SANE AUSTRALIA

5 April 2019

Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Dear Commissioners,

On behalf of SANE Australia, I would like to take this opportunity to provide input into the current Productivity Commission Inquiry on the Social and Economic Benefits of Improving Mental Health in Australia.

This Inquiry provides the opportunity to articulate the needs of more than 690,000 Australians living with complex mental health issues (NMHC, 2014), from both the perspectives of those with lived experience, including carers, as well commenting on broader service system challenges and opportunities for consideration to ensure those in most need no longer "fall through the cracks".

We believe that all those living with complex mental health issues should be treated with dignity and respect and have the opportunity to lead long and contributing lives.

Please find our submission attached.

Yours sincerely

Dr Michelle Blanchard
Acting CEO, SANE Australia
Director, Anne Deveson Research Centre

Background

Founded in 1986 as the Schizophrenia Australia Foundation, SANE Australia's focus is on supporting the approximately four million Australians affected by complex mental health issues. This includes the 690,000 who live with severe and persistent illnesses such as schizophrenia, bipolar disorder, personality disorder, OCD, PTSD and severe depression and anxiety. It also includes their carers, family, friends and colleagues who often play a critical role in their recovery.

A national organisation, SANE's work includes promoting mental health literacy, de-stigmatising poorly understood mental health issues, online peer support and information, specialist helpline support, research and advocacy.

The SANE Help Centre was established in 1998 and was Australia's first mental illness specific telephone Helpline. Through the Help Centre we provide confidential, professional support to those affected by complex mental health issues.

The SANE team moderate two online peer support forums; one to support those with lived experience of complex mental health issues and one to support those caring for them.

In mid 2018, SANE Australia merged with The Dax Centre. The Dax Centre houses the Cunningham Dax Collection, a collection of more than 15,000 artworks created by people who have experienced mental illness or psychological trauma, many of who were resident in Victoria's psychiatric institutions. The Dax Centre is a leader in the use of art to raise awareness and reduce stigma towards those affected by mental illness. Through exhibitions and educational programs, it engages, informs and encourages community connections and conversations about mental health.

Finally, SANE's Anne Deveson Research Centre (ADRC) has been established to drive social outcomes for people affected by complex mental health issues. The ADRC will partner with research institutes, other mental health organisations and people with lived experience of complex mental health issues, to undertake practical research that will drive policy change to produce better social outcomes for Australians affected by complex mental health issues. As the Founding Director of the Centre, I am pleased to be leading our flagship initiative, the National Stigma Report Card, which will involve a comprehensive survey of 7000 Australians living with complex mental health issues about their experiences of stigma and discrimination. This is the largest survey of its kind conducted in Australia to date and will highlight the impact of stigma and discrimination on many aspects of the lives of those affected by complex mental health issues. We are generously being supported by the Paul Ramsay Foundation to lead this work.

SANE Australia's multi-faceted approach to research and support, along with its long history of advocacy and awareness raising, provide it with a unique position to

respond to the Productivity Commission Issues Paper: The Social and Economic Benefits of Improving Mental Health.

We have framed our response in relation to three key areas:

1. Gaps in the discussion pertaining to those with complex mental illness and the different challenges they face compared to people with higher-prevalence disorders, such as anxiety and depression.

2. How our clients are at high risk of 'falling through the cracks' of a fractured mental health service system.

3. The changes required to engender a shift in culture in the workplace that fosters diversity and adequately meets the needs of those living with complex mental illness and their carers.

1. The Vital Role of Lived Experience in Informing Policy and Practice

We welcome the recognition of the need to consider measures that serve to improve continuity and integration of support to those living with severe, persistent and complex mental illness, and associated episodic presentation of certain conditions. However, it is disappointing to see a lack of a specific process for wide engagement of those with lived experience and their carers.

Previous inquiries and commissions have acknowledged the importance of such inclusion, recognising the inherent understanding that people with lived experience of mental health issues are the experts of their own lives, and representation in the process of policy decision-making that directly relates to service reform that affects them and their communities is imperative in this context. The Commission's Issues Paper itself states,

> "Measuring the things that matter to people with lived experience provides true measures of quality and valuable insights that help to interpret other indicators and understand how mental health services and systems are operating in practice." P.37

While the Commission invites the collective community to provide their views, experiences and feedback via online submission, it fails to ensure exhaustive assessment and analysis through the lens of those for whom the inquiry is intended to ultimately assist. Further, the submission process itself is likely to be daunting and overwhelming for some people living with complex mental illness (complex mental health issues). The Issues Paper as a whole, and the questions it seeks the community to answer are extensive, and we would challenge their accessibility to the "average person'' let alone many individuals living with complex mental health issues.

Further, there have been numerous federal Royal Commissions, Senate and other Inquiries in the past two decades where the focus has targeted individuals whose mental health has been affected in devastating proportions. Not taking into account respective state and territory Inquiries, these include:

- National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (report completed in April 1997);
- Senate Community Affairs References Committee on Child Migration (report completed in August 2001);
- Senate Inquiry into Children in Institutional Care (report completed in March 2005);
- Senate Community Affairs Reference Committee Inquiry into Contribution to Former Forced Adoption Policies and Practices (report completed in February 2012); and
- Royal Commission into Institutional Responses to Child Sexual Abuse (report completed (report completed in December 2017).

Sadly, for many Australians, their experiences have spanned more than one of these areas of focus. The process of sharing their stories through the relative options for submission in and of itself has been traumatising for many who participated, particularly those whose lives were affected by multiple practices, and some have expressed 'submission fatigue". Therefore, this Inquiry should consider not only the likelihood of the thousands, if not millions of Australians impacted by the above examples of abuse and trauma and who live with complex mental health issues, but whose capacity to contribute their experiences of mental health services and systems is either exhausted, or severely compromised.

We would therefore urge the Committee to refer to the recommendations of the aforementioned reports in its assessment of focus of resourcing, and service system modelling.

Scope of this Inquiry

In order to achieve a comprehensive understanding of the needs of those who experience complex mental health issues and their carers, and therefore adequately inform the scope of the Inquiry, SANE Australia would urge the Committee to consider the inclusion of the following groups who are currently either 'out of scope' or 'under consideration'.

Presentation to alcohol and other drug (AOD) treatment by people with co-occurring mental health and substance use issues (dual diagnosis) is widely considered the expectation, not the exception (Minkoff and Cline, 2004). Dual diagnosis is a significant treatment issue for AOD professionals. Up to 80 per cent of clients in AOD treatment also have a co-occurring mental health problem. Even greater numbers may have 'subclinical' symptoms of mental health issues, which can also result in significant distress as well as impact on relapse and recovery rates (Kay-Lambkin et al., 2004). Recognition of the inherent complexities associated with dual diagnosis

has been reflected in Australian policy since 2000 with the union of the National Drug Strategy and the National Mental Health Strategy (Teeson & Burns, 2001), and the National Comorbidity Initiative (NCI) in 2007 under the National Drug Strategy. What is well-established, is that people with dual diagnosis have poorer prognosis than those with a single problem. Co-occurring issues are more likely to become chronic and disabling and result in greater use of health services (Teeson et al., 2000). Effective management of dual diagnosis is therefore critical to the cost-effectiveness of services, and an essential component to this Inquiry.

In addition. those living with Autism Spectrum Disorder (ASD) intellectual disabilities and acquired brain injury experiencing mental health issues are on a continuum of need, and in many cases, with the right support, are more than capable of workforce participation. Finally, few mental services exist specific to the needs of Culturally and Linguistically Diverse Communities (CALD). We therefore advise the Committee to work within the framework of the Mental Health in Multicultural Australia project, which seeks to support services funded through local Primary Health Networks in growing cultural responsiveness.

2. Contributing components to improving mental health and wellbeing

Structural weaknesses in healthcare

The act of seeking support for a mental health condition is in and of itself, one of the most significant decisions a person can make; meaning the difference between living a comparatively fulfilling and productive life, or believing their lives are not worth living at all. The quality of experience the individual has at the very first point of engagement in help-seeking therefore, is an integral part of this discussion.

People with mental health issues and their families are rightly of the expectation that they will be provided with guidance, understanding and assistance in facilitating entry into the mental health service system, whether it be acute, in-patient or community setting. It is a time where people's decision-making capacity can be compromised and they experience fear, helplessness and uncertainty.

However, through the consistent findings of respective inquiries into the mental health needs of Australians, it is well-argued that the current Australian mental health system is failing the millions of people suffering from mental illness and their families, including those with complex mental health issues. Rather, some of the most vulnerable and in need in our community are experiencing non-linear journeys that are lengthy, often plagued by stigma and discrimination, and fail to provide sufficient care that accommodates presenting needs across a very broad biopsychosocial continuum.

Unfortunately, recommendations that have been repeatedly presented as solutions in part to the questions presented by the Productivity Commission, have failed to be implemented. Influencing factors are of course numerous, however, frequent changes to federal and state governments and their leadership in more recent years, has most certainly impeded the success of achieving tri-partisan agreement and commitment to policy and legislative changes beyond terms of government. The mix of state and federal funding and service systems is a further complexity faced by people with lived experience of mental health issues attempting to navigate appropriate and timely support.

For our clients who live with complex mental health issues and their carers, they are more often than not dealing with numerous psychosocial issues and thus, service providers. Despite some promising reforms in the 2000s to the ways in which service coordination and treatment in the health and welfare sectors could improve client outcomes i.e. shifting from a siloed service system toward more integrated care, we have witnessed a regression to a mental health system that is not only isolating in its role, but is once again failing to attend to the psychosocial complexities faced by people with lived experience of mental health issues.

More recently, the roll-out of the National Disability Insurance Scheme by state and territory governments has resulted in the redirection of funds from community-based services who have historically provided a strong and established network of psychosocial supports, to a system that is highly inaccessible and difficult to navigate. The Committee has reference material from the Productivity Commission reviews conducted in 2011, 2017 and 2018.

However, we welcome the commitment of the federal government in the May 2019 budget to fund additional alcohol and other drug treatment and support services in regional, rural and remote areas.

Specific health concerns

Suicide prevention and early intervention

Suicide is one of the main causes of early death in people living with mental illness. This is particularly so for those who have been diagnosed with serious and complex mental illness, where the risk of suicide increases by 13 to 45 times compared with the general population (Chesney, Goodwin, & Fazel, 2014). Mental illness, whether diagnosed or undiagnosed, is also associated with the vast majority of suicide attempts (Ridani et al., 2016). Current literature purports that suicide is mainly preventable, and that targeting appropriate support to those at the greatest risk of suicide and self-harm is both a cost-effective and meaningful way to reduce morbidity and mortality (McLaughlin, McGowan, Kernohan, & O'Neill, 2016).

While several sources of formal data are used to report on suicide rates and trends in local, state and federal jurisdictions e.g. ABS Causes of Death report, state and territory departments of health and coroner's reports, their methods, modalities and

timeframes of collection are varied, making it difficult to provide information that truly reflects the numbers of Australians dying from suicide. Similarly, rates of intentional self-harm are likely far higher than what the available data tells us. For example, the reliability of hospital records remains untested and therefore cannot be considered an accurate reflection of community trends. Further, the majority of mental health presentations to emergency departments are generally not admitted, and subsequently, records showing reasons for presentation won't always indicate self-harm or suicidality. It is therefore encouraging to see investment in mental health in the most recent federal budget announcement, including funding over three years to the Australian Institute of Health and Welfare to ensure more nationally coordinated data on suicide and self-harm to inform future service-provision and policy directions.

The Productivity Commission's Issues Paper acknowledges the number of previous reviews, inquiries and research already undertaken to investigate the mental health of Australians (including those mentioned in our opening comments), seeking recommendations to improve the inadequacies of primary, secondary and tertiary care models of service delivery.

It is therefore feasible to suggest that the failure to implement these recommendations, along with the resources required to adequately sustain systemic change, is by and large the greatest barrier to the improvement of the economic participation of people experiencing poor mental health. Prevention and early intervention as a means of improving mental health and social inclusion, and reducing the 'economic burden' which results from a failure to meet the needs of people experiencing mental illness, will only have a chance of success if there is meaningful attention and action paid to the 'what we already know'. Healthcare and other providers can only improve the quality of service if there is consistency and continuity of practice frameworks that are resourced and supported and monitored appropriately.

Comorbid alcohol and other drug issues

Please refer to our comments in the opening section of this submission regarding inclusion of those living with dual diagnosis in this inquiry.

Comorbid physical health issues

Physical and mental health and wellbeing are intrinsically related, as the Commission identifies. Chronic illness and chronic pain issues can have a debilitating effect on quality of life, particularly with regard to social inclusion and workforce participation. Edmond and colleagues (2019) observe the necessity of acknowledging pain as a guide for engagement, treatment and recovery for those with co-occurring mental health issues, and consequently, the need for integrated, evidence-based treatment to achieve pain management and increase function.

However, there is a paucity of physicians (GPs, psychiatrists, pain management, psychologists, occupation therapists and other allied health professions) with

specialisation in this area, and access to those that do is largely limited to private practitioners who often have narrow capacity to meet demand. Further, these is still a focus on a more medicalised approach to those with chronic pain/physical health issues, and subsequently treatment options are limited despite evidence to the contrary in achieving better health outcomes by including psychosocial elements to care (Qaseem et al., 2017).

Rehabilitation services for physical health issues may include a suite of allied health options, modelling a 'wrap around' approach to care. However, it is more likely to be provided in private hospitals and outpatient settings, accessible to those who have the correct level of private health insurance, WorkCover, TAC or other insurance claims.

Further comment will be provided later in our submission regarding workforce participation in this context, however, we would suggest the Commission consider a separate Medicare funded scheme which provides ongoing multidisciplinary care (e.g. options of psych, social work, OT, dietetics, exercise physiology) to meet both the physical and mental health needs of people with complex mental health issues.

Supporting the health workforce and informal carers

Arguably, investment in developing and building the capacity of a workforce that seeks to meet the needs of people with arguably some of the most complex needs is foundational to the success of any mental health reforms. However, the uncertainty many professionals face due to a lack of appropriate resourcing, short term funding and constant 'reviews' delaying implementation, continues to act as a barrier to attracting suitably qualified, trained and experienced workers. This has a direct impact on experience of care those with lived experience have, as well as impeding the overall health and wellbeing of mental health and allied health professionals.

From the first point of contact - whether it be an individual seeking information or an acute presentation at an emergency department – the receipt of appropriate care should be assumed, regardless of where on the spectrum of need a person enters the 'system'. However, this is obviously dependent on a workforce that can not only recognise presenting issues, but identify and apply appropriate treatment or referral interventions. It is as much about 'knowing what you don't know, as much as what you do know'.

While advances have been made in skills and knowledge regarding the early detection and treatment of issues like anxiety and depression many health professionals find it difficult to identify the needs of those with more complex concerns. There is a need to utilise a range of educational resources to expand awareness of complex mental illness, and of appropriate management and treatment approaches, throughout the sector nationally. Improvement of skills and knowledge of health professionals working in both specialist and generalist settings are equipped to work with individuals with complex mental illness is required (Grenyer, 2017).

Nationally consistent training and education curriculum for professionals in the mental health workforce which is inclusive of complex mental health issues and well as ongoing professional development is essential, particularly clinicians working in emergency department and inpatient settings where symptomology may be more acute require development. For example, core competency training in Borderline Personality Disorder for clinicians, based on the NHMRC guidelines, is currently offered by some services (such as Spectrum in Victoria). Training standards such as these should be expanded nationwide and become a requirement for clinicians who are likely to come into contact with individuals affected by personality disorder. A good model of example is that of the National Eating Disorders Collaboration which is delivered by the Butterfly Foundation on behalf of the Australian Government.

The gaps in quality care for those with complex mental health issues are vast when compared to those with higher prevalence mental health issues. Capacity for General Practitioners to refer on to services that are tailored to accommodate complex mental health issues and co-occuring issues such as substance use or disability is often limited to what can be reasonably provided through Better Access or through an Enhanced Primary Care Plan. For many, these supports are only one part of the picture and fail to address some of the psychosocial elements that are also critical to improving the likelihood of recovery and improved quality of life.

Decision-making processes regarding treatment options available to people living with complex mental health issues, can at times be overlooked due to levels of acuity in symptoms being experienced at any given time. Families, carers or medical staff may subsequently determine where a person is to receive treatment and support. While sometimes unavoidable, a sense of agency can be removed from patients, who when well, would not have made the same decision. It is therefore imperative that the mental health and allied health workforce be in a position to provide the most up-to-date information on treatment options such as medications (and their potential side-effects), procedures such as ECT, treatment settings etc. Emerging models such as Open Dialogue (open-dialogue.net) which looks at the individuals experiences within their network of family, friends and other supports is one way to overcome some of these challenges.

We would therefore support a national commitment to establish and disseminate clinical guidelines in areas where these do not exist, potentially developed and implemented, by the National Health and Medical Research Council (NHMRC). The aim would be to establish training and treatment standards to better prepare clinicians to work with complex mental health issues in an evidence-based and trauma informed way, increasing consistency between clinicians.

Five areas of priority:

- understanding the lived experience and care preferences of people with complex mental health issues and their families and friends.
- promoting examples of good practice resources/models;

- Providing support to general practitioners and other health workers to improve treatment outcomes;
- Facilitating resources and information for people with lived experience of mental health issues; and
- Improving data systems and collection methods within the mental health and related sectors to respond to and manage complex mental health issues more effectively

Lived experience/peer support

There is an increasing evidence-base that recognises the role of peer workers in delivering mental health support and peer support programs as viable model to drive health promotion and suicide prevention messages in reaching at-risk populations. These approaches can also be used to drive increased awareness, furthering the potential to influence attitudinal change and encourage help- seeking behaviours. The positive role of peer-to-peer engagement in suicide prevention has been a focus of the work of Dr Patrick Corrigan, one of the world's most respected researchers in the area of stigma reduction. Corrigan asserts that the most effective way to reduce stigma associated with suicidal behaviour and increase help-seeking rates is by sharing stories between those with lived experience, where those at risk are more likely to respond to a relatable and 'credible' source (Jones, Corrigan, James, Parker, & Larson, 2013).

Digital platforms and social media are increasingly being used to drive health promotion campaigns (Lim, Wright, & Hellard, 2014; Lim, Wright, Carrotte, & Pedrana, 2016). As described by Wakefield, Loken & Hornik (2010), a great benefit of these campaigns is their ability to disseminate cost-effective, well-defined and focused messages to large audiences repeatedly, over time, and in an incidental manner. The efficacy of multichannel digital media-based interventions has received increasing attention as an effective way of reaching and influencing people with suicidal ideations and behaviours.

When implemented successfully, these programs can result in improved social connectivity, social skills, a reduction in mental illness-related stigma and an increased sense of hope for the future (Repper and Carter, 2011). Peer-assisted programs may be particularly useful in addressing self-stigma around mental illness and suicide, with evidence suggesting that interventions augmented by people with lived experiences are more effective than those without a peer component in affecting suicide outcomes (Corrigan, Sokol, & Rüsch, 2013).

For example, SANE Australia hosts online forums moderated by health professionals, as discussion spaces for Australians 18 years and over who are living with mental illness, and families, friends and carers of people living with mental illness. The forums are peer-to-peer support services and the information provided is designed to complement, not replace, the relationship between a patient and their health care professionals.This service is provided in conjunction with partner organisations

throughout Australia and in the past 12 months, 35,000 Australians accessed the forums and 4,400 became new members. This demonstrates the strength and reach in connecting people with lived experience to others in the community who may be struggling to find the support they need.

We therefore suggest that peer work be formally recognised, remunerated and supported to be have a sustainable effect. It should not be seen as a 'cheaper alternative' but rather an essential part of a holistic system of support for those affected by complex mental health issues.

Informal carers

Understanding the significant financial burden carried by individuals in their role as carers being omitted as part of this Inquiry, signifies a failure to acknowledge the evidence that identifies adequate resourcing as integral to carer wellbeing – and subsequently, their capacity to live inclusive and productive lives.

Shifts to community-based services for people with mental health issues can be considered a positive, however, the flow on effect has resulted in increased responsibility on informal and unpaid carers. As identified by the Caring Fairly campaign, of which SANE is a supporter, almost one quarter of a million Australians are providing unpaid care to someone living with mental health issues, sacrificing their own health and wellbeing, social and workforce participation. It is therefore baffling that the Inquiry should view financial investment in carers as an unnecessary component of achieving their broader aims. A shift in the lens through which carers are currently viewed, to one that sees their contribution to the lives of people living with complex mental health issues as a 'workforce' in and of itself is one of the central changes to policy that SANE Australia supports.

Social services (including housing and income support)

It is our position that safe, secure and affordable housing is critical to a person's mental health and wellbeing.

Accommodation stability is one of the most significant base-level needs that can compromise the safety and wellbeing of those living with complex mental health issues, including the possibility of access to appropriate treatment, allied health and other psychosocial services. Lack of housing can also result in a 'revolving door' situation, particularly in the public mental health system where people living with complex mental health issues frequently enter while they are incredibly unwell because they have not had the capacity to maintain medication regimes, continue with substance use and come into contact with the justice system for example.

Fractures in the stepped-care model that ideally should involve shared-care planning with psychosocial support services, negates progress, stability, maintenance and recovery that may have been otherwise achieved. Again, siloed approaches to care

have been reinstated, and those with complex mental health issues are far more likely to fall through the gaps of insufficient cohesion across health and welfare sectors.

There is no evidence to suggest that those living with mental illness receiving income support payments is a deterrent to seeking employment. To the contrary, it is the experience of those we support that they face significant financial hardship not only if their sole source of income is in the form of government support payments, but how the complex nature of their conditions impacts job-seeking and employment-retention capacity. For example, the 'hidden costs' in treatment and recovery maintenance: private health insurance; gap fees charged by mental health professionals in both inpatient and community settings; the cost of medications without a health care card and for those that are not PBS listed; and the out of pocket expense (around $50) for each visit to a GP for script renewals.

Social participation and inclusion

SANE Australia believes the term "illness" places a strong focus on the medical, biological aspect of complex mental health issues, however, not all aspects of complex mental health issues are medical. The people we serve may or may not want to refer to themselves as ill, even though they may be affected by the issues that come with the illness. The use of the term "issues" however, expresses a holistic intent that 'illness' does not, and in turn plays a part in how people living with mental health issues view their capacity for inclusion and participation in their communities more broadly.

Those with complex mental health issues face more challenges to engage, remain, maintain and engage with community than those with higher prevalence mental health issues. Stigma remains a significant role in participation across a spectrum of psychosocial supports and services. Unless people feel safe, the more reluctant they are to engage in help-seeking and the less connected to or disengaged from friends, family, colleagues and community. Many feel isolated, particularly those with complex mental health issues, in part, because of the nature of their conditions such as complex trauma, Borderline Personality Disorder, and various other co-occurring conditions.

There is still stigma attached to complex mental health issues, largely because people don't have adequate understanding of these complex conditions. The individual themselves may experience high distress, feelings of embarrassment and isolation in their presenting situation. This can be increasingly so if not receiving and/or engaging in, adequate support by health professionals, employers, friends and family.

Other barriers to social participation include withdrawal or exclusion from social and other networks because of regular (and at times, long) hospital admissions, side-effects from medications and other treatment modalities (such as fatigue and memory loss,), the episodic nature of their conditions, and self-stigma. Further,

people with co-occuring conditions can become 'stuck' in a seemingly never-ending world of appointments with health providers, hence limiting capacity for work. This can become a cycle of attempting to take part, realising there are limitations to what they can do (sometimes self-perceived), feelings and experiences of stigma, decreased participation, increased isolation, increased reluctance in help-seeking, exacerbation of symptoms, and finally, potential relapse.

Role of peer support groups or networks

Building on the foundational work of Corrigan, engagement in peer support programs offers a significant benefit for people experiencing suicidal thoughts and mental illness (Repper & Carter, 2011). Also known as 'peer-to-peer' support, these programs are characterised by communication with an individual who shares the personal experiences of the other individual. Such individuals may be known as *peer support workers*, individuals with a *lived experience*, *consumer providers,* and *peer educators*. This form of messaging is based on principles of empathy and aims to connect peer support workers to people that share similar experiences, including thoughts of suicide. The aim is to foster a sense of holistic understanding (Mead, Hilton, & Curtis, 2001) and then to emphasise the strengths and recovery of the individual and promote help-seeking behaviour (Repper & Carter, 2011).

When implemented successfully, these programs have resulted in improved social connectivity, social skills, a reduction in mental illness-related stigma and an increased sense of hope for the future (Repper and Carter, 2011). Peer-assisted programs may be particularly useful in treating self-stigma around mental illness and suicide, with evidence suggesting that interventions augmented by people with lived experiences are more effective than those without a peer component in affecting suicide outcomes (Corrigan, Sokol, & Rüsch, 2013). We would therefore support the resourcing of peer-support services, that are evidence based, adhere to an appropriate quality standard and are embedded in psychosocial support services.

Mentally healthy workplaces

SANE Australia endorses the submission made to this Productivity Commission Inquiry by the Mentally Healthy Workplace Alliance of which we are a proud member.

Supporting Carers in the Workplace

SANE Australia supports the evidence-based policy positions recommended by the Caring Fairly Campaign, as previously mentioned in this submission.

Supporting employees with complex mental health issues

We acknowledge that the attitudes of the general public have come a long way in the past decade in terms of understanding high prevalence mental disorders such as anxiety and depression. However, we don't know how effectively this knowledge and

awareness is being translated in practice in the workplace. It is more likely, that however well-intentioned, businesses engage in more tokenistic, one-off awareness-raising activities, or inviting someone with mental health issues to talk about their experiences on mental health-related days of recognition.

It can be overwhelming for a workplace to embark on creating an environment where all employees feel confident in the knowledge they will be supported unconditionally should they disclose they are living mental health issues. There is a myriad of information from a range of well-known mental health organisations, which may in fact become a barrier to employers either doing anything at all, or implementing select initiatives, but poorly. It can be difficult for employers to know where to obtain the best advice in working toward a mentally healthy workplace, and what options/advice would be an appropriate 'fit' for their workforce.

As a starting point, it is obvious that a cultural shift is required from the stigma and discrimination that largely underpin people's perceptions of mental illness, which requires commitment from a whole of organisation approach. Leadership is one of the most significant factors in facilitating successful implementation of any organisational change. However, if there are not the appropriate and adequate systems and policies in place to respond effectively to change organisational culture, there is the risk of becoming an organisation who responds with rhetoric; one that only demonstrates a base level of effort and acknowledgement of the need for support options for employees.

In many workplaces there is only one support option available in the average workplace, being an Employee Assistant Program (EAP), and this may not always be a suitable option, particularly for those living with complex mental health issues. The reliance therefore on them as a backstop for referral is more often than not an adequate/appropriate entry point for people experiencing mental health issues. The complexity and structural dynamics of workplaces for example, often don't mirror the needs of employees – especially in the context of complex mental health issues. People are terrified of stigma, and this is a significant barrier to help-seeking, regardless of assurances of confidentiality and impartiality that may be given. The onus is still on the employee to navigate and manage the process, which can run the risk of actually exacerbating the underlying sense of shame, stigmatisation, abandonment ("I'm alone in all this") and self-doubt over the credibility of their issues.

What we do know, is that rates of suicide are not decreasing, which populations are most at risk of suicide and intentional self-harm, and that mental illness does not discriminate. It is therefore time to not only make people increasingly aware of these issues, but to gain a more in-depth understanding of the mental health conditions, their symptomology, and how people can be best supported to feel confident in participating in the community, workforce and their relationships. This is even more-so for those living with complex mental health issues, where stigma and discrimination are particularly entrenched. Lack of understanding and assumptions about particular conditions such as borderline personality disorder (BPD), complex trauma, schizophrenia, bipolar I and II and schizo-affective disorder for example,

makes it harder for people living with such conditions to disclose to employers and to engage and seek support when needed.

When conditions are well-managed, it is still possible (and common) for those with complex mental health issues to be 'high-functioning' in their positions of employment, often without colleagues having awareness of their conditions. However, in the event where an individual chooses to disclose their condition/s, it is imperative that workplaces do have an understanding that there is a continuum of presence, severity and longevity of symptoms, which may require flexibility in how a person is supported to remain in the workplace. For example, the need for absences related to medication changes where an in-patient setting is required; side-effects of some medications such as fatigue, where working from home or splitting working hours across the day can allow time for rest. In more extreme cases, cognitive function may be impaired as a result of certain forms of treatment (including medication), such as ECT, where limited duties are assigned while the employee recovers.

Regulation of workplace health and safety

The Commission will no doubt receive ample insights regarding factors which can lead to mentally unhealthy workplaces and also have access to a plethora of research and information obtained through previous inquiries that identify both problems and potential remedies at both policy and practice levels for with to refer. In the context of the community we serve, stigma and fear of discrimination surrounding complex mental health issues would be the most significant contributor to feelings of unsafety in the workplace. More generally, bullying and harassment is often unreported due to lack of confidence in organisational process and leadership, and fear of subsequent retribution, whether that be perceived or not.

3. Framework to enhance mental health and improve participation and workforce contribution

Coordination, integration and funding arrangements

Governance and institutional arrangements for mental health in Australia are neither achieving the objectives agreed by COAG Health Council in the 5th National Mental Health plan, nor effectively guiding mental health reform, as the Plan has not been resourced. In addition, recommendations of respective Royal Commissions and Inquiries where mental health has been of significant focus (identified previously), have not been fully adopted or, where some directives have been implemented, they are not adequately resourced for a sustainable period of time.

It is difficult to coordinate and integrate a service system across sectors when services are operating in an environment of competitive funding i.e. PHNs making decisions regarding allocation of funds. Pools of money are often made available with limited evidence to support or rationalise those decisions, such as budgets needing to be spent within a financial year. This demonstrates a mentality of 'short-

term-ism', whereby projects or initiatives for example aren't given adequate time or resourcing to design, implement and measure outcomes that may subsequently add to an evidence-base of best practice.

A further frustration lies in sub-optimal policy outcomes resulting from previous inquiries being limited to making recommendations within the existing funding envelope, resulting in recommendations to remove money from one area to give to another, rather than providing additional resourcing to fund both at an optimal level.

In a recent study examining integrated health systems under the Affordable Care Act in the United States, specifically pertaining to quality of individual versus population care, the use of incentivisation to foster cultural and attitudinal change are ineffective, largely due to entrenched professional and institutional norms (Moses, H. et al., 2019). Placing value on the importance of care at the individual level by health professionals therefore is a far more complex challenge.

The Better Access initiative does not subsidise the number of sessions required for treatment of many complex mental health issues, for example those with complex trauma, and Borderline Personality Disorder. Treatment guidelines for such conditions specify psycho-therapeutic interventions, for example, Dialectic Behavioural Therapy (DBT) for Borderline Personality Disorder. However, there are few free or low-cost specialist services that exist, and long waiting lists for those that do. Unrealistic programs also in terms of structure and expectation that people will be able to take time off work and be able to afford to do so. Inaccessibility of these programs on multiple levels, thus, recovery and maintenance are compromised.

We would recommend that consideration be given to establishing new MBS items specific to complex mental health issues, as has been trialled recently for severe eating disorders.

Monitoring and reporting

Frustration exists for both service providers and people with lived experience of mental health issues regarding the failure of all tiers of governments and the mental health system to consistently utilise existing evidence and recommendations.
We have provided comment on the importance of a nationally consistent approach to data collection, monitoring and evaluation. Our recommendation is that the NHMC administer the measurement and reporting of outcomes as a result of this inquiry.

References

Australian Government Productivity Commission. (2019). *The Social and Economic Benefits of Improving Mental Health*. Retrieved from https://www.pc.gov.au/inquiries/current/mental-health/submissions

Burns, L., Teesson, M., National Drug Strategy (Australia), National Drug and Alcohol Research Centre (Australia), Australia. Department of Health and Aged Care, & Strategy, N. M. H. (2001). *National Drug Strategy and National Mental Health Strategy: National Comorbidity Project*. Department of Health and Aged Care. Retrieved from https://books.google.com.au/books?id=2ljvAQAACAAJ

Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*, *13*(2), 153–160. https://doi.org/10.1002/wps.20128

Corrigan, P. W., Sokol, K. A., & Rüsch, N. (2013). The impact of self-stigma and mutual help programs on the quality of life of people with serious mental illnesses. *Community Mental Health Journal*, *49*(1), 1–6. https://doi.org/10.1007/s10597-011-9445-2

Edmond, S. N., Heapy, A. A., & Kerns, R. D. (2019). Engaging Mental Health Professionals in Addressing Pain. *JAMA Psychiatry* https://doi.org/10.1001/jamapsychiatry.2019.0254

Kay-Lambkin, F., Baker, A., & Lewin, T. (2004). The'co-morbidity roundabout': a framework to guide assessment and intervention strategies and engineer change among people with co-morbid problems. *Drug and Alcohol Review*, *23*(4), 407–423.

Lim, M. S. C., Wright, C., & Hellard, M. E. (2014). The Medium and the Message: Fitting Sound Health Promotion Methodology Into 160 Characters. *JMIR MHealth and UHealth*, *2*(4), e40. https://doi.org/10.2196/mhealth.3888

Lim, M. S. C., Wright, C. J. C., Carrotte, E. R., & Pedrana, A. E. (2016). Reach, engagement, and effectiveness: a systematic review of evaluation methodologies used in health promotion via social networking sites. *Health Promotion Journal of Australia*, *27*(3), 187–197.

McLaughlin, C., McGowan, I., Kernohan, G., & O'Neill, S. (2016). The unmet support needs of family members caring for a suicidal person. *Journal of Mental Health*, *25*(3), 212–216. https://doi.org/10.3109/09638237.2015.1101421

Minkoff, K., & Cline, C. A. (2004). Developing welcoming systems for individuals with co-occurring disorders: the role of the comprehensive continuous integrated system of care model. *Journal of Dual Diagnosis*, *1*(1), 65–89. https://doi.org/10.1300/J374v01n01_06

National Mental Health Commission. (2014). *Report of the National Review of Mental Health Programmes and Services Volume 1* (Vol. 1).

Qaseem, A., Wilt, T. J., McLean, R. M., & Forciea, M. A. (2017). Noninvasive treatments for acute, subacute, and chronic low back pain: A clinical practice guideline from the American College of Physicians. *Annals of Internal Medicine*, *166*(7), 514–530. https://doi.org/10.7326/M16-2367

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392–411. https://doi.org/10.3109/09638237.2011.583947

Ridani, R., Torok, M., Shand, F., Holland, C., Murray, S., Borrowdale, K., … Christensen, H. (2016). *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring*. Sydney. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/An

Teesson, M., & Proudfoot, J. (2003). *Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment*. Australian Government, Department of Health and Aging: Canberra.

Wright, M. (2017). *Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities*. State Government of NSW: Sydney. Retrieved from http://www.health.nsw.gov.au/patients/mentalhealth/Documents/report-seclusion-restraint-observation.pdf