MentalHealth Victoria
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Initial Submission: Productivity Commission Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth

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"Yes, it is about 'the system', but it is about a system being reoriented to focus on the need of individuals, families and communities, rather than supply as determined by funders and providers."

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Patron, Mental Health Victoria

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Who we are

Mental Health Victoria Ltd is a not-for-profit, independent organisation providing thought leadership and informed policy perspectives on mental health reform to ensure that people living with mental illness case access the treatment and support they need. Our membership is drawn from organisations that work within or intersect with the mental health system. Our Patron is **Professor Allan Fels AO** and our Ambassador is **Professor Patrick McGorry AO**.

Mental Health Victoria Ltd (ABN 79 174 342 927) is a public company limited by guarantee. Details about Mental Health Victoria, its purpose and governance are at the website: https://www.mhvic.org.au/about-us

Mental Health Victoria has a Vision to drive system reform to ensure that people receive the mental health care they need. Accordingly, it works closely with Members, consumer and carer groups, governments and professional bodies to pursue improvements in policy, consumer experiences, service access and overall system performance towards the achievement of mental health outcomes in Victoria – and accordingly, Australia-wide.

Executive Summary

The economic case for reform and investment in mental health is clear. The cost of mental illness to the Australian economy is around 4% of GDP; a marginal improvement in the mental health of the population will return dividends to the economic productivity of Australia as well as a positive health and social impact.

The scale and scope of reform required in how mental health is currently viewed and addressed is considerable. Now is a time for bold and major change across all aspects of mental health policy, funding, program delivery and accountability. The convergence of the Productivity Commission Inquiry and Royal Commissions into the Victorian Mental Health System, and Aged Care and Disability at a national level present a once in a generation opportunity to 'get it right'.

Fundamentally, governments need to view mental health as intrinsically related to economic and social participation and view policy areas such as employment and housing as just as important in fixing the 'mental health system' as the provision of greater resources to specific mental health programs and services. An integrated approach to mental health reform is required.

A more evenly spread approach to mental health is needed at a policy and program level. Resource and priority decisions need to find a balance across the population needs for general mental health promotion, early intervention, indicated, selected and targeted responses as well as recovery over the long term. The needs of people with mild to moderate, severe and continuing and complex mental health conditions require attention with no single group of needs being left under-addressed in policy and program terms.

Mental Health Victoria believes that improvements need to occur through changing the ways things are presently done. Several improvement areas are recommended below that are likely to generate real change:

- **Innovation Models:** draw on examples of more effective programs and services and replicate these across the whole system;
- **Service Hubs:** address the gap in the configuration of the mental health system regarding coordination and integration of services across disciplines and service types. Multidisciplinary service hubs are a concept that has been developed, sometimes used, and now warrants a more consistent application across Australia as a key area for reform.
- **Mental Health Promotion and Prevention:** invest in population wide promotion and education on mental wellbeing to shift the overall proportion of Australian population that requires mental health services to take action and address conditions before they become serious – a new focus on preventing the onset of mental ill health.
- **Social Determinants of Mental Health:** address the intersections of economic and social policy on the mental wellbeing of the Australian population; where there are risks and vulnerable sub-groups identified, such as those affected by social change or economic adjustments, initiate strategies to mitigate the potential for mental health impacts.

Mental Health Victoria urges the Productivity Commission to investigate further the following aspects of reform to the 'system':

1. **Critically reassess the structural responsibilities across levels of government (governance: who does what and how is accountability for achieving population level outcomes ensured).** This should include consideration of where the planning and 'management' of the mental health service system should lie and the potential for Mental Health Commissions at State and Commonwealth level to oversee management performance against targets and stated intended population outcomes. The role of primary health networks, government departments and regional or area service agencies should also be critically examined.
2. **Identify the data and reporting systems required for reliable and consistent planning and monitoring of the 'mental health system' across Australia.** The collection of data presently is mostly activity based and retrospective; it does not support sound planning and monitoring of performance. A key aspect of data collection needs to be national data on the mental health and suicidality status of the population which could be achieved through replications of the ABS National Mental Health and Wellbeing Survey. National agreement and data collection on broader measures of wellbeing across the Australian population would also be desirable to shift the monitoring of performance of mental health programs and services towards measuring their impact on population level outcomes.
3. **Establish realistic funding models and funding distribution mechanisms to achieve intended population mental health outcomes – to support major increases in the levels of funding and efficiency in mechanisms for allocation**. Mechanisms through which the net increase in funding for mental health need to be identified if there is to be appropriate levels of change in population mental health and the associated economic and social participation levels being sought. The existing funding arrangements create fragmentation

and complications to the operation of mental health services in an integrated manner. Yet, it is clear that consumer needs require a mix of services, and that this mix may shift with circumstance and episodes of mental ill health. Consideration should be given to bulk funding and package funding that draws together strings of Commonwealth, state and other funding sources. Longer term funding guarantees should be given.

4. **Formulate targets for workforce size, composition, capability and development.** The future arrangements for improved mental health system functionality cannot be achieved with the existing workforce. The size of the workforce and its deployment especially in regions and rural areas is one aspect of this misalignment. The other is the range of skills and roles that are necessary to implement innovative models of service and better coordination for consumers. In particular, the peer worker role needs to be developed.
5. **Review critically the NDIS relationship to mental health – help or hindrance?** Despite the considerable benefits of the NDIS to the Australian population in addressing disability support, the psychosocial elements of the NDIS have remained difficult to address effectively. While improvements within the NDIS structures and processes are welcome, a more fundamental review of how the NDIS and its activities relate to the wider mental health system is warranted.
6. **Determine effective complaints and feedback mechanisms** – for consumer rights. There is always the potential that failures in the mental health services individually or the system as a whole will cause harm to people. There must be clear and workable processes in place for consumers to raise complaints and for accountabilities regarding personal safety and human rights matters to be upheld. There is currently no clear national mechanism through which this can be achieved.

Background

The Productivity Commission Inquiry into Mental Health is welcomed as a major initiative to address long-standing and intractable failures in the achievement of measurable mental health and well-being outcomes in Australia.

The relationship between mental health, social and economic participation has been recognised in the Issues Paper presented by the Productivity Commission, showing a realisation of the importance of reform as a national priority. The KPMG Report in 2018, commissioned by Mental Health Australia notes:

"Mental ill-health costs the economy almost $60 billion a year."

As this report also notes from a study by Frijters et al in 2014, a critical impact from mental ill health is on employment participation and therefore related individual and family economic outcomes:

"The influence of mental ill-health on the workforce participation rate is such that realistic improvements in mental ill-health rates could improve workforce participation rates by 30 per cent."[1]

Another report by KPMG in 2013 for the organisation Menslink estimated the **national economic cost of suicide deaths as $1.7 billion a year**. While mental ill health is not the only factor surrounding suicides, it is a factor present in most of these deaths.

The economic case for change is clear. What often is less clear and relates to the imperative for national priority to be given to improved mental health outcomes is the impacts on quality of life and broader wellbeing for the Australian population.

Three key insights to this broader impact are as follows:

- **Unemployment and Poverty:** as acknowledged in the Productivity Commission Issues Paper, 34% of those receiving Disability Support Pension are receiving the payment due to mental ill health. An earlier study by the Productivity Commission, using the Household, Income and Labour Dynamics in Australia (HILDA) data set, found that a mental health condition is associated with low participation in the labour force.[2] This means a considerable number of working age people are living on very low incomes and experiencing a level of poverty simply because of their mental health status.
- **Housing and Homelessness:** the link between mental ill health and homelessness is well documented internationally, as reported in a Report to the Mental Health Commission of NSW by Costello, Thomason and Jones (2013).[3] The reasons for this range from low incomes, difficulties navigating the housing market and service systems and the experience of discrimination and stigma towards people living with mental ill health. Many people living in social (public) housing have underlying mental health issues. Critically, it is estimated that 50% to 75% of homeless youth have some experience of mental ill health.[4]
- **Wellbeing and Productivity:** taking a broader social and emotional wellbeing perspective to mental health suggests attention to the population levels of psychological distress, mental health functionality and social participation, including perceived quality of life and opportunity. For instance, the KPMG Report states: "The marginal impact of mild

depression on labour productivity is estimated to be 3.9%.... rising to 9.2% for severe depression."[5] In a report for the Mental Health Commission of NSW by the Sax Institute on the evidence of costs and impacts on the economy due to mental ill health, multiple studies are cited including a study cited by Hilton et al 2010 estimated that psychological distress reduces Australian employee productivity at a cost of $5.9 billion per annum.[6]

Some indexes have attempted to measure and monitor the economic impacts of wellbeing, such as the Lateral Economics Index of Wellbeing, the Australian Unity Wellbeing Index (Monash University) and the Subjective Wellbeing Measure (Australian National University). Models of economic measurement of wellbeing factors have also been developed including through The Treasury, notably under the work of Dr Ian Castles. These measures all reinforce the relationship between wellbeing and net economic development for Australia. **They demonstrate that a mentally healthy Australia will also be economically productive.**

Mental Health Victoria recognises the human cost associated with lower economic and social participation for people living with mental ill health. On a daily basis, our Members are involved in supporting people and see the reality of their struggles with making a living, accessing basic services and facilities and sustaining a participating life. Relatedly, physical health outcomes and life expectancy are lower for people with mental health issues. The same is true for those who are acting as carers for others with mental ill health. Aspects of the failure to effectively improve the mental health of individuals should be understood as human rights issues as well as an economic and social consideration.

With this background, Mental Health Victoria welcomes the opportunity to contribute to the Productivity Commission Inquiry into Mental Health in Australia, providing a Victorian perspective that has relevance to the national picture. Identification of system, service and community reforms is drawn on the experience of our Members and the expertise drawn from those individuals with personal experience as consumers and carers. This is a timely Inquiry with the Victorian Royal Commission into Mental Health occurring concurrently. We urge the Productivity Commission to look deeply and make bold recommendations for change.

Current Situation in Victoria

Victoria has gone from being regarded as a leader in mental health performance to being below national average on various measures in the space of a decade. There is considerable community concern about this, which is reflected in the Victorian Government's decision to establish the Royal Commission into Mental Health in this state. It is clear in Victoria that there is a widespread and deeply felt community expectation that governments will provide for the mental health and wellbeing of the populations that they serve.

We should not forget that the Victorian mental health 'system' is made up of Victorian Government and Commonwealth Government components. Years of minimal investment by the Commonwealth in the gap between primary care and hospital emergency departments has contributed to Victoria's decline.

The reasons for the downward shift in Victoria's mental health performance reflects many of the challenges facing the mental health system in Australia as a whole. The experience of Victoria is illustrative of issues that need to be addressed.

Several key measures demonstrate the severity of mental health system failure in Victoria:

- 13% below national average expenditure per capita on mental health services;
- 40% below national average access to mental health services.[7]

In Victoria, from 2009 to 2016 acute admissions on mental health conditions increased 19% while admissions to community mental health services decreased 17%.[8] This is the opposite of the national trend which suggests the reverse is occurring elsewhere: the KPMG Report found that funding and expenditure on non-secondary care (primary and community care) rather than secondary (acute/hospital care) has been increasing to a greater level nationally.[9] This reflects the experience and observations of many in the Victorian mental health sector, who have seen the once strong community mental health system decline.

This distortion in funding has seen increased activity in the Hospital Accident and Emergency Departments: around double the presentations from people with mental health issues, from 28,757 in 2004/5 to 54,114 in 2016/7.[10] This results in long waiting times and inadequate service response for people often in mental health crisis as well as adversely affecting the ability of the Hospital system to provide general service as intended. The Hospital Accident and Emergency wards are not appropriate places for intake and response on mental health.

The Victorian service system is under such funding and operational pressure as to effectively deny service to many who need it. The Department of Health and Human Services funds, according to the Victorian Auditor General, enough acute mental health services for 1.2% of the state population; however, 3.1% of the state population need these services. To put this into perspective, the national average is 1.8%, meaning that no state or territory is providing anywhere near the amount of acute mental health services needed to service the population.

In Victoria, 66% of the acute mental health services being provided are for existing registered users, suggesting there is little capacity to take on new patients and that many who seek care will be denied access to service. Further, 13.8% of the admissions to acute facilities are actually re-admissions of patients, suggesting ineffective care responses initially and an inability to provide length of stay treatments that will generate better clinical and personal outcomes.

Some of the critically affected population groups in Victoria are:

- 93,600 adults experiencing severe mental health issues that will not receive clinical services each year;
- 135,000 adults living with severe mental ill health that will not be eligible for NDIS payments, and accordingly will require continuing community-based services and support from State Government funded services;
- 296,528 adults experiencing moderate mental health issues per annum that will struggle to access services because of the concentration of resources on more acute presentations;

- 60,000 carers of people living with mental ill health who receive low or no payments;
- 500 persons who present as homeless following discharge from psychiatric facilities.[11]

In 2018, Mental Health Victoria issued the report: "Saving Lives. Saving Money: The case for better investment in Victorian Mental Health" which put the case for significant State Government investment in mental health. To develop the report, Mental Health Victoria commissioned KPMG to calculate the investment needed to bring Victoria up to the national average in terms of access to mental health services. KPMG estimated that it would require an additional $543 million per annum to raise Victoria to the national average.

The priority areas for increased investment in Victoria are similar to those outlined in the Mental Health Australia report for national targeted investments:

- Community mental health to reduce pressure on hospital emergency departments and emergency services such as police and ambulance, and to facilitate more responsive and dynamic services, drawing on stepped care methodologies and coordinated care that can best match mild to moderate mental health issues and underpin recovery;
- Acute beds and specialist facilities to boost the capacity of the service system to provide a level of clinical care to meet population needs – thereby enabling better use of evidence based treatments and utilisation of specialist professionals to achieve better outcomes for people experiencing more severe and continuing mental health issues;
- Suicide prevention service models that provide more intensive support for individuals undergoing suicidal crisis (including surviving attempts to end their lives) through assertive outreach and follow up supports;
- Prioritisation of outreach and specialist services for young people exhibiting early signs of mental ill health and for those requiring treatments, in the knowledge that 75% of mental health issues become apparent in people under the age of 25 years;
- Targeted programs to reduce homelessness and facilitate secure and appropriate housing for people living with mental ill health as a fundamental support to underpin other services relating to mental health and wellbeing for a highly vulnerable group;
- Broad whole of community awareness raising, education and stigma reduction programs to create social environments that positively promote mental health.

Underlying Challenges for Mental Health System

At the heart of the Victorian mental health service system difficulties are the following issues, which have been identified through consultations Mental Health Victoria has held with its members and community stakeholders:

Planning and prioritisation against population need for services.

Despite the existence of a State-wide policy on mental health: *Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009-2019,* and within this policy the development of Victoria's *10-year Mental Health Plan*, there remains no targets for funding investment to population need, no forward plans for capital infrastructure, no workforce strategy that contains targets or has actions to address shortages in regions, no actions to address service access issues across different geographic catchment areas. The recent Victorian Auditor General Office's Report 'Access to Mental Health Services' commented:

> ***"The lack of sufficient and appropriate system-level planning, investment, and monitoring over many years means the mental health system in Victoria lags significantly behind other jurisdictions in the available funding and infrastructure, and the percentage of the population supported."***[12]

The situation in Victoria is not greatly different to that in other jurisdictions and at Commonwealth level where mental health strategies and plans have been put forward but generally not matched to a prioritisation process for actions, nor aligned to budget allocations or the setting of realistic targets that can be progress can be measured against.

Fragmentation of services and programs.

Although the Victorian state mental health system has been found lacking, a challenge more broadly is the intersection of Commonwealth funded mental health services and the operation of private operated services, notably the Medicare funded primary care (General Practice) and psychological services for mental health. The overlay of the National Disability Insurance Scheme (NDIS) has exacerbated these structural fragmentations further.

A critical component of the mental health system is the operation of Primary Health Networks, through which the Commonwealth Government now distributes considerable funding for mental health programs and services. The PHNs are also charged with a planning and coordination function, on a regional basis. The intent is to provide for more regional population-based prioritisation of services and to facilitate local solutions to local characteristics. This is a policy principle to be supported. The difficulties lie in implementation.

The recently released Report on the PHN Advisory Panel on Mental Health[13] has made the following comments:

- Expresses concerns about the continued short term (three years or less) funding certainty for PHNs, viewing this as a blockage to funding services for longer term service provision with clients – a funding cycle of five years is recommended;
- Questions the concept of PHNs commissioning services on the assumption that there is a 'regional market' of suitable service providers in every region around the country;
- Finds variations in PHN capabilities to implement the scale and nature of changes in mental health services and system interactions that are required of them, including inconsistent engagement by PHNs with Local Hospital Networks and state services;
- Suggests outcome measures and alignment of regional data sets to a national data set would enable monitoring and reporting on mental health outcomes across Australia.

Clearly, State-based reforms on mental health services cannot be properly advanced without consideration of how the Commonwealth funded programs and services perform.

Consumer Focus

A theme emerging from a recent stakeholder workshop and the Mental Health Victoria conference in late 2018 is the importance of mental health services and programs being oriented towards improving the lives of those who use them – people living with mental ill health, whether their experience be a short-term or mild mental health issue requiring attention, or a longer term severe mental health condition requiring ongoing treatment. At the heart of the issue is the 'market failure' that has occurred in the funding and provision arrangements for mental health services – the consumer's needs are not often being met.

From the Mental Health Victoria conference some salient points emerged from more than 700 delegates:

- Consumer and carer involvement in mental health services is critical to their success in achieving outcomes and in there being use of the services by people with mental health needs. Co-design and direct involvement through peer workers and other mechanisms is required as fundamental reforms to the overall delivery of services and supports.
- Social determinants of mental health and wellbeing were mentioned by several speakers during the conference; the importance of social inclusion was specifically identified.
- The distinctions between the 'medical model' and the 'social model' for mental health remain lively and are often portrayed as mutually exclusive domains. This is difficult to understand with the general acceptance of the call for greater 'integration' of services.

Feedback from 60 stakeholder organisations at a workshop held in March 2019 to inform the Mental Health Victoria submission to the Productivity Inquiry also raised the importance of consumer-oriented reforms – services and programs that will generate outcomes in terms of increased social and economic participation for people living with mental ill health.

Workshop attendees nominated these key areas as features of services that will generate greater participation:

Navigability

Co-design and continual improvement in the delivery of service is necessary to maintain relevance and ease of access for consumers and those seeking help. The ability of service users to find entry points and suitable services to match their needs; the provision of assistance in explaining and navigating the complicated mental health service system. Design principles for services need to reinforce the ease of access and use as primary requirements – funding and monitoring of services should review user experiences.

Flexibility and adaptability

The provision of services over longer periods of time and flexibility in the care provided, to adapt to whole of person needs for mental health and wellbeing. Inclusion of resilience building supports that are person centred on an empowerment approach to recovery and sustained mental health.

Lived experience led designed with leadership buy-in

Drawing on the experiences of consumers and carers to inform how coordination and integration of services should be designed: less reliance on funding arrangements and organisational structures as the basis for service configuration. Broader service domains: not just clinical treatment, multi-disciplinary, diverse, responsive, proactive. Grow and utilise more the peer worker roles in services. Develop a suitably qualified and supported mental health workforce for the delivery of services.

Shared purpose

Service providers and consumers to establish common goals to enable ongoing monitoring, review and improvement in the operation of services to achieve positive outcomes. Focus on meaningful, purposeful activities and goals, with performance measured by the achievement of goal related outcomes for individual, not the service system or the funding body.

Seizing the opportunities

Experimenting with opportunities for an individual to take risks as the come along; looking for employment that provides a 'foot in the door opportunity' and then provide the support to engage successfully with that opportunity.

Holistic approach

Adopt a 'no assumptions approach' to providing services so that each individual receives a full assessment conducted by a suitably trained person who is able to interpret needs and translate these into a package of supports. Specially give attention to meeting basic physical needs for health care as well as mental health needs. Foster the ability of different service systems working together to address complicate personal needs across mental health, drug and alcohol, social services and income and employment supports. Draw on the knowledge gained from models such as Personal Helpers and Mentors (PHAMS) program and the Partners in Recovery trials.

Establishing trust and valuing lived experience

Place trust-building between client and service as an essential require for performance in mental health services and programs. Consumer satisfaction to be measured as the client feeling the service has faith in them. Provide services that are free from judgment – respectful of the individual.

Develop services and governance structures that have a consumer voice at every level; this will foster trust, respect and freedom from stigma in the design and operation of services. Have consumer participants in these structures feel that their contribution is valued.

Resourcing smartly

Operate well-resourced programs so that services for individual consumers can be flexible – move away from a simple inputs funding approach to one that is more responsive to tailoring to needs. Aim for right resources in the right place at the right time, where the client is.

Provide resourcing consistency between services so that the consumer is not left with contradictory arrangements between different providers or programs.

Customised care

Invest in the quality of the therapeutic relationship with the consumer – to maximise benefits of service. This involves listening deeply to people and providing enough time for an individual to build insight and confidence to engage with service workers and professionals (clinical and peer work).

Safe spaces

Ensure that there are safe spaces and environments in all services. Pay attention to the principle of doing no harm. In particular, adopt trauma informed care practices.

Early intervention & with whole family

Provide enough resources for attention to be given to prevention/early intervention, especially with regard to child and adolescent mental health. Generally, encourage a whole of family approach to mental health service, where possible.

How Can It Be Different?

Mental Health Victoria believes that the Productivity Commission Inquiry should be mostly concerned with what changes and improvements can be made to generate better mental health and wellbeing outcomes in Australia. The shortcomings of the current funding structures and service configurations are well documented. To some extent reform in mental health needs to be about changes to those structures and arrangements.

However, Mental Health Victoria's engagement with its Members and with consumer and carer representatives has shown that the reform of mental health services must not be just additional

investments in the existing service models, but also an investment in the development and replication of more innovative and effective models of service.

Innovation Models

Innovation may be seen in various pockets of the mental health system around Australia. There are examples of effective programs, responsive services and innovation models that can be replicated; these are worthy of greater attention and wider replication.

For instance:

Mental Health Crisis Units

- Mental health crisis units that replace the need for presentations at Hospital Accident and Emergency Departments and facilitate short-term intensive residential care: in Victoria some progress has been made in the introduction of alternative facilities at six hospitals for presentations surrounding mental health crisis; in Queensland the Gold Coast Hospital is trialling the Zero Suicide in Health Care approach to quality improvement in crisis responses to suicidal persons; in ACT Canberra Hospital is operating a short-stay mental health facility. These all create options and improved models of service when contact with the mental health system requires a crisis response. These models need to be pursued and tested further.

Police & Mental Health Service Partnerships

- Reliance on police to attend and transport a person in mental health crisis to a hospital is likely to be a traumatic and potentially ineffective activity, drawing also on the use of police as front line mental health workers which may not be a suitable use of their resources. Models of service in other States, notably Queensland, where response to and transportation on mental health crisis situations occurs through ambulance and with mental health workers in attendance, with police performing a safety role only.

Mental Health Nurses in GP Clinics

- The Commonwealth Government has funded a mental health nurses program since the 2006 COAG Mental Health Reforms, to varying levels and with period support for this as a priority. The benefit of placing mental health nurses in primary health care settings, however, seems universally accepted and this arrangement can perform a very useful linkage role between GPs, primary health care services overall and the wider service networks – all to the benefit of the person seeking care for mental health issues.

Housing

- Housing models such as the Housing First model and the NSW HASI program have been shown to be effective in achieving improved housing outcomes and mental health outcomes; these have the potential to be replicated widely and to better link to the mental health services as integrated care models, rather than additional or optional activities.

Health Justice Partnerships

- A high proportion of the prison population has a mental health condition. The experiences of many of those serving time in prison illustrate the associations between mental ill health, alcohol and substance abuse and interactions with the justice system. From a preventative and a recovery perspective, investments in health justice partnerships have a sound basis.

Suicide Prevention

- Suicide prevention aftercare models, including follow up supports and integrated clinical and non-clinical care, are being trialled in Australia, drawing on encouraging research evidence for their effectiveness in reducing re-attempts of suicide and facilitating recovery pathways for people who have experienced a suicidal crisis. The Beyondblue *The Way Back* trials and the Victorian Government's HOPE trials will generate knowledge in this regard. The intersection of these models of suicide prevention with mental health services needs to be confirmed.

Peer Support

- Peer worker roles and peer support programs in mental health are emerging as highly appropriate for engagement with people experiencing mental ill health and for fostering a renewed focus on recovery and return to health. Critically, these models of service and support directly address the power imbalance between consumer and service professional or service provider – an aspect of mental health reform that is vital for lasting change and better consumer outcomes. A recent report by the Sax Institute concluded: "There is a small but steadily growing number of research studies showing that services controlled and run by people with lived experience of mental illness ('consumer-operated services') are effective in supporting recovery."[14]

Service Hubs

The current configuration of the service system for mental health lacks functional capability and resources for the coordination of individual care and support, within the array of available services and professionals. It is difficult to identify the point at which a consumer can contact a coordinating agent: Primary Health Networks have a coordination function, but this is at service program and purchaser levels. Hospitals and specialist mental health services are not equipped to perform a coordination role. Primary health care through general practitioners is limited in the time it can provide to coordination beyond the immediate clinical needs of patients. Community mental health services, which are better placed to do so, are often unable to put resources to the task and may not be the obvious point of contact for consumers, given their role in crisis assessment and response and intensive treatment programs and the confusion of their place alongside primary care.

One option being put forward as an alternative model for organising programs and services to meet consumer needs in a more coordinated and deliberate fashion is the formation of local 'hubs' or centres as points of contact and service delivery. This is not unlike hub based or case coordination mechanisms utilised in youth and family support services.

Research and service concept development work is available to further examine the potential of Service Hubs as a model of reform in mental health services in Australia. However, care and attention to building the appropriate approach to suit Australian realities is required. In a review of the evidence surrounding primary care in mental health models prepared for the NHS London, the authors noted the following after identifying a full range of options from stepped care to collaborative care:

> ***"It is likely that no specific model will be a 'fit-all' solution: Rather, key component 'gold-standard' parts and 'themes' will need to be considered for different demographic and geographical areas, directed by available scientific evidence, knowledge of local population needs and by available resource."***[15]

In Victoria, Primary Mental Health and Early Intervention Teams were introduced in 2002 to all area mental health services to improve the capacity of primary care providers to recognise mental health issues in patients and respond more effectively – including through referrals to specialist mental health services. In 2005, a review of these Teams found that they had assisted with coordination of services for patients, but the service environment was becoming more confusing with the Commonwealth Government enhancements on access to Medicare subsidised mental health plans and psychological services.[16] There may, however, be value in re-examining the area based teams model for what can be learnt.

Mental Health Victoria commissioned KPMG in early 2019 to examine the options for Adult Community Mental Health Hubs. Teams would be multidisciplinary, including mental health workers, social workers, nurses, psychologists, counsellors, medical professionals and others, notably peer workers. They would provide a point of contact and communication to plan a package of care for a consumer, drawing on stepped care approaches to allow for responsiveness in service level. They would provide a range of services including: peer support, employment, housing, counselling, alcohol and drug programs, psychological services, primary health care and community mental health services.[17] Importantly, the 'hub' has the potential to help fill the 'missing middle' in mental health care – the gap between general practice and hospital emergency departments which often people having no alternative but to go to hospital.

With this in mind, we welcome the Australian Government's announcement on 02 April 2019 that it would fund a national trial of 8 adult mental health centres.

Mental Health Promotion and Prevention

There has been international and national development of policy frameworks for the promotion of mental health and prevention of the onset of mental health conditions. Internationally, the case for mental health promotion and prevention is articulated in the World Health Organisation Ottawa Charter in 1986 and the Jakarta Declaration in 1997. Relatedly, in 2002 the WHO released a research and evidence guide on Prevention and Promotion in Mental Health and has since then urged member countries to invest in these aspects in their national mental health strategies.

In Australia, the Commonwealth Department of Health released a major statement on mental health promotion, prevention and early intervention in 1997, drawing together the evidence and the policy implications for additional investment in these areas for population wide improvements in mental health. The National Mental Health Policy and the various National Mental Health Plans for Australia have consistently recognised the importance of promotion, prevention and early intervention as priorities in policy, budget allocations and program development.

Mental Health Victoria supports the principles, theory and evidence base for mental health prevention and promotion, especially the theme: 'No Health Without Mental Health' which implies that all aspects of health and wellbeing should be addressed in the pursuit of mental health outcomes. This outlook also encourages holistic health management, seeing linkages between physical health promotion and prevention and mental health. Practically this addresses the place of physical activity, diet, sleep and rest, substance abuse, stress management and specific prevention measures such as screening and harm reduction (e.g. quit smoking campaigns).

There is also justification for increasing the mental health literacy of individuals and communities towards greater resilience through information, social marketing and community outreach, as well as through counselling and group-based self-help programs. Schools based education programs also are consistent with an overall health education and promotion approach. Mental health elements should be included in these activities.

Social Determinants of Mental Ill Health

Social determinants of mental ill health should receive specific attention in the overall framework for mental health reforms, creating a basis from which economic and social inequality as it impacts on mental health and wellbeing are addressed. In particular, financial crisis and debt related difficulties, unemployment, disability (physical and psychiatric), discrimination and racism, and social isolation are relevant to these reforms. Specifically, approaches to Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, and immigrant/refugee communities should reflect an emphasis on addressing the social determinants of mental health.

Given the importance of income support for many Australians experience mental health issues, temporarily or on a continuing basis, closer partnerships between the mental health services with the Department of Human Services and Centrelink, as well as partnerships locally with Medicare Locals and local government would be useful mechanisms through which economic and social issues could be more explicitly addressed.

An element of the service system that can strengthen the linkages to social determinants is 'recovery support' to provide social supports either as stand-alone services, or potentially as a complementary service to post-acute care clinical programs. Community based supports can perform an important part of the recovery process for individuals and facilitate carer and family involvement in a coordinated plan of recovery and movement towards health.

Case Studies That Illustrate Recovery Factors

For this submission, Mental Health Victoria has compiled several case studies of individual experiences in mental health issues and the service and supports received that provide insights into the potential for change and recovery, but also the fragility of the service system to delivery these outcomes – it seems they may be achievements that are accidental rather than usual with a high reliance on the actions of individuals in the system.

NOTE: Names used in this document are pseudonyms to protect the privacy of individuals.

Jessica – Job Placement Creates Change

When she was aged 13, Jessica moved out of home due to domestic violence issues. At the age of 16, she was diagnosed with PTSD, anxiety and depression. This diagnosis occurred after a suicide attempt and her disclosure of childhood sexual abuse.

Jessica was referred to a psychologist and given a prescription for medication. She did not engage with the psychologist, nor take medication, at this time. She continued with her schooling until age 17 at which time she left school two weeks before final VCE exams.

She started using cocaine sporadically at the age of 16 and developed cocaine dependence at age 18. Relatedly, she was arrested by police at this time for 'bad behaviours'.

At age 21 she had a psychotic episode brought on by bad news and cocaine abuse and was placed in a psychiatric facility. Jessica was referred to a local social worker and psychologist. She undertook a detox program and was heavily supported by friends.

Jessica's recovery was aided by being able to set her own pace and through having choice within the overall program. It was beneficial having a social worker that understood her barriers, but also understood her needs; there was no power difference between them.

Since leaving school, Jessica has had a varied working life including advertising brothels, door to door sales, factory work and other casual employment. A breakthrough for her was a Work for the Dole placement at the Department of Primary Industries which resulted in full time employment. Since then, she has studied for a Diploma in Community Development and has been working for seven years as a peer support worker.

Jessica continues to manage her mental health with a regular check in with a psychologist and sees a very supportive GP. Her family are also understanding and supportive. Her employer understands that she has Bad Days and are supportive of her "doing what I need to do" to manage her mental health at those times.

Anton – Self-Management Skills Enable Recovery

Anton experienced emotional abuse and neglect as a child. Going into adulthood he often felt frustrated, angry and stressed. Although he was misusing alcohol and other drugs during his 20s, he held well-paid jobs. In his early 30's Anton quit his job following changes in the organisation. He started drinking heavily and smoking cannabis; eventually his closest relationship broke down.

As a result of experiencing significant physical pain Anton went to see a GP. She found Anton had liver damage, but she confronted him about his drinking and drug use and referred him to a psychiatrist and a counsellor at a drug and alcohol day program to help him reduce his drinking.

He says: "My entry into the 'mental health system' was a haphazard entry into various agencies".

Anton found the group program at the drug and alcohol service gave him tools and knowledge he hadn't had before. He'd heard of cognitive behavioural therapy but he'd never experienced it. He learnt about the psychology. He was thinking about how to think. He also learnt about being part of a community with people that had similar experiences.

Anton went back to TAFE to study Cert IV in AOD, but before long he had relapsed using drugs. However, this time he had the skills, knowledge and experience to know what to do to get himself out of the situation. Eventually he stopped using and went to see a psychologist. This ongoing therapeutic relationship has been crucial to his recovery.

Anton has restarted his vocational studies because of the State Government's free TAFE program. He is currently working as a consumer consultant with the drug and alcohol service but ultimately hoping to gain employment as a facilitator of peer work in the mental health sector.

Carly – Physical Health and Art/Culture Relate to Mental Health

Carly is an Aboriginal woman who has been diagnosed with autism; she has had multiple traumatic life experiences from an early age which, combined with her autism, have had an impact on her mental health and her sense of identity.

Before contact with mental health support services, Carly did not want to leave her house, avoided her mail or making phone calls, couldn't fill out forms, had difficulties with her housing and experienced troubled relationships with others. She felt she had no reason to get up in the morning.

She was fearful to seek help because "asking for help is scary".

Change occurred when Carly was introduced to a mental health support worker who listened was flexible to her needs and let Carly take the lead. The worker's weekly visits and ongoing communication via text message were incredibly important to Carly. With her workers support, she began seeing a GP, a psychiatrist and addressing her housing instability and relationship issues. Her financial management was also improving.

One significant milestone for Carly in her recovery was getting major dental work. As a result of many years of using narcotics and other drugs, Carly had no teeth. This had a massive impact on her self-perception - it impacted how people treated her. Over many months, her worker assisted her to negotiate for the dentist to attend her home and perform the remediation work on her teeth. The change in Carly was significant. She smiled at people and felt human again.

Carly now attends an Aboriginal Art group, which she often facilitates. Doing artwork is the only thing she had ever found that "quietened my brain". For the first time also, she felt she belonged somewhere.

Delvin – Homelessness, Mental ill health and employment are connected

Delvin came to Australia from overseas and worked as a teacher after arriving in Australia. She found this work very rewarding and enriching. Unfortunately, in 2014 her employer was forced to close the facility and Delvin lost her job. She decided to go back to University to study to make her teaching qualifications relevant in Australia.

Delvin was diagnosed with ADHD in her home country and this has an impact on her memory/attention and her ability to stick to time limits. She found the return to University difficult, not only because of her need for personalised support in these areas but also because she found her husband was not very supportive of her studies. Delvin's difficulties with the workload at university and the lack of support (which eventually became emotional abuse) at home eventually led to what she described as a kind of nervous breakdown.

Eventually Delvin decided to leave the family home; she became homeless at this time. She had no family or friends to support her. She found one crisis accommodation scary and dangerous, and the process of calling daily to get a place the next night – humiliating. After alternating between her car and the crisis accommodation, whilst still maintaining a student placement, Delvin found a housing support agency that she found truly supportive. They found Delvin a place in a hotel for a few days and then a transitional place (6-8 weeks) with another agency. At the conclusion of the transitional place, she was assisted to find a rooming house where she lives now.

Now Delvin is focused on reconceptualising where she is headed. She talked about one friend she met at a support group for people with mental illness. She said they connect on a deeper level because her friend appreciates her spirituality and the enlightenment religion can bring.

Delvin has been involved in a program called Wise Ways to Work. She said this program is different because it provides a welcoming, safe place. She said she likes how they give her feedback, based on formalised skill testing, which helps her to understand her strengths and allay her fears about her loss of skill or to focus her on where she needs to rebuild skill or where she wants to learn new skills. The program also allows her to focus on a question that is very scary for her to confront alone – that is, what are you going to do with your life now?

Gloria – Work-related Stress and Mental Health

Gloria worked as a management consultant for a large organisation but when she experienced a depressive episode she started to question the impact of her work on her mental health. Gloria's workplace was highly competitive and to do well or even survive there, you had to go "above and beyond". The work also depended on travel to meet clients' needs, arrangements which were often out of her control. Although it was a stressful job that didn't always bring out the best in people, Gloria enjoyed working with other ambitious people.

Her personal life was not where she would've liked and her work became increasingly important. Gloria remembers crying inconsolably at times. One day, driving her car, she remembers thinking it wouldn't matter if she crashed. This didn't seem right to her.

Gloria went to the Beyondblue website and it occurred to her that yes, this was depression. She went to a GP who listened to her and said it was "completely understandable" that she was feeling this way. She prescribed counselling sessions and anti-depressants.

Gloria didn't take sick leave. She feared she would miss work and opportunities and maybe, being a woman in a male oriented environment, she would have been perceived as weak. She didn't tell anyone at work about her experience.

Soon after, her brother took his own life. Gloria remembers numerous people opening up to her about their own experiences of suicide and mental illness.

Gloria began to see the workplace differently and she became more aware of the impact of the work environment had on her mental health and ability to live healthily. She ended up leaving her job and that organisation.

Katie – The Importance of a Job and Career

Katie maintained education and employment throughout her recovery from mental illness and believes it was a crucial focus/distraction for her during this time of personal challenge.

She experienced a depressive episode immediately after finishing high school. At the time her family was in turmoil. She knew her sibling had reluctantly disclosed being sexually abused but at that stage she had no conscious memory of her abuse.

After school, Katie started a teaching degree. Whilst at university, her family situation became increasingly unsettled and conflictual. Katie found going to university and working part time in retail was a distraction from the conflict and emotional abuse that was going on at home.

Katie saw different psychiatrists and a psychologist because her mental health deteriorated. The psychiatrists were helping her to find the right medication and a psychologist undertook cognitive behavioural therapy. In hindsight, what she really wanted was for her family and the medical professionals to acknowledge what had happened. She was angry, confused and grieving. She found a group program and counselling with a specialist, therapeutic focus and understanding of trauma most helpful.

After advice from a community disability employment service, Katie started work as an integration aid in a primary school. Being part of the school community helped her. She balanced work with participation in mental health group programs. Although her position was 19 hours, she could only be paid for 15 because of her Centrelink payment. She worked the extra hours without pay.

An opportunity to train as a mentor in one of the group programs allowed Katie to become a volunteer supporting others with mental illness. This refocused her career path and after completing a Masters of Social Work she became a peer worker.

Katie would really love to start her own family and to continue her career towards research or specialist social work. She is pursuing her potential. She would like to see peer work more highly valued and recognised so that others can reach their potential too.

Summary – Major Reform and Overhaul Required

Feedback from the sector in Victoria suggests major reform and overhaul is required, not incremental changes.

Attachment 1 shows the summary of stakeholder group's nomination of key areas for the Productivity Commission to examine, and then ranking their relative importance. All these areas are substantial shifts in the current approach. This workshop feedback demonstrates the appetite within the sector for change and improvement.

General reform will require a more deliberate and more evenly spread approach on mental health instead of simply relying on boosting existing service access and provision as the solution: Australia won't get the participation outcomes we seek using the current approach.

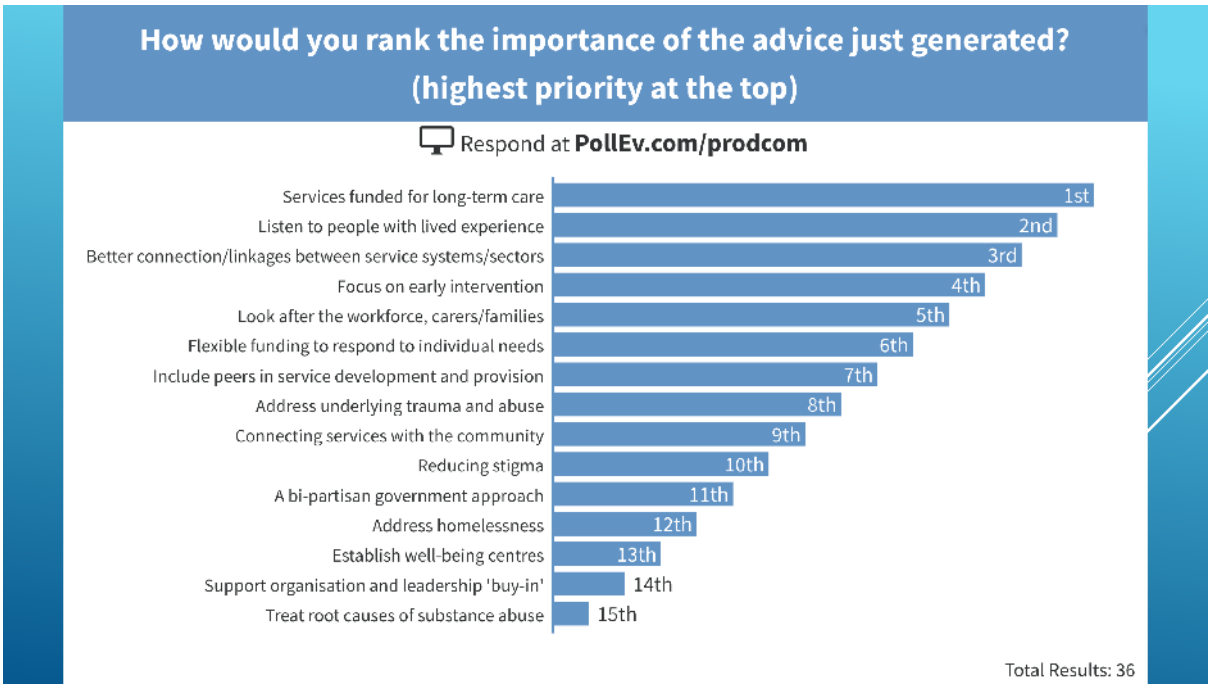
It is essential that an Australian approach to mental health reform is person-centred: it must address the elements of both 'market failure' and 'government failure' – address the question of how can the consumer's interests be addressed by appropriate service design, resource levels and continual improvement and accountability?

Further, community education and stigma reduction remain priorities in the wider community to reinforce mental health as a community wide priority and to underpin community support for increased participation by people living with mental ill health.

ATTACHMENT 1

The following graphic shows the summary of feedback from the participants at the Mental Health Victoria Stakeholder Workshop to inform the submission to the Productivity Commission:

Participants used an online tool to nominate themes and then were asked to rank the priority of these themes in terms of the importance of the advice to the Productivity Commission Inquiry, using the online tool to submit their preferences. The graphic below shows the results of this workshop activity:



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