Mental Health Australia

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Preliminary Analysis of the Productivity Commission Inquiry into Mental Health Draft Report

8 November 2019

Mentally healthy people,
Mentally healthy communities

Contents

Introduction

The aim of this briefing paper is to provide an analysis of the Productivity Commission (PC) Inquiry into Mental Health Draft Report (the Draft Report). The paper is offered to inform Mental Health Australia members and stakeholders consideration of and responses to the Draft Report. This paper is in addition to the quick scan summary previously prepared by Mental Health Australia.

This paper considers the 1200 page Draft Report and 88 recommendations against the nine key principles of Charter 2020: Time to Fix Mental Health ('Charter 2020'). With over 110 signatories, Charter 2020 is widely supported across the sector as the way forward for mental health reform.

In addition to this briefing paper, and provided at Attachment A, Mental Health Australia has prepared a complete listing of all recommendations made in the Draft Report grouped according to the Charter 2020 principles. We have provided a 'traffic light' analysis of Mental Health Australia's preliminary assessment of each recommendation.

The scope of the Draft Report is broad, covering not just health, but also education, employment, housing and other matters. This is not surprising given the terms of reference explicitly called for examination of how sectors beyond health can contribute to improving mental health and economic participation and productivity.

Some of the recommendations made in the Draft Report are very significant, for example:

- recommendations to effect no discharge from institutional or correctional care into homelessness
- new and detailed engagement by schools and universities in mental health and wellbeing
- new activities to promote early intervention
- new structures to bring together Primary Health Networks and Local Health Districts to pool resources and for better, joined up planning
- a new commitment to clearer national accountability for mental health, including a new National Mental Health and Suicide Prevention Agreement and National Mental Health Strategy, and redesign of the role of the National Mental Health Commission.

As this is a draft report on which the PC is seeking comment, the mental health sector will have the opportunity to identify areas where the Final Report could be strengthened.

It is difficult to get a sense of the overarching narrative in the Draft Report. While the Draft Report makes many sensible recommendations, the end goal is unclear. The PC includes an analysis of the number of people who will require different types of care, in a 'stepped care' diagram (Vol 1, p18). However, this does not outline a vision for recovery. Could we reduce the number of people who need high-intensity care, by increasing service availability and

quality? The level of ambition underpinning the Draft Report is unclear – are we aiming just to better manage a static level of mental illness, or to reduce the impact of and experience of mental illness? It is noteworthy the Draft Report includes no clear definition or commitment to an agreed concept of recovery.

Also unclear at this broad level is the response to what has become known as the 'missing middle'. The Draft Report spends considerable time reflecting on this matter, suggesting the term *"reflects the failure of clarity and coordination where primary and acute mental health care meet"* (Vol 1, p43). However, its response is less clear, with the term 'secondary mental health care' not occurring in the report at all. The whole landscape of the service sector, both clinical and psychosocial, that could populate the space between primary care and the emergency department is not well described. Psychosocial services in particular seem poorly understood, largely to be engaged only once clinical care has failed and mostly for people with longer term, chronic conditions:

Even with the best clinical treatment, episodic or persisting mental illness can result in the need for psychosocial and other supports... (Vol 1, p25).

The proposed new governance arrangements leave responsibility for psychosocial services split, with the Government managing them for NDIS recipients and the states and territories for everyone else, as shown below: (From Vol 1, p44)

Table 2 **Proposed government responsibilities in mental health**

	State and Territory Governments	Australian Government
Health	Hospital and community health services Drug and alcohol services Place based suicide prevention	Online mental health supports and education MBS funded health services Population-level suicide prevention
Education and training	In-school services in public schools Parenting support in community settings Perinatal mental health screening and support for new parents Mental health information and backup for ECEC service providers Government funded VET student services	Funding for in-school services in independent and Catholic schools Online and phone-based parenting support University student services and some VET student services
Specialised services	Psychosocial supports (outside NDIS) # Carer supports (outside NDIS) # Indigenous services # Justice services for offenders and victims	Psychosocial supports (NDIS) Income support for those unable to sustain employment or study Indigenous services # DES and jobactive
Housing	Tenancy support services Integrated supported housing services Homelessness services (including Housing first)	Long-term supported accommodation (NDIA)

current shared responsibility

The PC has recognised the need for longer term contracts for psychosocial service providers but its view about the role to be played by these organisations seems quite narrow.

The role for new community-based clinical and psychosocial services in keeping people out of hospital could be more fully described. The PC has proposed that Commonwealth and state and territory funding for mental health care, psychosocial supports and carer support services be pooled to new Regional Commissioning Authorities (RCA) to manage these services at regional levels. If this model is accepted, a clear priority must be for RCAs to properly invest in community-based services, rather than just in primary or acute care. Many would suggest this investment is the key to really shifting Australia's mental health. This is an area the Final Report could strengthen.

The Draft Report has a welcome focus too on consumers and carers, seeking to place them at the centre of system change. However, what seems missing is a clear-eyed appreciation of the skills, resources and structures needed to identify and enable consumer and carer representation and engagement to truly drive new thinking and new planning in mental health. And while much of the Draft Report suggests innovation, in reality many of the recommendations rely on the assistance of existing people, groups and structures that have been involved in mental health for decades. The next iteration of the report could reflect examples of best practice in genuine co-design, noting that such approaches specifically fund professional systemic advocacy by consumers and carers.

The briefing below provides more detail regarding the PC's Draft Report and recommendations, analysed according to the nine key principles described in Charter 2020. Each section below relates to one of the nine principles, and includes:

- Key messages from Charter 2020
- An overview of the Draft Report's deliberations in relation to this principle
- Summarised key recommendations relating to this principle (noting the full recommendations are provided at Attachment A)
- Analysis of whether the Draft Report is in line with the Charter 2020 key messages
- Key considerations for Mental Health Australia's membership arising from this analysis.

Principle 1: Strike a new national agreement for mental health

Key Charter 2020 Message:

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

Critical to this agreement is:

- Improved accountability, coordination and transparency through clarity of governance and funding responsibilities across Commonwealth and state and territory governments.
- Improved data collection to support accountability, effective funding arrangements, and monitoring of outcomes.
- Targeted actions for the most vulnerable populations disproportionately affected by mental health issues.

Overview:

The PC has recommended developing a new National Mental Health and Suicide Prevention Agreement ('the Agreement') as a key component to any systemic or structural reform in mental health. This is in line with the first principle of Charter 2020 and Mental Health Australia's recommendations to the PC throughout its Inquiry. The PC has also rightly recognised the importance of consumer and carer engagement as a critical success factor in developing the new Agreement.

The PC proposes the Agreement would exist separately from the National Health Reform Agreement, clarify roles and responsibilities between the Australian Government and states and territories, facilitate the transfer of funds from the Australian Government, and reinforce obligations around monitoring, reporting and evaluation.

The PC has also proposed a breakdown of responsibilities between the Australian Government and state and territory governments, including that states and territories would maintain responsibility for hospital and community health services and the Australian Government would maintain responsibility for MBS funded services. The PC proposes NDIS psychosocial supports remain with the Commonwealth but non-NDIS supports be the sole responsibility of the states and territories.

In addition, the PC has proposed the Council of Australian Governments (COAG) Health Council develop a new whole-of-government National Mental Health Strategy, which would integrate services and supports delivered in health and non-health sectors and improve population mental health over a generational time frame. The COAG Health Council would be encouraged to collaborate with other COAG Councils on issues that cut across the social determinants of health, and other COAG Councils are encouraged to ensure their agreements and strategies (as relevant to mental health) outline how they contribute to the aims of the new National Mental Health Strategy.

Key Recommendations

Recommendation	Traffic Light
COAG should develop a National Mental Health and Suicide Prevention Agreement between the Australian, States and Territory Governments. The COAG Health Council should be responsible for developing and implementing the proposed National Mental Health and Suicide Prevention Agreement. (Rec 22.1)	Support
The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding. (Rec 23.3)	Support
The COAG Health Council should develop a new whole-of-government National Mental Health Strategy to improve population mental health over a generational time frame. (Rec 22.2)	Support

Does the PC's framing and solutions reflect the key messages of Charter 2020?

Mental Health Australia welcomes the PC's recommendations to develop a new Mental Health and Suicide Prevention Agreement alongside a new whole of government National Mental Health Strategy. The PC has clearly articulated the need stating that:

"none of these [the Fifth National Mental Health and Suicide Prevention Plan, the National Health Reform Agreement and the National Healthcare Agreement] provides sufficient clarity or detail to promote system performance, nor to assuage concerns about the ability of governments, jointly or severally, to be held accountable for mental health outcomes" (Vol 2, p890).

Mental Health Australia's third submission to the PC Inquiry proposed a new National Agreement on Mental Health should be holistic and focussed on the needs of a population group rather than focussed on a particular service stream. This is also in line with recommendations made by the PC in relation to its recent review of the National Disability Agreement. The PC's current Draft Report considers how to ensure a whole-of-government agreement is developed in practice. Further analysis is required to consider whether its

proposed means of developing the Agreement would indeed lend itself to whole-of-government collaboration.

For example, the PC states the Agreement should "recognise the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports". But in terms of practical implementation, the PC prefers the COAG Health Council lead development of the National Agreement and National Mental Health Strategy, rather than establishing an alternative whole-of-government Council. The mental health sector is unlikely to see this proposal as strong enough to spark whole-of-government actions across the social determinants of mental health.

In addition, Mental Health Australia welcomes the PC's focus on consumer and carer engagement as a critical success factor in developing the new Agreement. However, the structural and funding processes through which the PC would recommend this occur remain unclear. This is covered in more detail under 'Principle 2 – Build a mental health system that is truly person led'.

In terms of the proposed content of the national agreement, the PC's proposal that state and territory governments have sole responsibility for non-NDIS psychosocial services requires careful consideration.

Key considerations for Mental Health Australia's members:

1. Will implementation of the process for development of the new National Agreement and National Mental Health Strategy, as outlined by the PC, enable whole-of-government collaboration across the social determinants of mental health? For example:
    a. Is it sufficient the proposed National Agreement "recognises the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports"? Or should the agreement have a stronger whole-of-government role in supporting mental health?
    b. Should the National Agreement be developed by the COAG Health Council or a newly established whole-of-government COAG Council?
2. What structural and financial arrangements are required to enable genuine consumer and carer co-design of the new National Agreement and National Mental Health Strategy?
3. What are the potential unintended consequences of the draft recommendation that responsibility for funding all psychosocial services, outside the NDIS, is to rest with state and territory governments?

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

Key Charter 2020 Message:

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.

- A mental health system that meets the needs of our diverse communities is one that is co-designed by our communities.
- Consumer and carer involvement in policy, service design, delivery and governance is essential.

Overview:

The Draft Report clearly intends to place consumers and carers at the centre of any changes. The PC's concern is at two levels: the individual level and the structural level.

At the individual level, the PC realises some people miss out on care and face greater likelihood of mental illness than others. They discuss the unique challenges facing some groups including young people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds, people living in social isolation (including in remote parts of Australia), and people in the LGBTIQ+ community. The Draft Report seeks sector views on the development of online resources for the CALD community in particular.

The PC notes out of pocket costs as a significant deterrent to care, reporting these have a direct impact on access to healthcare. People with depression, anxiety and other mental illnesses are 7.7 times more likely to skip treatment than people without a chronic health condition. (Vol 1, p177).

The PC is unclear regarding consumer acceptance of online mental health therapies. Based on existing evidence, they suggest consumers prefer face to face care but are typically unclear about how to find trusted online services as an alternative. The decision about the role to be played by online therapies is a critical element in considering mental health reform and designing a pathway of care. Yet according to the PC's findings, only 4000 Australians used clinician-supported online therapy in 2018. The Draft Report recommends a national

campaign to support online therapy and also better use of existing mental health telephone support services.

The Draft Report also calls for a significant expansion in consumer access to group therapy under Medicare (Rec 5.4), though the decision to provide this type of care rests with health professionals.

Importantly, the Draft Report also calls for the establishment of a new, electronic 'single care plan' for consumers with moderate to severe mental illness (Vol 1, p346) alongside improvements to care coordination. The idea is to better coordinate care across providers. The single care plans would be managed by the 'primary treating clinician' with GPs often playing the role of coordinating the single care plan.

At the structural level, the Draft Report recommends consumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives. The Draft Report does not examine whether the existing consumer and carer infrastructure is sufficiently robust enough and with the breadth of participation to be reflective of the broader mental health sector in order to effectively inform future changes. The Draft Report does support longer term funding to peak bodies to support collaboration and the role of these bodies in monitoring.

The PC's preferred structure to pursue reform is through establishing Regional Commissioning Authorities. The key question here is to understand the skills, resources and capacity required to build professional, systemic consumer advice to the proposed Regional Commissioning Authorities. This thinking has occurred in other places already.[1]

As the PC published its Draft Report there was an announcement of the formation of a National Peak Consumer Alliance, bringing together six mental health consumer peak bodies from Victoria, New South Wales, Tasmania, South Australia, the Australian Capital Territory and Western Australia to have more influence on national policy.[2] Consumers have been calling for this kind of national voice for some time. How this Alliance is supported to address the issues raised here will be very important.

Key Recommendations

Recommendation	Traffic Light
The Australian, state and territory governments should ensure that they collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation (Rec 22.3)	Support
The Australian Government should instigate an information campaign to increase awareness of the effectiveness, quality and safety of government-funded clinician-supported online therapy for treatment of mental ill-health for consumers and health professional (Rec 6.2)	Support

[1] for example, see: https://www.eu-patient.eu/globalassets/library/publications/epf_added_value_report_final.pdf

[2] see: https://croakey.org/mental-health-consumers-present-a-collective-dream-for-a-wonderful-future/

Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers (Rec 10.3)	Further analysis required
All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. (Rec 10.4)	Further analysis required
The COAG Health Council should agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time. (Rec 22.4)	Support

Does the PC's framing and solutions reflect the key messages of Charter 2020?

There is a strong general alignment between the key messages of the Charter and the solutions proposed by the Draft Report. However, consideration is required to develop a robust and tangible structure for effectively supporting consumer and carer engagement, particularly in systemic advocacy.

Key considerations for Mental Health Australia's members:

1. Should the Final Report include a clear definition of recovery? The absence of this definition in the Draft Report could be rectified, along with a clearer understanding of the role of psychosocial services and the social determinants of mental health.
2. The PC is seeking further information on out of pocket costs and alternative means of service payment that make access more likely. What could these look like?
3. The PC is looking for advice regarding the acceptability of online therapies to consumers, with a view to making it easier for people, and young people in particular, to find trusted online care. How can the sector help?
4. What structures, resources and capabilities are necessary to make consumers and carers the drivers of regional and national mental health reform?
5. How will consumers and carers influence the choice and priority given by the COAG Health Council regarding the targets of mental health reform in Australia? How can the sector ensure targets reflect consumer and carer priorities?
6. The proposed 'single care plans' and care coordination improvements seem a promising suggestion. How will consumers retain control of these plans and their own care coordination and ensure they articulate and align with desired recovery goals? Can non-clinicians manage the plans? What will be carers' rights and responsibilities under the plans?

Principle 3: Address the root causes of mental health issues

Key Charter 2020 Message:

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

- There is evidence that particular experiences and social circumstances can trigger and/or perpetuate mental health issues, including housing instability and homelessness, trauma, relationship stress, stigma and discrimination (among others).
- Holistic, tailored mental health care that tackles the root causes of mental health issues is critical for the mental wellbeing of Australians.
- The root causes of mental health issues transcend the health sector, and Australia's mental health is the responsibility of all sectors and all levels of government.

Overview:

The PC is to be commended for including the impact of service systems outside the mental health sector for people living with mental illness. The Draft Report looks into significant areas of social determinants of mental health including employment services, income support, housing, justice, experience of stigma and workplace health and safety. However, in examining these systems the PC takes a relatively narrow focus on improving the way these adjacent systems respond to people living with mental illness, rather than systemic reform to prevent mental illness.

EMPLOYMENT: The PC outlines the association between mental illness and unemployment, and barriers to work people with mental illness often face. The PC focuses on Government employment services, and makes recommendations to better identify people with mental illness accessing these services to ensure they can obtain more intensive supports, and increase flexibility in mutual obligation requirements. While not seeing a need to change eligibility requirements for the Disability Support Pension (DSP), the PC is recommending an increase to the threshold for the number of hours and amount of income someone on the DSP can work before they start losing payments. Such increased flexibility and access to supports would be welcome. However, these specific recommendations would need to be thoroughly worked through with consumers and carers, particularly in light of other reforms to Government employment services.

The PC has also reviewed evidence for the Individual Placement and Support employment model, which suggests it is more effective than other reviewed models. Greater availability of

employment services, and holistic connection with other supports, would be extremely welcome. We would also encourage consideration of other employment service models.

HOUSING: The PC demonstrates a good understanding of the relationship between insecure housing and mental illness. The recommendations are focussed on people living with severe or complex mental illness, rather than broader reforms to reduce housing stress, but if implemented would still be expected to make a significant impact. The PC is recommending governments commit to no discharge from institutional or correctional care into homelessness; and that governments work towards meeting the need for long-term housing, supported housing and homelessness services for people with mental illness, and consider Housing First policies. The report includes analysis of the current gaps in housing and homelessness services for people with mental illness, the need for new investment and the benefits of secure housing to support recovery.

JUSTICE: The PC acknowledges mental illness is highly prevalent amongst people in prison: people with mental illness are 11 times more likely to be a victim of crime (likely due to interaction with other risk factors) and people living with mental illness are more likely to experience legal problems and face barriers to accessing justice. The PC makes a number of recommendations with a view to seeing interaction with the justice system as an opportunity to intervene and divert people to mental health care and treatment. This includes embedding a co-response to mental health crises between police and mental health professionals; ensuring mental health service standards in correctional facilities match those in the community; ensuring mental health screening on admission to correctional facilities to inform care and continuity of support upon exiting; and ensuring Aboriginal and Torres Strait Islander people in correctional facilities have access to culturally appropriate mental health supports. There are also a number of recommendations to improve access to legal aid services for people appearing before mental health tribunals and ensure non-legal advocacy services are available for all people subject to involuntary treatment under mental health legislation.

WORK PLACE HEALTH AND SAFETY: The PC makes a number of targeted recommendations to elevate psychological health and safety in workplace health and safety legislation, and to increase the coverage of workers compensation for responding to and motivating prevention of psychological injury.

STIGMA: The PC acknowledges the impact of stigma, particularly for people living with mental illnesses that are not well understood in the general community, and stigma amongst health professionals. To address this, the PC recommends the National Mental Health Commission should develop and drive a national stigma reduction strategy focusing on poorly understood mental illnesses, in reliance on the leadership of people with lived experience, and targeting stigma by health professionals.

Key Recommendations

Recommendation	Traffic Light
Review assessment tools for employment services and the development of the new employment services model to better consider the needs of participants with mental illness (Recs 14.1 and 14.2)	Further analysis required
Rollout the Individual Placement and Support (IPS) model of employment support (Rec 14.3)	Support
Housing services should increase their capacity to prevent people with mental illness from experiencing housing issues, through: • mental health training for social housing workers • reduce risk of eviction by reviewing policies regarding tenants behaviour • ensure access to tenancy support services for private and public housing renters with mental illness. (Rec 15.1)	Support
Housing and homelessness services should have the capacity to support people with severe mental illness to find and maintain housing in the community: • Governments commit to no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and prisons • NDIA review Specialist Disability Accommodation strategy to encourage development of long-term supported accommodation for NDIS participants • Governments work towards meeting the gap in the number of 'supported housing' places and homelessness services for people with severe mental illness - this could include increasing programs such as Housing First programs (Rec 15.2)	Support
Implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations (Rec 16.1)	Support
Mental healthcare service provision in correctional facilities should meet the standard of those held in the community (Rec 16.2)	Support

Recommendation	Traffic Light
Individuals entering correctional facilities should be screened for mental health issues, to inform care/resourcing needed in the facility, and to support transition to community services when leaving correctional facility (Rec 16.3)	Support
State and Territory Governments should ensure Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally appropriate (Rec 16.4)	Support
All State and Territory Governments should continue to develop disability justice strategies to ensure the rights of people with mental illness are protected and promoted in their interactions with the justice system (Rec 16.5)	Support
Increase availability of legal aid for mental health related matters, by State and Territory Governments • adequately resource legal aid services to assist people appearing before tribunals that hear matters arising from mental health legislation • ensure that non-legal individual advocacy services are available for all individuals subject to involuntary treatment under mental health legislation (Rec 16.6)	Support
Improve Work Health and Safety protocols to protect mental health, by: • psychological health and safety having the same importance as physical in workplace health and safety laws (Rec 19.1) • develop codes of practice to assist employers to meet their duty of care for psychological health in the workplace (Rec 19.2) • workers compensation schemes provide lower premiums for employers who implement programs to reduce the risks of workplace related psychological injury (Rec 19.3) • workers compensation schemes to provide clinical treatment for all mental health related workers compensation claims (Rec 19.4) • WHS agencies should monitor and collect evidence from employer initiated interventions to create mentally healthy workplaces (Rec 19.5)	Support
Stigma reduction - the National Mental Health Commission should develop a national stigma reduction strategy that focuses on experience of mental illnesses that are poorly understood by the community. Stigma reduction programs should be incorporated in the initial training and continuing professional development requirements of health professionals, subject to periodic evaluation as to their appropriateness and effectiveness. (Rec 20.1)	Support
Increase awareness of mental illness in the insurance sector. (Rec 20.2)	Support

Does the PC's framing and solutions reflect the key messages of Charter 2020?

The examination of the experience of people with mental illness across housing, employment, income support and justice portfolios is very welcome, and represents a move towards addressing social determinants of mental health. However, the PC makes relatively targeted recommendations within each of these sectors and mostly for people experiencing severe or complex mental illness, rather than a holistic or preventative approach.

Key considerations for Mental Health Australia's members:

1. Are there further social determinants of mental health that the PC ought to consider? (e.g. climate change)
2. Do the PC's recommendations regarding better tailoring of government employment services, and expansion of Individual Placement Support, go far enough in driving change in employment for people living with mental illness?
3. Will targeted changes to housing and homelessness services for people living with mental illness make a considerable impact? Are there broader reforms that are more urgent?
4. Does the PC strike the right balance in its recommendations on the justice system?
5. Is the approach suggested for a national stigma reduction campaign, and training for health professionals, going to be the most effective?

Principle 4: Invest in early intervention and prevention

Key Charter 2020 Message:

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

- Early intervention and prevention is a cost-effective, long-term investment into Australia's mental wealth in 20 years' time.
- Early intervention should not be limited to the early years of life, but rather should occur across the lifespan.
- Awareness campaigns and the promotion of mental health are critical forms of prevention.

Overview:

The Draft Report states that under-investment in prevention and early intervention was one of the common recurring messages it received throughout its data gathering. On this basis, the Draft Report has a very strong focus here, covering several areas both in health and other services. For example, the Draft Report calls for mental health training for social housing workers to encourage earlier intervention. Early intervention is also recommended as part of a better response in the criminal justice system, on university campuses, and in relation to workers' compensation.

The Draft Report makes recommendations in several key areas in relation to early intervention in health care, some clearer than others. For example, there is a draft recommendation for universal screening for perinatal mental illness. There are also recommendations focusing on mental health services for preschool children and their families.

The PC's strong focus on education is predicated on the new expectation of the education system's role in actively supporting their students' mental health and wellbeing. However, the Draft Report cites concern with existing school 'wellbeing programs' and makes several practical suggestions, including that MBS-rebated health professionals treating children be required to include recommendations for parents/carers *and teachers* in their report to the referring medical practitioner.

Perhaps the most far reaching recommendation made is that each of Australia's 10,584 schools employ a designated "Wellbeing Leader" to manage and coordinate school activities and assist both teachers and students.

The Draft Report also calls on governments to expand the collection of data on child social and emotional wellbeing, and ensure data is used (and used consistently) in policy development and evaluation.

The PC also suggests that its recommendations in relation to the 'missing middle' represent a kind of early intervention, in that meeting the need for community services would serve to deter crisis. Their recommendations here, and overall pathway of early intervention and prevention, need further exploration.

Key Recommendations

Recommendation	Traffic Light
Governments should take coordinated action to achieve universal screening for perinatal mental illness. (Rec 17.1)	Support
State and Territory departments of education should ensure that all early childhood education and care services have ready access to support and advice from qualified mental health professionals. (Rec 17.2)	Support
Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum. The COAG Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. (Rec 17.3)	Support
The education system should review the support offered to children with mental illness and make necessary improvements. (Rec 17.4)	Support
All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support. (Rec 17.5)	Further analysis required

Does the PC's framing and solutions reflect the key messages of Charter 2020?

Given this is a PC report, it is not surprising their strong support for early intervention comes from both a community wellbeing perspective and a long-term economic perspective. This is welcome. Momentum for mental health reform may be stronger from central Australian Government agencies like Finance and Treasury than from Health.

Key considerations for Mental Health Australia's members:

1. There are very significant mental health workforce considerations in relation to early childhood – while the intent of the recommendations is clear and welcome, achieving them will require careful planning.
2. The significant recommendations made to improve mental health care in schools and universities raises important issues about the interaction between health and education. This kind of interaction is already problematic between health and housing. Teacher workloads are already contentious. Changes to education seem sensible but interactions between education, health and community services need careful thought and considerable resources. However, effective cooperation is critical in managing mental health after the school bell. The report notes the limited follow-up often available to children, from headspace or elsewhere. How can this be addressed?
3. The role of the Wellbeing Leader will need considerable further exploration, particularly in relation to connections into the mental health system when specialist assistance is required.

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

Key Charter 2020 Message:

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

- Indigenous leadership is essential to promote the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people and communities. This goes beyond co-design with Indigenous people, and includes funding of Aboriginal organisations to autonomously design, develop and implement services that meet the needs of their people.
- All proposed policy, system and practice changes across the full spectrum of mental health and suicide prevention should be considered in terms of their effect on Aboriginal and Torres Strait Islander people and communities.
- The vastly disproportionate impact of child and youth suicide in Aboriginal communities demonstrates a need for investment in community-led solutions.
- Solutions that promote Indigenous people's connection to culture are essential, alongside culturally safe clinical services.

Overview:

The PC's approach to improving Aboriginal and Torres Strait Islander mental health, wellbeing and suicide prevention is underpinned by two strategic proposals:

- To expedite 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
- To develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan to guide suicide prevention activities in Indigenous communities, with Aboriginal and Torres Strait Islander organisations to be preferred providers under the strategy.

In addition, the PC notes the importance of consulting with Aboriginal and Torres Strait Islander people or organisations which represent them in relation to evaluation, monitoring and reporting against these strategic plans (see recommendations 22.5 and 25.4).

In relation to specific services, the PC recommends:

- The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people
- Aboriginal and Torres Strait Islander people in correctional facilities should have access to mental health supports and services that are culturally appropriate and designed by Aboriginal and Torres Strait Islander people.

In addition, the PC notes the importance of tailoring other recommended programs to meet the specific needs of Aboriginal and Torres Strait Islander people. For example, in developing a systematic approach to support police to respond to mental health crisis situations (recommendation 16.1) and in strengthening the ability of schools to assist students and deliver an effective social and emotional learning curriculum (recommendation 17.3).

Key Recommendations

Recommendation	Traffic Light
The Australian Government should expedite the development of an implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023. (Rec 22.2)	Support
Empower Indigenous communities to prevent suicide: In the short term (in the next 2 years) • The Council of Australian Governments Health Council should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan • Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. (Rec 21.2)	Support
The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services. (Rec 20.3)	Support
State and Territory Governments should ensure Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally appropriate. (Rec 16.4)	Support

Does the PC's framing and solutions reflect the key messages of Charter 2020?

Mental Health Australia welcomes the PC's emphasis on ensuring Aboriginal and Torres Strait Islander people are at the forefront of making decisions about their own social and emotional wellbeing. Broadly, the PC states this should occur through broadening roles in governance within the mental health system and expanding the role of Indigenous controlled organisations in planning and delivery of mental health and suicide prevention services. However, further analysis is required to examine the extent to which the recommendations, as drafted, would result in this greater level of self-determination for Aboriginal and Torres Strait Islander people.

There are also plentiful references throughout this report to the need to consult with and tailor services specifically to Aboriginal and Torres Strait Islander people, where services are not Indigenous-controlled.

The PC's final report should provide greater emphasis on both the Gayaa Dhuwi (Proud Spirit) Declaration and strategies to increase Aboriginal and Torres Strait Islander participation in mental health professional occupations across the spectrum.

The strategic recommendation to expedite the implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 sets an overarching strategic framework within which services can operate. However, the PC's report falls short of recommending funding be specifically tied to the implementation plan, begging the question of what practical outcomes will likely be achieved.

In addition, recommendations about specific services for Aboriginal people go only to suicide prevention and services for incarcerated people, seemingly without a plan for development of the broader Aboriginal and Torres Strait Islander-run social and emotional wellbeing service environment.

Key considerations for Mental Health Australia's members:

- Is it enough for the PC to recommend the implementation plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 is expedited? Should the PC recommend funding is earmarked for Aboriginal and Torres Strait Islander Mental Health and Wellbeing and attached to this implementation plan?
- What key components should the PC's Final Report address in order to strengthen the broader Aboriginal and Torres Strait Islander run social and emotional wellbeing service environment?
- How do we increase Aboriginal and Torres Islander participation in mental health professional training to build that workforce?

Principle 6: Provide integrated, comprehensive support services and programs

Key Charter 2020 Message:

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

- Australia's mental health system requires a clear architecture that is adaptable to local circumstances.
- The fragmented nature of the current system has created large gaps through which many Australians are falling. There is a 'missing middle' between primary care and crisis support.

An integrated, comprehensive support system is needed to support continuity of care, and streamline consumer care pathways.

Overview:

The Draft Report acknowledges the unique needs of different parts of the community, though specific recommendations are harder to discern. The report does go to considerable lengths to consider the needs of non-urban populations through, for example, expanded access to teleconferencing or increasing incentives for psychiatry to practice in these areas.

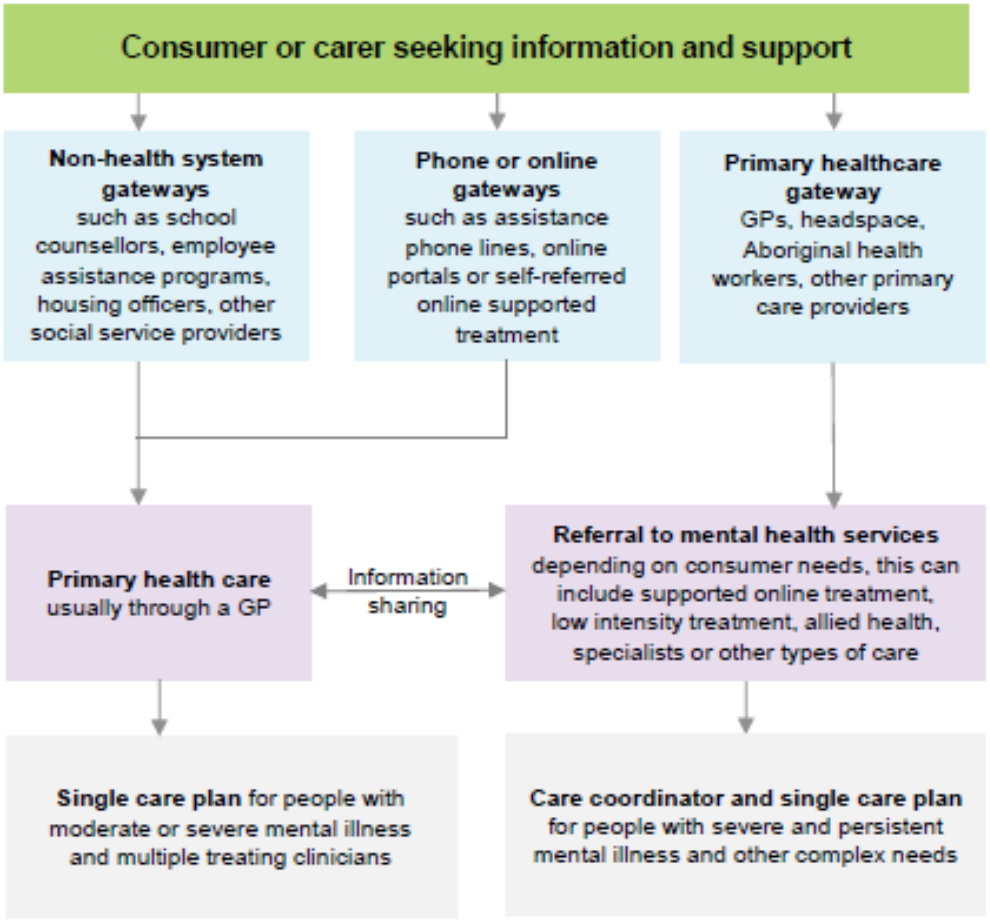
The Draft Report makes several suggestions about how to improve headspace performance, particularly in relation to expanding access to low intensity services as part of a stepped care model. An important recommendation is made to place full responsibility for continued headspace funding in the hands of each Primary Health Network, rather than centrally mandated.

There are two major recommendations made by the Draft Report in relation to better integrated care: one at the service level and the other at the structural level. The recommendation at the service level is a nominated 'primary treating clinician' will take responsibility for management of a new 'single care plan', designed to coordinate care for people with complex or severe mental illness.

The coverage of the plan would vary from person to person according to their needs at particular points in time, but could include a plan to address aspects such as mental

healthcare, physical healthcare, cultural and spiritual needs, psychosocial support needs, housing needs, community inclusion needs, the role of their carer or kinship group, and reintegration into education or the workforce. (Vol 1, p26).

Figure 10.1 **The Commission's model of consumer pathways in the mental healthcare system**



(Vol 1, p337)

This recommendation is predicated on addressing some traditionally difficult issues, such as data sharing between providers, consent and privacy, carer rights, follow-up and, of course, necessary financial incentives. But the theory is sound – to make coordinated care more likely and to prevent the consumer from having to repeat their story.

Single care plans sound promising. However, they are clearly designed to be managed in clinical settings, by clinicians working on behalf of 'their' patient. This may be unacceptable to some consumers. And while the intent is clearly to link the single care plan with non-health providers, the capacity of organisations outside of health to participate in the necessary data

sharing systems is clearly an issue. This kind of barrier would serve to marginalise psychosocial services, making it less likely consumers would or could choose this care.

The second key recommendation made in the Draft Report to integrate care is structural. Two options are presented, both aiming to drive regional mental health planning to the next level.

The 'renovate' model involves increasing the capacity of Primary Health Networks to plan and respond to local needs, working with their state or territory authorities. The 'rebuild' model calls for the establishment of a new level of governance altogether –Regional Commissioning Authorities. The RCA model is preferred by the PC, suggesting it could effectively pool resources and surmount traditional funding silos. The Productivity Commission described their purpose RCAs as being, "*to create a seamless mental healthcare system that offers continuity of service for people with mental ill-health and fills gaps in service provision. RCAs would overcome unnecessary and inefficient care discontinuities, duplication and gaps that would otherwise persist at the interface between Australian Government and State and Territory Government responsibilities. These new bodies will be responsible for allocating all mental healthcare, psychosocial and carer supports (with the exception of those for people receiving NDIS funding)".*

Some key issues to consider here are how, under either structure, community mental health services and psychosocial services in particular fit into regional model of care. The new structures are also supposed to engage consumers and carers. This means seriously considering the skills and resources consumers and carers need to effectively lead regional planning processes. For them to participate in these processes as equals, they will need to know how to analyse systemic data about both services and finances, and possess mapping, modelling and other skills relevant to local planners.

Both models have implications for health professionals, appearing to suggest PC support for shifting from fee-for-service payment models to other models designed to foster more multidisciplinary or team-based care. This would be supported by a new Mental Health Innovation Fund, to trial these new models.

The Draft Report also suggests activity-based funding could be applied community mental health services to "both improve their efficiency and reduce incentives to prioritise hospital-based care" (Vol 1, p47). This claim merits considerable further investigation.

Table 23.2 **Roles and responsibilities under the Renovate and Rebuild models**

Includes only services that would differ in funding and/or administration between the two options. Services highlighted in green are those for which service delivery responsibility sits with a different level of government between the two models.

	Renovate model		*Rebuild model*	
	State and territory governments	*Australian Government*	*State and territory governments*	*Australian Government*
Health	• Public hospital and community mental healthcare services • *Place-based suicide prevention services (in concert with PHNs)*	• Medicare Benefit Schedule-funded mental health services • *Commissioned primary mental health services (devolved to PHNs)* • *Care coordinators (devolved to PHNs)* • *Place-based suicide prevention services (devolved to PHNs, and in concert with LHNs)*	• Public hospital and community mental healthcare services • *Commissioned mental health services* • *Care coordinators* • *Place-based suicide prevention services*	• Medicare Benefit Schedule-funded mental health services (rebates for allied mental healthcare are linked to the size of the Regional Commissioning Authorities' pools)
Psychosocial supports	• Psychosocial supports (outside of the NDIS)		• Psychosocial supports (outside of the NDIS)	
Carer supports	• Carer supports (outside of the NDIS)		• Carer supports (outside of the NDIS)	

Managed by Regional Commissioning Authorities

(Vol 2, p951)

Key Recommendations

Recommendation	Traffic Light
The Department of Health should cease directing PHNs to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit (Rec 5.3)	Further analysis required
Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers (Rec 10.3)	Further analysis required
All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed. (Rec 10.4)	Further analysis required
The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding (Rec 23.3)	Support
Review proposed activity-based funding classification for mental healthcare (Rec 23.1)	Further analysis required

Does the PC's framing and solutions reflect the key messages of Charter 2020?

There is a general alignment between the key messages of the Charter and the solutions and framing proposed by the Draft Report. There is some emphasis on groups that have traditionally missed out, though this could go further. Similarly, there is strong emphasis on the missing middle without clear solutions.

Key considerations for Mental Health Australia's members:

1. What are the implications for professional role delineation arising from a single care plan? How would non-health services and e-health services be included?
2. How will consumers retain control of single care plans and ensure they articulate and align with desired recovery goals? Can non-clinicians manage the plans? What will be carers' rights and responsibilities under the plans?
3. What structures, resources and capabilities are necessary to make consumers and carers the drivers of regional mental health reform?
4. If RCAs are comprised of primary care networks and local health districts, what will be the incentives to fund 'secondary' care services in the community? Can activity-based funding create desirable incentives for keeping people out of hospital and community mental health care?
5. Is there an alternative model to both the Renovate or Rebuild models that needs to be considered?

Principle 7: Expand community based mental health care

Key Charter 2020 Message:

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, in the right time, in the right place across metropolitan, regional and rural locations.

Overview:

One of the major key themes in recurring inquiries into mental health over decades has been to highlight the significant service gap between primary care and crisis services. Simply put, inquiries commonly find Australia has failed to invest in the clinical and non-clinical services necessary to keep people out of hospital and to provide care for them on discharge from hospital. These services are sometimes called 'secondary care' (a term not used in the draft PC report).

Like its predecessors, the PC's Draft Report acknowledges the major gap in mental health services between primary and acute care, and the impact of this on personal wellbeing and over-reliance on crisis services. The PC sees this gap as the result of unclear state and territory government and Commonwealth responsibilities, and funding arrangements that incentivise direction of resources to acute care (pp280, 928).

The report includes analysis of the shortfall in both psychosocial support services and specialised clinical care provided in the community. The workforce providing specialised clinical community services is 28% below the benchmark calculated by the National Mental Health Services Planning Framework (NMHSPF). The number of available non-acute beds is less than 60% of the NMHSPF benchmark (with considerable differences across states, though it is worth noting the intent and process underpinning the establishment of these benchmarks is unclear).

While the PC's outline of the issue seems reasonable, the Draft Report's recommended response is less clear. Rather than a clear commitment to preferentially grow the community sector, the Draft Report offers a series of recommendations which, while seeking to address identified gaps, leave the future of community mental health services uncertain.

The PC recommends state governments and Local Hospital Networks continue to manage contracting for clinical community based mental health services, but with greater clarification of their responsibility, increased incentives for efficiency, and evaluation of this funding arrangement by the National Mental Health Commission.

Historically states and territories have generally chosen *not* to fund non-government organisations to provide community services. In 2016-17, combined state and territory funding for these services comprised less than 7.5% of total national mental health spending. This is an increase of about 0.5% since 2009-10 (MHSIA, AIHW).

Investment by state and territory governments in their own public community health services has also changed. Data problems mean understanding these changes is difficult. However, we know that concerns about risk have driven increased provision of 'community' services onto hospital premises, often provided as outpatient clinics requiring patient attendance.

More services are provided by telephone. In 2005-06, 38% of total community service activities were community contacts lasting less than 15 minutes. This was 43% in 2017-18. More than 400,000 community contacts are now recorded as taking less than 5 minutes, up from 40,000. The patient is recorded as present in just over 50% of all 9.5m recorded community service contacts (CMHC 19). The average across all community service contacts has dropped from 45 minutes to 35 minutes in this period.[3]

The PC also reports the "very large service gap" in psychosocial support services (p430). The most recent estimates are that 684,000 Australians require some form of psychosocial support, 64,000 of whom will access services through the NDIS, and 290,000 of whom who will require considerable ongoing support. However, even prior to the NDIS, only 90-95,000 people were receiving support through government funded psychosocial support programs.

Further, the psychosocial support sector has been hugely disrupted in transition to the NDIS. The PC strongly emphasises the decision to apply for psychosocial supports in the NDIS should be the decision of the consumer, and that people should be able to access ongoing supports where they need them. This means changing the eligibility requirements for Continuity of Supports so people do not have to be rejected from the NDIS before they are able to access services, ensuring people continue to be supported during an application process for the NDIS, and are able to continue accessing support through the National Psychosocial Support Measure if they choose not to apply for the NDIS. The report calls for the Australian Government to make public the anticipated long-term arrangements for psychosocial support for people not eligible for the NDIS.

In the Draft Report, the PC proposes that in the long term, psychosocial support services are funded by Regional Commissioning Authorities (if the Rebuild model is successful) or state and territory-commissioned programs. They argue the National Psychosocial Support measure should continue until this alternative model is established. The report also recommends evaluating and removing the barriers for people with psychosocial disability who do not apply for the NDIS, so that as many eligible people as possible enter the Scheme.

The PC regards the current funding arrangements for psychosocial support services as inefficient and duplicative. The report finds "The large service gap that existed before the NDIS, and is becoming more acute, can be bridged in two ways. The first is to make the existing funding work more efficiently, while the second is to increase funding overall." (p454)

[3] MHSIA, AIHW, Table CMHC 23

Despite outlining the huge and increasing gap in psychosocial support services, the PC stops short of explicitly recommending increased funding, saying "While system changes can improve funding efficiency, the overall level of funding may need to increase as well." The PC recommends level of need for psychosocial services should be assessed using an evidence-based framework, such as the National Mental Health Service Planning Framework, and funding levels should be matched to that level of need.

The PC has a sound understanding of the impact of short-term funding arrangements – particularly for consistency in staff, and the flow-on impact for consumers. Longer term contracts facilitate stability and certainty for staff and consumers, which is very important for psychosocial recovery (p427). The PC recommends the extension of contract cycles to five years for psychosocial services. This would be well-supported by the sector. However, it is less clear how this recommendation fits with the transition from the current state to a future model of psychosocial service funding.

The PC considers other funding arrangements, and the incentive for private health insurers to fund services that prevent hospitalisation. The PC reviews indications of effectiveness of some funding of community-based mental health interventions by private health insurers for people with chronic illness. The PC is recommending review of regulations to increase the scope for private insurers to fund programs to prevent avoidable mental-health related hospitalisations. However, there could be unintended consequences of this such as further muddying responsibility for funding community based mental health, and increasing inequities in access to care.

The report includes an overview of shortcomings of the NDIS for people with psychosocial disability regarding psychosocial supports provided through the NDIS. This includes strenuous application process, less people with psychosocial disability participating in the Scheme than expected, unclear interface with mainstream services, and comparatively poorer experiences in the Scheme. The PC acknowledges work underway to improve the interaction of people with psychosocial disability with the NDIS, and recommends the psychosocial disability stream should be fully rolled out by the end of 2020. Mental Health Australia is supportive of these recommendations, and also wants to see the recommendations of the psychosocial stream working group implemented.

Key Recommendations

Recommendation	Traffic Light
Guarantee continuity of psychosocial supports • Requirements for continued access to psychosocial support should be changed so that anyone who requires it is able to access it • Should someone choose to apply for the National Disability Insurance Scheme (NDIS), they should continue to be supported during the application process • Should someone choose not to apply for the NDIS, they should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out In the medium term (over 2 – 5 years)	Further analysis required

Recommendation	Traffic Light
· For those who did not apply for the NDIS, the psychosocial support commissioning agencies should conduct an evaluation of barriers and remove them as necessary · When the National Psychosocial Support Measure is phased out, participants should either be shifted onto the NDIS, if appropriate, or access the replacement psychosocial support. (Rec 12.2)	
The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years (Rec 12.1)	Support
NDIS support – NDIA continue to improve approach to people with psychosocial disability, by completing evaluations of psychosocial trial sites, fully rolling out the psychosocial disability stream by the end of 2020, and incorporating lessons from the Independent Assessment Pilot into access and planning processes (Rec 12.3)	Support
State and Territory Governments should take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the National Disability Insurance Scheme. The Australian Government should provide funding to support the new and expanded roles that State and Territory Governments are taking on, and continue to administer the Carer Gateway's service navigation and information services for all carers (Rec 23.2)	Further analysis required
The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions (Rec 24.5)	Further analysis required

Does the PC's framing and solutions reflect the key messages of Charter 2020?

The PC provides a sound overview of the benefits of community-based mental health services, and the enormous gap that currently exists. However, the report does not go far enough in recommending significant expansion of community-based services.

While making recommendations to ensure continuation and availability of psychosocial support services for people who need them, the lack of explicit articulation of the need to expand community based care means the recommendations fail to ensure integration of the medical approach to mental health with social care and support, and the level of community services necessary to support recovery. The psychosocial recovery section lacks understanding of the importance of team-based care (though this is discussed briefly in relation to care coordination).

Key considerations for Mental Health Australia's members:

1. How do we prosecute to the PC the need for much more ambitious reform to fill the 'missing middle'? What is the sector's vision of a mental health system with

appropriate psychosocial services to support recovery and people living with mental illness to live contributing lives?

2. Would the sector support the consolidation of responsibility for community based mental health services (specialist clinical and psychosocial) to state and territory governments? What are the potential unintended consequences?
3. How can the mental health sector better understand the planning assumptions which underpin the National Mental Health Service Planning Framework?
4. How can the sector ensure greater transparency about funding and services provided in the community versus those provided in hospital settings? How can we ensure prioritisation of the former over the latter?
5. What would be the consequences of expanding the scope of private health insurance funding for community-based mental health services?

Principle 8: Support workforce development

Key Charter 2020 Message:

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

Australia needs a National Mental Health Workforce Strategy that is developed in consultation with and agreed with the sector. Critical to this strategy is consideration of:

- Australia's rapidly growing peer support workforce.
- the physical and emotional safety parameters required to enable safe and productive working environments for staff across the mental health workforce.
- funding arrangements which attract mental health workforce to grow in regional and remote areas and to work with harder to reach people, such as those experiencing homelessness.
- the impact of short-term and individualised funding arrangements on workforce stability and job security.
- new data collection requirements to enable the community mental health sector to be better accounted for in workforce planning.

Overview:

The PC's approach to mental health workforce development, outlined in the Draft Report, appears to be solidly entrenched in a biomedical approach to mental health service delivery, with little consideration for the community mental health sector. It appears to be firmly focussed on closing the most pressing gaps within the current mental health workforce, rather than anticipating an aspirational new system and proposing workforce development to match. This is perhaps a reflection of the report's overall reliance on small fixes rather than setting ambitious new direction.

The PC's overarching recommendation is the forthcoming National Mental Health Workforce Strategy align health workforce skills, availability and location with the need for mental health services. This places great hope on, and in some ways defers much decision making to, the National Mental Health Workforce Strategy, a strategy the sector is yet to be consulted about.

In relation to health specific professions, the report recommends strategies to increase the numbers of psychiatrists and mental health nurses in particular, noting the significant workforce shortages experienced across these professions. In addition, it makes recommendations about how to upskill GP mental health expertise, particularly in relation to mental health medication management.

The report also goes to the culture and safety of staff working within the mental health sector and makes key recommendations around "exposing health students and practising health professionals to people with a mental illness... outside a clinical environment" and "rebalancing where trainees undertake clinical placements and internships..." However, these recommendations fall short of directly addressing cultural change within health settings.

In addition, the report offers recommendations to increase access to health professionals in rural and remote areas but it does not address attracting mental health workforce with other people typically considered hard to reach, for example those experiencing homelessness or dual diagnosis.

While Mental Health Australia welcomes these recommendations, which are necessary to strengthen Australia's clinical mental health services, it does highlight a rather glaring omission in relation to development of the community mental health workforce. Perhaps the report's one saving grace in this respect is its focus on strengthening the peer workforce (across both the community and clinical sectors).

Mental Health Australia welcomes all the PC's recommendations in relation to strengthening the peer workforce. These are necessary but not sufficient to address the workforce development needs of the community mental health sector; a sector which has been under significant strain due to recent but now long running major national transitions both to the National Disability Insurance Scheme and from national to regional commissioning through Primary Health Networks (PHN). Anecdotal evidence from service providers suggests this has resulted in difficulty in retaining staff, increase in casualisation and has necessitated hiring on attributes rather than requiring qualifications (such as the Mental Health Certificate IV). If there is any part of the sector in need of workforce development support, this is it.

It may be that better data is required to quantify the workforce to increase its visibility as an integral component to the success of an overarching sector. In fact, with more focus on the community mental health workforce, there is an opportunity to envisage a more aspirational mental health system. One which is recovery focussed, community-based and keeps people out of hospital. In the long term, this type of system may even lead to less pressure on the clinical workforce, easing some of the critical mental health workforce shortages noted above.

Key Recommendations

Recommendation	Traffic Light
The forthcoming update of the National Mental Health Workforce Strategy should align health workforce skills, availability and location with the need for mental health services. (Rec 11.1)	Support
The Australian, State and Territory Governments should collectively develop a national plan to increase the number of psychiatrists in clinical practice, particularly outside major cities and in sub-specialities with significant shortages, such as child and adolescent psychiatry. (Rec 11.2)	Support

Recommendation	Traffic Light
The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years. (Rec 5.1)	Support
Accreditation standards should be developed for a three-year direct-entry (undergraduate) degree in mental health nursing. In the medium term (over 2 – 5 years) · The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health should be assessed. (Rec 11.3)	Support
Strengthen the Peer Workforce: · The National Mental Health Commission should recommend how its national guidelines on peer workers should be supported by work standards for particular areas of practice. · The National Mental Health Commission should, recommend to the Australian Government how to establish a professional organisation to represent peer workers. In the medium term (over 2 – 5 years): · The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers. · The Australian Government should commission a national review to develop a comprehensive system of qualifications and professional development for peer workers. (Rec 11.4)	Support
Improve medical practitioners' training on medication side effects and consider specialist registration for GPs who have advanced specialist training in mental health. (Rec 11.5)	Support
Governments and specialist medical colleges should take further steps to reduce the negative perception of, and to promote, mental health as a career option. (Rec 11.6)	Support
The Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave. (Rec 11.7)	Support

Does the PC's framing and solutions reflect the key messages of Charter 2020?

Although the Draft Report's recommendations are sound, they are not sufficient. They represent a narrow and health-centric view of the mental health workforce. Not only does this miss an opportunity to re-establish a community mental health workforce, it also fails to acknowledge the cross-sector workforces requiring mental health skill development such as justice, housing, social services and education.

The PC's Draft Report provides robust recommendations that would improve the current system, enable more timely and equitable care, and address critical shortages in key health professions. However at this stage of the drafting process, it is not a catalyst for change.

Key considerations for Mental Health Australia's members:

1. What system would we advise the National Mental Health Workforce Strategy be designed for?
2. What are the key workforce requirements for this system?
3. How would the sector expect to be engaged in relation to the Strategy's development?

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

Key Charter 2020 Message:

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

There is a need for:

- More formal evaluation requirements and independent monitoring of outcomes, specifically against the Fifth National Mental Health Plan.
- A centralised Mental Health Outcomes Framework for community-based and clinical mental health services that measures outcomes across the social determinants for mental health.
- Formalised and consistent allocation of evaluation funding for all pilot programs to monitor program outcomes, improve accountability, and contribute to the country's evidence base of effective mental health interventions.

Overview:

Reforms to accountability are a central part of the Draft Report (Reform Area 5). The Draft Report acknowledges the limited accountability for mental health outcomes currently, with "vast amounts" of information collected but poorly applied for the purpose of systemic quality improvement (Vol 1, p47). The Draft Report calls for routine surveys of mental health and wellbeing. The Draft Report also suggests the need for urgent improvements to accountability in relation to suicide prevention.

Responsibility for improving this situation, according to the Draft Report, would be met through a significant re-design of the role of the National Mental Health Commission (NMHC), to become an interjurisdictional statutory authority charged with systemic oversight. How this could be achieved while delivering independence is not clear. The report recommends the NMHC should *not* advocate, defend or publicly canvass the merits of governments' or oppositions' policies (Vol 1, p102).

New accountability arrangements would be underpinned by a new National Mental Health and Suicide Prevention Agreement, a new National Mental Health Strategy and expansion of the scope of the COAG Health Council to ensure fuller consideration of the social determinants of mental health. The Draft Report acknowledges the importance of new data linkage capacities, to enable this fuller picture to be established.

Key Recommendations

Recommendation	Traffic Light
A new national mental health and suicide prevention agreement, engaging consumers and carers in the process of establishing new and transparent systemic performance reporting requirements (Rec 22.1)	Support
Accountability for mental health outcomes should include measurement against predetermined performance targets (Rec 22.4)	Support
The Australian, State and Territory Governments should task the Mental Health Information Strategy Steering Committee with developing a strategy to improve data linkage in mental health (Rec 25.1)	Support
The National Mental Health Commission (NMHC) should have statutory authority to lead the evaluation of [all] mental health and suicide prevention programs The NMHC should be an interjurisdictional body (Rec 22.5)	Further analysis required

Does the PC's framing and solutions reflect the key messages of Charter 2020?

The Draft Report's acknowledgment of the need for much stronger accountability is both clear and welcome. However, it should be remembered the PC's preferred option is a fundamental rebuild of mental health funding arrangements with new state and territory Regional Commissioning Authorities given new responsibilities. Ensuring these new arrangements are supported by an appropriate and properly resourced system of accountability for quality improvement will be a challenge.

Key considerations for Mental Health Australia's members:

1. What new resources need to be available to ensure accountability goals are realised? This is particularly important if we are to assess the health and welfare of people in relation to the social determinants of health.
2. How will new accountability arrangements be different to existing processes?
3. Who will determine the priorities? Will new measures and targets reflect consumer and carer interests?
4. The Draft Report makes no reference to real-time consumer/carer feedback as part of quality improvement process. Is this important?
5. How can regional differences in performance be evaluated as part of a national mental health quality assurance/improvement framework?
6. On what basis could the National Mental Health Commission provide an independent account of progress? What skills and resources would it need?

Other issues for consideration

Physical Illness, Integrated Care

From its outset, the Draft Report has misgivings about the relationship between mental health and the rest of the health system, suggesting key problems arise from the former appearing 'tacked on' to the latter (Vol 1, p4). The PC recognises co-morbidity, particularly for people with severe mental illness, as a significant issue. They identify the proposed new single care plan as a potential new tool to respond to this complexity. They note, for example, that where complexity requires multidisciplinary team care this team should be responsible for the joint development of the single care plan.

It should also be noted, and beyond physical illness, that the Draft Report calls for significant focus on 'care navigation' in order to better respond to co-morbidities. During the webinar[4] with Mental Health Australia members, Presiding Commissioner Dr Stephen King stated this was an unapologetic call for the reconstitution of the type of service provided by the Commonwealth program Partners in Recovery.

One of the most significant current trends in health is integrated care. Mental health has been part of this concept as it has evolved. It is worth considering the impact of establishing quite separate mental health-specific commissioning bodies on systemic capacity to further drive integrated care for people with a mental illness. This is critical given the link between chronic illness and premature mortality among people with a mental illness.

The Draft Report goes further. It recommends a key feature of the proposed COAG National Mental Health and Suicide Prevention Agreement should be separate funding and governance arrangements of mental health from those of physical health, to strengthen the accountability of individual jurisdictions for mental health outcomes.

Surprisingly, the Draft Report makes no specific recommendations in relation to the better physical health care of people with a mental illness.

Climate Change

The impact of climate change on communities and mental health is emerging as a genuine area of concern and interest. The mental health of people living in rural and remote areas is a significant issue that is further exacerbated by the long drought and heightened risk of bushfires inflicting a financial and emotional burden that impacts upon their mental health. The Draft Report does not cover this issue at all and makes no recommendations. This may be an issue to consider further for the Final Report.

[4] Webinar held on 31 October 2019 for Mental health Australia members

Mental Health Beds

The Draft Report points to pressures on mental health beds, for adults and particularly for children and adolescents. It calls for better planning in Rec 7.1. The report also suggests that while Australia had 3,436 non-acute mental health beds in the public sector this was less than 60% of the National Mental Health Service Planning Framework benchmark for this kind of care (meaning 5,852 beds should be available).

At the same time, the report states there are hundreds, even thousands, of people in acute hospital beds whose admission could have been avoided, or who could be discharged if the less acute services they needed were available

The report's recommendations in relation to beds need further analysis so they can be assessed against overall goals and principles. There is clearly pressure on emergency departments and on bed-based services. However, it is unclear how a fundamental shift towards earlier intervention and community-based care would affect currently accepted benchmarks. History suggests that the resources needed to respond to crisis tend to overwhelm other parts of the service system. We need to establish a judicious balance between meeting existing demands for crisis care while building impactful alternatives that meet people's needs in a timely way.

Suicide Prevention

This is a key focus for the report which goes to considerable length to cost the economic impact of deaths by suicide and attempted suicide – between $16bn and $34bn annually. The Draft Report makes several recommendations, including:

- school based suicide prevention awareness programs
- universal access to aftercare following an attempted suicide
- a new National Aboriginal and Torres Strait Islander Suicide Prevention Strategy
- better role delineation between governments
- better research and evaluation.

Rural and Remote Mental Health

The Draft Report identifies issues related to poor access to people living in rural and remote areas and has recommended increasing access to clinician-led online e-health interventions, expansion of telehealth consultations, provision of psychiatrist's advice to GPs, and via enhancements to many existing training programs to improve the rural workforce. While all of these recommendations are laudable, they will only go part way to address the needs of these communities. Access to face to face consultations remains as important to people living in rural and remote areas as they are for their urban counterparts.

Workforce training solutions are long term and have been unreliable in the past due to a range of variables such as career opportunities available in urban areas. Primary Health Networks have an important role in identifying local solutions to service provision. Yet purchasing processes contributed to the decline in local rural workforces due to contracting large corporate providers of many PHNs at the expense of small local providers.

Innovative local solutions that increase access to services, including face to face consultations, and build the local workforce should be considered as high priorities.

Conclusion

Mental Health Australia welcomes the careful thinking and detail the PC provided in the Draft Report.

There was a great deal of expectation surrounding the release of the report, with terms like "once in a generation" being used. While living up to this billing was always going to be difficult, the Draft Report has many positive aspects. It is a useful and contemporary statement of the breadth and depth of the community and economic impact of mental illness. It works hard to properly place the experience of mental illness in a broader social context. It has set out new areas for focus, like housing, justice and education. It has attempted to grapple with details of accountability and governance.

The Draft Report is at times damning about national progress. For example, it states:

There is no clear national vision for mental health. Although the National Mental Health Policy 2008 declares that it 'provides a strategic vision for further whole-of-government mental health reform in Australia' there is little evidence that its development involved collaboration with non-health portfolios. This is consistent with the subject of the vision being the mental health system, rather than mental health outcomes.

There is also a disconnect between the national vision statement and those developed by individual State and Territory Governments... While the vision statement in the National Mental Health Policy provides context, no jurisdictions refer to COAG's vision in their strategic mental health plans. (Vol 2, p898)

The PC's Draft Report provides similar critiques of all existing key mental health strategies and plans and notes the repeated failure of these documents to drive reform. Yet their recommendations then call for a full suite of new plans, policies and strategies. The experience of the sector, learned over decades, is that the key to change is sustained and supported implementation. There is an urgent need for the mental health sector to critically assess the extent to which the Draft Report will deliver this implementation.

The sector should also be mindful of a range of activities underway that can influence the direction of future reform. The National Mental Health Commission is preparing Vision 2030. The Victorian Mental Health and Aged Care Royal Commissions are progressing. The Government has already committed to the development of childhood mental health strategy and there is clearly work underway in relation suicide prevention. As usual, the policy environment is complex.

It is up to the mental health sector to manage this complexity and consider how it can best assist the PC to realise the full extent of its ambition. We understand how little benefit comes from just applying more band-aid solutions. We also understand how easy it is to ignore recommendations, no matter how well written.

In looking to provide the PC with sector-wide feedback, it is interesting to consider hypothetically, if everything in the Draft Report was implemented fully and completely, would

it have enough of an impact to really shift the national response to mental illness? Some critical elements appear to be missing, like a concept of recovery, structures to support broader consumer and carer systemic advocacy and a clear commitment to community-based services. How can the sector work with the PC to further articulate a suitably ambitious reform agenda that represents generational change? It is not enough to simply do what we are doing now but better.

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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