Mental Health Australia

Analysis of the Productivity Commission Inquiry into Mental Health: final report

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Mentally healthy people,
mentally healthy communities

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Contents

Executive summary

In this paper Mental Health Australia aims to provide members with a detailed review of the **final report** of the Productivity Commission (the Commission) Inquiry into mental health, and to illustrate key issues and questions arising from the report with a view to implementing reform. This is in addition to the **brief overview** of the report Mental Health Australia has already provided to members.

Mental Health Australia has worked closely with the Commission and member organisations during the course of its Inquiry, providing multiple submissions and facilitating engagement with the mental health sector. This included providing the findings of the **Investing to Save Report** in which Mental Health Australia and KPMG initially made the economic case for mental health reform. Commissioners were also committed and diligent in providing opportunities for stakeholders to further inform their work. The mental health sector's investment has been rewarded with a final report that provides some welcome recommendations across each of the **Charter 2020** Principles.

At its heart, the report shifts the conversation in three key ways. Firstly, it places people with mental ill-health and the people who love and care for them at the heart of the reform agenda. Secondly, it takes a life cycle and social determinants approach, recognising that both developmental life stages and the contexts in which people live impact on our mental health and wellbeing, and that mental health responses should take these circumstances into account. Thirdly, it recognises that system reform will require a broad set of actions, across a range of domains, over a period of time and with clear coordination and strong leadership. Mental Health Australia fundamentally supports these three key themes and urges governments to prioritise investment in expanded community-based mental health care options to implement this change.

The mental health sector has embraced the opportunity afforded by the Commission Inquiry into mental health, providing 1,244 submissions and 488 comments in the period between November 2018 and June 2020 — a record for any inquiry conducted by the Commission. The enthusiasm for positive change is shared right across the sector and is perhaps stronger than ever. This change needs to be structural and systemic, rather than programmatic, with a clear, sequenced implementation plan and an accompanying national investment plan.

The key task now is to harness this enthusiasm for change within the context of the Commission's report and recommendations, and the ensuing Government response outlined by the Prime Minister when launching the report. This response involves public consultation until February 2021. Letters inviting comment have already been issued to people and organisations who made submissions, seeking their feedback and ideas. Mental Health Australia will contribute to this process as well as to the Federal Budget process in May 2021. And finally, the Prime Minister undertook to develop a new national mental health agreement with the states and territories by November 2021. The Australian Government's response to the Commission's report will likely take into account several accompanying factors, including advice from a new reference group to inform the national agreement, the Vision 2030 Roadmap being developed by the National Mental Health Commission (NMHC), the advice on suicide prevention provided by the National Suicide Prevention Advisor, and the fact that the Fifth National Mental Health Plan is due to lapse in 2022. This is in addition to the work of the Aged Care, Disability and Victorian Royal Commissions.

This crowded reform landscape comes on top of myriad past reports and reviews. It is not surprising that the Commission highlights issues and makes recommendations in familiar

areas. Fundamental challenges regarding resources, governance, and balancing the mental health system are well known. Mental Health Australia and its members articulated many of these in submissions to the Commission as it gathered evidence.

This paper assesses the extent to which the Commission took on board Mental Health Australia's advice, reflecting the areas of consensus and expertise of our diverse members. We have analysed the Commission's recommendations for their alignment to the nine key principles outlined in **Charter 2020** and provide an analysis of key issues. Signed by over 110 organisations, Charter 2020 reflects the key priorities of the mental health and suicide prevention sector for mental health reform, and shaped our recommendations to the Commission throughout their Inquiry.

Beyond this however, we also hope to give members a sense of the overall reform direction set by the Commission for mental health and consider the implications. This is not simple. The final report is long (over 1600 pages) and broad — appropriately covering not just health, but other key factors impacting mental health including housing, employment, education, and social connection. This is most welcome and sees the Commission place mental health in a much more holistic context, akin to the position taken in the Fourth National Mental Health Plan, rather than the more strictly health-focused Fifth National Mental Health and Suicide Prevention Plan.

The Commission's report is an important opportunity for change in the mental health eco-system. This paper aims to set a platform for the discussions members will have together, with constituent communities and with governments about how best to capitalise on this opportunity. As such, there are several questions and issues raised throughout this document as discussion prompts.

Overview

This section summarises key themes and issues considering the Commission's report as a whole.

As already stated, a key strength of the report is the Commission's capacity to calculate the economic impact of mental illness. Some of the key statistics published were that:

- In total, mental illness, on a conservative basis, is costing Australia about $200-220 billion per year (p.9). To put that in context, this is just over one-tenth of the size of Australia's entire economic production in 2019. The cost is between $550 million and $600 million per day. The report states that not all of this cost is avoidable, but there is considerable scope for Australia to do better.
- In 2018-19, the annual cost to the economy of mental ill-health and suicide in Australia was estimated to be up to $70 billion (p.149), comprised of:
    - direct expenditure on mental healthcare and support services, in the order of $16 billion
    - the annual cost of lower economic participation and lost productivity, up to $39 billion
    - the total annual cost of replacing the support provided by carers of people with mental illness, at about $15 billion.
- Further, the cost of disability and premature death due to mental illness, suicide and self-inflicted injury was calculated to be equivalent to $151 billion per year.

The report's presentation of this data provides a compelling argument for policy attention. In order to address these costs, the Commission makes 21 recommendations with around 100 associated actions, with some prioritised for immediate action. The Commission notes that (p.172):

- implementation of the priority reforms requires expenditure of up to $2.4 billion per year
- these reforms are expected to generate savings of up to $1.2 billion per year and increase aggregate incomes by up to $1.1 billion
- full implementation of all recommended reforms that have been costed by the Commission is expected to require expenditure of $3.5–$4.2 billion annually, which represents the total cost of reform for the Australian Government and state and territory governments
- reforms are expected to lead to cost savings of up to $1.7 billion and increases in aggregate income of up to $1.3 billion per year.

In order to derive these calculations, the Commission relied heavily on the National Mental Health Service Planning Framework (the Framework).

Drawing on existing epidemiological data, particularly the 2007 Australian Bureau of Statistics Survey of Mental Health and Wellbeing, the Framework offers an estimate of both the demand for mental health services and the 'supply' of services (staff, hours, etc) required to meet that demand. The extent to which this is appropriate and adequate deserves consideration, given the Framework has (until now) been a commercial product, subject to only limited external scrutiny. The Framework also only addresses a slice of the system. It

does not include the interaction of prevention and broader psychosocial supports with overall mental health that are also important areas for attention and investment.

The Commission's report relies heavily on the Framework as a scaffold for overall system design – frequently calling on planners and funders to use it to identify and address shortfalls in mental health services at a regional level. This is not as simple as it sounds. For example, the report suggests that about 30% of people in hospital with mental illness could be discharged if suitable accommodation, clinical and community supports were available (p.187). At the same time, it also suggests there are shortfalls in mental health bed-based services which should be addressed (p.583).

This complexity is also highlighted by a significant change made between the draft and the final report in which the underlying organising principle of 'stepped care' has been largely replaced with the concept of 'person-centred care' (p.24). Here the Commission echoes the emphasis on autonomy and choice, which underpins the design of the National Disability Insurance Scheme (p.453).

The Commission is concerned that stepped care is overly service focused and that person-centred care provides a better starting point. However, the report does not provide detailed descriptions of preferred service models or care pathways – who should get what care, from whom, for how long, with what expected outcomes, and what should happen next. There is some tension then between the principles of person-centeredness and the population-based planning and resource allocation that underpins the Framework. This same tension also applies to the development and determination of appropriate mental health outcomes which can operate at both the level of the individual and of whole populations.

The report notes the needs of particular groups in the community. There is, for example, acknowledgement that humanitarian entrants including people seeking asylum are more likely to have higher psychological distress compared to the general population, and there is particular concern for international students. The Commission highlights the importance of building culturally capable mental health services, responsive to the cultural, social, and clinical preferences of the consumer.

The report recognises the 'missing middle' (p.30), as a service gap encountered by several hundred thousand people who have symptoms that are too complex to be adequately treated under Medicare but who will not be eligible to access state-funded public mental health services. The report suggests (Figure 5, p.25) that new low-intensity, group therapy and online services can supplement primary mental health care, leaving general practitioners (GPs) able to invest more time managing people with greater complexity. This may seem unrealistic considering the Commission's comments about the need to improve GP training in mental health. But there are other aspects to the 'missing middle' which require an organised response not yet articulated, such as for people requiring team-based multidisciplinary care, often with complex or co-morbid needs, or people not in care at all, or people with complex or low prevalence disorders who require ongoing community support on discharge from acute care.

The 'renovate' or 're-build' models of regional governance articulated in the draft report did not make it through to the Commission's final report. Instead, the recommended approach is for Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) to be given another opportunity to work together to deliver regional planning. If they fail, the Commission now recommends state and territory governments impose a new regional commissioning model under their own legislation, with pooling of PHN-commissioned funds, state and territory community funding, and psychosocial support funding (outside of the NDIS) for that region, with regional planning to incorporate the provision of services from (un-pooled) Medicare and hospital funding.

While the report highlights a massive gap in the availability of psychosocial supports (p.41), it places responsibility for addressing this squarely with the states and territories, where non-

hospital investment must be balanced with the political reality of managing acute care services every hour of every day.

The Commission was clear in its desire to improve systemic accountability for mental health expenditure and governance. Recognising persistent limitations in this area, it calls for a dramatic revamp of the role to be played by the NMHC (p.1266), seeking to re-establish it as an interjurisdictional statutory authority with responsibility for leading evaluation; developing the National Stigma Reduction Strategy; monitoring reform progress; and reporting on progress towards system-level targets developed in consultation with consumers, carers, and the community. The NMHC would be tasked with leading development of the new National Mental Health Strategy and the next National Mental Health Action Plan in collaboration with all jurisdictions and for endorsement by them (p.1092).

While the recommendations reflect current evidence, there may be unrealised opportunities to combine these with community-driven innovations that will shape the next wave of new ideas. This is an opportunity for the sector to demonstrate innovation and leadership, and to support and complement the existing evidence base documented by the Productivity Commission.

Key considerations for implementation of the report as a whole

Systemic change

The report is complex, long, and offers many recommended actions aimed at improving the way mental health services operate and the system responds to the needs of people with mental illness, their families, and carers. Less clear is the extent to which the document sets out an overall vision for mental health in Australia and desired principles and goals that should underpin systemic change. Mental Health Australia urges the NMHC to address this gap as part of the Vision 2030 Roadmap.

The individual or the population

Described in more detail later in the paper is the report's goal of person-centred care and the traditional population-based approaches to planning and funding which have characterised health and mental health to date. These need to be reconciled to enable more integrated and effective approaches to emerge.

Local or national

Another tension running through the report is to reconcile what needs to be national versus what is best managed and determined locally or regionally. While identification of appropriate service standards is clearly a national function, delivery of services to particular groups will benefit from more tailored regional approaches rather than central mandate. The Australian Government Department of Health will need to take a leadership role in better articulating and delivering evidence-informed services that incorporate national consistency but are delivered with regional variation that best meet the needs of people living in different areas.

Benchmarking

The report relies on the Framework to describe the ideal 'as is' state to which mental health should aspire, be planned and funded. The Framework is used to set benchmarks for agreed mental health staffing and service levels. The report has clearly stated the Framework needs to be open to scrutiny and be publicly available. This should be done as soon as possible to enable the mental health sector to determine if these aspirations can be met using this tool or if there are other service planning and modelling tools that may better complement local decision making.

Outcome measurement

Mental Health Australia advocated for the introduction of real-time consumer- and carer-driven outcomes measurement. Yet, while the report strongly supports an improved mental health system that is led and informed by consumer and carer experience, it is silent on the introduction of outcome measurements to assess quality and efficacy of care. A national approach has been problematic to date, however regional approaches on service value and quality are more achievable and worthy of immediate consideration to inform a larger systemic approach in the future.

Missing middle

As stated, the report's recommendations regarding the missing middle are incomplete, particularly as they do not address the lack of multidisciplinary care available in the community. Additional Better Access sessions, better referral pathways, low-intensity services, and single complex care plans are welcome additions but these are all operating with a largely privatised mental health primary care system that places additional costs on consumers by providers operating independently and often with their own service silo. The Victorian multidisciplinary service sites funded under the COVID-19 response are an innovative addition to address this major gap and should be watched closely as a potential solution to address this major service gap.

Psychosocial support

The extent to which the report properly understands and describes the role that could be played by psychosocial care in a better balanced and contemporary mental health system in Australia is limited. There remains much work to be done to achieve this goal which requires comprehensive articulation of the future service model with both the NDIS service components and those provided outside of the NDIS in each state and territory, and to design a broad leadership and governance model. As a matter of urgency, Mental Health Australia is calling for the funding of psychosocial services outside of the NDIS to be addressed in an interim package in the next budget to ensure continuity of funding after the National Psychosocial Support Program funding concludes in June 2021.

Workforce

The report offers a welcome focus on the role of peer workers. But overall, there seems to be a heavy reliance on existing workforces and existing ways of delivering services. The National Mental Health Workforce Strategy needs to address how we can recruit and train the qualified, multidisciplinary workforce necessary to deliver quality mental health care.

Local governance

The report gives regional organisations another chance to lead mental health reform, suggesting in the first instance, PHNs and their state-funded LHN counterparts develop new partnerships. So far, this approach has proven patchy at best, raising questions about whether these organisations have the right resources and incentives to build these partnerships.

Mental Health Australia supports the concept that a regional-level focus for mental health planning — based on population needs, service design, procurement, implementation, monitoring, and evaluation — has a sound basis for success. For this to become a reality and deliver real outcomes for people living with mental illness across the continuum of care, the following will be required: strong commitment from the Australian Government, states and territories, bound in a clear partnership agreement that requires PHNs and LHNs and their mental health funding streams to be pooled and co-commissioned, with high levels of accountability and transparency to the community. The local service providers, including

those that are community managed, and the local consumer and carer communities, must be integrated into governance systems across the whole cycle of commissioning.

It should be noted the report also states that if these local partnerships do not progress sufficiently then regional control should shift entirely to the states and territories. The implications of such a change are uncertain, as the capacity and willingness of the jurisdictions to invest in non-hospital mental health care has been an historic issue. Mental Health Australia would expect sector consultations to form part of the process to inform these changes, if they proceed.

National governance

The Commission places unprecedented responsibility on a revamped NMHC to drive change and monitor progress. The NMHC will need real 'teeth' to execute this role, as well as legislative and persuasive powers. In the shorter-term, the Australian Government has established a new sub-committee of the National Reform Committee to consider the Commission's recommendations. Oversight of the reforms that must emerge from the Commission's work will be critical for their successful implementation. It is Mental Health Australia's view that successful implementation is only possible with strong sector advice and support.

The following sections of this paper examine the detailed recommendations made by the Commission, set out according to the nine Charter 2020 principles, and the key considerations for implementation.

Principle 1: Strike a new national agreement for mental health

Charter 2020 key messages

An agreement that delivers integration and coordination of mental health services, including agreed objectives, indicators, monitoring arrangements and funding between all levels of government.

Overview of the final report

Mental Health Australia welcomes the Commission's recommendation that all governments develop a new National Mental Health and Suicide Prevention Agreement (Action 23.3). The Prime Minister has committed to this action already, for completion by November 2021.[1] The final report recognises that "major reforms are needed to the governance arrangements that underpin Australia's mental health system" (p.1079), and proposes the recommendations be implemented through the National Agreement (p.1146). The Agreement would have three key purposes: "clarifying roles for mental healthcare, psychosocial supports, mental health carer supports and suicide prevention; authorising Australian Government transfers to state and territory governments to support provision of these services; and establishing arrangements for monitoring, reporting, and evaluation" (p.1146). The Commission realistically acknowledges the success of such an Agreement would depend on significant contributions to expand mental health care and psychosocial supports nationally, by all governments.

The Agreement is to be developed by the newly established Health Reform Committee of the National Federation Reform Council (NFRC), in consultation with mental health consumers and carers and with the assistance of a small strategic advisory group, including experts, people with lived experience, and the business sector.[2,3]

Key considerations for implementation

Mental Health Australia's submission to the Commission's draft report requested this kind of Agreement be established. The way the Agreement is developed will determine if it reflects the cross-portfolio nature of effective responses to mental ill-health. The Commission has already flagged the limitations of the inappropriately health-centric nature of the Fifth National Mental Health and Suicide Prevention Plan and the need for a whole-of-government approach (p.1086). An Agreement developed solely by health ministers risks perpetuating a health-centric approach (p.132) and undermining efforts to address the root causes of mental ill-health, which span well beyond the health portfolio (see Principle 3 below). Another potential pitfall in implementing reform through a whole-of-government taskforce, is that its remit would be so broad that it risks not be owned by any Government

[1] Morrison, S. (2020). *Speech – 16 November 2020, Parkville, Victoria.* Retrieved 26 November 2020 from https://www.pm.gov.au/media/speech-parkville
[2] Morrison, S. (2020). *Speech – 16 November 2020, Parkville, Victoria.*
[3] Morrison, S. (2020). *National Federation Reform Council Statement – 11 December 2020*. Retrieved 16 December 2020 from https://www.pm.gov.au/media/national-federation-reform-council-statement

agency and thus will be limited in its effect. To address this Mental Health Australia supports prioritising an agreement by health ministers initially to get clarity around who has responsibility for what services are delivered and how they will be funded. There could then be a separate, broader taskforce to develop a cross-portfolio approach.

One remedy may be that a whole-of-government, time-limited, cross-jurisdictional taskforce be established at government official level to support development of the Agreement. In establishing such a taskforce, governments should balance health and social care representation, as well as expertise across the social determinants of mental health. The Agreement also needs to privilege consumer and carer voices and take input from other mental health sector stakeholders. In light of this, it is imperative that members of the strategic advisory group offer a broad range of expertise across lived experience, social determinants of mental health, and health and social care. Strategic advisory group members should also be able to genuinely reflect views across the community, including people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander peoples and the LGBTIQ+ community. The diversity of this coalition should be represented not just in policy development, but also in establishing the targets and measures necessary to assess progress.

As the peak body for the mental health sector, Mental Health Australia can play a unique, pivotal role as an independent facilitator for engagement and advice to inform this work.

Principle 2: Build a mental health system that is truly person-led

Charter 2020 key messages

A system centred on what people with lived experience of mental health issues and their carers say they need, including the structures and processes required to ensure co-design of services and programs.

Overview of the final report

The Commission has recognised the complexities of the current system and programs which will need to collaborate and align to build towards a person-centred mental health system (see Figure 4.1, p.167). The Commission outlines more than 100 recommended actions which have potential to improve lives at the individual and/or community level, and/or benefit the economy; or would support reform. The Commission acknowledges “these actions would take a relatively long time to complete, but governments should consider them as part of planning for a person-centred mental health system” (p.15).

Better outcomes for consumers

In addition to economic gains, the Commission’s core driver for implementing reforms is improving the experience of consumers accessing the mental health service system, shifting from a ‘one-size-fits-all’ approach to a reimagined system that would better serve individual and community needs, while respecting and sensitively responding to the diversity of communities. Mental Health Australia supports this move towards more equitable, inclusive, culturally-responsive services that are person-centred (not bureaucracy- or compliance-centred). While shying away from specifically recommending real-time publicly available data to ensure services demonstrate their value and effectiveness for consumers, the Commission recommends a national, independent review of the current consumer complaints system (Action 22.5).

More informed choice for consumers

Throughout the consultation periods, Mental Health Australia has affirmed that consumers and carers need choice and control of service delivery. To increase consumer choice in referrals (p.460), the Commission recommends ensuring people know they can choose their Medicare provider and can also more transparently understand the costs associated with care, through the Medical Costs Finder website (Action 10.1). The Commission also recommends actions in relation to improved prescribing (Action 10.2) and a new Medicare Benefits Schedule (MBS) item to fund phone advice from psychiatrists to GPs on diagnosis and management issues (Action 10.3).

One of the more significant recommendations made by the Commission calls for the development of a new online assessment and referral tool, available to both GPs and individuals, to replace the current GP Mental Health Treatment Plan under the Better Access program (Action 10.4). This tool would link to the Commission’s other important recommendations in relation to significantly expanding consumer access to supported online

treatments (Action 11.1 and Recommendation 12). The Commission sees a much greater role for low-intensity therapies (such as 'New Access') and online treatments, increasing consumer access and choice. Similarly, the Commission recommends state and territory governments develop a range of service alternatives to hospital and emergency care (Action 13.1). When strategies with a technological focus are implemented, it will be important to ensure that people with complex mental health issues — including those who are homeless, and those living below the poverty line — are not being left behind if they are not be able to access the internet or connect with sufficient bandwidth, or do not have the skills to use the technology required. Strategies will need to be put into place to ensure equitable access to the technology and learn the skills to use it.

Better linkages for ease of navigating the system

In our response to the draft report, Mental Health Australia strongly advocated for properly resourced arrangements for consumer and carer participation, alongside robust infrastructure and mechanisms to link consumers to services they need. In the final report, the Commission recommends developing and improving assistance phone lines and websites that offer support to consumers and carers (Action 15.1).

The report recommends "all regional commissioning bodies should, either individually or collaboratively, develop and maintain an online navigation portal, including detailed clinical and non-clinical referral pathways" (Action 15.2, p.674). The Commission also recommends developing "single care plans for people with moderate-to-severe mental illness who receive services from multiple clinical and non-clinical providers" (p.224), to better involve consumers in developing their care plan and increase information sharing between services (Action 15.3). As part of this better integration, the Commission calls for much closer cooperation and integrated commissioning between mental health and addiction services (Action 14.2).

Empowering consumer and carer participation in system design

To support the major reforms required to create a person-centred mental health system (Recommendation 4), the Commission recommends "consumers and carers should have the opportunity to participate in the design of policies and programs that affect their lives" (p.1113). This is consistent with input given by Mental Health Australia, as genuine engagement results in greater consumer and carer empowerment and ownership of mental health programs and initiatives. There are several recommended actions to drive this reform, including establishment of new, separate peak bodies for consumers and carers (Action 22.4, p.1113). The Commission recommends the Australian Government facilitates a process through which Mental Health Australia establishes these separate peaks "that are able to represent the separate views of mental health consumers, and of carers and families, at the national level" (Action 22.4, p.1113). To make the most of these structures we would need to be clear about the kind of training and development such bodies need in order to be effective and how they can establish strong, useful connections to be informed by experiences at the local level. The final report notes the Australian Government should "provide sufficient funding to cover the development, establishment and ongoing functions of these peak bodies" (p.1113), and over the longer term, Mental Health Australia "should create formal mechanisms to bring the new peak bodies together regularly to progress issues of mutual interest and develop common policy positions and advice" (p.1113). Mental Health Australia looks forward to the opportunity to help facilitate this consumer- and carer-led initiative.

Support for families and carers

The Commission makes several recommendations to move towards family- and carer-inclusive practices, including a review of the Adult Disability Assessment Tool used to assess eligibility for the Carer Payment and Carer Allowance, to reduce barriers to carers accessing income support (Action 18.3).

Key considerations for implementation

The online portal and assessment tool being proposed to replace the Mental Health Care Plan provides an opportunity for more informed referral pathways for consumers, but this needs to co-designed, agile and able to improve over time. This must be a tool for both GPs and consumers, so that planning and referral are done together, to increase choice and respond to articulated consumer preferences. It will be important to consider how choices about supports reflect clinical, psychosocial, and other elements of care that align with a social prescribing model.[4]

The report's recommendation to develop single care plans needs close consideration regarding how this will work in operation. The Plan does not provide any additional services or supports. The existing Mental Health Care Plan was intended to be a planning tool but has performed more of a gatekeeping role. The report suggests such an approach is most critical for people with moderate-to-severe mental illness but there may well be other groups who would benefit from this type of planning and coordinated care (people with early psychosis, multiple co-morbidities, new parents at risk, etc.).

The mental health sector is fully conscious of the priority hospital-based mental health care receives in terms of funding and policy attention. This report continues a tradition of calling for re-balancing priorities away from hospitals and towards non-hospital care in the community. The issue, as it has always been, is how to equip states and territories with incentives or sanctions to make this re-balancing occur, particularly when hospitals remain a focus of political and media attention.

Similarly, the notion of a more aligned approach to mental health and addictions has been long sought but remains largely aspirational. Developing a more integrated system of care between these two key service domains is an urgent goal not just in terms of service provision, but also in terms of cross-disciplinary education and training.

[4] Consumers Health Forum and Royal Australian College of General Practitioners (2020). *Social Prescribing Roundtable November 2019: Report*. Retrieved 15 December 2020 from https://chf.org.au/publications/social-prescribing-roundtable-report

Principle 3: Address the root causes of mental health issues

Charter 2020 key messages

Eliminate stigma and discrimination and address the social and environmental determinants of poor mental health including housing, employment, trauma, physical health, and financial security.

Overview of the final report

It is very positive that in considering measures to improve the social and economic participation of people experiencing mental ill-health, the Commission has considered changes in areas beyond the health sector. As stated, in this regard the Commission has a similar approach to the Fourth National Mental Health Plan, rather than the Fifth, which it describes as inappropriately health centric (p.132). The Commission provides recommendations pertaining to social determinants such as employment, income support, housing, and justice systems.

Recommended actions could go further to prevent the development or exacerbation of mental ill-health. For example, the Commission viewed the (in)adequacy of income support payments as outside the scope of this Inquiry, as "it is not specific to people with mental illness" (p.930). Nevertheless, many of the Commission's recommendations would make an immediate impact on people currently living with mental ill-health and negotiating our social support system.

Housing

While some aspects of the report are original and innovative, other elements echo and reinforce ideas or recommendations made in multiple previous inquiries. This is epitomised by the Commission's recommendation that there be "no discharge to homelessness" following hospitalisation for acute care (Action 20.2, p.1009). The Commission is cognizant that many acute care places are currently occupied by people better cared for in other settings (p.596), and of the often poor connections between housing and mental health services. The Commission calls for a transparent calculation of the shortfall in housing places (Action 20.3, p.1010), stating "there would be benefit from governments increasing the quantum of funding for housing and homelessness services" as part of the next negotiation of the National Housing and Homelessness Agreement.

The report offers other recommendations to improve the way the housing system interacts with people experiencing mental illness, including mental health training for social housing workers, a review of housing policies and 'no grounds' evictions legislation, and access to tenancy support for people in private housing (Action 20.1).

Employment

The Commission's major recommendation in this area is to extend the Individual Placement and Support (IPS) employment support model, eventually rolling out to all community ambulatory mental healthcare services (Action 19.4). This program has a strong evidence base. The overall approach would be further strengthened by considering and testing other

successful models, in addition to IPS, to increase consumer choice and access (see Principle 4 below).

Mental Health Australia had urged the Commission to recommend consultation with consumers and carers to improve the current employment services, but this does not appear to be central in the final report. The Commission instead proposes several tweaks to the current system through: changes to employment support assessment tools to more explicitly assess mental ill-health (Action 19.1); supporting continued access to face-to-face supports for people with mental illness in transition to an online employment support system (Action 19.2); and more flexibility for people with mental illness in meeting mutual obligation requirements (Action 19.3).

Financial security

The Commission reported that the adequacy of income support payments was beyond the scope of the Inquiry. This is unfortunate because financial health and mental health go hand-in-hand. However, the report does recommend an increase to the number of hours per week people receiving the Disability Support Pension can work before their payment is reduced (Action 19.5), and improving access to income support for mental health carers through the current review of the disability assessment tool, and revisions of eligibility criteria for the Carer Payment and Carer Allowance (Action 18.3).

Justice

The Commission makes significant recommendations in relation to early intervention (Action 21.1) and diversion (Action 21.3) within the justice system, embedding mental health professionals with police and ambulance services to co-respond to mental health related incidents (Action 21.2), and ensuring people appearing before tribunals related to mental health legislation have access to legal representation (Action 21.8). The mutual recognition of mental health legislation across jurisdictions (Action 21.11) is another ‘eternal’ recommendation, long championed by Mental Health Australia and the mental health sector.

Trauma

The Commission describes the relationship between trauma and mental ill-health, and the importance of trauma informed care (pp.123-5), yet lacks specific recommendations as to embedding trauma-informed care across mental health services (apart from care provided to Aboriginal and Torres Strait Islander communities).

Access to physical health care

Mental Health Australia called for the Commission to incorporate actions of the Equally Well Consensus Statement in its final report. Pleasingly, the Commission has included a priority recommendation that all governments agree to an explicit target to reduce the life expectancy gap for people with severe mental illness (Action 14.1), and a further recommendation to implement all actions of the Equally Well Consensus Statement to address disparities in access to physical health care for people living with mental illness (Action 14.1).

Stigma, social isolation and discrimination

The Commission provides an extensive description of the association between the experience of stigma, discrimination, social isolation, and mental ill-health, and the kinds of community involvement that can be helpful in recovery. The major recommendation remains the development of a National Stigma Reduction Strategy (Action 8.1), followed by changes to reduce discrimination against people experiencing mental ill-health in accessing insurance (Action 8.2). The insurance industry has been slow to respond to the Financial Services Royal Commission’s recommendation on discriminatory practices which echo

those of the Productivity Commission. The self-regulatory approach needs to be strengthened with greater government oversight and accountability.

Key considerations for implementation

The report provides a platform for renewed advocacy linking mental health and the social determinants of health. Experience has shown this is more easily said than done. It is not enough for regional mental health planning to involve just PHNs and LHNs. For broader change to emerge, it needs to involve consumers and carers and other local agencies representing those social determinants of health concerns. The mental health sector should work with partners from other sectors to promote synchronicity across these areas. This takes time and resources. At the national level, the Commission is seeking to use tools like National Education and Housing/Homelessness Agreements as vehicles to promote change and accountability.

Despite considerable recent efforts, we know there is much still to be achieved to fundamentally embed trauma-informed care across the mental health system. This requires planning, time, and resources.

The Commission's final report proposes a stigma reduction strategy to achieve community-wide attitude change. This change must be measured and monitored.

Principle 4: Invest in early intervention and prevention

Charter 2020 key messages

Programs and supports that intervene early to prevent people from becoming mentally ill and stop emerging mental illnesses from becoming more severe.

Overview of the final report

The final report is notable for its concern with developing schools and workplaces as logical places for prevention and early intervention (see Recommendations 5, 6, and 7). The economists at the Commission fully appreciate the long-term consequences of failing to explore opportunities for early intervention, particularly among infants, preschool and primary school children, and young people.

Early childhood

The Commission notes the connection between the mental health of parents and the social and emotional wellbeing of their children. It recommends that governments take coordinated action to achieve universal screening for mental illness for all new parents (but disappointingly not the infants themselves) (Action 5.1). The report also calls for state and territory governments to expand routine health checks in early childhood years to include social and emotional wellbeing (Action 5.2). This universally targeted measure is welcomed.

Education system

The Commission also seeks to cement reforms across all governments through changes to the National School Reform Agreement. They call for inclusion of student wellbeing as an explicit outcome for the education system, supported by clear, measurable wellbeing targets (Action 5.3). Recognising the confusing plethora of school-based social and emotional learning programs, the Commission calls for accreditation of wellbeing programs, to inform decisions about quality and impact (Action 5.5).

Another important recommendation made by the Commission is for the upcoming Disability Standards for Education evaluation of the effectiveness of disability funding structures for children with social/emotional disability. The report recommends that state and territory governments should review outreach programs for children who have disengaged from their schooling due to mental illness as part of their evaluations (Action 5.8).

Underpinning all this activity is the Commission's recommendation for the development of standards for initial teacher education and professional development programs to incorporate social and emotional development and mental health (Actions 5.3 and 5.4, see p.224). This should extend to early childhood professionals and preschool teachers.

The Commission's location of education as a critical site for early intervention extends from school to universities and TAFE, with a series of recommendations (p.254) made to expand online mental health services and counselling services to better meet tertiary student needs.

Tertiary education institutions would need to develop a student mental health and wellbeing strategy as part of their regular quality accreditation.

Workplace and employment

The report focuses on workplaces as key locations for new interventions. There is specific concern for apprentices and trainees as a vulnerable group (p.284). The report also recommends new support for youth focused IPS employment services, aiming to re-engage young people with the world of work (p.290).

More generally, the Commission points out there are benefits to workers, employers and the wider community from improvements to workplace mental health that lower employee absenteeism, increase productivity, and reduce mental health-related compensation claims. Again, the Commission's capacity to cost the impact of these issues is a key strength of the report.

The National Workplace Initiative being developed by the National Mentally Healthy Workplace Alliance will be pivotal in strengthening the capacity of employers to support their employees' mental health, and support prevention and early intervention through workplaces. The Commission notes the variations in relevant laws between jurisdictions and makes several recommendations designed to encourage all governments to amend their workplace health and safety arrangements to make psychological health and safety as important in the workplace as physical health and safety (p.296).

Key considerations for implementation

The Commission's recommendations for universal screening of children and parents, and more education programs in family and children's health services are positive and welcomed. However, much more comprehensive reform is required to ensure children and families get the support they need when they need it most. Specialist child mental health services are chronically under-resourced yet face continually growing demand, meaning children miss out or have to wait until they age into youth services, missing the opportunity for early intervention. These issues are exacerbated in regional and remote locations, especially in Aboriginal and Torres Strait Islander communities.

We need a comprehensive system of child and family supports, spanning the continuum from prevention and early intervention through to crisis responses, including expanding home visiting programs, with additional supports available for those who need them; repositioning parenting programs as universally helpful (rather than just problem-oriented); and expanding access to evidence-based parenting advice.

The research[5] tells us that very early childhood is a critical developmental stage for young children and their families. Focussing on parents' mental health as proposed by the Commission is not enough – the focus must equally be on the developmental and mental health needs of the child and of the family as a whole. The NMHC was charged in 2019 with the task of developing a National Child Mental Health Strategy, which is yet to be publicly released. It is not clear, therefore, how these recommendations may be aligned with that work.

Schools have long been considered key sites for early intervention in mental health and the reforms recommended by the Commission in this report are sensible and will require committed shared action across the mental health and education domains at state and federal levels.

[5] See, for example: Center on the Developing Child, Harvard University (2016). *Early Childhood Mental Health*. Retrieved 15 December 2020 from https://developingchild.harvard.edu/science/deep-dives/mental-health/

The report focuses on employment support for people with mental illness on the IPS model. There is good evidence to support this approach. It would be very useful to augment this evidence with further research into what works in helping people with mental illness find and keep a job. There are a range of programs (including social firms) and other models worth exploring.

More generally, the mental health sector typically discusses prevention, promotion and early intervention as a bundle of related activities. The report does not explicitly do this and links have not been made with the existing efforts underway for a national preventative health strategy which would provide the most appropriate opportunity to design whole-of-person preventative health and mental health response. It does not discuss the promotion of mental health in significant detail, other than in preschool and school settings, though the stigma reduction recommendations are relevant.

Principle 5: Fund Indigenous mental health, wellbeing and suicide prevention according to need

Charter 2020 key messages

Including dedicated strategic responses co-designed and co-implemented with Indigenous leaders, consumers, and communities. This should be guided by the *Gayaa Dhuwi (Proud Spirit) Declaration,* the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, and the *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013*.

Overview of the final report

The Commission recognises both the cultural and traditional needs of Aboriginal and Torres Strait Islander peoples with mental illness, as well as the disproportionate rates of psychological distress (p.93, p.138, and p.399), exposure to trauma (p.94, pp.123-5), socio-economic disadvantage (pp.95-6) and suicide (p.140) experienced in these communities compared with non-Aboriginal and Torres Strait Islander peoples with mental illness. The final report notes the "accumulated effects of traumatic experiences over many generations, and racism and discrimination that are endemic in many communities, can impede efforts to improve wellbeing. Improvements in the mental health of Aboriginal and Torres Strait Islander peoples require improvements in the conditions of daily life, as well as actions to promote healing of past traumas and address discrimination" (p.406). In addition to many of the whole-of-population reforms which may benefit many Aboriginal and Torres Strait Islander peoples with mental illness, the Commission makes several recommendations and suggested actions which address the social determinants contributing to the poorer mental health outcomes for these communities.

Indigenous control and influence over services for Indigenous peoples

The Commission notes the "limited control that Aboriginal and Torres Strait Islander people have, and feel that they have, over the circumstances in which they live is seen by them as limiting both their social and emotional wellbeing and their own ability to do anything about it" (p.404), what the *Uluru Statement from the Heart* describes as the "torment of our powerlessness".[6] The final report does not align a specific action to this issue, but notes in Finding 8.2 (p.406), "Government actions that support inclusion and empowerment of Aboriginal and Torres Strait Islander people to positively shape and control their futures are likely to improve social and emotional wellbeing both for Aboriginal and Torres Strait Islander people and the broader community" (p.405). The final report recommends considering

[6] Davis, M. (2017). *Uluru Statement from the Heart*. Retrieved 15 December 2020 from https://ulurustatement.org/the-statement; quoted on p.405 of the final report.

funding arrangements reform where the Australian Government Department of Health would "position Aboriginal Community Controlled Health Services as the preferred providers of services to Aboriginal and Torres Strait Islander people" (Action 23.6).

Integrating traditional healers with mainstream services

To support the social inclusion of people living with mental illness, the final report recommends evaluating "best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people" (Action 8.3, p.404). The Commission importantly notes this evaluation "should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve evidence about how a partnership between traditional healers and mainstream mental health care can most effectively support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community" (Action 8.3).

Supporting incarcerated Aboriginal and Torres Strait Islander peoples

The Commission offers the view that "state and territory governments should continue working with Aboriginal and Torres Strait Islander organisations to ensure that Aboriginal and Torres Strait Islander peoples in correctional facilities are connected to Aboriginal and Torres Strait Islander health services in the community following release" (p.1053). The final report recommends that "Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally capable … designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible." These supports and services should also be "trauma-informed" (Action 21.6, p.1054).

Empowering Indigenous communities to prevent suicide

Building on the theme of self-determination for Indigenous communities, the final report recommends "commissioning bodies should ensure that Indigenous organisations are the preferred providers of suicide prevention activities for Aboriginal and Torres Strait Islander people" and all levels of government and all health ministers "should initiate and implement a renewed Indigenous-led National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan to guide suicide prevention in Indigenous communities" (Action 9.2). To enable this, there must also be adequate resourcing allocated to continue developing the Aboriginal and Torres Strait Islander mental health workforce (see Principle 8).

Improving governance

As a priority reform to drive continuous improvement and promote accountability, the final report recommends all governments "agree on a set of targets and timeframes that specify key mental health and suicide prevention outcomes" (Recommendation 24), which includes the important caveat that "Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce should be included in discussions about any targets that may affect Aboriginal and Torres Strait Islander people" (Action 24.4 p.1217). The final report also recommends the "Gayaa Dhuwi (Proud Spirit) Declaration should guide any evaluation by the [NMHC] of programs affecting Aboriginal and Torres Strait Islander people" (Action 22.7, p.1131).

The Commission also recommends the Australian Government should, as a priority reform, "expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023" (Action 22.2, p.1095). Additionally, the final report states "performance monitoring, reporting and evaluation requirements for programs to prevent suicide among Aboriginal and Torres Strait Islander people should be adapted to ensure

they are appropriate to the cultural context in which they are delivered and consistent with Indigenous evaluation principles" (Action 9.2, p.437).

Key considerations for implementation

Mental Health Australia supports Aboriginal and Torres Strait Islander peoples self-determination. We are conscious of the valid hurdle of mistrust in government felt by many communities, which must be acknowledged in any mental health reform agenda. To start building necessary trust, policy developers and service providers must ensure promised Indigenous-specific strategies have timely implementation plans, which are followed up and reported. The process of developing such strategies must reflect self-determination – 'consulting with' or 'seeking advice from' Indigenous services is not the same as having Indigenous-led governance structures and services.

Paradoxically, there are frequent assertions that Aboriginal and Torres Strait Islander community health organisations offer an effective template of care for these communities. This provokes a need to consider how mental health services can replicate or support and build on this success.

Principle 6: Provide integrated, comprehensive support services and programs

Charter 2020 key messages

Full suites of services and programs required to support mental health and ensure intensive, team-based, and integrated care is available for all people experiencing a mental health crisis, and addressing the needs of people who have historically missed out, such as culturally and linguistically diverse populations, LGBTIQ+ populations, and people living with intellectual disability.

Overview of the final report

The Commission provides a sound analysis of the major barriers preventing integrated, comprehensive mental health support services and offers recommendations that would improve the current system. In our response to the draft report, Mental Health Australia called for the Commission to provide an ambitious vision for an ideal future mental health ecosystem, balancing health with social care and support. While the Commission does emphasise key principles such as person-centred care, it focuses more on the practical rather than the visionary.

Gaps

The report acknowledges significant gaps in the delivery of mental health services, due to insufficiency of funding and ways in which funding has been administered. The key gaps highlighted are includes the 'low-intensity gap', describing the shortfall of low-intensity services that increases demands on less appropriate Medicare-rebated care. And secondly, the 'missing middle' where there is a lack of team-based, multi-disciplinary clinical and non-clinical mental health services for people with moderate-to-severe mental illness. As stated earlier, the report also often refers to the National Mental Health Service Planning Framework as a point of reference, to demonstrate significant 'shortfalls' in service availability.

The Commission recommends that MBS telehealth items introduced during the COVID-19 pandemic be made permanent to increase access to mental health services (Action 12.2). The Commission also supports an evaluation of the Better Access program and a trial increasing the number of Better Access-rebated sessions from 10 to 20. The Government has increased the number of sessions to 20, but not acted on these further recommendations regarding evaluation.

Regionality and commissioning

In its final report, the Commission lands somewhere between the previously proposed 'renovate' or 'rebuild' models described in the draft report. The Commission instead opts to give regional cooperation another chance. It eschews centralised decision making for more

local approaches, despite that current levels of cooperation between federally funded PHNs and state funded LHNs is patchy. The Commission's report suggests that PHNs have not always funded evidence-based programs (p.1134), and that LHNs permit inefficiency in community ambulatory mental healthcare services and incentivise relative overreliance on hospital-based care (p.1133).

The report sets out guidelines to encourage cooperation between PHNs and LHNs, including an annual audit by the NMHC on progress (p.1137). The extent to which the Commission's report lays the foundation to draw healthcare responses to mental ill-health together towards systemic integration bears consideration. The Commission sets out a new and fairer way to apportion funding to regions (Appendix G).

Where cooperation between PHNs and LHNs fails, the Commission recommends redress via new Regional Commissioning Authorities (RCAs), established by the states and territories. The Commission asserts that a principal advantage of RCAs over PHN–LHN groupings is that RCAs would better clarify who has statutory responsibility for mental health service commissioning, thereby reducing gaps in service provision to consumers (pp.1149-50).

There is currently a joint responsibility between the Australian Government and the state and territory governments for psychosocial support services. The Commission says that this situation has led to gaps, and that psychosocial services outside of those provided through the NDIS should be funded by one level of government. It recommends this should be the states and territories, as they would be better placed to manage the transition through RCAs (if RCAs are implemented), and more submissions to the Commission favoured this approach. The extent to which state and territory jurisdictions can and do choose to invest in non-hospital services, when these facilities are themselves struggling, is a familiar stumbling block to national reform and systemic re-balancing. If state and territory governments are to take sole responsibility for psychosocial supports, federal funding currently invested in these programs would need to transfer to states and territories and an appropriate source of revenue would need to be identified to fund the necessary expansion of these services.

The Commission report also suggests that existing private health insurance and life insurance regulations prohibit insurers from investing in the mental health of consumers and recommends the Australian Government review the regulations that currently prevent private health insurers from funding community-based mental healthcare activities (Actions 23.9 and 23.10).

Care for people experiencing crisis

The Commission recommends as a priority that state and territory governments provide alternative services (including peer- and clinician-led services) to emergency departments for people experiencing mental health crises (Action 13.1). The Commission also recommends increasing funding for bed-based services to meet demand, and to have specialised wards for children and adolescents, and wards segregated by gender (Action 13.3 and 13.2).

Mental Health Australia would urge that consideration of the demand for hospital beds for people experiencing mental ill-health must sit within the context of provision of adequate community care, because – as the Commission notes – consumers are much more likely to have a positive experience of care in the community (p.618).

Service navigation

The Commission recommends the development of a National Digital Mental Health Platform (discussed in relation to Principle 2), which would offer individuals and service providers access to information about services available in their local area and access to evidence-based assessment to match people to the services best suited to their needs. This would be

a significant step in implementing a 'no wrong door' approach and improving accessibility and navigation of the mental health ecosystem.

The Commission also recommends that regional commissioning bodies (individually or collaboratively) develop an online navigation portal, including detailed clinical and non-clinical referral pathways (Action 15.2). These portal/s would be shared with teachers and others who may make referrals, and eventually become integrated into the National Digital Platform. The portal/s would utilise healthcare management software so users can book appointments directly through the platform.

Coordination of care

The Commission provides a tier of recommendations to support better coordination of care, starting with improved information sharing between service providers through expanding the use of existing digital records systems (Finding 15.1, p.669).

Secondly, the Commission proposes the use of single care plans (also discussed under Principle 2 above), to be developed and agreed on by a consumer, their carer/s (if applicable), and their service providers. The plans would also identify the clinical and non-clinical supports a consumer receives (Action 15.3). Consumers would choose which service provider would help them manage their plan, which is a welcome revision to the draft report which appeared to favour clinical management over person-led. The Commission sees that people with physical health or substance use comorbidities, and people with moderate and severe mental illness who require psychosocial support, would most benefit from a single care plan (p.680).

Consumers with the most complex needs would have a dedicated care coordinator who works with consumers alongside service providers to oversee implementation of the single care plan.

Support for family and carers

The Commission recommends that families and carers be included and supported in a way that upholds the rights of consumers. This would more likely occur if family- and carer-inclusive practice was mandated. The Commission recommends all state and territory governments collect and report on the Carer Experience Survey, improve workforce capacity for family- and carer-inclusive practice, and the Australian Government amend the MBS to provide rebates for family and carer consultations (Action 18.1). The Commission also recommends that planning and funding of carer support services be the clear responsibility of state and territory governments, and the Australian Government would evaluate the effectiveness of Carer Gateway services for mental health carers (Action 18.2). This could be done immediately. There were no specific recommendations relating to respite services, which are a lifeline for many carers and warrants further consideration.

Expanding online treatment

The Commission recommends the Australian Government increase funding to expand online supported treatment, increase awareness amongst carers and professionals of online treatment options through information campaigns, and evaluate the performance of online treatment services (Action 11.1). Such services also have the potential to be particularly beneficial for people who are not accessing other mental health services, including young people. Online services can also facilitate greater engagement with people from culturally and linguistically diverse backgrounds, allowing individuals to connect with mental health workers who speak their preferred language and/or understand their cultural norms and values in relation to mental health and wellbeing.

At-risk population groups and people who have historically missed out must be included in system design

Mental Health Australia urged the Commission to provide explicit recommendations that would progress the representation and advocacy of people and groups who experience systemic exclusion and discrimination. The Commission acknowledges the mental health impacts of racism and stigma associated with sexuality or gender identity, but does not provide specific recommendations relating to these issues. The Commission supports existing standards, holding that governments should partner with consumers service design and delivery, and engage with cohorts (for example, young people, gender diverse consumers and carers, and people from culturally and linguistically diverse backgrounds) where policies and programs are particularly relevant for them (pp.1104-5).

Key considerations for implementation

The report refers to shortfalls in services a considerable 69 times. While it is encouraging that these shortfalls are highlighted, the overall trajectory and outcomes of improving Australia's mental health are less clearly defined. If all the identified gaps are filled, it is unclear what we will really have achieved. Will we have simply addressed known demand, or reinforced some pre-determined, acceptable level of community 'unwellness'? We must do more than address preconceived shortfalls, and fundamentally improve the mental health of all Australians, shifting communities towards preventing mental ill-health in the first place.

There are other questions in relation to integration arising from the report. The states and territories are struggling to ensure their acute care and hospital services are functioning 24/7. The extent to which they can and choose to invest in non-hospital services is a long-standing stumbling block to national reform and a systemic re-balancing of the system towards community care. There is a need to properly explore the extent to which social prescribing can better connect people to local community-based supports that may help keep them out of hospital.

How can we learn from the development of **Head to Health** in creating a National Digital Mental Health Platform – and ensure the mental health sector is engaged in creating an accurate and highly useful product?

The removal of Partners in Recovery and Personal Helpers and Mentors programs has left a major gap in the sector. The Commission report recommends the introduction of single care plans and care coordination which may address some of this gap, but is unclear who would fund and perform the important roles of providing practical support, connection, and mentorship to mental health consumers.

Principle 7: Expand community based mental health care

Charter 2020 key messages

Ensure there are psychosocial programs and team-based care options to provide community-based care and to avoid hospitalisation wherever possible. Australia is capable of a world class community mental health system that is supported by two tiers of government. The lack of community-based mental health services across the country is leading people into crisis responses, with many Australians relying on emergency services for support. Expansion of Australia's community based mental health services will ensure that all Australians receive the right care, at the right time, in the right place, across metropolitan, regional and rural locations.

Overview of the final report

The Commission states its "recommendations aim to establish a comprehensive community support system that operates seamlessly and in balance with the clinical care system, based on consumer and carer input and local requirements" (p.6). This aim is clearly welcome.

There are two issues that hamper the Commission's ability to ascertain an accurate understanding of the current scope of community mental health, let alone envision a world-class community mental health system for the future. First, the final report acknowledges there are significant data gaps in community mental health (see for example p.862). Secondly, as outlined in Mental Health Australia's submission to the draft report, there is large variation in the way the scope of activities that encompass community mental health are described.

The Commission makes sensible recommendations to address chronic underfunding and some of the most glaring gaps in community mental health, including: psychosocial support; community ambulatory care; and non-acute, bed-based services provided in the community. The report describes psychosocial services in some detail (p.826) and calls for their very significant expansion. This could be built on now through developing a better description of how these augmented services could work, particularly in tandem with related clinical and primary care services.

The report also makes recommendations about funding governance, care integration, and the community mental health workforce, all of which are relevant to community mental health and are addressed in other sections of this analysis (Principles 1, 6, and 8, respectively).

Psychosocial support

Recommendation 17 addresses psychosocial supports, an important component of community mental healthcare. The Commission acknowledges there is a shortfall in psychosocial support outside of the NDIS and asks that the extent of the shortfall be estimated and that state and territory governments, with support from the Australian

Government, fund psychosocial supports to meet the shortfall (p.826). The Commission estimates state and territory government spending would need to increase by between $373 and $1085 million per annum to meet the existing psychosocial service delivery gaps (p.1147). Mental Health Australia supports the Commission's intention to grow psychosocial support nationally to match need. As stated above, a key activity could be to fully explore the possible contribution of social prescribing, not as a medical intervention but as part of a social or recovery-based model of mental health where people choose what support they want from a range of clinical and non-clinical sources.

To remove unnecessary red tape, and therefore increase the productivity of psychosocial support services, the Commission sensibly recommends increasing the length of service provider funding contracts to five years (p.826).

The Commission also proposes a streamlined access process for psychosocial supports and recommends the interface between the mainstream mental health system and NDIS be clarified (p.826). The simplification of pathways to psychosocial support is sorely needed. It will be important for consumers to play a central role in designing pathways into care.

The concern for the sector will be that as these matters are being negotiated, a funding cliff is rapidly approaching: the National Psychosocial Support Program concludes in June 2021. Interim arrangements will need to be put into place to ensure the continuity and security of funding which was also one of the report's recommendations (p.843).

Primary care

Recommendation 12 of the report (p.524) is to "Address the healthcare gaps: community mental healthcare". Given that psychosocial services are outlined in separate sections of the report, the Commission appears to view community mental health care mainly through a primary care and clinical lens. The Commission recommends evaluation of MBS-rebated psychological therapy, addressing the shortfall in community ambulatory services (discussed below), improving access to online, telephone and videoconference therapies, and encouraging group therapy (p.524).

Other recommendations, which impact primary care (and therefore are likely to have an impact on the community mental health service system if implemented), are addressed under Principles 2 and 6, and include:

- the development of a Digital Mental Health Platform, including an assessment and referral tool that would replace the current mental health treatment plan and assist GPs in their assessment and referral of consumers, delivery of low-intensity digital services and a gateway to mental health services (p.524)
- better care coordination (p.691) through better use of existing digital records systems and the creation of new single care plans (as discussed above) (p.678).

There remains a gap for access to multidisciplinary team-based care in the community for people with more complex presentations. Building this kind of care is particularly challenging in a fee-for-service environment. The trials put in place in Victoria in response to COVID-19 are an innovation that should be considered as a potential model for wider implementation.

Community ambulatory care

The Commission defines community ambulatory services as "clinical services mostly provided in community or outpatient clinics, including hospitals' outpatient services and day programs, and outreach services provided at a person's home or at an aged care facility" (p.570). The final report highlights gaps both in terms of time clinicians are spending face-to-face with consumers and overall funding for community ambulatory services. One of the more extraordinary findings of the report is that across Australia, only about 29% of clinical staff time at community ambulatory mental healthcare services was spent on

consumer-related activities (20% with consumers present and 9% without) in 2017-18. This falls well short of National Mental Health Service Planning Framework benchmark rate of 67% (p.1164).

The final report makes recommendations for states and territories to investigate and address the disparity between the actual time community ambulatory staff spend on consumer-related activities and what is considered optimal (p.580). In addition, it recommends the Australian Institute of Health and Welfare make public the estimated shortfalls in community ambulatory services and then state and territory governments, with support from the Australian Government, increase funding to meet need (p.580).

Community non-acute, bed-based support

The Commission emphasises the importance of non-acute, bed-based support for people with mental illness, noting treatment in the community can be preferable to hospital (p.618). As examples of community-based non-acute, bed-based care, the Commission notes step up/step down services and community residential rehabilitation services.

The Commission has again recommended state and territory governments measure the shortfall of such services and, with assistance from the Australian Government, increase funding for these services (p.618).

Key considerations for implementation

Mental Health Australia called for the final report to articulate a clear plan for governments to significantly expand successful services across the community mental health sector. The Report on Government Services,[7] published regularly by the Commission itself, found that the time public mental health staff spend with consumers has been decreasing over recent years, with “short” or “very short” outpatient consultations increasing, and longer consults becoming rarer.

While the Commission does not provide an overarching view of a community mental health service system for the future, it does call out some of the more glaring and chronic gaps in the current system and urges governments to address these gaps. This is a welcome addition to the chorus of voices, which have long called for investment in community mental health to meet need. Implementation of these recommendations will go some way to ensure consumers can access appropriate care in the community and avoid unnecessary hospitalisations.

It is urgent that consumers, carers, the mental health sector, and governments work together to design a better community mental health system. This is because the assumptions that underpin the current community mental health system are no longer relevant, especially if the broader goals of economic participation for people with mental ill-health are to be realised. With the community mental health sector already stretched as it adapts to the implementation of the NDIS and other mental health reforms, there are evident challenges here already. There are also broader sector-wide challenges such as an ageing population, growing chronic illness, and the impact of climate change. A vibrant and agile community mental health workforce, including peer workers and supported by technology, lies at the heart of our capacity to manage these challenges.

[7] Productivity Commission (2020). *Report on Government Services*. Retrieved 16 December 2020 from https://www.pc.gov.au/research/ongoing/report-on-government-services

Principle 8: Support workforce development

Charter 2020 key messages

Invest in systematic workforce development, including peer workers, volunteers, paid and unpaid carers, community workers and clinicians.

Overview of the final report

In relation to workforce planning, the Commission's report relies on the National Mental Health Workforce Strategy, currently under development. Where it makes recommendations for workforce growth, these generally emphasise traditional clinical roles, with the report strongly advocating for more psychiatrists (p.712) and mental health nurses (p.717). There are also recommendations (p.712) aimed at strengthening GP provision of mental health services through providing training to GPs on mental health medications and non-pharmacological interventions alongside funding social prescribing trials.

Community mental health workforce

The report recognises community mental health and support workers as "a crucial linchpin in supporting the recovery of people with mental illness and their capacity to remain active, connected and contributing within their family and community" (p.733). However, the report also states that "it can be difficult to encapsulate the role of community mental health and support workers, particularly because there are no predictable education pathways into the sector and their role can vary substantially between service providers" (p.735). This may partly explain why the Commission makes no specific recommendations or suggested actions, focusing instead on data gaps rather than staffing gaps. These data gaps perpetuate a negative cycle, impeding the ability of planners to measure the current status of the workforce, let alone design future growth.

The report makes a welcome recommendation for a new professional organisation to represent peer workers (p.732). The report does not call for wholesale investment in, or expansion of, non-clinical mental health services in the community mental health sector, as recommended in Mental Health Australia's submission to the draft report. Nor does it recommend growth of the non-clinical mental health workforce corresponding with the recommended growth of the clinical workforce.

Workforce planning and reform

The report makes sensible recommendations to align consumer needs with workforce skills, costs, cultural capability, sustainability, availability, and location of mental health practitioners. It rightly emphasises the need to ensure consumers, carers, mental health workers and service providers are consulted about workforce development (p.739). It recognises that the National Mental Health Workforce Strategy should be flexible, estimating workforce needs under alternate scenarios – urban, rural, culturally diverse, etc.

It will be important for governments to act quickly to ensure the Commission's recommendations are enacted as a part of development of the workforce Strategy.

Mental Health Australia welcomes the Commission's efforts to highlight consumer experiences of stigma from health professionals (p.742), and the importance of the availability of culturally-competent practice in mental health care. It will be important for approaches to stigma reduction and cultural competence to be systematic and pervasive throughout mental health service delivery.

Key considerations for implementation

There is a clear disconnect between the report's enthusiastic support for psychosocial services and its relative lack of commitment to build the workforce necessary to deliver this care.

Given its focus on the National Mental Health Workforce Strategy, and a more traditional, clinical workforce, the Commission is clearly focusing on using existing tools to plug the existing (large) gaps. It does not purport to set out a broader vision or shift the balance to increase community mental health workforce capability.

There is clearly a question for the community sector about how it challenges the prospect of being marginalised or even ignored. Marginalisation of the community sector is not in the interest of consumers and carers.

A very clear recommendation from Mental Health Australia, missing in the Commission's final report, was the establishment of a centre for mental health workforce development, such as **Te Pou o te Whakaaro Nui** in New Zealand, that supports the mental health, addiction, and disability sectors on a national level. Such a cross-sectoral workforce planning and training centre could be the driver of workforce changes and strategies to meet future challenges, delivering a more multi-disciplinary, person-led mental health service system. This would include undertaking research, developing and coordinating education and training for service providers and trainers, as well as providing resources, tools, and support to improve service delivery.

Such a centre could also be the catalyst for developing workforce strategies to better manage future disasters as experienced by the devastation caused by recent bushfires and COVID-19. The centre could develop contingency plans to ensure there is a workforce capable of meeting needs without impacting upon current service delivery (that is, the workforce would maintain 'surge capacity'). Further work also needs to be done to strengthen the capacity of the mental health workforce to engage effectively with people from culturally and linguistically diverse backgrounds, including through attracting, retaining, and appropriately remunerating bilingual and bicultural peer and other workers.

The Commission's workforce recommendations largely rely on the National Mental Health Services Planning Framework to set benchmarks. The lack of transparency with the tool leads to uncertainty about whether community mental health and psychosocial services in particular are adequately represented. It is imperative that consumers, carers, and community mental health experts are able to test the tool's assumptions to ensure it is in keeping with consumer needs and expectations across mental health services, not just the clinical sector. The recommendation to make the Framework publicly accessible is welcome in this regard. It is also important to create alignment within the workforce to deliver the multidisciplinary, cross-sector care necessary to address social determinants of mental health.

Principle 9: Build an evidence based, accountable and responsive system

Charter 2020 key messages

Ensure constant research and evaluation, transparent monitoring of prevalence, availability of services and programs, system performance and gaps. Ensure targeted and timely response to identified gaps, system failures and poor performance.

Overview of the final report

The Commission has highlighted the need for stronger accountability in the delivery of effective mental health services, with stakeholder input to the Inquiry pointing to a lack of accountability as "the major governance issue", significantly contributing to strategic failures in the mental health sector (p.1114). The final report includes recommendations to increase accountability through transparent monitoring, reporting, and evaluation as outlined below.

The role of the National Mental Health Commission

The Commission recommends significantly expanding the role of the NMHC to lead the monitoring and evaluation of government-funded mental health and suicide prevention programs and policies to promote accountability for delivery of the mental health system.

The Commission envisages the NMHC "positioning itself as an 'honest broker' in providing evidence-based advice to ministers and informing the wider community of 'what's working and what's not'" (p.1123). Mental Health Australia raised concerns in our response to the draft report as to how the NMHC could be redesigned to have both the necessary independence and capacity to deliver these roles.

The Commission recommends the NMHC be made an independent statutory authority, governed by a board, granted powers to appoint a CEO, given legislative provisions to request information from government agencies, and having cross-jurisdictional authority (Action 22.7). The Commission also recommends equivalent bodies be established for every state and territory where they do not yet exist (Action 22.6). These are welcome recommendations supported by Mental Health Australia. However, where such bodies do currently exist, they are not all constructed in the same manner. Implementation of this recommendation would also then require consideration of reconstituting existing bodies for the purpose of standardisation.

Data collection and use

The Commission is very critical of the current state of mental health data, where "in the absence of high-quality and informative data, many decisions about service and program priorities are being made without evidence of either clinical or cost effectiveness, nor robust

consideration of alternatives" (pp.1189-90). The Commission recommends actions to address the most limiting data gaps: an ongoing commitment to regular national mental health surveys to ensure updated population prevalence and service utilisation data (Action 24.2); collating a dataset of non-government mental health services across all states and territories (Action 24.3); more regional-level data reporting (Action 24.6); and that governments improve usability of existing data by identifying data linkage projects and addressing other barriers to data access (Action 24.1).

Recommendations to address mental health data gaps, including data on specific demographic groups, are welcome. However, there is more to be done in relation to priority populations, such as Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, and people identifying as LGBTIQ+.

Monitoring and Reporting

The Commission outlines how important targets can be in achieving change, but notes that Australian governments have been reluctant to commit to agreed targets. The Commission recommends the Australian Government and state and territory governments all agree on a set of realistic targets and timeframes that specify key mental health and suicide prevention outcomes (Action 24.4). The Commission suggests the Contributing Life Framework could shape the development of meaningful national outcome measures as it provides a possible list of indicators (p.1211). The need to establish effective regional benchmarking is also clear (Action 24.5). There is an important recommendation to make public the assumptions and modelling underpinning the National Mental Health Services Planning Framework (Action 24.9). This will be critical in increasing transparency and confidence in its role in influencing regional planning and funding.

Evaluation

The Commission recommends requiring all mental health funding applications include a cost-effectiveness assessment, and that all new programs should be trialled as pilot programs before being scaled up (Action 24.4).

As part of reforms to the Medicare-funded Better Access program, the Commission recommends a trial introduction of feedback-informed practice (Action 12.3), where consumer feedback through outcome or experience measures informs the care provided by clinicians. This would be one way to include greater real-time feedback from consumers and carers to inform service provision.

Research

According to the Commission, Australia performs highly in the quantity and quality of mental health research. However, our research agenda has lagged behind policy reform, leading to research gaps in real-world priorities like prevention and whole-of-life support. The Commission argues there is a need for greater top-down strategic prioritisation of research and direction from consumers and carers. It provides no recommendation to this effect, but refers to work the NMHC is undertaking to develop a national mental health research strategy (under the National Mental Health and Suicide Prevention Plan) as an example. The Commission also recommends the Australian Government fund a national mental health clinical trials network, covering clinical and community services (Action 24.2).

Key considerations for implementation

Effective accountability for mental health service delivery has been elusive. It seems as if the same bureaucratic structures that have governed developments to date will remain influential, like the Mental Health Information Strategy Sub-committee (MHISSC). A key

issue for the sector will be how to broaden the process of developing accountability systems so they receive due priority and reflect the issues that matter most for systemic quality improvement, and issues that matter most to consumers and carers. This will require a major cultural and behaviour shift — catalysed by funding and capacity-building mechanisms — to a system where the routine collection, analysis and reporting of data and outcomes is expected and the norm.

Holding governments to account for acting on the collection and integration of data — both quantitative and qualitative — as recommended by the Commission, will be essential here. The sector needs to help design the outcome measures we want to use for mental health and determine whether comparisons to the National Mental Health Service Planning Framework are meaningful, and/or as the Commission suggests, the Contributing Life Framework also provides useful guidance.

Conclusion

The Productivity Commission Report makes 21 recommendations, incorporating more than 100 individual and prioritised actions. These are all summarised between pages 61-83 of the Report.

There are many meritorious recommendations provided by the Productivity Commission that have been long supported by the sector. Many other recommendations are very high level and discussions will need to take place to gain the detail necessary to ensure that the best outcomes are achieved.

However, from an overall and systemic perspective, a key question for the sector is whether the Commission's recommendations provide the scope to deliver the desired change to build community-based services and supports to meet the majority of the community's mental health needs while reducing the need for hospital admission that is used only as the last resort for care. If not, what is missing? And how can the mental health sector help to identify and address gaps?

A comprehensive implementation road map needs to be developed — informed by consumers and carers — to pick up additional issues not addressed in the report such as giving more priority to early intervention, and prevention. Implementation processes need to bring together other relevant key planning documents endorsed or in the process of endorsement by government, and at the same time attend to some of the areas less well addressed by the Commission.

The Prime Minister's attention and commitment to the issue of mental health is both clear and welcome. National Cabinet has agreed the National Health Reform Committee will develop a new National Mental Health Agreement by November 2021, supported by a new strategic advisory group. The Fifth National Mental Health and Suicide Prevention Plan is due to lapse in 2022. The pathway towards reform has been set and Mental Health Australia has already been invited to participate in these processes on behalf of members and the sector. Fundamental change in mental health relies on more than 'better' jurisdictional oversight. It needs genuine, properly resourced, local engagement of stakeholders, including consumers, carers, providers, clinicians, and others. While regions may do things differently, this change management task is common and needs support. Executing this change requires community buy-in and cannot be achieved by governments alone.

The Productivity Commission's report is a unique take on a mental health system the community already understands to be facing unsustainable pressures. It considers this system through the lens of national productivity and economic impact. It quantifies the impact poor mental health has on our economy and suggests ways this can be lessened. This economic analysis is the real strength of the Commission's work. It represents a valuable opportunity for Mental Health Australia and our members and stakeholders to change the national conversation about planning for mental health care away from only pills and beds, and towards a community based system.

Mental Health Australia

Mentally healthy people,
mentally healthy communities

Mental Health Australia is the peak independent national representative body of the mental health sector in Australia.

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