



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

MHCC ACT Submission

April 2019



mental health
community coalition ACT

Peak Body in the ACT for the Community Mental Health Sector

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About Mental Health Community Coalition ACT Inc.

The Mental Health Community Coalition of the ACT (MHCC ACT), established in 2004 as a peak agency, provides vital advocacy, representational and capacity building roles for the community-managed mental health sector in the ACT. This sector covers the range of non-government organisations that offer recovery, early intervention, prevention, health promotion and community support services for people with a mental illness.

The MHCC ACT vision is to be the voice for quality mental health services shaped by lived experience. Our purpose is to foster the capacity of ACT community managed mental health services to support people to live a meaningful and dignified life.

Our strategic goals are:

- To support providers deliver quality, sustainable, recovery-oriented services
- To represent our members and provide advice that is valued and respected
- To showcase the role of community managed services in supporting peoples' recovery
- To ensure MHCC ACT is well governed, ethical and has good employment practices.

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Introduction

MHCC ACT would like to thank the Productivity Commission for the opportunity to contribute to this important inquiry. As well as comments and suggestions in response to the Commissions Issues Paper, MHCC ACT has included a number of ‘resource suggestions’ in our submission. These are people, websites and articles which may further inform the Commission in its work, and are placed according to the relevant subject matter.

We also support the recommendations in the submission of Community Mental Health Australia (CMHA), of which we are a member.

In many cultures of the world there are no specific words for mental illness. Mental ill health is viewed as a symptom of something wrong in the community and is viewed as a community responsibility. In our own country, the *“Aboriginal concept of health is holistic, encompassing mental health and physical, cultural, and spiritual health. Land is central to well-being. This holistic concept does not merely refer to the “whole body” but in fact is steeped in the harmonised inter-relations which constitute cultural well-being. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist.”*¹

In Cambodia, *“... an antidepressant wasn’t about changing brain chemistry, an idea that seemed bizarre to their culture. It was about the community, together, empowering the depressed person to change his life.”*²

Western culture, however, largely views mental illness within a clinical, medical and individualistic prism quite separate from community, culture and environment. A huge industry has developed from this perspective, focussed heavily on medications which are not always backed by the evidence commonly assumed.³ Many people seek the ‘quick fix’ expected to come from medication. They fail to go beyond that to view people’s life and their illness from a more holistic perspective.

¹ “Ways Forward” sited on 4 April 2019 at http://library.bsl.org.au/jspui/bitstream/123456789/353/1/Ways%20forward_vol.1%20%26%20%20_1995.pdf

² Johann Hari, 2018, “Lost Connections” p.160

³ Ibid, “Part I: The crack in the old story”

As the ACT peak body for Not-for-Profit (NFP) community based mental health services, we represent the views of organisations which understand the importance of community connection, in all its different manifestations, to people's mental health and recovery from mental illness. They also understand the importance of a whole of person approach, and that people need to have choice and control in their recovery from mental illness – best encapsulated in the expression “nothing about us without us”.

This Productivity Commission Inquiry into the social and economic benefits of mental health is important as it provides an opportunity to show the benefits to everyone of positive mental health across our population – and the costs of doing nothing. In this way it also provides an opportunity to increase understanding and acceptance that positive mental health is a community responsibility – we all own it and we all need to take action to value and support it. We have a lot to learn from the Aboriginal, Cambodian and other cultural approaches to mental illness, recovery and positive mental health.

We are “stronger together” – in this case, strength drawn from different approaches and taking community wide ownership, for population mental health. In reflection of this it is important that a whole of government – jurisdictions and portfolios – commitment is made to the mental health and wellbeing of all people, in all their roles in life. As far back as 2008, Australia's national mental health policy aspired to *“a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable participation fully in the community.”*⁴

As noted in the Productivity Commission Issues Paper for this inquiry, and as examined in the publication *“Obsessive Hope Disorder”*⁵, there have been dozens of inquiries, reports, plans, policies and strategies around mental illness and mental health and wellbeing. Since the release of that publication in 2013 there have been more, including the review of services by the National Mental Health Commission (NMHC) in 2014, the introduction of Primary Healthcare Networks in 2015 (PHN), the gradual introduction of the National Disability Insurance Scheme (NDIS) from 2014, and several inquiries into aspects of the NDIS.

While improvements have been made there are still too many issues remaining and too many people falling through the gaps and missing out on the opportunity to recover from mental

⁴ Commonwealth of Australia (2009a). National Mental Health Policy 2008. Canberra: Department of Health and Ageing.

⁵ John Mendoza et al (2013), “Obsessive Hope Disorder: Reflections on 30 years of mental health reform and visions for the future. Summary report”

illness and live a meaningful life. Worse still some of these gaps have resulted from reform initiatives such as, for example, the NDIS. Furthermore, we are still not doing enough early intervention and prevention so that people do not become sick in the first place, or do not become so unwell that they need hospital admission.

This raises important questions – is Australia, as a nation, really prepared to make the necessary economic and social investments to ensure the best mental health and wellbeing of its population? Do we really understand how much it is costing us and how much we are losing by not doing so? Conversely, do we appreciate how we would all gain if we did make these changes?

Issues

A. Inquiry Scope

MHCC ACT commends the board scope of this inquiry to include the social and economic determinants of mental health and wellbeing. The sector we represent has long argued the importance of a more holistic, community based, recovery-oriented approach to mental health: *“It is possible for people to recover from mental illness with access to the right mix of medical, psychosocial rehabilitation and support services. Most experts now agree that mental health services are optimally delivered in community settings and address more than just symptoms of illness.*

... As with general health care, optimal service access and health and social outcomes for people affected by mental illness need a ‘continuum of care’ — a variety of flexible options that meet diverse needs and make the best use of resources. To illustrate this, the World Health Organisation (WHO) has created a ‘Service Organisation Pyramid for an Optimal Mix of Services for Mental Health’.

The WHO model works on the premise that no single type of service can meet an entire population’s mental health needs. The various levels of care work in partnership — with support, supervision, collaboration, information sharing, and education taking place throughout the system. The model also promotes the involvement of people with lived experience of mental illness in their own recovery and that self-care continues at all levels, which in turn promotes and encourages recovery and better mental health.”⁶

Given the strong economic and productivity focus of the Commissions work, we urge the Commission to not lose site of the fundamental importance of the inclusion of the social aspects in this inquiry.

Specific comments on scope

⁶ Community Mental Health Australia (CMHA: 2012). Taking Our Place — Community Mental Health Australia: Working together to improve mental health in the community. Sydney: CMHA.

1. The scope of the inquiry as described in the Issues Paper is very broad. It is easy to understand why, given that positive mental health is important for everyone, and mental illness does not discriminate in who it strikes. As stated by the World Health Organisation “*At a purely conceptual level, a solid case can be made for investing in mental health, whether on the grounds of enhancing individual and population health and well-being, reducing social inequalities, protecting human rights, or improving economic efficiency.*”⁷ MHCC ACT, like others making submissions, will point to areas we see as important. However, we understand that the Commission will need to decide on a scope which enables the best possible outcomes.

RESOURCE SUGGESTION: Interview Professor Luis Salvador-Carulla, MD, PhD
Centre Head, Professor CMHR, ANU College of Health and Medicine
E: luis.salvador-carulla@anu.edu.au
T: +61 2 6125 2741
<https://researchers.anu.edu.au/researchers/salvador-carulla-l>

2. We strongly support the emphasis on early intervention and prevention on page four of the Issues Paper. The quote included from Mudler, Rucklidge and Wilkinsone 2017, accurately sums up the importance of this. This is also consistent with the findings of the National Mental Health Commission in which it “*proposes reallocating funding from downstream to upstream services, including prevention and early intervention.*”⁸

We remind those undertaking the Inquiry that in mental health, early intervention and prevention refers not only to early in life, but also in first onset of illness and in repeat episodes of illness.

3. While the Commission and other government and non-government organisations have already reviewed aspects of the NDIS, it is very important that this inquiry pay close attention to the findings and recommendations from these processes. Where it is working well the NDIS has been life changing. However, the operational framework and implementation of the NDIS as it applies to psychosocial disability has been far from ideal, is responsible for leaving many people without adequate services and supports, and has led to instability in the provision of quality services.

⁷ World Health Organisation, 2013, “Investing in mental health: evidence for action”, p.13, Geneva

⁸ National Mental Health Commission, 2014, “National review of mental health programmes and services, Summary” p.5

The lack of adequate funding for transport is an area of growing concern. People with disability, even with generous NDIS packages, are often left in a position of not being able to access the services and supports they need. Furthermore, it is impacting the ability of Service Providers to engage in assertive outreach as they are unable to afford to keep vehicles previously used for such.

What must also be considered is the ramifications from the NDIS on the rest of the mental health service and support environment. Gaps have opened as funding for services such as Personal Helpers and Mentors (PHaMs) and Partners in Recovery (PIR) has been moved into the NDIS regardless of whether people are found eligible or have access to an equivalent type of support. Many other services have been withdrawn as they are not viable under the NDIS. In particular, many group-based activities and spaces have closed in the ACT. These have been (and are) important in providing a safe place for social connection, soft outreach and support.

An important ramification which we are experiencing in the ACT but is not fully grasped in other jurisdictions who are newer to the NDIS, is on the workforce. Put simply, the most qualified and experienced workers are moving out of NDIS services and into other areas where they are better paid and spend more time working directly with clients, using their skill set to achieve recovery outcomes. The NDIS is intended to support the ten percent of people with the most complex, severe and enduring disability. However, in many cases services can only afford to employ people with a lower level of qualification and expertise to provide NDIS services. We are starting to refer to this as the '90/10 paradox'.

4. MHCC ACT on behalf of its member organisations has some concerns about the scope of the inquiry as defined on page five of the Issues Paper. The description of the scope of the inquiry is difficult to comprehend as it contains several internal contradictions between what is in/out of scope, population groups and issues to be focussed on, and where the biggest gains can be made (see next point).

MHCC ACT regards the second paragraph on page five as crucial as it highlights the importance of focussing on the functional impact of mental ill health rather than the diagnosis: *"A person without a diagnosed 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.”

5. Contrary to Table 1 in the Issues Paper, MHCC ACT and its stakeholders believe this Inquiry MUST include (a) substance use disorders, and must put equal focus on (b) people with more complex and severe mental health issues

In any case it would be limiting to focus only on anxiety and depressive disorders. Most diagnosed disorders have ranges in severity, and experience living with these illnesses varies between people (we refer again to the paragraph on page 5 already quoted). Even the efficacy of making a diagnosis and robustness of diagnostic criteria is still debated. Most people want to live a contributing life, they want the dignity of independence, control and security gained from paid work and other forms of community integration; they want friendships and family life.

Focussing on where the *‘largest potential improvements in population health, participation and contribution over the long term’* (p.5) might be gained is understandable. But defining this in the way proposed in the Issues Paper is problematic. Excluding people with substance use disorders and paying less attention to people with more complex and severe mental health issues is to overlook groups in which many lives are lost or not lived to their potential because of a lack of adequate services, resourcing and policies. Too often they are put in the ‘too hard basket’, viewed as hopeless, shuffled between services without ever being properly supported, and subsequently end up homeless, destitute or worse.

People making up these two groups can recover and can have a future. Our society needs to understand the costs of inaction and the benefits of positive change. We need to collectively commit to invest in making recovery and a meaningful life a reality for anyone who experiences mental ill health, regardless of the complexities. As the peak organisation for NFP community based mental health services in the ACT, MHCC ACT can point to many people who have recovered, and are now active in, and contributing to the community, given the right mix of supports and services.

The meaning of focussing on where the '*largest potential improvements in population health, participation and contribution over the long term*' and how this defines the scope of the Inquiry, is open to interpretation:

- a. Where does mild to moderate mental illness end and more severe and complex illness begin? How will this be defined without causing confusion?
- b. People with mental illness are not static – individuals can move across the spectrum from mild to severe and complex mental illness, and back again
- c. What is the cost of excluding people with more complex and severe mental illness and people with substance use disorders? An improvement in the social and economic participation of this group of people would lead to reduced budgetary pressures on our health and social services systems in the longer term, as well as gains from increased economic and community engagement.
- d. There is strong and growing evidence for the important role of peer workers⁹ – many of these people come from an experience of severe mental illness and substance abuse. They are living proof that recovery is possible, and they have a powerful role to play in supporting other people to recover.
- e. To exclude these two groups implies that they are too hard and/or cannot recover. This is untrue. It is well documented that many of these people can recover and can lead contributing lives. It is also well documented the sort of investments and systemic changes that need to occur in order for this to happen (see below).
- f. Given the relatively low base we start from, could it be argued that it is indeed these population groups where the largest social and economic gains might actually be achieved over time?

Overlooking the aforementioned population groups would be to ignore two of the most complex, vulnerable and under-served groups in society. It would:

- a. compromise the ability of the Commission to adequately investigate the type of issues and measures raised in sections three and four of the Issues Paper.
- b. be a lost opportunity to highlight the considerable social and economic benefits of properly supporting these people; and thereby provide justification for the necessary investment in the costly specialised treatment and support required.

⁹ State of New South Wales, 2016 'Employers guide to implementing a peer workforce', pp 22-28, sited on 5 April at <http://peerworkhub.com.au/wp-content/uploads/2016/05/Business-Case.pdf>

- c. be a lost opportunity to demonstrates the substantial benefits to individuals and society from greater investment in early intervention and prevention in mental health and wellbeing from a holistic perspective.

“Mental illnesses are the leading causes of the non-fatal disease burden and account for about 13 per cent pf Australia’s total burden of disease. This means that of the non-fatal disease burden (ie. years lost through illness and disease) in Australia, 24 per cent were lost through the effects of mental illness. Anxiety and depression, alcohol abuse and personality disorders accounted for almost three-quarters of this burden.”

National Mental Health Commission 2014, “National Review of Mental health Programmes and Services – Summary”, p.8

For these reasons MHCC ACT and its stakeholders would view the omission of these two groups as compromising the integrity of the process and potential outcomes of the Inquiry.

Complex and severe mental health issues

People with complex and severe mental health issues are typically underserved¹⁰. It is also important to note that many of these people will not or cannot access the NDIS. In one study it is estimated “that 91% of people with a severe mental illness ... will have to rely on non-NDIS community mental health services to meet their needs.”¹¹ The same report also confirms that many people with psychosocial disability are not testing their eligibility for the NDIS.

Substance use disorders

Many people with substance use disorders have a range of mental health problems at higher rates than the general community. Estimates on the scale of dual diagnosis in Australia vary¹², but include:

¹⁰ Refer to the ‘Atlas of Mental Health Care’ available on the Research School of Population Health, ANU, website, sited 16 April 2019 at <https://rsph.anu.edu.au/research/projects/atlas-mental-health-care>

¹¹ Smith-Merry, J, N. Hancock, A. Bresnan, I. Yen, J. Gilroy, G. Llewellyn (2018) “Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Final Report: Stakeholder identified gaps and solutions” pp.8-9, University of Sydney: Lidcombe

¹² Victoria State Government, Better Health Channel, “Substance abuse and mental illness – dual diagnosis”, sited on 5 April 2019 at <https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/substance-abuse-and-mental-illness-dual-diagnosis>

- a. About 25 per cent of people with anxiety disorders, affective disorders and substance use disorders also have another mental disorder.
- b. Around 64 per cent of psychiatric in-patients may have a current or previous drug use problem.
- c. Around 75 per cent of people with alcohol and substance use problems may have a mental illness.
- d. About 90 per cent of males with schizophrenia may have a substance use problem.

Despite research that “*suggests that people with a dual diagnosis respond well to integrated programs that address both their mental illness and their substance abuse*”¹³, many services will not or cannot treat people concurrently for mental health and substance use disorders. Again and again it is reported that services refuse to treat both at once – this leaves individuals in a ‘chicken and egg’ conundrum. On the other hand, where people have been lucky enough to find the right mix of support, their lives have been transformed and they are able to live contributing lives in the community.

6. While not questioning suicide prevention as a priority issue (p.5) we do question its inclusion in this particular list as it is a policy and set of measures and programs rather than a subsection of the population. Indeed, most of the population groups at risk of suicide will already be covered in the other dot points in this list. The trend in suicide rates can be an important indicator of the mental health and wellbeing in a population, and the success or otherwise of a broad range of policies and programs.

RESOURCE SUGGESTION: Examine the sites, including the ACT, where the Black Dog Institute Life Span suicide prevention model is being implemented.

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

Inquiry process and consultation

7. MHCC ACT commends the Commission on its undertaking to conduct a wide ranging consultation for this inquiry. To facilitate this, we encourage the Commission to use a range of methods to facilitate participation from people who have limited or no access

¹³ Ibid.

to information technology, need the assistance of interpreters, are sight impaired, have cultural requirements, etc. Libraries offer a useful conduit for consultation. Websites and writing are not enough on their own.

8. We also urge the Commission to give as much lead time for deadlines, and transparency around timelines and methods as possible.

B. Assessment approach

MHCC ACT is reasonably comfortable with the Assessment Approach proposed by the Commission in the Issues Paper, while noting our recommendations on the scope of the Inquiry.

However, value could be added to the approach proposed by also looking at the benefits of the presence of the factors driving positive mental health across the population. It would also be beneficial to define what a mentally healthy population looks like, and what are the checks and balances in place that value and protect mental health and wellbeing, and to stop people sliding into mental illness. For example, a differentiation is made between grief and depression – but what do we or could we do, as a society, to prevent grief precipitating depression? Similarly – what do we do to heal trauma and prevent that from becoming serious mental illness and an intergenerational issue?

1. In terms of other costs to be taken account of (p.8) we make the following suggestions:
 - a. Collecting taxes to redistribute wealth and provide services that the private sector might not otherwise do is an important tenet of the democracy we live in. The question here (figure 4, middle column, 3rd row, p.8) should be more in terms of the amount of taxes that might in theory be needed to be collected and/or the diversion of tax revenue away from other more productive investments such as education and training. The distorting effects referenced in the box flow from this.
 - b. Intergenerational trauma and flow on/longer term impacts should be included in the column 'Intangible Costs' (figure 4, p.8). Mental illness has an impact on the carers - the families and children who live with and care for the person with mental illness: "*Children of parents with a mental illness are at a greater risk of experiencing a range of behavioural, education, social and developmental*

challenges, as well as a higher risk of experiencing their own mental health difficulties.”¹⁴

- c. As well as looking at how positive mental health interventions can generate net financial returns to the investor (p.10, para 6), the return to investment at a societal level on assisting people who already have mental illness to gain, and be supported to keep, meaningful employment should be examined. Smaller organisations/businesses are likely to need more tax payer funded support to enable them to do this.

C. Contributing components to improving mental health and wellbeing

The Commission raises many important questions in this part of the Issues Paper – too many for MHCC ACT to do justice to.

There is a certain degree of overlap between this part of the paper and final part of the paper. As noted earlier, many of the issues raised have been examined in other reports and studies.

Following are the comments we do have.

1. NFP community based mental health services should be given more consideration by the Commission in the list under healthcare on page 11. To some extent this is covered in the second dot point. However, in the ACT as in other jurisdictions, there are both government managed and NFP (but government funded) managed entities working in this space. The roles they play are complementary but distinctly different.

The discussion in the Issues Paper does not appear to recognise the distinction between these two types of community-based care.¹⁵ This is important because the holistic recovery focussed work of the NFP organisations is effective in keeping people well, reintegrating them with their community and reducing demand on the more expensive clinical services managed by governments.

¹⁴ Sited on 17 April at <http://www.copmi.net.au/professionals-organisations/how-can-i-help/why-copmi>

¹⁵ Refer to Community Mental Health Australia website for more information: <https://cmha.org.au/>; also the submission by CMHA to this Inquiry.

2. MHCC ACT can point to many reasons for the limited efficacy of reforms by governments in mental health (questions on p.13). Following are some of the more important ones:
- a. Although a more bipartisan approach is developing around mental health, political imperative often trumps solid effective reform – particularly in relation to cherry picking recommendations and rushing processes for quick outcomes.
 - b. Partial implementation of recommendations: cherry picking/ scatter gun approach to recommendations from past reports and reviews leading to skewed results, fragmentation, gaps in service, and poor outcomes (eg. government response to recommendations of the NMHC 2014 review into mental health services)
 - c. Incomplete reform – addressing part of an issue (eg. deinstitutionalisation)
 - d. Inadequate funding to achieve quality outcomes (eg. NDIS)
 - e. Lack of expertise in implementation of change and transition: often rushed with little consideration/understanding of unintended consequences or processes and costs involved in making reform a reality on the ground. Need for investment in government employee training in this area (eg. implementation process for the NDIS). Often money is spent on consultants' reports when it might be better spent by allocating directly to organisations impacted by the reform to assist them to make the changes while minimising impact on service users.
 - f. Wholesale change made (perhaps because it's easier than identifying and remediating the actual issue?) resulting in proven effective programs and policies being lost – ‘throwing the baby out with the bathwater’ (eg. folding the funding for PHaMs, PIR and D2DL into the NDIS without provision of equivalent support for the same group of people)
 - g. Still an overly clinical and medicalised view of mental illness and its treatment – despite the evidence behind the efficacy and cost effectiveness of a stronger focus on early intervention and prevention; and a more holistic, social and economic determinants of health and wellbeing approach (eg. quick government dismissal of recommendation from NMHC 2014 review into mental health services for a gradual movement of growth funding from clinical/downstream services to upstream/early intervention and prevention services)
 - h. Lack of a comprehensive national guiding framework and certainty of direction around mental health policy in Australia – including targets, investment,

evaluation, outcomes, transparency and accountability. The National Mental Health and Suicide Prevention Plans go some way to addressing this

- i. Lack of clarity and effective mechanisms to manage grey areas of definition and funding between health and disability government services behind the scenes – instead often leaving consumers stuck with no support/service
- j. A fragmented approach to mental health policy and funding leading to a fragmented system which is difficult to navigate and full of artificial boundaries and gaps; this is made worse by the different responsibilities of different levels of government.
- k. Short term funding which often ends just as people are gaining confidence in a service/program and before outcomes can be properly understood. Often this is accompanied by unreasonable uncertainty about extension of funding which results in loss of experienced staff, and anxiety amongst service users.
- l. Lack of a national data collection framework, and thus a publicly accessible data set, to measure real outcomes and guide future analysis, design of policy reform and new programs - which would ultimately result in better value for tax payers.
- m. Stigma and subconscious bias shaping approach to mental illness – fear of people just pretending and ‘ripping off’ the system leads to unnecessary red tape and restrictions in design of policies, programs and services.
- n. Lack of solid understanding and acceptance of the real prevalence of mental illness in our population and the true costs of effectively supporting people to recover. This leads to service gaps, underfunding of programs and an overreliance on ‘informal supports’ (often carers, with significant impact on their own ability to live what could be viewed as a ‘normal’, meaningful contributing life).
- o. Lack of a true partnership approach from government with service providers, consumers and carers which values the range of expertise, experience and perspectives they bring. Not doing so is often blamed on ‘vested interests’. This results in an ‘us and them’ type scenario, and the sense of things being done to people rather than with them. A partnership approach leads to better outcomes and helps avoid costly mistakes (eg. NDIS trials sites were not funded for transparent baseline data analysis before implementation, nor transparent analysis of learnings from the trial sites; many costly mistakes made during national rollout may have been avoided if the experience of test sites had been more closely heeded).

- p. A 'them and us' attitude also often exists between consumers and carers on the one side and service providers on the other. While there is always room for improvement, there is also much to be gained in focusing on common ground and developing frameworks which ensure providers have the capacity to deliver best practice quality services informed by lived experience.
- q. Lack of widespread understanding of the impact of trauma on population health and wellbeing, particularly intergenerational trauma. There is need for investment in broad population understanding of trauma, training in trauma informed care across health and non-health services, and provision of treatment for trauma.
- r. Inherent conflicts and tensions in government policy and approaches. Some examples include:
 - i. Objective of (1) consumers having choice and control and (2) organisations operating in a more competitive environment, but tendering for services with a requirement for no duplication
 - ii. Often questionable interpretation of 'conflict of interest' and the impact this has on ability of government to be well informed
 - iii. use of privacy restrictions (which certainly have their place) and how this impacts collaboration, client and staff safety, and efficiency
 - iv. seeking to implement best practice services but unrealistic squeezing of timelines and funding for tender development, response, assessment and implementation of said services; also aversion to innovation and risk taking
 - v. wanting NFP service provision organisations to behave more like competitive businesses but not providing adequate information or resources to build a business case and placing undue restrictions on pricing and of what can and cant be done, rather than a focus on outcomes, accountability and sustainability
 - vi. encouraging collaboration and competition at the same time
 - vii. Taking a 'one hat fits all' view and not allowing for flexibility and a truly whole of person and whole of life approach
 - viii. Conflict between improving mental health and wellbeing on the one hand, and the push for ever increasing levels of productivity and consumption, and greater levels of income inequality, on the other.

Specific health concerns

3. MHCC ACT would like to see a focus on a range of issues under the topic of population wide health promotion (p.14):
 - a. stigma reduction
 - b. dispelling of myths about mental illness
 - c. upskilling the population about how to engage with someone with mental illness to support them
 - d. upskilling the population about how to ask for help if you have mental illness

RESOURCE SUGGESTION: Interview Mental Illness Education ACT (MIEACT) – providing a range of mental health promotion programs using the voice of lived experience in the ACT for more than 25 years. Go to www.mieact.org.au. EO: Heidi Prouse. T: 02 6257 1195

4. As previously noted, the definition of comorbidities should be broadened to include substance abuse.

In relation to co-occurring conditions another suggestion would to increase the availability of longer appointments with GPs for people with co-occurring conditions. The time allowed for standard consultations is inadequate to manage several conditions. Currently long appointments are expensive and difficult to obtain.

RESOURCE SUGGESTION: Read “*Finding the Path: Service access and navigation for serious mental illness in Australia. Recommendations from a Thought Leaders’ Forum*” – Michelle Banfield and Michael Cole
Centre for Mental Health Research, Research School of Population Health, ANU
<https://researchers.anu.edu.au/researchers/banfield-ma>
T: 02 6125 6547

RESOURCE SUGGESTION: Consider “Social prescribing”
<https://www.abc.net.au/radionational/programs/lifematters/social-prescribing/10944140>

Health workforce and informal carers

5. We commend the Commission’s recognition of the important role of peer workers (p.17). There is a need to develop this further in Australia and for it to be regarded as a profession - and not just a source of cheap staff. There is work being done around Australia on peer workers to try and increase their employment and ensure best practice working conditions, in a wide range of organisations.

RESOURCE SUGGESTIONS: (1) Read ‘*Peer Work in Australia - A new future for mental health*’ – Edited by J Meagher et al, Sydney: RichmondPRA and Mind Australia - <https://www.flourishaustralia.org.au/peer-work-australia>
(2) Explore the Peer Work Hub - <http://peerworkhub.com.au/the-case-for-peer-work/peer-work-in-australia/>

6. The downward pressure on wages in community mental health services since the introduction of the NDIS should not be underestimated by the Commission in addressing the questions posed on page 17 of the Issues Paper. In the ACT we are seeing the emergence of a market where the least qualified and lower paid workers are employed in NDIS services, while more qualified and highly paid workers are employed in non NDIS services. This is concerning given that the NDIS is for people with the most severe and enduring disability.

People working in mental health support services need specialist skills if they are to work in a trauma informed recovery oriented framework (which best practice supports), particularly when mental illness is complex and severe. In the ACT a collaboration between the ACT Government and the community sector before the advent of the NDIS saw the average qualifications of people employed in NFP community mental health services increased to a Certificate Level 4, and often higher. Employers spoke openly about the ability to choose from well qualified applicants for job openings for the first time.

Since the NDIS, this achievement has been eroded as organisations are no longer funded to hire such qualified staff, and many of the best qualified staff have moved to other better paying positions, and positions where they can work more directly with clients. The instability in the market has also led to increasing casualisation of the workforce and associated job insecurity. This has also led to people leaving the sector.

In answer to the questions raised it would be interesting for the Commission to test the hypothesis of what would happen if organisations were funded to (1) pay higher wages so as to attract more highly qualified staff, and (2) were funded to employ adequate numbers of staff to deliver the specialised work required in this sector.

7. Informal carers make a significant contribution to the Australian economy¹⁶, often at great personal cost. The NDIS has left many of these people in a worse position. Carers need more respite care and more support for their own mental health and wellbeing. They will always be the primary caregiver for their loved ones – they should be supported in this so that they too can participate in and contribute to family, social and community life.
8. Another casualty from the NDIS is the ability for service providers to engage in assertive outreach. This leaves many people without the ability to connect with support.

Even when it comes to depression and anxiety it can be difficult for people to leave their homes to access services. Consideration should be given to the cost and benefits of reaching out to people with mental ill health in their homes and delivering services

¹⁶ Deloitte Access Economics, The economic value of informal care in Australia in 2015, Carers Australia, June 2015 sited on 17 April 2019 at <https://www.carersaustralia.com.au/storage/access-economics-report-2015.pdf>

to them there – even people with mild to moderate mental illness could benefit from this. It could aid in early intervention and prevention efforts.

Housing, income support and social services

9. As well as the well documented need for a greater investment in a variety of models of public housing by all levels of government¹⁷, once again the issues here highlight the importance of investment in prevention and early intervention, as well as a whole of life, holistic approach. Safe secure housing/accommodation is essential for a person to be able to recover from mental illness and build positive wellbeing. It is the launching pad for nearly everything else in life. But too often people are required to be ‘housing ready’ before accommodation is made available. This inevitably leads to a worsening of their condition and circumstances. It would be preferable for services to wrap around a person to support them into accommodation and help them maintain housing security – through appropriate supports and skills development.

RESOURCE SUGGESTIONS: Investigate the Housing First Model.
<https://www.ahuri.edu.au/policy/ahuri-briefs/what-is-the-housing-first-model>

Income support

10. Not only is it difficult for a person with mental illness to access income support due to the access requirements, it is clear from the Issues Paper that people needing to rely on these payments are left in a very precarious financial situation. Mental illness does not discriminate according to class, education or work experience.

MHCC ACT commends the Commission’s intention to examine a better way of meeting the needs of people whose working lives are impacted by mental illness (p.20). In doing so we urge the Commission to be mindful that a nuanced approach might be necessary – perhaps a combination of some work and some income support. The episodic nature of mental illness – from mild to severe – is indeed a particular challenge that needs to be better catered for. The notion of supporting people’s efforts to work and supporting employers of people with mental illness is supported. As previously noted, most people would like to work if possible.

¹⁷ <https://www.acoss.org.au/housing-homelessness/>

Psychosocial disability support services

11. The questions posed on page 21 of the Issues Paper are fundamental. They also reinforce the importance of keeping focus on the more severe end of mental illness, as well as the inclusion of substance use disorders, in the scope of this Inquiry. As noted in the Issues Paper, much has recently been examined in relation to these questions and in many cases the responses to subsequent recommendations are only just starting to emerge, making it difficult to gauge yet what the impact will be.

CMHA and University of Sydney have been doing useful work in the area of gaps in service and the NDIS – see following Resource Suggestion.

RESOURCE SUGGESTIONS: Read and interview authors (1) ‘*Tracking transitions of people from PIR, PHaMs and D2DL into the NDIS Commonwealth Mental Health Programs Monitoring Project – Interim Report, Phase 2, April 2019*’ CMHA and Sydney University <https://waamh.org.au/assets/documents/media-releases/media-release-national-report-exposes-more-holes-in-ndis-transition-16.4.19-.pdf>

(2) “*Mind the Gap: The National Disability Insurance Scheme and psychosocial disability. Final Report: Stakeholder identified gaps and solutions*” Smith-Merry, J, N. Hancock, A. Bresnan, I. Yen, J. Gilroy, G. Llewellyn (2018) pp.8-9, University of Sydney: Lidcombe

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12. In the ACT the following new programs have been very recently introduced:
- a. Contracts have been awarded by the Capital Health Network for the National Psychosocial Support Measure to Woden Community Service and Flourish Australia
 - b. The ACT Government Office for Disability has introduced the Integrated Service Response Program¹⁸ to provide short term coordination support for people with severe and complex mental illness
 - c. The Capital Health Network is yet to award contracts for the provision of the Continuity of Support programs.

¹⁸ See https://www.communityservices.act.gov.au/disability_act/integrated-service-response-program

13. As a generalisation, professional cultural barriers often prevent better integration between clinical and non-clinical mental health services. MHCC ACT is currently working with stakeholder sand the ACT government exploring the concept of joint recovery plans and the use of an existing collaborative engagement forum as ways of helping to overcome these barriers. Such improvement requires all professionals to recognise the unique and complementary roles they play in supporting a person's recovery from mental illness

Social participation and inclusion

14. MHCC ACT refers to earlier parts of our submission for the important role of NFP community mental health services; mental health promotion and stigma reduction; also to our opening statements about the importance of connection into all parts of life.

RESOURCE SUGGESTION: Read 'Lost Connections' by Johann Hari
<https://thelostconnections.com/>

15. Sadly, one of the unintended consequences of the NDIS in the ACT is the disappearance of many group programs and community spaces for people with mental ill health.

Justice and child protection

16. While these two issues overlap we recommend that children and mental health be investigated as a separate entity. If we can get the mental health of young people right it will go a long way to contributing to population wide mental health and wellbeing in the future. Child safety and wellbeing is a much broader issue than the justice system.

As already noted, childhood trauma can lead to intergenerational trauma and its associated issues, if left untreated.

17. Recidivism rates should be regarded as an indicator of the success or otherwise of our justice system and the structure and priorities of our society. It is a travesty if people leave prison only to reoffend again and with worse mental health and wellbeing than when they entered the justice system. 'Doing time' is punishment enough. The system

should be grounded squarely on rehabilitation and reform, and resourced and staffed accordingly.

Some programs of note in the ACT include:

- a. Menslink¹⁹ - a program designed to support boys and young men
- b. DECO²⁰ - the Detention Exit Community Outreach program run by Wellways and Karralika
- c. Everyman Australia²¹ - supports men at risk of homelessness, living with mental health issues and disabilities, perpetrators or survivors of violence, ex-prisoners, socially isolated, or having relationship or parenting difficulties
- d. Prisoners Aid ACT²² - supports prisoners and their families
- e. Throughcare²³ – supporting prisoners post release

Skills acquisition, employment and healthy workplaces

18. Schools need properly qualified mental health professionals (psychologists, social workers and mental health nurses) to work with students and their families. Teachers need more education and support in identifying and supporting students with mental health issues – but they should not be expected to take the place of a mental health professional.

Innovative solutions need to be found to offer the services of mental health professionals to very small and independent schools in urban areas, students who are home schooled/distance educated, and students of regional and remote schools.

19. It would be interesting to understand (1) the rate of uptake, (2) the knowledge around the availability of, and (3) the ease or otherwise of accessing, the assistance discussed in the last paragraph on p.27 in relation to mental health.

¹⁹ See <https://menslink.org.au/>

²⁰ See <https://www.wellways.org/our-services/detention-exit-community-outreach-program>

²¹ See <https://www.everyman.org.au/>

²² See <http://www.paact.org.au/index.php>

²³ See

https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/rattenbury/2017/post-release-care-program-reduces-re-offending-rates

In relation to mentally healthy workplaces, the costs associated with absenteeism are raised in several parts of the Issues Paper. This suggests that perhaps one area to explore is assistance with additional leave and/or more flexibility in terms of work hours/part time work/work from home type arrangements.

Also, some mental health issues can be caused by workplaces while others have nothing to do with the workplace – what can employers do and how can they be assisted to support staff when mental ill health is nothing to do with the workplace? Certain life events can make it very difficult for a person to maintain their mental health and wellbeing, let alone their workplace performance and reputation. There is also the impact on their co-workers, and the sort of stigma and misunderstandings that this can lead to.

In terms of the lack of investment given the potential benefits (p. 29, first paragraph), there is still a lot of stigma, misinformation and suspicion, and lack of skills in this area – at all levels of management and all types of staff. There is also the inherent conflict between workforce productivity/profits/ dividends and what might be seen by some as measures that undermine these things in terms of a mentally healthy workforce.

20. It is important for the Commission to examine the barriers to people already living with mental health issues – from mild to severe – in gaining meaningful employment. The application and interview process can be a huge barrier for people with anxiety type disorders; to disclose pre-existing mental illness (or that you care for someone with a mental illness) in many cases is to almost guarantee you don't make it to a short list. All this even though the person might be highly qualified and highly experienced in the area they are seeking employment.

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

MHCC ACT commends the Commission in highlighting the aims and recommendations included in the section '*Towards coordinated care and a fully integrated system*' (p.31). A whole of person, whole of life approach is crucial – people are more than economic widgets and need to be able to live life and contribute to, and participate in, life, in a variety of different ways. Workforce contribution is just one (albeit important) part of this, and for some people

their contribution may be different (eg. Caring, Volunteering, maintaining their mental health and wellbeing).

Many of the questions raised in this final section of the Issues paper have already been answered earlier in the MHCC ACT submission. Following are additional comments.

1. Despite the rise in governments' expenditure related to mental health in recent years, and as noted in the issues paper (p.34, second paragraph), it is still moderate by international standards and in relation to the total burden of disease. Additional investment is needed. In NFP Community Mental health services, organisations need to be able to offer salaries that attract the right set of qualifications and experience to work in a trauma informed and recovery-oriented framework.
2. The changes following the introduction of the NDIS have produced a state of flux and market instability across the mental health sector - ie. it is broader than just NDIS services and participants. As many jurisdictions are only just beginning their implementation of the NDIS, the nation-wide impacts of the NDIS will not be known for some time. It is important therefore that:
 - a. Transparent monitoring and reporting of the broad impacts and changes continues for some years to come
 - b. That recommendations made by the Commission as a result of this Inquiry are done so with the best possible understanding of the impact and likely changes resulting from the NDIS.

The questions posed on page 36 have largely been answered earlier in our submission. In brief, suboptimal outcomes have resulted from a range of factors including:

- a. Rushed processes with tight timeframes
- b. Lack of deep consultation and partnership with a wide variety of consumers, carers, service providers, academics and others, as well as learnings from international experience.
- c. Funding periods too short
- d. Funding renewal uncertainty too close to the expiry of funding
- e. Current arrangements often leading to fragmentation rather than integration; and a system which is onerous to understand and navigate, and full of too many steps and 'wrong doors'.

- f. Reporting requirements for funding often onerous, focussing too much on outputs rather than outcomes; results not analysed and released for public scrutiny and learning
 - g. The loss of the previous mixed model of funding – bloc and grant – following the NDIS, has made it difficult for many organisations to maintain overheads; invest in staff induction, training and development; be involved in collaboration; work with flexibility, and engage in other best practice policies.
 - h. Medicare too restrictive
 - i. Whole system needs a more holistic focus – whole of person and whole of life
 - j. Whole system too often viewed through narrow medicalised prism.
3. The answers to the questions on page 37 are mostly negative:
- a. Decision making forums often discuss and recommend similar things year after year – yet very little changes.
 - b. They don't have access to the best information because of the lack of transparent national monitoring and reporting; and the lack of a national data set. What data is collected is usually kept 'in house' (especially by governments) and is not consistent between organisations and jurisdictions.
 - c. The monitoring, reporting and analyses is done is therefore lacking. It is particularly lacking in data from the consumer and carer perspective, and from the perspective of outcomes rather than outputs.
 - d. A whole of government commitment and approach needs to be made to data, monitoring, reporting and analyses, and dedicated funding allocated to achieve this. Every bit of data etc collected should be justified in terms of why it is collected and how it will help drive improvements.
 - e. As a result, there is little evidence that robust information is used by governments to drive service efficiency and effectiveness.
4. It would be helpful for the Commission to identify both access barriers, and ways to address them, for people with all levels of mental health issues wishing to engage with mental health services and support: eg. cost, logistics, integration or lack thereof between public/private medical services; having to be very unwell before anyone will refer/accept into a service; stigma; availability; choice and control; etc.

ENDS