directly targeted at mental health should this inquiry seek to quantify, and how should this be done?*
-

Measurement and reporting of outcomes

Measurement and reporting of mental health outcomes can play a pivotal role in improving supports for individuals living with mental ill-health, their families and carers. If well-designed, measurement and reporting can help hold governments to account by making information available to the public. It can also inform mental health policy and funding decisions made by government. Measurement and reporting can track mental health policy initiatives to determine if desired outcomes are being achieved or not.

At a national level, the Mental Health Information Strategy Standing Committee (MHISSC) has been established to provide expert technical advice on monitoring and reporting, including on further developing mental health data collections (AIHW 2018c).

Australia has been routinely collecting, analysing and reporting on outcomes for consumers of mental health services for over a decade, with routine outcome measurement implemented under the National Outcomes and Casemix Collection (NOCC) (Burgess, Pirkis and Coombs 2015). In Australia, when consumers present for care, clinicians are mandated to assess them using relevant clinician-rated outcome measures, and are expected to offer them self-reported outcome measures (Burgess, Pirkis and Coombs 2015). The NOCC measures

contribute to the development of clinical practice, aiming to improve the quality of care for consumers of Australia's public sector mental health services (AMHOCN 2019).

Although the NOCC provides information about consumer outcomes that can help develop clinical practice, information is also needed to track the whole-of-life outcomes (such as workforce participation and contribution) for mental health consumers and carers (NMHC 2016). Measuring the things that matter to people with lived experience provides true measures of quality, and valuable insights that help to interpret other indicators and understand how mental health services and systems are operating in practice (NMHC 2016).

The NMHC recently worked with Nous Group to develop a new framework for monitoring and reporting, which was finalised for use in October 2018. The framework sought to fill gaps in monitoring and reporting, and includes broader social factors (such as economic and social participation, justice and housing), activity in health and non-health services, and mental health and wellbeing outcomes (Nous Group 2018). The NMHC also monitors and reports on the progress of implementation of the Fifth National Mental Health and Suicide Prevention Plan.

Despite this, gaps in outcomes measurement and reporting still exist. For example, untreated mental illness in the workforce can lead to productivity losses and sickness absences, which are outcomes not measured or reported on. The indirect costs of these outcomes are estimated to be significant. Further, data challenges continue to limit the potential for monitoring and reporting such as lack of standardisation and linkage between sectors and jurisdictions (Nous Group 2018). Additional measurement and reporting could address these shortfalls, and build on recent reforms and other existing frameworks. What is also unclear is the extent to which the information that is collected is used to improve service efficiency and effectiveness.

QUESTIONS ON MONITORING AND REPORTING OUTCOMES

- *Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?*
 - *Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?*
 - *Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?*
 - *Which agency or agencies are best placed to administer measurement and reporting of outcomes?*
 - *What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?*
 - *What approaches to monitoring and reporting are implemented internationally? What can Australia learn from developments in other countries?*
 - *To what extent is currently collected information used to improve service efficiency and effectiveness?*
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Attachment A: How to make a submission or online comment

What you should and should not include

Submissions may range from a brief comment or short letter outlining your views on a particular topic to a much more substantial document covering a range of issues. Where possible, you should provide evidence, such as relevant data and documentation, to support your views.

Each submission and comment, except for any attachment supplied in confidence, will be considered for publication on the Commission's website shortly after receipt, and will, if published, remain there **indefinitely** as a public document.

We reserve the right to not publish material on the Commission's website that is offensive, potentially defamatory, would be likely to enable the identification of a third party, or is clearly out of scope for the inquiry.

Copyright

- Copyright in submissions and comments sent to the Commission resides with the author(s), not with the Commission.
- Do not send us material for which you are not the copyright owner — such as newspaper articles — you should just reference or link to this material in your submission.

In confidence material

- This is a public inquiry and, as far as possible, all submissions and comments should be provided as public documents that can be placed on the Commission's website for others to read and comment on. However, information which is of a confidential nature or which is submitted in confidence can be treated as such by the Commission, provided the cause for such treatment is shown. We may request a non-confidential summary of any confidential material that you provide.
- Material supplied in confidence should be clearly marked 'IN CONFIDENCE' and be in a separate attachment to non-confidential material.
- You are encouraged to contact us for further information and advice before submitting such material.

Privacy

- For privacy reasons, all **personal** details (e.g. home and email address, signatures, phone, mobile and fax numbers) will be removed before your submission or comment is published on the website. Please do not provide these details within the body of the submission or comment.

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- While specific examples and evidence included in submissions and comments are particularly useful to the Commission, information that is not already public that would be likely to enable the identification of a **third party individual** should be removed by the submitter.
 - You may wish to remain anonymous or use a pseudonym. Please note that if your anonymity or use of a pseudonym means that we cannot contact you about material that you have included, then we may place less weight on your submission or comment.

Technical tips

- We prefer, for accessibility reasons, to receive submissions as a Microsoft Word (.docx) files. PDF files are acceptable if produced from a Word document or similar text based software. You may wish to research the Internet on how to make your documents more accessible or for the more technical, follow advice from Web Content Accessibility Guidelines (WCAG) 2.0<<http://www.w3.org/TR/WCAG20/>>.
- Do not send password protected files.
- Track changes, editing marks, hidden text and internal links should be removed from submissions. Where links are included, please type the full web address (for example, <http://www.referred-website.com/folder/file-name.html>) to minimise linking problems.

How to lodge a submission or online comment

Submissions and online comments should be lodged using the online form on the Commission's website — this is our preferred way of receiving submissions. If, for some reason you need to lodge a submission by post, then this should be accompanied by the submission cover sheet that is available on the inquiry website.

Online* www.pc.gov.au/mental-health

Post* Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

* If you do not receive notification of receipt of your submission to the Commission, please contact Tracey Horsfall on 02 6240 3261.

Due date for initial submissions

Please send **submissions** to the Commission by Friday 5 April 2019.

Brief online comments will be accepted continuously throughout the inquiry but will be published in bulk groupings, as and when processed.