Mental Health Australia

Productivity Commission Inquiry into Mental Health – Final Report

Introduction

The **Productivity Commission Inquiry into Mental Health** has delivered a robust Final Report to address the wide-ranging issues that it has heard from consumers, carers and mental health stakeholders during the course of its inquiry. The Report is pragmatic, as might be expected from an Inquiry driven by economic imperatives. It provides a strong rationale for action and investment in areas like employment, training, education and housing, and clearly states the costs associated with inaction.

The Commissioners should be commended for their diligence, commitment and engagement to inform this once in a generation opportunity for major reform of the mental health sector.

It is a long report (1600 pages), and justifiably so, to reflect the breadth of challenges, opportunities and recommendations needed to inform what the sector hopes will be an equally comprehensive response from Government.

This initial response by Mental Health Australia provides a brief overview of the Report, and will be followed by more detailed analysis in the coming weeks, including priorities for investment.

Key Points

In our response to the Draft Report, Mental Health Australia advised the Productivity Commission that it needed to recommend tangible structures to ensure consumer- and carer-led design, significant growth of community mental health, and actions to address the social determinants of mental ill health.

The Report has addressed these issues. There are multiple recommendations to empower consumers and carers, improve funding certainty, provide additional primary care pathways to support, build capacity in the mental health workforce, and help address physical health disparities, housing, employment, workplace mental health and stigma to name but a few.

The Report also provides a range of specific recommendations to address the dysfunctional governance of the mental health system, improve data collection and set targets which the sector has advocated for over many decades.

The Productivity Commission's recommended reforms fall into five broad areas:

1. *Helping people to maintain their mental health and reduce their need for future clinical intervention, including by tackling early mental health problems and suicide risks*

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2. *Improving people's experience of the mental healthcare system to ensure the care received is person-centred, timely, consistent with treatment needs and does not impose undue burden on consumers or carers*
3. *Improving the experience of people with mental illness and their carers beyond the healthcare system, recognising there are numerous gateways in the community through which people enter the mental health system and a range of services beyond healthcare — in particular, psychosocial services, housing and justice — that are important for an individual's social and emotional wellbeing and recovery*
4. *Helping people to remain engaged in education and stable employment; reforms designed to support and enable Australians with mental health problems to reach their potential in life, have purpose and meaning to them, and contribute to the lives of others*
5. *Reforming the behind-the-scenes arrangements and incentives to ensure services for people in need are as seamless, connected, and timely as possible.*

It should be noted that when releasing this Report, the Prime Minister did not announce any Government response to the immediate actions recommended by the Productivity Commission. Rather the Government will develop a "comprehensive report" to the Productivity Commission's Report by the May 2021 Budget, drawing on public consultation and other significant inquiries due to report shortly. Implementation of other recommendations may also be referred to a new Health Reform Committee reporting to National Cabinet, charged to deliver a new agreement on mental health and suicide prevention by November 2021 (noting that the Fifth National Mental Health and Suicide Prevention Plan is due to expire in 2022). The Committee would be supported by a strategic advisory group – possibly reflecting the Report's recommendation that Australian, state and territory governments should establish a Special Purpose Mental Health Council (SPMHC) (Action 22.3).

Despite the urgent need for action, Mental Health Australia recognises that reform at the scale outlined through the Report will need careful planning and 'buy-in' across jurisdictions, but it must also have broad advice from the sector if real co-design and implementation is to be achieved. This cannot be about governments alone. It must include the people whose lives are affected and the services that support them.

A person-led system

The Report advocates for a person-centred approach to mental health care (Finding 4.1).

Increased consumer choice about mental health care fits with person-centred principles (Action 10.1) but the Report suggests a focus only on cost, and future planning and reform must also consider quality of care.

The Productivity Commission identifies the need to establish national consumer and carer peak bodies, facilitated by Mental Health Australia and we look forward to supporting such a welcome recommendation (Action 22.4).

We congratulate the Productivity Commission for incorporating the needs of people from culturally and linguistically diverse (CALD) backgrounds in the Report. The acknowledgement that humanitarian entrants are more likely to have higher psychological distress compared to the general population and that mental health reform is needed due to the unique challenges facing people from CALD backgrounds is significant.

Of note also is the recognition of the need to provide culturally capable services to international students, and that all mental health services should reflect the cultural, social

and clinical preferences of each person. In particular the CALD Fact Sheet is a welcome feature to draw attention to this issue.

Early intervention, prevention and addressing social determinants

The systematic investment proposals for each developmental life stage (babies, pre-school, primary school, secondary, post-school, tertiary) is a model that clearly recognises the unique drivers for mental ill health across the lifecycle and the need to address particular factors such as parenting, poverty, and the impact of trauma at different life stages. This approach could be broadened to address the challenges faced by adults through life and relationship transitions into old age and retirement.

The Report's emphasis on assisting schools and teachers to respond to the needs of children and teenagers with mental ill health is most welcome, as are those for increased support for Australian and International students and young people in the tertiary sector (Actions 5.4 and 6.3).

The Productivity Commission has considered actions to reduce stigma and discrimination and strategic action should address the general community. The specific role for such a strategy aimed at health professionals is welcome (Action 8.1), however measures of success will need to be developed. Action on discrimination in relation to insurance access is also welcomed (Action 8.2). A stigma reduction strategy must form part of a broader mental health prevention plan yet to be identified.

Support for employment is critically important (Action 19.4) both in supporting people to access and retain employment but also to address the mental health challenges that can emerge at work. The National Workplace Initiative is a critical enabler in this context.

Consideration of actions on housing and homelessness are welcome and reflect a holistic response to mental health challenges (Action 20.1). A key recommendation to establish a policy of no discharge into homelessness has been a longstanding but elusive goal (Action 20.2) and action to achieve it will require housing or supported accommodation to discharge people to.

Providing integrated, comprehensive mental health services

The Report suggests replacing the GP mental health treatment planning process with an online assessment and referral tool, in development by Government (Action 10.4). This recognises the central role of GPs in primary mental health care as service providers. Online low intensity services like New Access are to be developed to add alternatives to face-to-face care with health professionals under Better Access (Action 11.1). We support the call for Better Access to be immediately and fully evaluated (Action 12.3).

Improving emergency department experiences for mental health consumers is a very welcome goal (Action 13.2), with much further work to do in identifying implementation parameters particularly in relation to non-hospital alternatives.

Community based mental health care

The Report highlights the lack of certainty of psychosocial support services in Australia (Action 23.2), with governance and funding unclear. This leaves the sector without the necessary resources to better address the needs for people that cannot be adequately met in a primary care context but who do not need acute clinical care.

The Report states clearly the initial intention is to transfer responsibility for all psychosocial funding to the states and territories (Action 23.3).

The Report also refers to better understanding the shortfall in acute inpatient beds (Action 13.3). What qualifies as a shortfall needs to be better understood. We need to be clear about the expected role beds and hospitals are to play in mental health care in the 21st century, and for whom. Hospital bed numbers should not be permitted to drive all other changes and reforms in mental health. However there is a danger of this, particularly when the nature and future role of 'community ambulatory' services provided by the states and territories (Action 12.4), as well as the nature of psychosocial services, are not well described (Action 17.1).

Workforce development

The Report's strong emphasis on workforce is welcome (Actions 16), especially a new association of peer workers (Action 16.5). However, despite several references to the need for multidisciplinary care for more people with more complex needs (including Finding 15.2), it is not clear how these workforce recommendations foster this outcome.

Governance and accountability

Mental Health Australia supports the principle of robust collaborative regional governance arrangements across the mental health continuum of care and integrated fully with broader health care.

The Report supports existing arrangements promoting joint planning and commissioning by federally-funded Primary Health Networks and state-funded Local Health Networks/Districts. Establishment of new Regional Commissioning Authorities is supported in this Report where they already exist, or would be established where local organisations cannot cooperate as envisaged to deliver better systems of care.

There is no precedent, in Australia or internationally, for a national mental health commission of the type described by the Report (Action 22.7). The Report recommends that every jurisdiction should have a commission-type body (Action 22.6). There is a need to clarify how all these bodies might work together, and to what extent a national commission of this kind could independently monitor a strategy it has itself devised.

Conclusion

Such a large of body of work will require time to review, assess, consult and provide further comment on. There are also complex interactions with other bodies of work to consider, including Vision 2030, the Royal Commission into Victoria's Mental Health System, the National Mental Health Pandemic Plan, and the National Mental Health Workforce Strategy, as well as current broader reforms in primary care, preventative health, disability and aged care.

The current context of the global pandemic further underlines the need to actively progress reform with leadership and coordinated action across jurisdictions. It must be focussed on promoting the health and wellbeing of people. It must be informed by data, evidence and sector experience – and by the people who live with mental illness, and those who love and care for them.