SUMMARY KEY ISSUES

THE PRODUCTIVITY COMMISSION INQUIRY INTO MENTAL HEALTH

FINAL REPORT

"Strong, inclusive and resilient mental health communities."

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Queensland Alliance FOR MENTAL HEALTH

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Overview

This paper aims to provide members of the Queensland Alliance for Mental Health (QAMH) a summary of key sections of the Report from the Productivity Commission Inquiry into Mental Health (The Report). We have focused on those areas which are likely to be of most interest to, and have most impact on, the Community Mental Health and Wellbeing Sector. The paper explores several key themes, providing a brief analysis as well as considering the implications and opportunities arising.

The Report was published in November 2020 and has set an ambitious agenda for reform. There is a significant focus on creating a person-centred mental health care system and engaging with lived experience at all levels of strategy development. The Report acknowledges the need to improve people's experience of mental health care and strengthen efforts to provide prevention and early intervention in mental health and suicide prevention. Whilst the final report highlights the gaps in services available and notes the importance of community mental health services and psychosocial approaches, it does not clearly articulate how this will be driven and supported by a skilled workforce. Many of the issues raised in the report are not new and have been highlighted in previous reports and reviews without resulting in significant reform. It will take strong leadership and coordination of key actions across a range of domains to implement such comprehensive system reform. It calls for a whole of government approach to mental health care outlining key recommendations and strategies aimed at improving coordination between services and systems, as well as improving accountability to improve outcomes.

In the lead up to the release of The Report, QAMH made two submissions to the Productivity Commission. The first was in response to the initial issues paper, and then a more comprehensive paper in early 2020 in response to the Draft Report. QAMH developed comprehensive feedback urging the Productivity Commission to recommend innovative community-based solutions to some of the gaps identified in the draft report including the group identified as the 'missing middle'. The 'missing middle' describes those people too unwell for the primary care services on offer but not unwell enough to meet the criteria for acute care. Central to our submissions were the following key issues to be addressed:

- A lack of articulation of the current and potential role and scope of the Community Mental Health and Wellbeing sector.
- An over reliance on the acute end of the system missing opportunities to support people to live well in their communities.
- Investment needed in community-based solutions which take a broader view of wellness and address the gap in early intervention in episode.
- Challenges in delivering mental health care in rural, regional and remote areas.
- The need for development and investment in the community mental health workforce.
- Greater investment in housing and homelessness support.
- The response to mental health issues in the justice system.
- A research agenda bringing lived experience together with clinical and non-clinical sectors to develop evidence.

While some of these areas were addressed in The Report, the role of the Community Mental Health and Wellbeing Sector in addressing the gaps was not as clearly articulated, but rather there was a focus on investment into the acute stream of care. The Report acknowledged that data gaps in the description of the current community-based service system made it difficult to assess and define the scope of the sector and plan for a future model. This lack of clarity is compounded by the variation in the way that services have evolved and developed in the community mental health space. Although The Report recommended governance changes to deal with inequities in service availability, QAMH would like to have seen a greater focus on rural, regional and remote strategies to develop a community mental health workforce and increase access and choice in support options for people in those communities.

We were pleased to see The Report articulate a focus on a person-centred mental health system at the core of the reform. We note however, that this language is commonly used already in the system to describe practice, so this will require some fundamental culture change to make the shift. Ensuring the needs of individuals and those they want involved in their mental health recovery are at the centre of decision making and design of care is crucial to success. The role of the community mental health sector in delivering person-centred services and supports is not clearly articulated in The Report, and the work ahead will be to advocate at a national and state level to ensure governments are clear about the substantial expertise the sector has in recovery-oriented practice and person-centred and person-led approaches.

Creating a person-centred system requires a cultural shift in how mental healthcare is accessed and experienced. QAMH understands that individuals who require psychosocial or mental health supports should have easy access to these without a referral from a health service, and without first reaching a point of crisis or presenting to an emergency department where their distress might be medicalised. Action 17.3 in The Report calls for access to psychosocial supports not requiring a diagnosis of mental illness which is a positive step towards a community early intervention approach. Currently, the mental health system is overstretched and designed to respond when a point of crisis has been reached. This perpetuates a cycle of demand at the acute care end and overlooks the crucial role that can be played by the Community Mental Health and Wellbeing Sector in early intervention and the promotion of wellbeing across the community.

In addressing the problems of access to the right services at the right time, The Report acknowledges the gap of the 'missing middle' and suggests that this reflects the lack of community mental health services. However, the recommendations throughout The Report recommend investment and systemic focus on strengthening the clinical mental health sector and on enhancing digital solutions, without recognising the significant role non-government organisations play. While digital platforms have proven to offer an alternative, the reality remains that many people will be excluded from access to digital technologies due to limitations in digital literacy, geographic location, personal preference and the key consideration that mental health supports are found to be more successful in face-to-face settings.

Person Centred Mental Health System

Discussion and Analysis

The Report sets a way forward towards a person-centred mental health system. It describes this as a system where people would be empowered to choose the services that are right for them across a full spectrum of clinical and non-clinical supports. Such a system would focus on the outcomes that matter to people, delivering better quality, more efficient services, that integrate clinical treatment and community supports.

The achievement of a person-centred mental health system requires significant reform efforts in ensuring that mental health services are widely accessible to everyone who needs them. It would also allow people to have more choice over which services are appropriate for them. This would require change in organisational culture for mental health services and changing governance, funding and evaluation to drive the necessary change.

The Report recommends reforms such as addressing service gaps, removing barriers to access to services, fostering collaboration within the mental health system, improved coordination between services, greater efficiency of services and an evaluation and monitoring system for the sector. Whilst all commendable recommendations, these are largely not new issues that have been raised, but The Report does not offer specific detail of what these service models look like and how the changes should be made.

Implications and Opportunities

The reforms suggested by The Report contribute to a person-centred mental health system are set to deliver a wide variety of benefits to people using mental health services as well as service providers. We have been using the language of person-centred care for many years but the system has been largely unable to make the transition to anything more than increased participation, so it is difficult to see how the transition will be made.

QAMH knows that person-centred approaches are at the heart of the models underpinning the Community Mental Health and Wellbeing Sector, but The Report has not acknowledged that contribution or potential. It is QAMH's view that we need to build on our model of care and clearly advocate on behalf of the sector to ensure government and funding bodies are aware of the unique contribution that the sector makes or can make in leading this approach in the mental health ecosystem.

Psychosocial Support

Discussion and Analysis

Psychosocial supports provide a variety of services that assist people to stay well, lead meaningful and productive lives within their communities, and support people in the recovery from an acute episode of mental illness. However, The Report highlights that at present not everyone who needs psychosocial support is able to access services, largely due to service gaps stemming from short funding cycles and a lack of economies of scale. The barriers to accessing support through the transition to the National Disability Insurance Scheme (NDIS) has created uncertainty for all, with many providers reporting difficulty retaining high quality staff in this environment.

The vital importance and contribution of psychosocial supports is well articulated in The Report by people accessing services, government bodies, community service providers and peak bodies, as are the issues and barriers to accessing these supports. The roll out of the NDIS altered the psychosocial support landscape significantly, decreasing the availability of supports for those outside of the scheme, changing the workforce makeup and creating confusing and reduced access pathways. Multiple funding channels and excessive administrative burden, particularly in relation to multiple reporting requirements act as further barriers to support.

The Report estimates that 690,000 people with mental illness are likely to benefit from access to psychosocial support services if they were available. It suggests a massive gap with only 34,000 people with a primary psychosocial disability receiving NDIS supports which is still only just over 50% of those expected to be eligible once the scheme is fully rolled out. It also estimates about 75,000 people are receiving psychosocial support directly from states and territories. The Report also acknowledges that many other people who do not have a formal diagnosis of mental illness may benefit from psychosocial support but would currently need to enter a medical pathway to receive this care.

The Report concludes that there are too many funding channels for psychosocial supports, with Inquiry participants reporting that multiple funding channels lead to "poorer consumer outcomes" and "lack of coordination and cooperation". These issues have negatively affected people with mental illness and their families due to the lack of support that many people with mental illness are receiving.

Implications and Opportunities

Action 17.1 calls for an extension of contract lengths for psychosocial supports from twelve months to five years. This will have concrete implications for community mental health services offering psychosocial supports. The recommendation that providers are given six months notification of contract extensions may alleviate uncertainty and improve continuity of support for people. Continuity of supports will also be improved through Action 17.2 which recommends people applying for the NDIS should be supported by their current service providers during their application and people not on the NDIS should be supported through the National Psychosocial Support Measure until it has been phased out.

This will ensure that people who are currently applying for the NDIS, or are not part of the NDIS, are able to continue to receive psychosocial supports. This is a significant commitment as many of the current service gaps in psychosocial supports have arisen from people being ineligible for their previous support programs being ceased because of the transition to the NDIS. In addition, an evaluation of the National Psychosocial Support Measure is underway to determine what will be required in the future.

Many peak bodies have identified that there is an urgent need for increased funding for psychosocial supports. QAMH continues to work with Community Mental Health Australia and support their proposal for the timeline for Federal funding of psychosocial support services to be shortened to the May 2021 Federal Budget, and for the funding to be budgeted for at least five years.

Prevention and Early Intervention

Discussion and Analysis

The Report has a significant and important focus on prevention and early intervention in life, with an acknowledgement that mental illness often emerges in childhood and adolescence but identifies the barriers to children and young people seeking support and treatment. It recommends screening for perinatal mental illness for all new parents and an expanded scope of voluntary early childhood health checks to assess children's social and emotional development prior to preschool.

In addition, it sets out a path to strengthen the ability of schools to deliver an effective social and emotional learning curriculum including targets and measures for student wellbeing. This would include a nationally consistent minimum student wellbeing dataset to be collected by all schools, as well as accreditation of social and emotional learning programs offered by schools. Schools would be required to report on their progress against wellbeing outcomes as set out by an updated National School Reform Agreement. For younger adults, a range of initiatives are suggested to improve the mental health and wellbeing strategies to be the responsibility of tertiary education providers.

The Report also creates the strong link between employment and mental health, proposing that investment in mentally healthy workplaces is important to maintain the mental health of those who work there. It makes an economic argument for reducing work-related mental health conditions including the incidence of workplace bullying, which it reports is increasingly common in workers compensation claims.

Implications and Opportunities

The Productivity Commission understands the economic impact of ensuring a good start in life and the long-term mental health benefits. It seems logical that the focus of these interventions should be targeted at educational institutions for maximum benefit and this is in line with a cross sector approach to mental health and wellbeing.

What seems to be less clear is the importance of early intervention in episode of illness. We know from The Report that the main point of contact for people in crisis is the emergency department, which is not working well for people. QAMH advocates strongly within the ecosystem for the Community Mental Health and Wellbeing Sector to be supported and funded to develop alternatives to hospital environments. We are confident that the few alternatives that have been tried in Queensland are based on the importance of a wellbeing approach early in episode. QAMH will continue to advocate for the expansion of community-based realistic alternatives to emergency presentation and hospital admission.

QAMH support the value of mentally healthy workplaces and have gathered a range of resources which are on our website, through our work in this area with the Brisbane North PHN. We will continue to develop resources locally to support member organisations to create practices in line with legislation for mentally healthy workplaces.

Workforce

Discussion and Analysis

The Report acknowledges the crucial work of the community mental health workers in supporting the recovery of people with mental illness. Beyond that, it makes specific recommendations for building the clinical workforce, despite recommending an increase in low intensity and community mental health services and associated workforces. The chapter focusing on workforce offers few strategies to build and grow the community mental health and wellbeing workforce even though this was a substantial focus of the QAMH submissions during the Inquiry. From a Queensland perspective, the focus on supporting the rural, regional and remote mental health workforce is welcome, although again, the focus relates to clinical access rather than building a community mental health sector workforce.

Despite a lack of recommendations around the development of a skilled community mental health workforce it was pleasing to see a focus on the role of a peer workforce. It highlights the important contribution of peer workers and the value of their first-hand experience of mental illness and recovery. Obstacles to the development of the peer workforce were outlined by Inquiry participants, such as a lack of recognition of the value of peer workers, inadequate supervision and support, lack of professional development and the lack of a representative professional body. To address this, Action 16.5 of the report calls for the Australian Government to provide once-off seed funding for a professional association for peer workers. It also asks Australian, State and Territory Governments to develop a program for educating health professionals about the role and value of peer workers.

The Report concludes that although the workforce is diverse, estimating the size is constrained by data inadequacies, particularly for community mental health workers and peer workers. It states that this has made it difficult to develop an accurate picture of the size of the workforce. To address this, Action 16.1 describes the National Mental Workforce Strategy to enable a person-centred mental health care supported by data collection (including community mental health workers) which enables linkage of workforce planning to broader mental health reform.

The Productivity Commission found compelling evidence about the role discrimination plays in our mental health system which can lead to stigma. It acknowledges that this can discourage people from seeking help, increase their psychological distress and exacerbate mental illness. It recommends mental health stigma reduction programs to be incorporated into training with periodic evaluation of their effectiveness.

Implications and Opportunities

The recommendation for systematic data collection about the community mental health workforce is a positive step towards being able to accurately assess the size and composition of the sector and to identify workforce gaps. However, outside this commitment, there are no further actions aimed specifically at the community mental health sector. Given the report articulates the crucial role that community mental health and wellbeing services play in the broader mental health system, it will be important that the sector adequately positions itself to develop its workforce. There is an opportunity for QAMH to build on its current workforce mapping project to make recommendations to both the sector and government to contribute to future workforce development strategies.

Social Inclusion and Stigma Reduction

Discussion and Analysis

The Report acknowledges the difference between social participation (involvement in activities with other people) and social inclusion which relates to feelings of belonging and being respected by others. It describes the impacts of social exclusion which can occur because of the barriers to social participation. Causes of social exclusion span different areas of people's lives including access to material resources, employment, education and skills, health and disability, social connection, community and personal safety.

The Report outlines the links between social exclusion and mental ill-health, stating that many people with mental illness are likely to be socially excluded and those facing social exclusion are likely to subsequently experience mental ill-health.

The Report outlines that people with mental illness are particularly at risk of social exclusion and that facilitating social interaction and connection with community are important aspects of recovery. There are numerous barriers to social participation that people with mental illness may face such as socioeconomic disadvantage, and experiences of discrimination leading to stigma. Social exclusion is also more likely in specific populations including women, Aboriginal and Torres Strait Islander people, people in community housing and single parents.

The recommendations and actions in this section include a recommendation that the National Mental Health Commission develop and lead the implementation of a National Stigma Reduction Strategy which focuses on the experiences of people with mental illness that are poorly understood in the community. It calls for supporting the leadership and direction of people with lived experience in this work and targeted stigma reduction messages for different audiences.

More broadly, this section contains little mention of the Community Mental Health and Wellbeing Sector despite its philosophy which is more conducive to social inclusion than many other services due to its emphasis on wellbeing and community participation.

Implications and Opportunities

The actions and recommendations developed indicate a strong focus on reducing stigma and promoting social inclusion within the mental health system and broader community.

The Community Mental Health and Wellbeing Sector focuses largely on community-based group and individual support with an emphasis on increasing social inclusion and ensuring people are supported to live contributing lives within their chosen community. Despite this, The Report did not recognise the work of the sector in delivering person-centred mental health care or the key role it could take in contributing to the national stigma reduction strategy.

There is an opportunity for QAMH to work with the National Mental Health Commission in their development of the National Stigma Reduction Strategy to carve out a role and influence the specific action of the strategy.

Suicide Prevention

Discussion and Analysis

The Report focuses on the social and emotional cost of suicide and suicide attempts, as well as the medical costs and the value that the community places on lives lost, which it estimates to be about $30 billion each year. It notes that the suicide rate in Australia has not declined noticeably despite substantial community interventions revealing a stark indicator of population mental health.

Action 9.1 recommends that aftercare to be provided to anyone who has presented to a hospital, GP or community mental health service following a suicide attempt. This action is based on evidence which suggests that adequate aftercare for people who have attempted suicide, including discharge and follow up support can prevent future suicide deaths and attempts. It states that effective aftercare should be provided before people are discharged or leave a service, with proactive follow-up support within the first day, week and three months of discharge.

In addition, The Report highlights the need to focus on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people and development of a National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and Implementation Plan, with Indigenous organisations being the preferred providers of local programs and activities.

Finally, it recommends a National Mental Health and Suicide Prevention Agreement be developed to identify responsibilities for suicide prevention activities across different levels of government and across portfolios to ensure a whole of government approach.

Implications and Opportunities

The aftercare component of the suicide prevention strategy is one which is already emerging as a key role the Community Mental Health and Wellbeing Sector can contribute to suicide prevention and further investment in community-based approaches will be welcomed.

Families and Carers

Discussion and Analysis

The Report acknowledges the fundamental role families, partners and friends play in providing care this includes emotional, financial, and psychological support to people experiencing mental illness. It highlights the personal toll on their carers mental health and wellbeing stemming from reduced community participation, difficulty sustaining employment and access to education due to the unpredictable nature of informal care demands.

The Report outlines the assistance offered by the Government for carers such as carer support services and income support payments, however it acknowledges that there is scope for improvement in these supports. The chapter provides several reform options for improving supports offered to families and carers.

The Report urges services to consider family members and carers needs, and their role in contributing to the recovery and support of their loved one. Whilst The Report focuses on improvements in clinical settings in the recommendations, it does suggest that the government responsibilities for family and carer support services should be clarified.

The commitment to the collection and evaluation of data concerning Carer Gateway and Mental Health Carer Support Services to determine how well they meet the needs of mental health carers relative to other types of carers, will provide valuable information about how best to improve supports. The action to change eligibility requirements for income support payments for carers is a positive step towards simplifying what is currently a complex process.

Implications and Opportunities

The Community Mental Health and Wellbeing Sector prides itself on models which consider individuals and families in their social context, including their families and carers, positioning it well to expand service delivery in this area. This is evident through the various community managed organisations that offer carer support services including assistance to families and friends of those living with mental illness, carer respite supports services and training and support networks. These examples indicate that the Community Mental Health and Wellbeing Sector plays an important role in the embedding of family and carer-inclusive practice within mental health services and has scope to contribute to the further development of these practices and service types.

Housing

Discussion and Analysis

The Inquiry acknowledges the importance of secure housing as a protective factor supporting recovery for people with mental illness. It notes that many people living with mental illness live in unsuitable or unstable housing which negatively impacts on their ability to manage their mental illness. It also highlights that in some regions there is a chronic shortage of short and long term supported housing for people with moderate and severe mental illness.

The Report unpacks the problems for people experiencing mental health issues and recognises that not only can mental illness reduce a person's ability to find and maintain housing but also that low quality housing, which may be unhygienic, unsafe, of poor design, affected by noise and pollution, provide insecure tenure and affordability issues can contribute to mental ill health. Homelessness is also known to exacerbate or contribute to mental illness.

There are financial supports that exist to assist people to find and maintain housing, however The Report indicates that supports need improving. It concludes that social housing policies often do not reflect the needs of people with mental illness and that housing workers are often not well equipped to respond to these needs. This issue also exists in the private rental market, where people with mental illness can face discrimination when looking for housing and are at risk of eviction.

Action 20.1 aims to address the problem of housing insecurity for people with mental illness by calling for State and Territory Governments to provide mental health training and resources to social housing workers. This includes mental health training and resources for social housing workers and private sector real estate agents, to recognise early warning signs and the value of early intervention and ensuring people have access to tenancy support.

Action 20.2 ensures that people with mental illness are not discharged from hospitals, correctional facilities or institutional care into homelessness. This includes receiving a comprehensive mental health discharge plan and timely access to transitional housing.

Action 20.3 calls for support for people with severe mental illness to find and maintain housing. This includes an action for the NDIA to update its Specialist Disability Accommodation strategy to develop long-term supported accommodation for NDIS recipients with severe and persistent mental illness. State and Territory Governments are also called to provide long-term housing options for people with severe mental illness who need integrated housing and mental health supports.

Implications and Opportunities

If adopted successfully, the Actions in The Report concerning improving and increasing housing supports for those with mental illness will assist in the recovery process for many people using mental health services. Many of these supports could be provided by existing Community Mental Health and Wellbeing providers (including options such as Housing First programs).

Funding

Discussion and Analysis

The Report finds that the gaps in mental health services are partly a reflection of inadequate funding for services in some regions in Australia and a lack of clarity in Government responsibilities. It goes on to say that there is a lack of cooperation and coordination between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) which undermines accountability. It highlights that there is an over reliance on Medicare Benefits Schedule-rebated (MBS) care which is not suitable for all people and that LHN funding arrangements allow inefficiency in community care and prioritise hospital-based care.

The Report suggests strengthening the approach to joint regional planning to ensure the involvement of consumers and carers in the development of the plans. It suggests the National Mental Health Commission should develop a key set of performance indicators to capture improved cooperation.

The Report recommends that State and Territory Governments should take sole responsibility for commissioning psychosocial supports outside the NDIS which should be supported by additional Australian Government funding. It concludes that if Australian, State and Territory Governments cannot agree to this that they suggest that the responsibility should remain with the Australian Government who should task the PHNs with commissioning all psychosocial services outside the NDIS.

It recommends a transition to State and Territory based Regional Commissioning Authorities (RCAs) to commission mental healthcare, alcohol and drug services, psychosocial and mental health carer supports outside the NDIS and place-based suicide prevention services. It also suggests reform to the methodology used to determine the allocation of the PHN flexible funding pool to promote greater equity. In addition, there should be a mental health innovation fund to allow RCAs to trial and evaluate new models of care in specific to their regions.

Implications and Opportunities

As a sector, we are acutely aware that the responsibilities of the Australian Government and State and Territory Governments for mental health services such as clinical mental healthcare, psychosocial supports, suicide prevention services and mental health carer supports are unclear and inconsistently implemented. From a Community Mental Health and Wellbeing Sector viewpoint the over reliance on hospital-based services and MBS treatments divert funds from alternatives and low intensity supports that are likely to benefit the group described as the 'missing middle'.

The idea of shifting funding allocation decisions to be based on identified need at the regional level with the involvement of consumers and carers makes sense and addresses some inequities. A strategy for the identification of psychosocial need outside the NDIS is also welcome and QAMH will continue to work with local PHNs in Queensland in their joint regional planning.

The establishment of an innovation fund is an opportunity for the Community Mental Health and Wellbeing Sector to lead innovations which are person-led and locally co-designed and work with commissioning authorities to build in evaluation to build our evidence base.

Governance

Discussion and Analysis

The Report confirms that major reforms are needed to the governance arrangements that underpin Australia's mental health system and these inadequacies are contributing to system failure. It determines that there is minimal accountability for mental health outcomes and that strategic planning is squarely focused on the health sector without integration with other sectors. It talks about the absence of a robust evaluation culture which impedes innovation and system improvement. It also finds a lack of consumer and carer involvement in strategy programs and accountability mechanisms.

It calls on the Australian, State and Territory governments to develop a whole of government National Mental Health Strategy that aligns the collective efforts of health and non-health sectors which has the demonstrable support and involvement of consumer and carers in its development. In addition, it suggests that the National Mental Health Commission should undertake annual monitoring and reporting on the strategy's implementation.

Aligned with the person-centred focus is a recommendation that governments should establish clear roles for consumers and carers to participate in all aspects of system planning, design, monitoring and evaluation. It suggests

the establishment of funded peak bodies at a national level to facilitate this and a role for Mental Health Australia to create formal mechanisms to bring these peak bodies together to progress relevant issues.

The Report suggests that the National Mental Health Commission be responsible for reporting annually on the state of systemic advocacy in Australia at a state, territory, and national level. It also calls for all State and Territories to set up a body such as a mental health commission which is responsible for promoting continuous policy and program improvement and fostering genuine accountability for commitments.

Implications and Opportunities

The need for reform of the governance processes and structures is not new and there have been a plethora of reports which have highlighted this issue in the past, without being able to successfully make the changes required. One rationale given for this failure is that the current mental health strategy is not linked to funding commitments.

It will take strong leadership to facilitate a clear vision for mental health in Australia and a whole of government approach, which looks beyond jurisdictions and the focus on the clinical mental health system. It will require developing a collective vision in partnership with other sectors to develop and establish of strategies, responsibilities and outcomes which address the social determinants which impact on the wellbeing of Australians.

The Report presents the work of the National Mental Health Commission in developing Vision 2030 and the Implementation Roadmap as an opportunity to address some of the recommendations in the report. QAMH works closely with Community Mental Health Australia and Mental Health Australia in consultations around the Vision 2030 and will continue to do so during its development.