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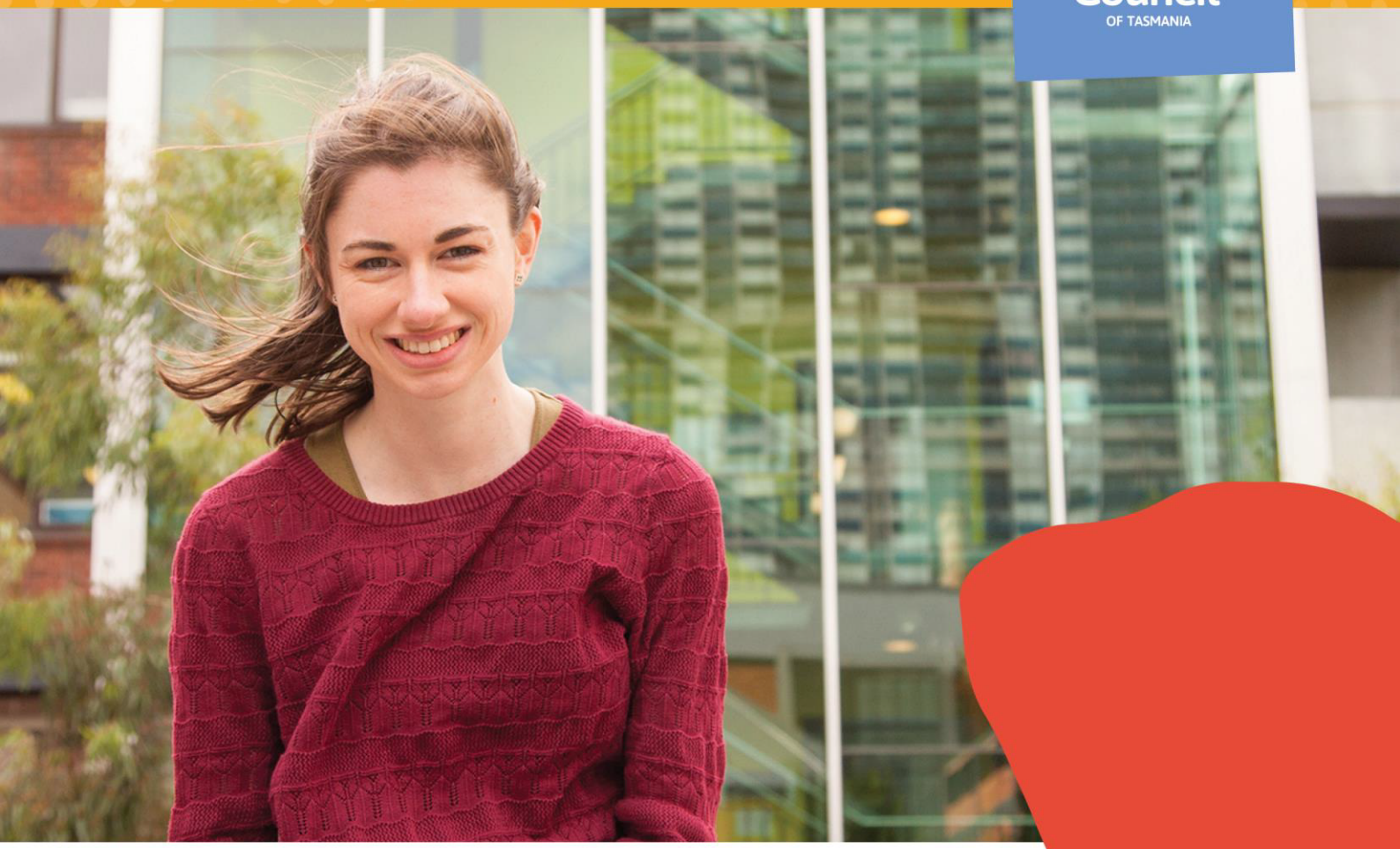
Mental Health Council OF TASMANIA



Productivity Commission Inquiry into Mental Health 2019

Submission from Mental Health Council of Tasmania

AUTHORISED BY:

Connie Digolis
Chief Executive Officer

Level 1, 131A Collins Street
Hobart TAS 7000

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Executive Summary and Recommendations

Section 1: Executive Summary

This submission constitutes a response from the Mental Health Council of Tasmania (MHCT), coupled with a series of recommendations, to the Productivity Commission Inquiry into Mental Health 2019. The Mental Health Council of Tasmania has partnered with the Tasmanian Council for Social Services (TasCOSS) and Flourish Mental Health Action in Our Hands Inc. to provide responses within our submission, which are clearly identified within the document. We have also coordinated our submission planning process with JusTas and Shelter Tasmania, who are lodging their own submissions, to ensure that the fullest possible Tasmanian context is provided. MHCT acknowledges that other organisations and individuals from our jurisdiction may also be lodging submissions or responses to the Productivity Commission's Issues paper and questions.

Section 2: Recommendations on structural weaknesses in healthcare

1. **Undertake scoping and planning for a foundational framework for an integrated, community-based mental health system focused on prevention and early intensive intervention with reference to best-practice global models, with particular attention given to resourcing this system appropriately and considering the economic and social imperatives for systemic reform**

2. **Embed consideration of, and support for, mental health as an intrinsic underlying cross-portfolio principle that is reflected in each government portfolio's policies, programs and outcome measurements, such that all portfolios share accountability for improving mental health outcomes and are individually held accountable for the impact of policies and programs on population mental health**

3. **Create specific structural underpinnings in the domains of housing, social participation and inclusion, justice, child safety, education, training, and workplace health and safety, with the aim of:**
    a. **Ensuring access to appropriate, affordable housing for people with mental illness**
    b. **Creating mechanisms to enable people with mental illness to undertake meaningful activities and/or employment which supports their autonomy, and providing active support for people to self-plan and manage these**
    c. **Ensuring access to affordable transport for people with mental illness**
    d. **Providing timely, accessible treatment for substance abuse inside a non-punitive framework**
    e. **Provide support for family and relationship issues**

4. **Determine whether all data necessary for effective outcomes measurement is currently being collected, and:**
    a. **If so, review its accessibility and linkage options to maximise utility**

   b. **If not, determine how best to source and capture necessary data, with reference to its future accessibility and linkage**
   c. **Consider how best to address data ownership issues that may restrict access and linkage options**

Section 3: Recommendations on specific health concerns

1. **Introduce population mental health screening measures and deliver a concurrent increase in preventive and early intensive mental health care programs and services, such that capacity is sufficient to service projected additional demand**

2. **Institute effective referral pathways to suicide prevention services for:**
   a. **People at high risk of suicide who are being discharged from inpatient care**
   b. **People with risk factors for suicide who present at hospital emergency departments**
   c. **People with risk factors for suicide who present to independent service providers such as general practitioners and other health care professionals**

3. **Consider Tasmania as the preferred trial site for a fully integrated, community-based mental health care system focused on prevention and early intervention (with reference to Recommendation 1 under Section 2 of this Submission), with all services delivered seamlessly under a governance structure that is reflective of a full partnership between the Australian and Tasmanian governments, in alignment with Priority 1 of the Fifth National Mental Health and Suicide Prevention Plan**

Section 4: Recommendations on health workforce and informal carers

1. **Provide mental health care training to clinical staff who interact with, or care for, people with risk factors for mental illness, suicide or self-harm**

Section 5: Recommendations on housing and homelessness (TasCOSS)

1. **Ensure that funding is directed into establishing mental health specific supported housing accommodation**
2. **Provide funding for existing one worker model specialist homeless accommodation services to have direct access to an on-call psychiatrist or psychologist**
3. **Ensure that funding is directed into establishing an alcohol and drug specific supported housing model**
4. **Ensure that funding is directed into establishing multi-disciplinary supported mental health accommodation for young people**
5. **State and Federal Governments explore best-practice models to better integrate housing, homelessness and mental health services for the population as a whole**
6. **State and Federal governments take immediate and concrete steps to alleviate housing stress, build more housing stock and provide support to sustain tenancies**

Section 6: Recommendations on social services (TasCOSS)

1. **Ensure that everyone who needs Disability Support Pension (DSP) receives it**
2. **Independent oversight and regular monitoring of DSP rejections**
3. **Increase the rate of Newstart so that people, with or without a mental health condition, are not left destitute**

4. **Federal funding for education programs targeting employers to hire people with disability**
5. **Introduce an income bank for all people receiving social security payments whose income fluctuates due to casual or insecure work**

Section 9: Recommendations on child safety

1. **Provide assertive, wraparound therapeutic support for children in Out of Home Care (OOHC), particularly around complex trauma, to begin immediately and removed only if the support is assessed as no longer needed**
2. **Support all preferred providers to receive training in trauma-informed care**
3. **Support carers to receive additional trauma-related training, as required**
4. **Assign priority status for healthcare to children in OOHC**
5. **Provide all children and young people in OOHC with regular and meaningful opportunities to be active participants in decisions that affect their lives**

Section 14: Recommendations on regulation of workplace health and safety

- **Urgently prioritise research to create an evidence base for first responder workplace mental health risks**
- **Consider implementation of national standards to ensure best-practice trauma recovery practices are in place to help protect all Australian workers, especially first responders, from the harmful effects of intrinsic workplace risks**

Guide to this Submission

This Submission responds to topics raised in the Issues Paper for the Productivity Commission's Inquiry into Mental Health, 2019.

For indexing purposes, the Issues Paper's subject headers have been apportioned a numerical reference as shown in the table below.

Numerical reference	Issues Paper Subject Heading
1	Assessment approach [for Issues Paper]
2	Structural weaknesses in healthcare
3	Specific health concerns
4	Health workforce and informal carers
5	Housing and homelessness
6	Social services
7	Social participation and inclusion
8	Justice
9	Child safety
10	Education and training
11	Government-funded employment support
12	General employment support to firms
13	Mentally healthy workplaces
14	Regulation of workplace health and safety
15	Coordination and integration
16	Funding arrangements
17	Monitoring and reporting outcomes

Questions appearing in the Issues Paper in bullet points under each subject heading have been apportioned numbers that correspond to in the order in which they appear in each bulleted list. The two numeric sets have then been combined:

Example: 2.2 = Section 2 (Structural weaknesses in healthcare), second dot point.

Please note that this Submission does not cover all sections of the Issues Paper. Therefore, section numbers in this Submission are not necessarily consecutive.

Preamble

Submission author: Mental Health Council of Tasmania

The Mental Health Council of Tasmania (MHCT) is the peak body for community-managed mental health services in Tasmania. We represent and promote the interests of our members and work closely with Tasmanian Government agencies and Primary Health Tasmania to ensure sectoral input into public policies and programs. We have a strong commitment to enabling better mental health care access and outcomes for every Tasmanian. Our purpose is to improve mental health for all Tasmanians, and our vision is for all Tasmanians to have awareness of, and value, their mental health and wellbeing.

Submission partner: TasCOSS

TasCOSS is the peak body for the community services sector in Tasmania. Our membership includes individuals and organisations active in the provision of community services to low-income Tasmanians living in vulnerable and disadvantaged circumstances. TasCOSS represents the interests of our members and their clients to government, regulators, the media and the public. Through advocacy and policy development, we draw attention to the causes of poverty and disadvantage and promote the adoption of effective solutions to address these issues.

Submission represents Tasmanian mental health and community sectors

Together, MHCT and TasCOSS represent approximately 180 Tasmanian community-sector organisations. MHCT and TasCOSS have collaborated on this Submission to ensure the Productivity Commission receives a comprehensive, evidence-based cross-sectoral response that is situated within a Tasmanian context and broadly reflective of a national context. In working together to provide such a response, both organisations acknowledge the significance and timeliness of this Inquiry and hope that the information provided herein will assist the Productivity Commission in its Inquiry and the development of its recommendations.

MHCT has taken the lead role in preparing this Submission, consulting with its members to ensure that the Submission will properly reflect their views. MHCT has chosen to address the twenty Issues Paper questions that most closely align with its organisational remit. TasCOSS has worked to contribute responses on housing and homelessness and support payments. MHCT and TasCOSS partnered last year to create an evidence base on supporting the mental health of children in out of home care; that work is summarised here, with matching recommendations.

Where TasCOSS has authored a response or recommendation, this is clearly acknowledged in the text.

Introduction

The Tasmanian context: demographic and social features

Tasmania is the only Australian state or territory without land borders. This geographic anomaly has ensured relative remoteness for its population and contributes to distinct demographic and socio-political features that differ from other Australian jurisdictions.

Tasmania's population, measured at 522,152 in 2017, is the smallest of any Australian state.[1] The Tasmanian population is widely dispersed compared to other states and territories; less than half of all Tasmanians live in or near the state capital, Hobart.[2] These two population characteristics negatively impact the provision of goods and services, including mental health services, within Tasmania. The first does not provide for economies of scale that are routinely achieved in other states, while the second compounds the effects of poor scalability to create relatively poor access to services for many Tasmanians, since services tend to be clustered in highly populated areas, and most of Tasmania's satellite population centres are too small to ensure service viability.

Tasmania also has relatively poor public transport. The state's passenger rail service ceased in 1978. Daily bus services provide connectivity between some regional centres (Hobart, Launceston, Devonport), but regional public transport connectivity continues to worsen.[3] Transport accessibility is further diminished by petrol prices which are consistently amongst the highest in the country.[4]

Further examination of Tasmania's population reveals characteristic measures of disadvantage, some operating intergenerationally, associated with poorer population mental health:

- In relation to educational status, 38.3% of Tasmanians complete year 12 compared to the national average of 51.9% with 44% of Tasmanians leaving school at year 10 or below;[5]
- In relation to health literacy, 36.6% of all Tasmanians have adequate skills to understand and use information on health issues such as drug and alcohol use, disease prevention and treatment, first aid and emergencies, compared to a national average of 40.5%;[6]
- The average Tasmanian household income is the lowest of any state or territory, and is 19% lower than the Australian average;[7]

[1] ABS, *Data by Region*, 2011-17, 9 November 2018. Australian territories (NT and Canberra) have smaller populations than Tasmania.
[2] In 2017, 229,088 people (or 43.9%) lived in Greater Hobart, with 293,064 people living in other parts of Tasmania. The average metropolitan to rest-of-state population load across other Australian states and territories is 69.6%, although there is wide variation between jurisdictions Modelled on raw data from ABS *Data by Region*, 2011-17, 9 November 2018.
[3] For instance, bus services between Hobart and the West Coast centres of Strahan and Queenstown require an overnight connection through Burnie as of March 2019, making this route both expensive and inconvenient.
[4] For instance, a snapshot of 'cheapest available' fuel prices in Australian capital cities on 21 March 2019 indicated a cost of 137.7 cents/litre in Hobart compared to 133.4 cents/litre averaged across all states and territories; data drawn from Petrolspy.com.
[5] Data shows 2016 figures; ABS, *Education and Employment*, 2018
[6] ABS, *Literacy in Tasmania*, 2008. Data is from 2006, however, an analysis of general Tasmanian educational attainment using ABS data from 2011 and 2018 indicates a relatively small (less than 10%) upward shift over that period, making it unlikely that that health literacy has risen markedly since last measured.
[7] Data shows 2016 figures; ABS, *Income*, 2018

- A steep rise in residential housing prices and a chronic lack of rental availability have resulted in greater housing instability and a rise in homelessness, particularly in the greater Hobart region, within the last 3 years.

Tasmanian mental health: crisis presentations to emergency departments

Tasmania is experiencing unprecedented hospital presentations for mental illness. The state's emergency department mental health crisis presentations have been rising for the last decade. Mental-health-related emergency department presentations increased by 35 per cent between 2013 and 2017.[8] Disturbingly, such presentations are appearing at a greatly increased rate amongst young Tasmanians. Youth mental-health-related emergency department presentations rose by 52.2% between 2009 and 2016.[9] Such rapid growth in this key mental ill-health indicator over a relatively short period of time could indicate a breaking point in provision of preventive and early intensive mental health interventions in Tasmania, although further research is needed to better understand the underlying causes.

[8] Tasmanian State Government, Office of the Minister for Health and Human Services

[9] Tasmanian Health Service, *Mental Health Presentations to Emergency Departments for Patients Aged 12 to 18 years* (data table), 2018.

Responses to Issues Paper Questions

Assessment approach

1.1 What suggestions, if any, do you have on the Commission's proposed assessment approach for the inquiry? Please provide any data or other evidence that could be used to inform the assessment.

MHCT acknowledges Issues Paper commentary on the significant personal, social and economic costs of mental ill-health, including suicide. In MHCT's view, however, the Issues Paper understates the scope and significance of the problems facing Australia in relation to suicide and attempted suicide. MHCT believes that detailed modelling of these issues based on the most recent data will assist Commissioners to understand these issues more fully, prior to any consideration of what may be needed to tackle these effectively. To that end, MHCT has provided the following information on suicide and attempted suicide prevalence, trends and economic impacts to further inform the Commission's deliberations.

Suicide: social and economic burdens

In addressing the complex issue of suicide in Australia, MHCT firstly wishes to acknowledge the profoundly distressing nature of suicide, and the severity of its impact on all who are touched by it. This includes people who take their own lives, often in circumstances of the greatest distress; their families, partners, friends and workmates; first responders, medical staff, coronial officials and others who, in the course of their duties, are charged with the responsibility of caring for the deceased or investigating their deaths. For these people, and indeed for the entire Australian community, suicide is a traumatic event which leaves an impact often felt for many decades and intergenerationally. The emotional and spiritual losses that it creates are impossible to quantify.

In addition to these extremely serious impacts on Australians and their communities, suicide also creates a significant and ongoing economic burden to Australia, negatively impacting productivity, limiting economic growth and impeding global competitiveness to the nation's long-term detriment. To assist the Productivity Commission to better understand the quantum of this economic burden, MHCT has used the most recent data on Australian suicide rates and, using a comprehensive model developed in Australia, has modelled the current economic impact of suicide.

Australian suicide rate

In the decade from 2001 to 2011, Australian suicide rates stabilised and began to fall.[10] From 2011, however, this trend reversed. While trend instability from 2012 to 2016 partially obscured the rate of climb, recently-released 2017 data confirms a steep upward trajectory. 2017's provisional figures (likely

[10] CRESP, 2015

to be revised upward) indicate that 3128 Australians died by suicide that year, a rise of 20.9% in the five years to 2017 (fig.1). This unsustainably high rate of climb is unprecedented in Australian history.[11]

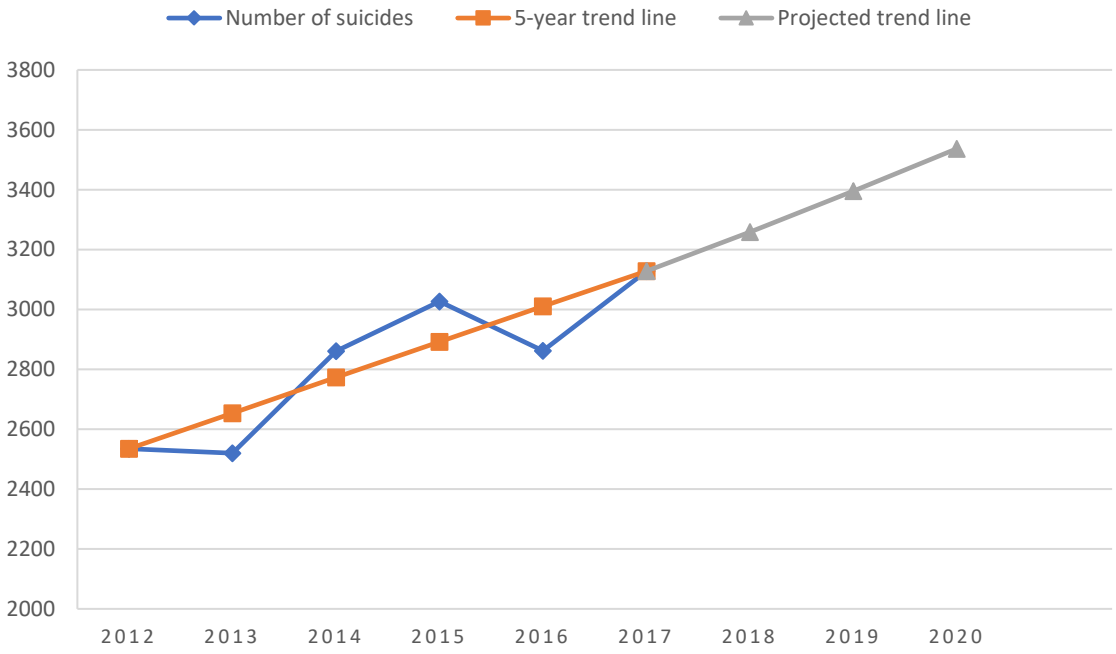

Fig.1: Australian suicide deaths 2012-2017: (Blue) number of suicides; (Orange) Adjusted 5-year trend; (Grey) Adjusted trend extended to 2020

Fig. 1 graphs the number of suicides in Australia for the years 2012 to 2017, provides a smoothed trend line showing the average climb rate, and projects the trend line forward to 2020. This indicates that if the annual number of suicides continues to rise at the rate observed since 2012, Australia will likely have over 3500 suicide deaths in 2020.

Attempted suicides

Attempted suicide is an indicator of extreme psychological distress. People who have attempted suicide are at increased risk of further suicide attempts and of dying from suicide. Most, but not all, people who attempt suicide have an underlying mental illness or disorder.

Suicide attempts place people at high risk of injury and ongoing physical disability. Approximately 17% of people who attempt suicide will incur a permanent disability from the attempt, limiting their potential to live a full, enjoyable and productive life. These highly significant psychological and physical factors indicate the severity of attempted suicide, both as a measure of current and future quality of life, and in terms of the risk of permanent disability.

[11] Chart data from ABS *Causes of Death* 2012, 2013, 2014, 2015, 2016, 2017. Please note that the 2017 figure is uncorrected data and will likely be revised upward to reflect results of ongoing coronial inquiries.

There is little data available on suicide attempts, making it difficult to estimate prevalence. Australian sources often cite a ratio of between 20 and 30 suicide attempts for every completed suicide.[12] This appears to originate from a World Health Organisation (WHO) global estimate in common use since the 1970s. If the WHO-derived ratio of attempted suicide to suicide is used to model the number of attempted suicides in Australia, that would indicate that 62,500 Australians attempted suicide in 2017, with over 10,000 incurring a permanent physical disability.

Fig. 2 uses the WHO ratio to model attempted suicides in Australia from 2012 to 2017 and to project the rate of attempted suicide from 2018-2020. Assuming the ratio remains constant over time, over 70,000 Australians will attempt suicide in 2020:

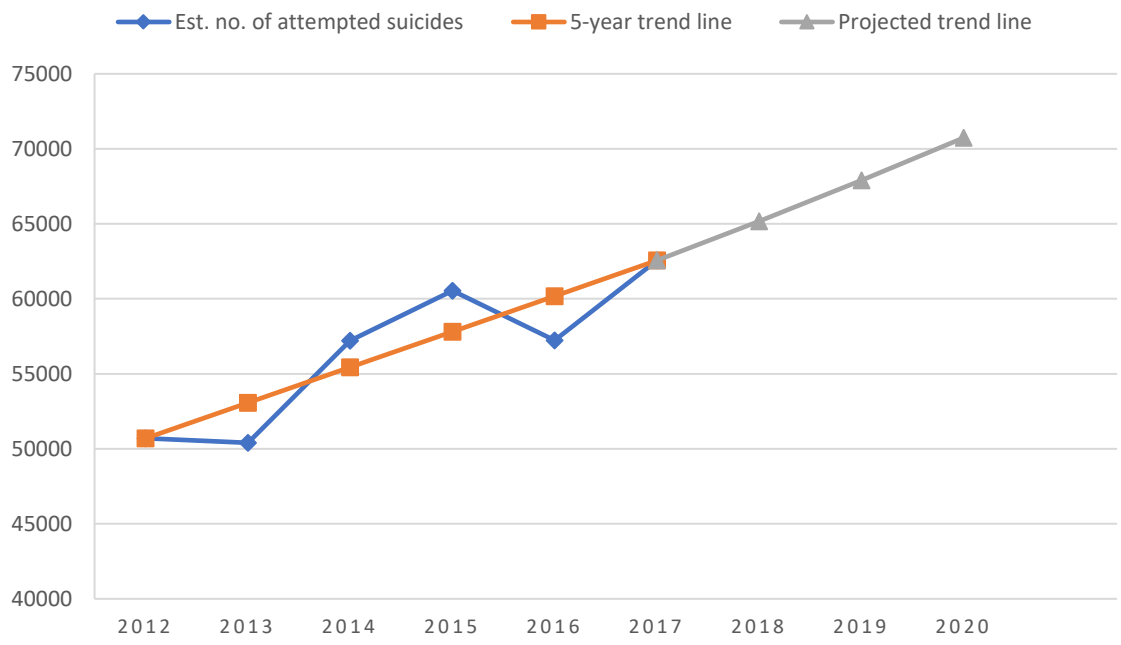

Fig.2: Estimated attempted suicides 2012-2017: (Blue) estimated numbers; (Orange) Estimated adjusted 5-year trend; (Grey) Estimated adjusted trend extended to 2020. Based on WHO comparative ratio of 20 attempted suicides to each suicide death

However, the Australian 2007 *National Survey of Mental Health and Wellbeing* revealed an attempted suicide prevalence rate of 0.4% within the previous 12 months, with this figure accepted by the Australian Government as a key finding of the report.[13] This equates to about 71 suicide attempts for each death by suicide in that year.[14]

[12]For instance, this figure is used in the National Mental Health Commission, 2018 and by SANE Australia, while the Black Dog Institute and Lifeline use a 30:1 ratio to estimate the number of suicide attempts per suicide; none of these ratios are referenced.
[13] ABS, *National Survey of Mental Health and Wellbeing* (SMHWB), 2007; see also discussion in Johnston et. al., 2009; the 0.4% suicide attempt prevalence rate is cited in *Mental Health of Australians 2*, 2009, p.41. Over 8800 Australian households were surveyed with the age of survey respondents between 16-85 years. No data was collected about suicide attempt prevalence in age brackets 0-15 years or 85+ years.
[14] Given a population size of 21.1 million in the year the survey was taken, 0.4% prevalence equates to 84,400 suicide attempts. This is equivalent to a ratio-based estimate of 71:1 (being the number of suicide attempts measured against the number of suicides in that year, 1181 deaths).

If the 2007 population prevalence rate of 0.4% is used to estimate the number of attempted suicides in 2017, a far bleaker picture appears than is indicated in the graph above, indicating that over 98,000 Australians may have attempted suicide that year.

In summary, every suicide attempt is a sign of a person's profound psychological distress. Suicide attempts have significant and inherent psychical and physical risks, not least the risk of permanent physical disability. A prior suicide attempt is the most significant risk factor for death by suicide. More data and research are needed to confirm the size and scope of this problem, which has the potential to adversely affect Australia's identity, culture, social and community values.

Economic costs of suicide and attempted suicide

In relation to the economic cost of suicides and attempted suicides in Australia, a recent costing analysis based on Australian Industry Commission methodology estimates costs associated with Australian suicides,[15] identifying direct and indirect costs for the following:

- Production disturbance costs (value of lost production / staff turnover costs borne by employer)
- Human capital costs (value of lost earnings for worker; impost on government of welfare payments, tax revenue foregone)
- Medical and rehabilitation costs (to the individual, the employer and government)
- Administrative (investigation costs, funeral costs, cost impost to government of running compensation and investigatory systems)
- Other (carer payments, cost of aids, equipment, modifications, prevention care costs)
- Transfer costs (deadweight costs of tax revenue foregone).

The analysis concludes that every suicide death in Australia costs approximately $1.69 million. A suicide attempt that results in permanent disability costs approximately $2.26 million, while a suicide attempt that does not result in permanent disability costs approximately $1180.

While the model itself appears robust, several underlying assumptions are extremely conservative. For instance, the model assumes that:

- A person who attempts suicide will be absent from work for less than 5 days and will return to work at full productivity;
- A person who incurs a permanent disability from a suicide attempt will bear no costs (over and above any costs borne by governments or employers) in relation to carer payments, aids and equipment; and
- A suicide attempt that does not result in permanent disability will have medical costs of $820.[16]

[15] The methodology was originally developed by the Australian Industry Commission in 1995, refined by the Australian National Occupational Health and Safety Commission in 2004 and applied by Safe Work Australia in 2012 and 2015; see Kinchin and Doran, 2017 for details.
[16] This figure is used by Safe Work Australia as the average cost of a (general) health-related work absence lasting less than 5 days; Kinchin and Doran, 2017

The assumption of $820 for medical costs associated with a suicide attempt is particularly problematic, considering the following factors:

- Likelihood of hospitalisation following a suicide attempt;
- Average length of a mental-health-related hospitalisation (17 days);[17]
- Results of a recent study indicating an average medical cost of $27,230 per acute mental health episode.[18]

If the model's most problematic assumption (medical costs per suicide attempt) is corrected without making any changes to other assumptions or to the method of calculation, the estimated economic cost per attempted suicide rises to $27,590 (consisting of $27,230 in medical costs and $360 in other costs including lost productivity). MHCT believes this is a more accurate representation of the economic cost of attempted suicide than has been made in the past.

Economic costs of suicide and attempted suicide correlated with Australian suicide rate

When the estimated economic cost per suicide and attempted suicide is correlated with the Australian suicide rate, it is possible to gain an understanding of just how much Australia is losing in pure economic terms.

Fig. 3 (below) estimates the economic cost of suicide and attempted suicide in Australia for 2015, 2016 and 2017 using the following assumptions:

- ABS Causes of Death classification of Intentional Self-Harm is equivalent to death by suicide
- ABS Causes of Death datasets are correct for years 2015-17
- 20 suicide attempts per suicide
- 17% of suicide attempts will incur permanent physical disability
- $1.69 million per suicide
- $2.26 million per suicide attempt incurring permanent disability
- $27,590 per suicide attempt not incurring permanent disability

Year	Cost of suicides in $AUD	Cost of suicide attempts resulting in permanent disability in $AUD	Cost of suicide attempts not resulting in permanent disability in $AUD	Total cost of suicide and attempted suicide in $AUD
2015	*$5.116bn*	*$2.326bn*	*$1.386bn*	*$8.828bn*
2016	*$4.836bn*	*$2.199bn*	*$1.310bn*	*$8.345bn*
2017	*$5.286bn*	*$2.403bn*	*$1.432bn*	*$9.121bn*

Fig.3: Cost of suicide and attempted suicide in Australia, 2015-2017

[17] AIHW *Mental Health Services in Brief*, 2018, p. 11
[18] *Mental Health Costing Study*, p. 36; the figure includes acute mental health episodes managed in community as well as inpatient settings and aligns with estimated daily acute care costs and average length of stay.

This indicates that the aggregate annual economic burden of attempted suicide is almost as significant as that of suicide. While the economic costs associated with most suicide attempts are far lower than those associated with a suicide, the number of suicide attempts is far larger than the number of suicides. It should be noted that the 17% of suicide attempts that result in a permanent physical disability are disproportionately costly, reflecting an ongoing need for care and support payments.

The table reveals that the cost of suicide and attempted suicide reached over $9 billion in 2017. It is worth noting, moreover, that the steep rising trend of suicide in Australia will act to increase the costs associated with suicide and attempted suicide year on year; it can be estimated, for instance, that the total economic costs of suicide and attempted suicide will reach nearly $11 billion by 2020.[19]

Structural weaknesses in healthcare

2.1 Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?

There is a persistent view in political and media commentary that current levels of government funding for mental health in Australia are higher now than ever before. The Productivity Commission Inquiry's Issues Paper appears to validate that view, with a graph of mental health expenditure over time demonstrating a significant rise in per capita expenditure by federal and state governments, equivalent to a doubling of expenditure each 16 years, between 1992 and 2016.

This view of an ever-increasing upward trend in mental health funding to the current 'record' level is incorrect, however. A more careful examination of historic funding of mental health is required to gain a more nuanced understanding of current funding drivers and contexts.

Following the release of the Richmond Report[20] in 1983, Australia moved to de-institutionalise the mental health system on human rights grounds (and following international best practice). The Report outlined a plan in which funding that had supported mental health institutions would be set aside to establish a new national community-based, preventive and early intensive mental health system.

However, when de-institutionalisation commenced in 1988, the consequent funding windfall was not quarantined as had been contemplated. In 1993 the Burdekin Report noted that the anticipated redirection of institutional mental health funding into community-based mental health programs had not occurred.[21] Two years later Bircanin and Short noted that de-institutionalisation in Australia had been "inadequately funded and poorly orchestrated".[22]

[19] This figure is based on suicide rate projections shown in Fig. 1 and costing assumptions listed above Fig.3 (Cost of suicide: $6 billion; cost of attempted suicide not incurring permanent disability, $1.6 billion; cost of attempted suicide incurring permanent disability, $3.2 billion.
[20] Richmond Report, 1983
[21] Burdekin Report, 1993
[22] Bircanin and Short, 1995

In support of that view, an examination of historical state and federal government mental health expenditure clearly shows that mental health was stripped of more than half of its entire funding quantum between 1989 and 1992, the period in which de-institutionalisation occurred. Comparison of mental health spends over this period (Fig. 4) shows that a per capita, per annum mental health spend of $405 in 1988 declined extremely rapidly, bottoming out at just $155 in 1993, indicating that slightly more than 60%[23] of the funding available in 1988 had been removed within a five-year period:

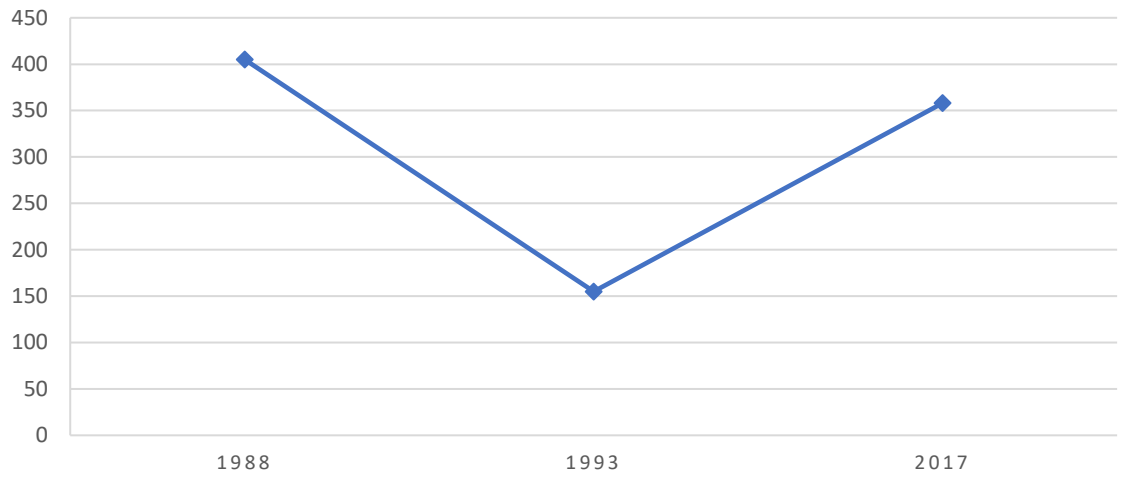

Fig. 4: $AUD per capita Australian and state/territory government funding for mental health, 1988 - 2017

The Issues Paper graph, which splits federal and state-based funding sources,[24] indicates that post-1993 federal mental health budget allocations rose marginally year-on-year for the following 15 years. State and territory mental health spends continued to decline for another 12 months, then from 1994 rose in a slow upward trajectory that closely tracked federal spending. This steady rise in funding allocations of approximately 6% year-on-year over a 25-year period, continuing to the present day, is a telltale sign of an overburdened system, in which demand continually outstrips resources and small rises in funding allocations are used to 'paper over the cracks'.

This disturbing pattern, apparent in Australian mental health funding allocations for three decades, reflects the long-term economic consequences of funding for failure. The wholesale removal of funding for mental health in the face of unchanged service demand (the number of mentally ill people did not lessen, nor did the need to support and care for them) was disastrous. Without foundational support, the community-based mental health model was never effectively established and was unable to fulfil its purpose (to identify and treat incipient and early-stage mental illness, and to support people recovering from mental illness to transition back into study, work and daily life). Without effective early treatment, people at risk of mental illness were left unsupported and were highly likely to go on to develop a mental illness, while people with early-stage mental illness were highly likely to experience progression, eventually resulting in a crisis presentation. The consequent increase in demand for crisis care (and the very high financial burden of such care), necessitated a funding response in which crisis care was prioritised and community-based mental health care considered less important in terms of budget priorities.

[23] Comparative data analysis on funding allocations for 1988 and 1993 reveals that 61.7% of the funding quantum for 1988 had disappeared by 1993 and did not reappear in future years.
[24] See Issues Paper, p. 34. In the graph on this page, federal and state funding sources have been combined.

This data-based, historically-informed view of Australia's mental health funding evidences the destructive power of dismantling a mental health system without ensuring the adequacy of its replacement. In attempting to move from an institutional mental health model to a community-based model without funding the full establishment of the latter, Australia effectively ensured that the new community-based system would fail.

As is seen in numerous jurisdictions worldwide, the failure of a community-based mental health system inevitably leads, over time, to an increase in the number of mental health crisis presentations. This places an ever-increasing burden on crisis care, which is expensive; consequently, a greater proportion of available budgetary resources are directed towards crisis care, for which there is rising demand, and a lower proportion of funding is directed toward community-based, preventive and early intensive mental health care.

Fig. 5 below shows the negative cycle created by the substantial defunding of Australian mental health services at the time of de-institutionalisation, and still in evidence today:

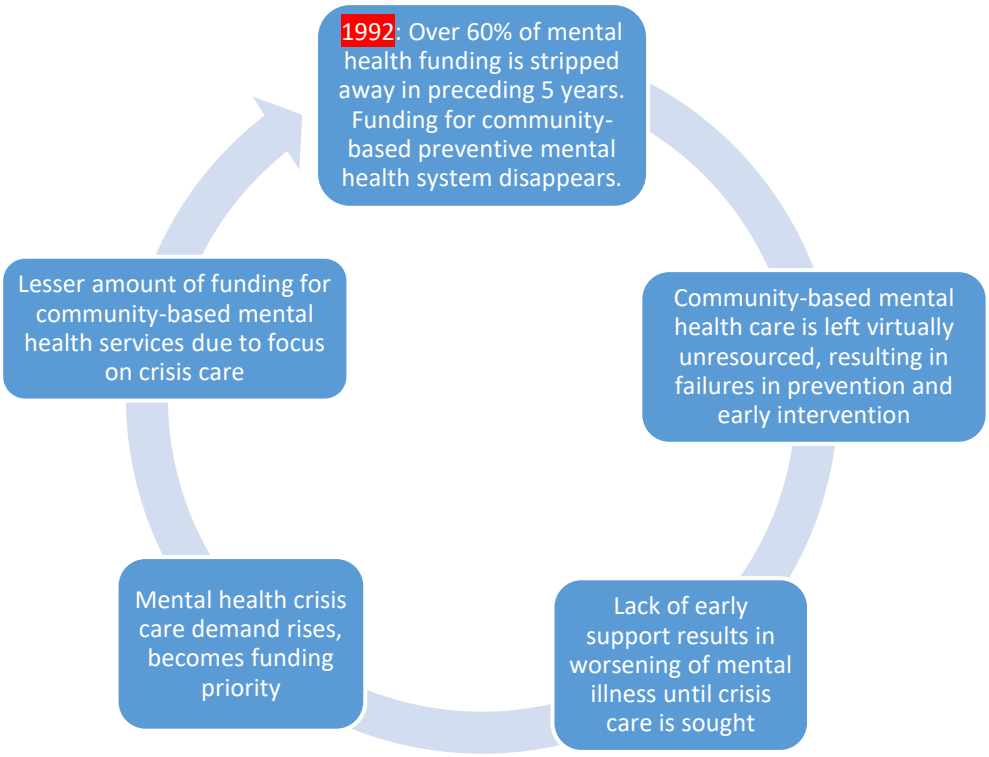

Fig. 5: Long-term impact of underinvestment: lack of community services leads to progression of mental illness, increased demand for crisis care

The elucidation of this cycle and its drivers explains why past reform efforts of previous governments over many years have failed to strengthen and support mental health care in Australia. These reforms – including current reforms being put in place – have failed to address the chronic underfunding of community-based mental health, tending instead to introduce specific services or programs rather than tackling the fundamental foundational instability of the mental health system.

The pattern of small (around 6%) year-on-year increases seen in Australian mental health funding from 1992 onwards is typical of a fund-for-failure pattern best described as 'catch-up'. Each increase is not sufficient to permit any meaningful change to occur. Funding increases that occur within this pattern rarely build long-term benefit, since they are primarily reactive, intended to prevent system failure. This kind of reactivity in mental health funding leads almost inevitably to poor long-term outcomes and high long-term costs.

This certainly seems to be the case in Australia. The 2016/17 per capita, per annum Australian mental health spend of $358, far from being at record levels, is lower in per capita terms than it was in 1988, prior to de-institutionalisation.[25] Without systemic change, cost increases are likely to continue on the current trajectory, reaching $716 per capita ($17.6 bn in dollar figures) by 2032/3.

Breaking the cycle of crisis: foundational investment in preventive care

To interrupt the 'cycle of failure' outlined above, government must direct significant resources to build a long-overdue foundational underpinning which can properly support the multiple programmatic offerings being introduced and give them a greater chance of success. While such an undertaking will necessarily require a large front-end investment, it is far more cost-effective over the long term. International jurisdictional analyses indicate that a fully mature community-based mental health system is significantly less expensive to run than a crisis care system. For instance, Trieste's community-based mental health system, established in the late 1960s and discussed elsewhere in this Submission, had a per capita cost of approximately AUD 141[26] in 2012, compared to Australia's per capita cost of approximately AUD 380[27] that same year.

The following pie chart (Fig. 6) illustrates how funding is directed within a successful, mature community-based mental health system.[28] Only 6% of funding is spent on acute care beds (inpatient services), with a further 6% spent on pharmaceutical services. 68% of all funding is spent on community-based mental health services (for example, day programs, group and individual therapies), with 20% set aside for individually-tailored community and social supports, including workplace and professional training, group activities and trips, economic subsidies and personalised 'health care budgets.'

[25] The total dollar amount was higher in 2016/17 ($8.8b) than in 1988 ($6.7bn, adjusted for inflation to 2017 values), but concurrent population growth (16.53m in 1988 to 24.6m in 2016/17) has driven the per capita spend downward.

26 Trieste's mental health system had a per capita cost of USD106 (exchanged into $AUD above) in 2012, the latest year for which data is available. See Portacolone et al., 2015

[27] Data sourced from *Issues Paper* graph "Mental health expenditure over time', p. 34; Federal and state/territory-based funding streams shown in that graph have been aggregated for jurisdictional comparative purposes.

[28] The funding breakdown described for Trieste's mental health service in 2012, as cited in Portacolone et al., 2015, forms the basis for this chart.

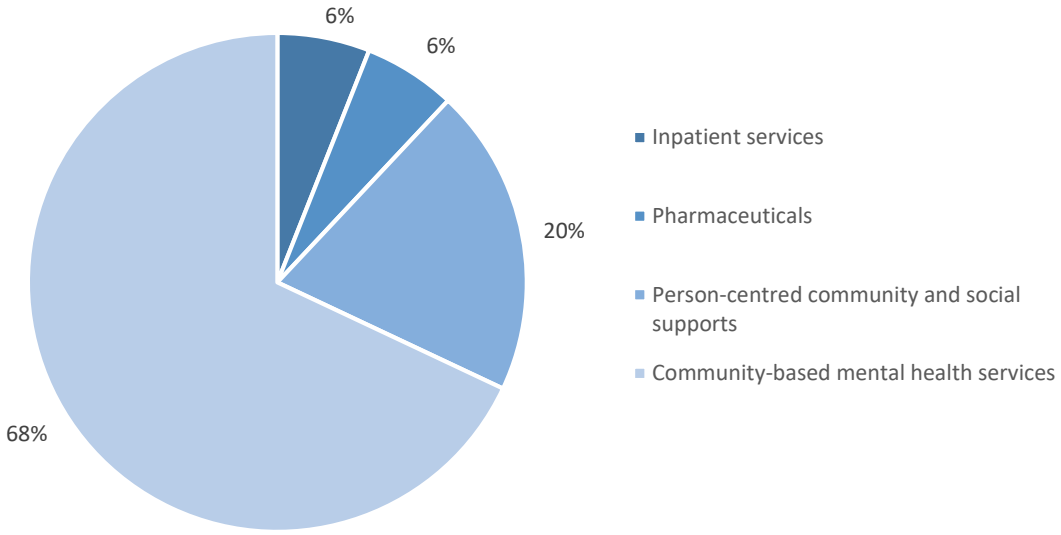

Fig. 6: Best-practice mental health system: proportionate funding targets

This proportionate funding breakdown reflects the reduced need for inpatient services in a system geared toward prevention and early intervention. When nearly 70% of the entire quantum of mental health funding is used to identify, treat and support people at risk of mental illness or people whose illness is relatively early in its course, demand for acute care dramatically reduces, since most people receive sufficient early support to halt or reverse the progression of their mental illness. Since acute care is extremely costly, this reduced demand frees up a substantial amount of funding. The funding freed up may then be used to increase community-based services, which in turn further obviate the need for acute care. As is seen in Fig. 7, the negative cycle outlined above is reversed:

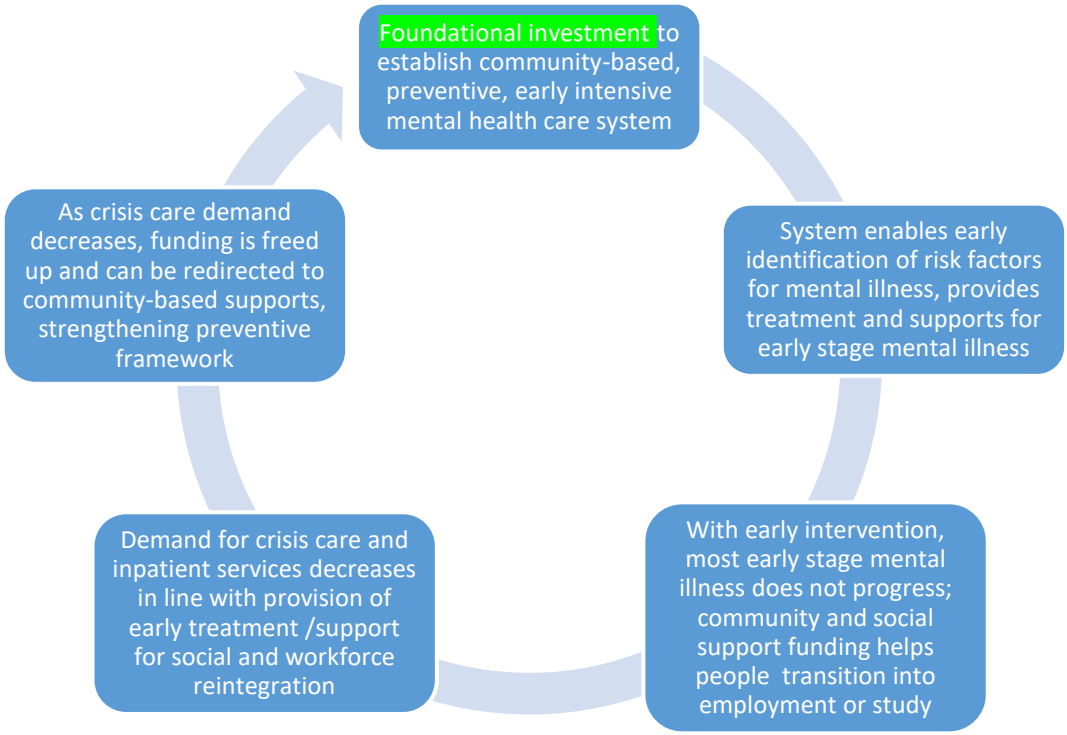

Fig. 7: Foundational investment in community-based mental health creates 'positive' cycle of reduced need for crisis care and consequent reduction in costs

It is important to note that the funding distribution shown at Fig. 6 is reflective of a fully mature system in which preventive and early intensive mental health care has been provided for several decades. The first stage of transition from a crisis care system to a community-based, preventive, early-intervention system would likely display a long, expensive crisis care 'tail', reflecting a generationally based, whole-of-life mental illness risk in a community without prior access to effective preventive and early intensive treatments.

Situating mental health care within a supportive environment

In the Australian context, creating an appropriate environment in which to situate a best-practice mental health care system is equally as important as the design of the system itself (see discussion in response to Question 3.5). Creation and maintenance of such an environment would require a degree of government intervention to compensate for the effect of free market profitability goals; for instance, several decades of growth in the housing market has exacerbated the current lack of housing affordability, housing instability and homelessness, which affect people with a mental illness at a disproportionately high rate. Ensuring that a best-practice, community based mental health system is properly supported within the broader social and economic environment in which it is situated, therefore, requires acceptance of responsibility and accountability for mental health policy, programs and outcomes across and within all government portfolios.

Expected outcomes of reform

Long-term indicators available from Trieste clearly demonstrate that the establishment of an integrated, community based mental health care system geared towards prevention and early intervention, situated within a 'hospitable context' as described in the response to Question 3.5, has potential to effect substantive positive changes in population mental health, social participation and workforce participation, leading to a net decrease in welfare costs and a net increase in national productivity.

Key outcomes from Trieste include:

- The suicide rate reduced by over 50% in 20 years, from 25 suicides per 100,000 to 12 per 100,000 by 2002,[29] and fell twice as rapidly in the decade from 2003, reaching 5.7 per 100,000 in 2013 (one of the lowest suicide rates observed in any OECD nation),[30] demonstrating the increased benefits of systemic maturity over time;

- In the 20 years following implementation, Trieste experienced a 50% reduction in the number of mental health crisis presentations at hospital emergency departments. [31]

[29] Mezzina, 2014, p. 442
[30] OECD, 2019
[31] Mezzina, 2014, p.443

High rates of social recovery and increases in social functioning were repeatedly observed in qualitative research studies. A five-year follow-up study of users of the Trieste system showed:[32]

- 78% of users were living independently
- 30% of users had returned to the professional (non-supported) workforce
- 20% reduction in mental illness symptoms was reported
- 50% increase in social functioning was reported
- 70% reduction in admission days (including day program admissions).

If Australia were to institute such a system and ensure that it was situated within a supportive context, this would likely result in improvements across a range of indicators over time, including (but not necessarily limited to):

- Significant (up to 50%) reduction in Australian suicide rate from implementation baseline;
- Significant (up to 50%) reduction in psychological crisis presentations to emergency departments;
- Improvements in workforce participation, independent living and social functioning in people who had received treatment for a mental illness;[33]
- Reduction in mental health 28-day readmission rate.

Based on what was observed in Trieste, it may be assumed that small, steady positive changes could be measured at 2-5 years, with an increase in the rate of positive change at 12-16 years, as early benefits of implementation begin to compound. The full effect of implementation would likely be observable at 25-30 years (full generational maturity).

Consequences of past funding decisions

In summary, Australia's mental health system was dismantled in the paradigmatic shift of de-institutionalisation. Its intended replacement, a community-based mental health system, was so poorly funded and managed that it was unable to fully establish itself. Its failures, obvious even at the outset,[34] have compounded over time, resulting in today's poorly planned, expensive and non-future-focused system geared toward crisis care in which programmatic reforms are essentially doomed to fail due to the absence of appropriate structural support.

The consequences for the Australian community have been severe and are manifest in the decades-long upward trend in rates of mental illness in the community, emergency department psychological crisis

[32] The following data is noted by Mezzina, 2014, p. 443. While sample sizes are small, numerous qualitative studies have yielded consistent results.
[33] It is difficult to estimate the degree of change likely to be seen in this indicator because Australian indicators of participation for people with a mental illness are not specific enough to determine what percentage of people with a mental illness severe enough to preclude participation were enabled to begin participation following treatment for mental illness.
[34] As discussed in the Burdekin Report, 1993, and Bircanin and Short, 1995

presentations, and high suicide rates. At a certain point the compounding nature of these problems acts to accelerate the rate at which they worsen; hence, as discussed in the response to Question 1.1 above, in the five years to 2017, Australia's suicide rate rose by 20.9% off a relatively high base.[35] It seems unlikely that this upward trend will lessen without substantial foundational and structural investment into a best-practice, effective, community-based mental health care system focused on prevention and early intensive intervention and treatment.

Recommendations on structural weaknesses in healthcare

1. **Undertake scoping and planning for a foundational framework for an integrated, community-based mental health system focused on prevention and early intensive intervention with reference to best-practice global models, with particular attention given to resourcing this system appropriately considering the economic and social imperatives for systemic reform**
2. **Embed consideration of, and support for, mental health as an intrinsic underlying cross-portfolio principle that is reflected in each government portfolio's policies, programs and outcome measurements, such that all portfolios share accountability for improving mental health outcomes and are individually held accountable for the impact of policies and programs on population mental health**
3. **Create specific structural underpinnings in the domains of housing, social participation and inclusion, justice, child safety, education, training, and workplace health and safety, with the aim of:**
    a. **Ensuring access to appropriate, affordable housing for people with mental illness**
    b. **Creating mechanisms to enable people with mental illness to undertake meaningful activities and/or employment which supports their autonomy, and providing active support for people to self-plan and manage these**
    c. **Ensuring access to affordable transport for people with mental illness**
    d. **Providing timely, accessible treatment for substance abuse inside a non-punitive framework**
    e. **Provide support for family and relationship issues**

2.2 What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed, and what would be the improvements in population mental health, participation and productivity?

Purposeful, effective use of mental health outcomes data

In addition to the structural weaknesses described in the responses to Question 2.1 above, which are not being targeted by any recent or foreshadowed reforms by governments, there is a need to systematise the purposeful collection, ownership, management and analysis of mental health data.

[35] The World Health Organisation ranked Australia's suicide rate as 15th highest of the 36 OECD nations. Australia's suicide rate of 11.7 in 2016 was high compared to the WHO's crude global rate of 10.6.

Currently, the most significant Australian mental health data sources are the Australian Bureau of Statistics (ABS), the Australian Institute of Health and Welfare (AIHW) and the National Mental Health Commission (NMHC). In addition to these, the NHMRC Centre of Research Excellence in Suicide Prevention Report of 2015 contains a comprehensive listing of currently available, mental health-related datasets listed by state, together with information on accessibility and linkage options.[36] This is a useful resource to which MHCT directs the attention of the Commissioners.

In summary, however, Australian mental health data is problematic in many ways. There are inconsistencies in form, usage, purpose, accessibility and linkage potential of data collected across multiple agencies and organisations. While outcomes-focused data collection has increased, there is still a tendency to measure activity rather than outcomes. Funding bodies must develop a more nuanced understanding of the concepts of 'value' and 'success' in relation to reporting requirements. While these may be well understood at a high level within governments and individual agencies, this understanding is not always shared by the staff tasked with designing and delivering programs; there is a persistent belief that activity measurements provide proof of value for money. Attention should be directed to educating staff responsible for funding, designing, assessing and evaluating programs as to the high value of outcome measures (what did this achieve for the participant?) that are benchmarked at commencement, followed up in the medium to long term, and integrated with other indicators where available to create the fullest possible picture of program efficacy. Value for money assessments should be comparative in nature and pinned to outcomes measurements (i.e., the cost of one program should be compared to the cost of another program with similar efficacy to determine which of the two represents better value for money, as opposed to assessing the per capita cost of an individual program without reference to the cost of achieving the same outcome by different means).

In addition, multiple, siloed data flow channels exist, with no central point of visibility. This is a significant impediment to the effective use of data to measure success, or to compare relative efficacy across different systems, programs and domains.

Some critical approaches to address current issues in data collection, management, aggregation, analysis and usage are outlined below.

What data should be collected?

In considering the type of mental health data to be collected, government should focus on:

- The need to create baseline indicators for the situation that each system or program is intended to address;
- The need to measure outcomes, rather than actions – activity does not equate to success;
- The need to establish data fields that remain consistent over time, so that medium and long-term outcomes can be measured; and
- The relevance of the data to the goals of the systems and programs being measured.

[36] CRESP, 2015, Appendix F, *Dataset Descriptions*.

Big data for best-practice research and evaluation of mental health systems and programs

Government should investigate mechanisms for aggregating and consolidating data to create open-access, anonymised 'big data' fields which can be mined for research and evaluation purposes.

Effective person-centred long-term outcome measurement requires data tracking of a person's whole of life interaction with mental health and associated services. This requires comprehensive data linkage across (for instance) diverse providers, sectors, and funding channels.

Establishment of targets to enable effective performance measurement

To derive meaning from outcomes-focused data, it is critical to establish outcomes-based targets for each system or program being measured. Targets should be as realistic as possible, independent of political will, and based on the best evidence and/or research available at the time the system or program is designed. In this way systemic and programmatic effectiveness can be measured against intended utility and cost (particularly relative to other mechanisms with the same intended purpose).

Recommendations on data collection and linkage:

1. **Consider what data is needed for the most effective measurement of mental health outcomes with specific regard to purpose and relevance**
2. **Examine information on existing datasets to fully understand what data is currently being captured, its accessibility, and current or potential linkages likely to increase its utility**
3. **Determine whether all data necessary for effective outcomes measurement is currently being collected, and:**
    a. **If so, review its accessibility and linkage options to maximise utility**
    b. **If not, determine how best to source and capture necessary data, with reference to its future accessibility and linkage**
    c. **Consider how best to address data ownership issues that may restrict access and linkage options, resulting in decreased utility**

Specific health concerns

3.1 Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?

Population-based approaches to mental health

Population-based approaches to mental illness prevention and early intervention have been successfully introduced in some international jurisdictions in recent years. For instance, the adoption of population

screening for mental health risks has proven to be an effective strategy in Philadelphia. Public health authorities launched Healthy Minds Philly, a program that seeks to engage with community members online, in person at regular events, and through their regular clinicians (GPs and allied health professionals) to provide information on mental health.[37] Healthy Minds Philly has developed a number of mental health 'at risk' screening tools which are freely available across a range of platforms designed to reach as many community members as possible:

- A free, anonymous 5-minute digital survey accessed via a web link that screens for risk factors for generalized anxiety disorder, depression, bipolar, PTSD and substance abuse issues, and advises the person to seek advice if they are found; services are nominated for this. The survey is available in Spanish as well as English to heighten accessibility for culturally and linguistically diverse people;
- A free, downloadable set of screening resources designed to assist clinicians to screen for PTSD, generalized anxiety disorder, depression, bipolar and suicidal ideation. These provide clinicians with the skills to screen for incipient or early-stage mental illness during routine health check-ups; and
- Drop-in service providing free face-to-face behavioral health screenings at community events and (in partnership with service providers) at several permanent 'kiosks'

These population-based approaches provide open-access support and information in a way that supports autonomy and encourages self-care. Community members can use these to become active participants in their own mental health care, learning to understand their own mental health risks and identifying points at which they should seek support.

The introduction of population screening measures such as these, together with broad-scale marketing campaigns to encourage their take-up, would enable early identification of risk factors for mental illness and early-stage mental illness. Since early intervention tends to prevent a person with risk factors developing a mental illness or halt the progression of mental illness, population screening could be highly effective in reducing mental ill-health in the community.

It is important to note that population screening would likely lead to an increase in demand for accessible, timely mental illness prevention and early intervention services. Additional services should be provided *prior* to the introduction of population screening mechanisms, in anticipation of increased demand. Otherwise there is a risk that initial demand will overwhelm service capacity, leading to failures in prevention and early intervention further complicated by an inferred betrayal of trust (screening infers the existence and ready accessibility of follow-up services; if this is not the case, the person who has been encouraged to seek follow-up support may feel more distressed by service failure than they were prior to the screening). In such a situation, the population mental health benefits of screening would be lost, as these accrue not from early identification of mental illness, but from early and effective management of the illness and any associated risk factors. Indeed, the entire screening framework would be at increased risk of failure, since early negative experiences, including failures in follow-up support, tend to discourage any further participation.

[37] Healthy Minds Philly is an initiative of the Department of Behavioral Health and Intellectual Disability Services of the City of Philadelphia; see here for more information.

Recommendation on specific health concerns (population mental health):

1. **Introduce population screening measures and deliver a concurrent increase in preventive and early intensive mental health care programs and services, such that capacity is sufficient to service projected additional demand**

3.2 Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?

Please refer to discussion in the response to Question 3.1 above.

3.3 What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?

In responding to this question, MHCT has chosen to address the issue of suicide amongst people with a mental illness, and has intentionally excluded the issue of comorbidities, which is discussed in the response to Question 3.4.

Clinical suicide prevention approaches (1): Avoiding relational failures

Although suicides occur infrequently within a clinical setting, some service delivery factors are associated with a higher risk of suicide both within, and after discharge from, clinical settings.

The attitude of clinical staff towards people who have attempted suicide is important. A compassionate, positive attitude can assist people to recover, whereas a negative attitude can have long-lasting detrimental impacts and lower the chances of the person seeking help in the future.[38] It is disturbing to note in this regard that many clinical staff have negative attitudes to people who self-harm and often feel anger or irritation when caring for them.[39] Increased knowledge about suicidal and self-harming behaviour has been seen to improve both the knowledge and the attitudes of clinical staff.

Other factors that heighten the risk of suicide in people recently discharged from a clinical setting have been identified as:

- Unplanned discharge
- Key personnel on leave or leaving
- Short admissions (under seven days)
- Person admitted under a new consultant
- Time when not in contact with services in the period following discharge from hospital.[40]

[38] CRESP, 2015, p. 7
[39] A systematic review of over 70 studies on the attitudes of clinical staff towards people who self-harm indicated that attitudes of general hospital staff, particularly doctors, were largely negative, while specialised psychiatric staff in both clinical and community settings were more positive; active training led to improvements in attitude and knowledge. Saunders et al., 2012
[40] All factors discussed in CRESP, 2015, p. 13.

As some of these situations are unavoidable, it may be useful to see them as indicators of relational failures in a clinical context rather than situations that are intrinsically problematic. If these situations are viewed as 'high risk' for the disruption of critical relational pathways (and managed accordingly), it may be possible to compensate for their negative relational effect, thereby diminishing the associated risk.

For instance, in the case of key personnel going on leave, this is a high-risk relational situation in which a patient may experience the staffer's absence as a relational loss. Given the patient's high vulnerability, this loss may be highly distressing. Ideally the patient will be supported to build trusting relationships with other staffers to substitute for the loss. Improvement of the patient's relational capacity may be an appropriate long-term goal, to be developed in community care.

A short admission may not allow sufficient time for a positive therapeutic relationship to be established or to enable open and honest communication of the patient's needs and state of mind. If communication between the patient and clinical staff is not effective, the patient may face discharge while key issues remain unaddressed. Establishing continuity of care at admission and when articulating between clinical and community contexts may be protective, as it is more likely to support effective communication.

Patients admitted under a new consultant may be exposed to increased risks resulting from the consultant's lack of familiarity with workplace-specific practices and dynamics, and consequent failures in staff communication. An increased focus on formal and informal orientation practices for new clinical staff may be useful to mitigate some of these risks.

Loss of contact with support services following discharge from hospital is also in part a relational loss, in that the recently-discharged patient undergoes the loss of relationships with clinical staff established during hospitalisation, and loss of peer relationships with fellow patients. Careful discharge management including assertive follow-up (discussed below) can help the person establish new relationships with community support workers and peers; this may help to manage feelings of isolation and loneliness post-discharge.

Clinical suicide prevention approaches (2): Discharge and referral

It is critically important to understand key risk factors associated with suicides that occur after discharge from clinical settings. Failure to provide outpatient follow-up care after suicide attempts is associated with an increased risk of reattempt and death by suicide.[41] A recent UK study identified that 47% of all suicide deaths in the UK occurred within one month of the person being discharged from a clinical setting; of those, 43% occurred before the first scheduled follow-up appointment.[42] It is extremely important, therefore, to fully articulate the pathway to community-based support services as part of the discharge process. This would better ensure continuity of support through this high-risk period.

The importance of assertive (or directive) follow up should be noted. At discharge, clinical staff may assume that the person will seek community support on their own or that a brief discussion on available services is sufficient. Often, however, this is not the case. People who are discharged from hospital following treatment for a suicide attempt may be lacking the knowledge, capacity or motivation to seek

[41] CRESP, 2015, p. 2
[42] CRESP, 2015, p. 13

assistance from a 'new' service. While they may recognise their own need for further support, they may not be able to marshal the resources to ask for it. This is particularly well articulated in a report from the Centre of Research Excellence in Suicide Prevention that describes the situation from a consumer perspective:

> Hope … felt a weight in having to be proactive in accessing support services:
>
> *"I guess my thought process was – was very jumbled and unclear and – and I'd had to, I suppose, take the steps and such to – to get back into some sort of routine and – and the fact that all of the things were at my instigation, I probably found a little hard. Like, there was no – it was kind of like I was responsible for having to organise everything*."[43]

Hope's statement shows just how difficult it can be for people to arrange their own mental health care at this critical juncture. It is important, therefore, for providers of suicide prevention services to engage with people assertively. Additionally, given the disturbing findings on the high risk of suicide prior to the first scheduled follow-up appointment, post-discharge follow-up should occur as swiftly as possible.

Barriers to suicide prevention

Suicide prevention services in Tasmania appear to have poor systemic linkage to clinical programs. Consumers report that referral to such services during discharge is sporadic. Anecdotally, many consumers are discharged without a clear pathway for ongoing community support, and do not receive assertive follow up. Tasmanian suicide prevention service providers report low take-up of services and cite a lack of referrals at discharge as a primary reason; this is thought to stem from a lack of knowledge on the part of clinical staff as to what services are available, an effect of siloed systems in which staff knowledge is linked to funding pathways (federal government, state government, community sector, private sector) and hence does not effectively support person-centred care. Systemic integration of such referrals into the discharge process may improve access to and usage of these services by people who have recently been discharged.

Another barrier to effective suicide prevention is the absence of any structural referral pathways for people who present in psychological crisis at hospital emergency departments. A high proportion of these people will leave hospital without being admitted, so there is no discharge process to prompt a referral. People who have not been admitted are rarely given an onward referral; if the person has a history of mental illness but is not admitted, they may be advised to seek support from their existing service provider if they have one (for instance, a psychiatrist, psychologist, counsellor or GP). Referral to specialist suicide prevention services may better address the urgency of their psychological crisis, rather than a recommendation to attend their next scheduled appointment, which may be some time away.

[43] CRESP, 2015, p.28

Expected impact of improved suicide prevention strategies

Evidence that suicide prevention strategies are working effectively would include:

- ABS data on annual number of deaths due to intentional self-harm stabilises at or near 2017 rate, then falls gradually over time
- Number of non-completed suicide attempts per annum stabilises / falls[44]

Recommendations on specific health concerns (mental illness - suicide prevention)

Institute effective referral pathways to suicide prevention services for:

1. **People at high risk of suicide who are being discharged from inpatient care**
2. **People with risk factors for suicide who present at hospital emergency departments**
3. **People with risk factors for suicide who present to independent service providers such as general practitioners and other health care professionals**

3.4 What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?

A staggering 80% of people with a mental illness also have a serious physical health condition.[45] There is strong evidence that depression and a history of trauma are directly linked to chronic disease.[46] People with a mental illness are far likely to have behavioral and biomedical risk factors associated with chronic disease, including smoking, high alcohol consumption, illicit drug use and high levels of risk-taking behaviours.[47] They are also more likely to experience social isolation, poor engagement with workforce or study, and poverty, all of which are negatively correlated with health and wellbeing.

People with severe mental illness are particularly likely to have serious comorbidities. They are six times more likely than the general population to die from cardiovascular disease and four times more likely to die from respiratory disease. They have a significantly shorter lifespan (up to 23 years shorter than that of the general population).[48] Consequently, the cost impost of physical illness for these people is extremely high, at an estimated $15 billion per annum, equating to 0.9% of GDP.[49] While the drivers of this situation are complex, it appears that a contributing factor may be a lack of clinical attention to early risk factors, signs and symptoms of physical illness in this cohort; the presence of severe mental illness may cause clinicians to overlook physical signs, either because they feel the patient's description of symptoms is not credible, or because they are solely focused on management of the co-occurring mental illness.

[44] This will be difficult to measure given the lack of accurate baseline data. Current data on non-completed attempts as modelled in this Submission is a ratio-based estimate, as used in the 5th National Mental Health and Suicide Prevention Plan (Australia). Ratios between 10:1 and 20:1 have been used globally since the 1990s to estimate prevalence of non-completed attempts in the absence of direct data.
[45] Equally Well, 2017, p.10.
[46] AIHW, 2019, *Evidence for chronic disease factors, Behavioural and biomedical risk factors*, Table 1
[47] AIHW, 2019, *Evidence for chronic disease factors,* Fig. 1: Conceptual framework for determinants of health
[48] Equally Well, 2017, p.10.
[49] Equally Well, 2017, p. 12.

Equally Well's Consensus Statement[50] states the need to improve the quality of health care supplied to people with a mental illness (particularly a severe mental illness), and to ensure their equity of access to health care services; current practices are often discriminatory (possibly influenced by negative attitudes towards mental illness on the part of health care workers). The Statement articulates an aim to provide seamless integrated care across health, mental health and social services, in a context where health and mental health workers fully understand their own and others' role in the provision of integrated care and accept responsibility for ensuring that people living with mental illness receive quality health care. It notes that the implementation of an integrated care model will require national leadership and regional coordination to ensure that services work together smoothly and recommends the setting of targets and indicators to monitor progress.

From a pure economic perspective, it is important to note that the management of physical comorbidities experienced by people with a mental illness is subject to the same negative economic cycle outlined in the response to Question 2.1 above; that is, failures in prevention and early intervention inevitably lead to crisis presentations, which are far more costly to manage. The cost of managing late-stage cardiovascular disease, for instance, is enormous. Preventive and early interventive management of physical comorbidities in people with a mental illness will create significant long-term cost savings within the public health system.

MHCT supports the aims, essential elements and comprehensive list of actions articulated in the Consensus Statement and wishes to draw the attention of the Productivity Commission towards this important document in order to consider how best to implement the actions it describes.

3.5 What overseas practices for supporting mental health and reducing suicide and comorbidities should be considered for Australia? Why? Is there formal evidence of the success of these practices, such as an independent evaluation?

Trieste – International best practice mental health care model

The city of Trieste, Italy, is widely acknowledged to have the best mental health care system in the world. The system arose in the context of mental health de-institutionalisation in the 1960s and has thus been refined and has reached full maturity. It focuses strongly on early intervention, stepped care and community-based support, a shift from 'bare survival' to long-term social integration.

In 1987 the World Health Organization designated Trieste as a pilot collaborating centre for community mental health care. Trieste is still formally recognised in this way by the WHO and regularly provides training and advice to other jurisdictions worldwide.

[50] Equally Well, 2017; *Consensus Statement* p.7; discussion of key elements from p.14 onward.

The Trieste approach is based on five principles:

1. Individualised care plans through active negotiation;
2. Ensuring comprehensive responsibility of Community Mental Health Centers in all phases of treatment;
3. Working with and on the environment and the social fabric;
4. Supporting individual freedom and strengths; and
5. Fostering service accountability toward the community.[51]

Trieste public psychiatrist Dr Mario Colucci characterised the Trieste model, and its outcomes over time, in the following way:

> *The previous … model was replaced by an emphasis on interpersonal relations, improved living conditions, and opportunities to work and play … The focus is on the person; the illness is put 'in brackets.' Long stays in hospital never treat mental illness; they often make it chronic and promote demoralization, along with new and worse symptoms.*
>
> *… The Department of Mental Health now has four Community Mental Health Centers (open door and no restraint). Each provides services to a population of about 60,000 inhabitants; is active 24 hours a day, seven days a week; and needs only 6-8 beds for temporary patient sleepovers. The Department also has one general hospital psychiatric unit with six beds; a network of supported housing facilities; and several social and work enterprises.*
>
> *The Community Centers are the access point and also the planning, caring, and social focus of the mental health system. They provide therapeutic, social, and rehabilitative continuity … Rehabilitation is promoted through cooperatives, expressive workshops, school, sports, recreational activities, youth groups, and self-help. The few [hospital] beds are used for varying periods for crisis situations; to protect against specific risk; or to give a respite to both patient and family.*
>
> *Community services also operate wherever else the user is to be found—at home, in hospital, nursing homes, prisons, and forensic facilities. We respond to calls for urgent help and are open 24 hours every day.*[52]

In addition to its workforce return programs, Trieste supports the creation of community social enterprises run entirely by participants, supported by government tax incentives, that act to transition participants supported workforce which also increases productivity and decreases welfare imposts. The community social enterprises act to transition people from welfare dependency into meaningful, self-directed paid work.

Trieste's outcomes reflect the efficacy of its approach, with all key indicators evidencing high rates of population mental health relative to comparable jurisdictions (see discussion at response to Question 2.2 above). As discussed in the response to Question 2.1, the cost of running Trieste's system is very low, approximately USD106 per capita per annum (the similarly-sized mental health system of San

[51] Dr Mario Colucci, Trieste public psychiatrist, in *Psychology Today*, 28 December 2015
[52] Dr Mario Colucci, Trieste public psychiatrist, in *Psychology Today*, 28 December 2015

Francisco, California, a crisis care model, has a per-capita, per-annum spend of USD249, more than double that of Trieste).

Learning the lessons of a failed implementation: the importance of context

A recent research paper that examined a failed attempt to introduce the Trieste model of mental health care into San Francisco, CA, elucidated key findings pointing to reasons for the failure.[53] This is particularly useful in considering how the Trieste system can best be implemented outside of its original context, an issue that has long been considered problematic. San Francisco's experience prompted a multinational research team to study the reasons for the failure of the implementation.

What the San Francisco researchers found was that Trieste's community-based preventive and early intensive mental health system is deeply interwoven with social and community supports outside of the mental health system, which act to cement its effectiveness. This was termed a 'hospitable environment', namely, a broad social environment with specific supportive characteristics, each of which supplement and strengthen the mental health care system that is situated within it. This environment is so important to the success of the Trieste model that any attempt to transplant its mental health system without first ensuring that the environment is appropriately hospitable is likely to result in failure. Specific positive characteristics of the environment in which the system is situated can support its success; conversely, negative environmental characteristics can result in system failure.

Trieste's 'hospitable environment' includes:

- Opportunity to engage in meaningful employment and activities, and active support to plan and manage these
- Housing affordability
- Relative homogeneity between wealthy and poor community residents (for example, mixed-use housing)
- Access to affordable transport
- Early, accessible treatment for substance abuse (non-punitive approaches)
- Support for family and relationship issues.

The San Francisco experience demonstrates the central importance of context in the effective functioning of mental health systems. San Francisco's endemic problems included a chronic lack of welfare support, housing instability, high rates of homelessness, enormous disparity of wealth between the city's richest and poorest inhabitants, very high rates of substance abuse, a no-tolerance drugs policy with resulting high incarceration rates, and a disproportionate number of people who had no local familial support (this stemmed from San Francisco's previously high tolerance for illicit drugs, which drew an influx of people escaping more restrictive jurisdictions in the late 60s and 70s). In terms of an environment in which to situate a Trieste-style mental health system, San Francisco could hardly have been worse. Its experience shows that mental health systems are integrally connected to, and dependent upon, specific contextual characteristics which may support it or in this case, cause it to fail.

The Australian context, fortunately, is better suited to a Trieste-style mental health care model. Better 'safety nets' are provided than is the case in San Francisco and many other global jurisdictions, although

[53] See Portacolone et al., 2015.

it should be noted that current support payments are insufficient to lift vulnerable people out of poverty. In addition, Australian employment programs exist within a punitive framework that measures meaningless activity (number of jobs applied for), and forces participants into poorly paid work placements unrelated to the person's life and work goals. In short, while some of the features of a supportive environment exist in Australia, government intervention will be required to strengthen key financial and workforce participation supports to properly support a Trieste-style mental health system.

The state of Tasmania would provide a valuable testing ground for a Trieste-style system. While Tasmania experiences relatively high rates of disadvantage measured across a number of standard indicators, the small size of its population and its high dispersion rate across many small towns means that its communities' social and familial structures are relatively intact. Tasmania's very high rate of volunteering is a positive indicator for common values that prioritise the needs of the community over those of the individual, resulting in a relatively high background level of social integration and connectedness. These positive features could be harnessed to support an initial trial of a fully-integrated mental health care system in which prevention and early intensive treatment are central, and current siloed funding streams (federal, state, community sector) are drawn together in a partnership arrangement that would ensure full visibility of programs and services, integrated care for physical and mental health, and integrated social and financial supports for people who are mentally ill. Such a system would be better able to identify and eliminate duplication in services and address any remaining gaps in service provision.

Recommendation on specific healthcare concerns (Tasmanian trial site)

1. **Consider Tasmania as the preferred trial site for a fully integrated, community-based mental health care system focused on prevention and early intervention (with reference to Recommendation 1 under Question 2.1 of this Submission), with all services delivered seamlessly under a governance structure that is reflective of a full partnership between the Australian and Tasmanian governments, in alignment with Priority 1 of the Fifth National Mental Health and Suicide Prevention Plan**

Health workforce and informal carers

4.1 Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?

In seeking to address workforce questions, MHCT formally sought the advice of its members through a Tasmanian Mental Health Leaders' Forum Network meeting, at which these issues were discussed. Key points arising are presented below:

- It was noted that the capability (the full extent or potential) of the existing professional health workforce is being fully utilised. Opportunities for growth are limited by an undersupply of workers. The projected undersupply of psychiatrists in Australia is being addressed,[54] although it remains unclear whether increases in the number of psychiatrists available nationally will address shortages in regional, rural and remote areas.

- Tasmania is relatively exposed to staff undersupply issues, since these tend to be worse in rural and remote areas and areas of lower population density. For instance, there is a significant undersupply of psychiatric nurses statewide. The Tasmanian state government has commenced an international recruitment program to address this issue although results are still unclear.

- It was suggested that better use of supervisory frameworks in mental health nursing may help to ensure quality and consistency of nursing practice for early-career and trainee nurses in the context of a rapidly growing health workforce. For instance, one nurse supervisor with advanced training could oversee a team of nurses with basic training, providing on-the-job supervision and critical feedback to support team nursing practice.

- In some situations (aged care was suggested), the role of community carers is significant, and questions have been raised as to whether it is necessary to have clinical staff performing their current range of duties. In this and similar contexts, it may be possible for (non-clinically-trained) carers to shoulder more of the care load, with clinical staff on call to advise on clinical matters.

[54] *Australia's Future Health Workforce – Psychiatry*, 2016, pp.2-3

4.2 What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and tele-health services be suitable? What prevents greater remote provision of services to address the shortages?

Mental health service delivery in rural and remote areas has been clearly identified as problematic across numerous forums.[55] While some health workforce shortages may be addressed through incentive schemes and recruitment drives,[56] technology and tele-health clearly present opportunities to improve service delivery in areas where face-to-face services are unviable due to low population density.

MHCT strongly supports the use of technology to provide access to mental health services for rural and remote areas. A consultation undertaken by MHCT in 2018 collected feedback from consumers, carers, family members, service providers and other community members involved with the mental health sector (first responders, teachers, nurses). This indicated positive attitudes towards using technology to support access to mental health services, with 68.03% of respondents indicating they would be comfortable in doing so.

Of these, respondents indicated video link or skype from home, mental health web-pages and live chat as the most appealing options. Many also emphasised the importance of technology being used in conjunction with traditional face to face services rather than as a stand-alone support option, with one respondent asserting, “Maybe for maintenance appointments but initial assessments and initial appointments need to be in person to build rapport.”

Whilst this initial feedback indicates there are potential opportunities for technology to be used to improve service delivery, 22.13% of respondents did not feel comfortable using technology to access mental health services, naming concerns around connectivity and digital literacy. In considering the use of technology, therefore, MHCT advises that the Productivity Commission give attention to its use in conjunction with face-to-face services and take full account of the potential connectivity and digital literacy issues that may be experienced by some community members to ensure that people without access to technology are still able to access mental health services.

4.4 What could be done to reduce stress and turnover among mental health workers?

Given that a history of trauma is found in a high proportion of people who seek treatment for mental illness, mental health workers are frequently exposed to traumatic personal narratives and histories of the people for whom they care. This can have negative psychological effects on the worker and can lead to vicarious traumatisation or (for workers with lived experience of trauma) re-traumatisation. Vicarious traumatisation and re-traumatisation can result in compassion fatigue and burnout. These can have profound effects on the worker’s mental health and capacity to continue in their role.

There is evidence to show that the introduction of trauma-informed practice in mental health workplaces can help to prevent vicarious trauma and re-traumatisation in workers.[57] Trauma-informed practice acknowledges that workers may have their own trauma histories (whether disclosed or not),

[55] Most recently in the Australian Senate Community Affairs References Committee *Inquiry into the accessibility and quality of mental health services in rural and remote Australia,* 2018, to which MHCT made a submission.
[56] For instance, the Tasmanian Government recently commenced a recruitment drive in the UK for psychiatric nurses.
[57] MHCC, 2018, p. 73.

and that working with mental health consumers with a history of trauma can have a negative impact on any worker. A trauma-informed practice approach is correlated with supportive workplace strategies that help prevent vicarious trauma.

All mental health workers should have access to appropriate support and supervision. This can be provided internally (by a supervisor or manager) and/or externally (by a trained and experienced practitioner). The purpose of supervision in this context is to provide a mechanism for the worker to discuss their experience of working with consumers, seek advice and suggestions if needed, and give conscious attention to the possibility of vicarious traumatisation.

4.5 How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?

There are opportunities to skill up allied health workers with mental health-related training to enable them to take on roles within multi-disciplinary mental health care teams. Allied health professionals such as nurses, physiotherapists, physical therapists, professional carers and others can play a significant role in community-based mental health care and can usefully bring a diverse range of skills and experience to the sector. It is critical, however, to ensure that all workers practicing in mental health care have received specific mental health care training.

There is evidence that clinical staff who have not undergone mental health care training often feel angry or irritated toward patients who present after self-harming or a suicide attempt. These feelings can manifest in comments and actions that have a significant and detrimental impact on the patient, with the potential for long term adverse effects.[58] It has further been shown that when clinical staff are given specific mental health training, this improves their understanding of, and attitude toward, these patients.

In view of this, it is extremely important that allied health workers, community workers and others with the skills and experience to contribute to aspects of mental health care and supports receive training that is specific to mental health care.

For the same reason, it is suggested that clinical staff working within high-flow hospital environments (triage, emergency department, intensive care) receive supplementary mental health care training to support their interactions with people who have a mental illness, are at risk of mental illness, who present in psychological crisis, or who present after self-harming or following a suicide attempt. Given the number of psychological crisis presentations at emergency departments and the number of hospital patients admitted for medical reasons following self-harm or a suicide attempt, it is imperative to ensure that the staff who care for them do not cause them additional psychological damage.

[58] CRESP, 2015, p. 7.

Recommendations on health workforce and informal carers

2. **Provide mental health care training to clinical staff who interact with, or care for, people with risk factors for mental illness, suicide or self-harm**

Housing and homelessness

MHCT wishes to acknowledge and thank its Submission partner TasCOSS for providing this section of the Submission.

5.1 What approaches can governments at all levels and non-government organisations adopt to improve:

- Support for people experiencing mental illness to prevent and respond to homelessness and accommodation instability?
- Integration between services for housing, homelessness and mental health?
- Housing support for people experiencing mental illness who are discharged from institutions, such as hospitals or correctional facilities?
- Flexibility of social housing to respond to the needs of people experiencing mental illness?
- Other areas of the housing system to improve mental health outcomes?

It is the view of TasCOSS that significant increased government funding and investment into housing, income support and social services is integral to support mental health in our community. We particularly advocate and call on government to invest in evidence-based preventive programs.

We refer to pages 18 and 19 of the Issues Paper which discusses housing and homelessness and agree that mental ill-health is closely linked with housing and homelessness.[59] TasCOSS believes that mental health issues must be included in any discussion, planning and funding for housing and homelessness and *vice versa.* "There is a complex bi-directional relationship between housing, homelessness and mental health".[60]

The Australian Housing and Urban Research Institute (AHURI) Report for the National Mental Health Commission*, Housing, homelessness and mental health: towards systems change* (November 2018) provides comprehensive recent data, evidence and advice regarding the intersection of mental health

[59] Productivity Commission, The Social and Economic Benefits of Improving Mental Health – Issues paper, p.18-19 https://www.pc.gov.au/inquiries/current/mental-health/issues/mental-health-issues.pdf

[60] Australian Housing and Urban Research Institute for Australian Government National Mental Health Commission. 2018. *Housing, homelessness and mental health: towards systems change,* p. 1.

and homelessness. TasCOSS endorses AHURI's recommendations and would encourage the Commission to consider adopting them in its recommendations.

A key finding of the AHURI report was:

> *The evidence shows that existing programs that integrate housing and mental health supports are effective in generating government cost savings (especially in health), and reduce hospital admissions and length of hospital stay. They also contribute to tenancy stability, improve consumer mental health and wellbeing, social connectedness and lead to modest improvements in involvement in education and work.*[61]

Further, AHURI identified a number of existing models of consumer and recovery-orientated housing for people experiencing mental ill health which evaluations have found to be successful. Both State and Federal governments should therefore invest in these proven integrated models and expand successfully evaluated pilot programs in order to meet the unmet need and the increasing demand for housing for people experiencing mental ill health.

Participants in TasCOSS consultations identified the above integration of mental health services with housing and homelessness services as the most important, but under-funded and under-resourced issue facing people experiencing mental ill-health in Tasmania. Specific observations were:

- That highly vulnerable people experiencing inpatient mental health admissions are regularly subject to failed discharge planning. For example, adults and young people are being discharged into shelters which operate on a 'one worker model'. This means there are no specifically trained mental health clinicians on site to meet specific mental health needs of residents.
- Members expressed frustration that government was not responding to the unmet need due to short-term electoral cycles.
- People who are experiencing both mental health issues and housing issues/homelessness need to be provided with integrated or 'wrap around' supports. This is especially important for anyone being released from closed environments such as psychiatric facilities or prisons.

The current Tasmanian experience

Homelessness in Tasmania is rising. The data from the 2016 census shows that the total number of people experiencing homelessness was 1,622 (an increase from 1,145 in 2006 and 1,537 in 2011). The regional breakdown shows greater Hobart and the South-East had the highest proportion of people experiencing homelessness at 57%; Launceston and the North-East had 23% and the West and North-West coast areas a very similar 20%.

Age Distribution

On census night in 2016, the majority of people experiencing homelessness in Tasmania were aged under 44 years old. Young people aged 12 to 24 comprised one quarter of all Tasmanian people experiencing homelessness (25%). The next highest age group were those aged between 25-34 years (17%) and 35-44 (13%).

[61] ibid.

The latest Australian Institute of Health and Welfare (AIHW) report on specialist homelessness services shows:[62]

- Tasmania has the third highest rate of clients accessing specialist homelessness services in the nation behind the Northern Territory and Victoria – 124.9 (rate per 10,000) compared to the national rate of 117.4.
- Inappropriate dwelling conditions sit well above the national average – sitting at 39% compared with 24%.
- Of particular note is the high unmet housing need of both young people and people reporting mental health needs. About one-quarter of the state's homeless population are young Tasmanians. For these young people, the rate of need for a home is 8.5% higher than the national average and for those with mental health needs their unmet housing requirements are 23.1% higher than the national average.
- Significantly, along with South Australia, Tasmania has the highest rate of returning clients – that is, clients not having their needs met the first time around.
- The number of Tasmanians experiencing mental health issues has increased steadily since 2012 – currently sitting at 56 per 10,000.

The above data from the Census and from AHIW shows there is an increasing unmet need for specialist homelessness services to assist youth who are homelessness or at risk of homelessness. TasCOSS therefore strongly agrees with the Issues Paper that young people should be a priority of this inquiry. As stated on page 5 of the issues paper:

> *Mental illness at a young age can affect schooling and other factors which influence opportunities over a person's lifetime – moreover, most mental illnesses experienced in adult lifetime have their onset in childhood or adolescence.*[63]

Specialist Homelessness Services (SHS) in Tasmania provide housing and accommodation. This includes immediate emergency accommodation (including shelters), supervised accommodation and placement support services for young people and transitional support services for people experiencing homelessness to (re)establish themselves in independent living. These services also provide information and advice, advocacy and financial supports.

In Tasmania there is no specialist homeless accommodation service for young people experiencing mental ill health.

In Tasmania there are youth-specific crisis and transitional supported accommodation but these options are very limited. All supported crisis accommodation options for young people are based on a one worker model. Consultations with workers from youth shelters were strongly of the view that providing a shelter for people who are experiencing mental health issues without any specific mental health supports is wholly inadequate.

[62] https://www.aihw.gov.au/reports/homelessness-services/people-short-term-or-emergency-accommodation-shs/formats
[63] McGorry et. al 2011, cited in PC op. cit., p. 5.

This is reiterated in a soon-to-be-published article from the Manager of a Tasmanian shelter in *Parity* magazine:[64]

> *At Mara house, our team see every day the long term effects of trauma experienced by young people and the implications this has when a young person is working their way out of homelessness. Everyday events can trigger the emotions of a previous trauma and leave young people in a situation of fight or flight on a regular basis… If these issues are left untreated, the cumulative effects of years of living with these traumas can progress into complex emotional and behavioural issues, resulting in the inability to thrive socially, academically and emotionally.*
>
> *Histories of complex trauma that have been left unattended are a major indicator of long-term homelessness risk and poor mental health outcomes…*

Further, there are no youth-specific alcohol and drug (AOD) specialist housing services in Tasmania. This means that young people who are experiencing homelessness in combination with complex mental health issues and/or AOD do not have access to optimal clinical support for their health needs.

Coordination of services

The foregoing discussion relates to a more general theme to emerge from TasCOSS' consultations, which is that existing services/government agencies are not effectively communicating between each other. This was also captured in the AHURI report, with Tasmanian service providers arguing that "better policy integration between housing, homelessness and mental health has the potential to contribute to better housing and health outcomes for people with lived experience of mental ill health….Policy integration will need to take place across all levels of government and across government structures."[65]

TasCOSS Recommendations on housing and homelessness:

7. **Ensure that funding is directed into establishing mental health specific supported housing accommodation**
8. **Provide funding for existing one worker model specialist homeless accommodation services to have direct access to an on-call psychiatrist or psychologist**
9. **Ensure that funding is directed into establishing an alcohol and drug specific supported housing model**
10. **Ensure that funding is directed into establishing multi-disciplinary supported mental health accommodation for young people**
11. **State and Federal Governments explore best-practice models to better integrate housing, homelessness and mental health services for the population as a whole**
12. **State and Federal governments take immediate and concrete steps to alleviate housing stress, build more housing stock and provide support to sustain tenancies**

[64] Louise Cornish, 'Youth homelessness in Tasmania: shutting the doors on Tasmania's most vulnerable', *in press,* http://chp.org.au/parity/
[65] Australian Housing and Urban Research Institute for Australian Government National Mental Health Commission. 2018. *Housing, homelessness and mental health: towards systems change,* p. 53

Social services

6.1 How could non-clinical mental health support services be better coordinated with clinical mental health services?

MHCT believes that principles of *service co-location* and *centralisation of client records* are fundamental to delivering integrated non-clinical and clinical mental health services.

Service co-location

One Australian exemplar of an integrated, co-located model of mental health services is the Floresco Integrated Service Hub, established in 2014 by a community-sector consortium led by Aftercare. It operates from the Floresco Centre in Ipswich.[66] Multiple services across the domains of mental health, allied health, alcohol and drug abuse support, housing and employment are all co-located onsite and work together to provide a holistic model of person-centred care. Services include:

- Psychosocial support, including peer and group support;
- Alcohol and drug management;
- Public mental health services;
- A private psychiatrist;
- Primary and allied health care;
- Housing services; and
- Employment services.

Since its establishment the Hub has experienced significant demand for services; it takes referrals from acute care services, GPs and other allied health services, while a large proportion of clients are self-referred ('walk-ins').

A recent review highlighted higher-than-expected demand as a factor that could put pressure on the model, citing the need for more funding to match service supply to demand levels.[67] Another factor identified as problematic by the evaluation team was poor articulation with inpatient clinical services; the Floresco model does not include acute care inpatient services, and this was seen as a barrier to the full integration of person-centred care. This finding evidences the need for Trieste-style, fully-integrated acute care as an extension to the model; without it, predictable weaknesses in articulation between inpatient and community settings emerged.

Centralisation of client records

The centralisation of client records within an integrated service delivery model enables a person-centred 'team' of diverse service providers to easily access client records that are outside of a conventional clinical model, enabling community and social supports to be recorded to provide a fuller picture of the client's whole-of-life circumstances and needs. Such a system supports seamless transition between service for the client, who does not need to 'tell their story' repeatedly to different service providers.

[66] For more information on the Floresco model, please see Queensland Mental Health Commission, Floresco service model (page here)
[67] Diana Beere et. al., *Floresco Service Model Evaluation: Final Report*, 2018 (available here)

Centralised records also provide opportunities for real-time data analytics, analysis, and outcome measuring.[68]

6.2 Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

At this stage, there appear to be constant emerging gaps in service for people with a psychosocial disability who do not qualify for the NDIS. More research is needed to establish the significance of the gaps that have become apparent, and a watching brief should be maintained so that gaps that are yet to emerge are picked up early and managed appropriately.

The recent decision by the Australian Government to extend the Partners in Recovery (PIR), Day to Day Living (D2DL) and Personal Helpers and Mentors (PHaM) schemes until 30 June 2020 has taken some of the immediate pressure off structural gaps in the provision of support for people with a psychosocial disability who are ineligible for the NDIS.

An important consideration for the Productivity Commission to note is the number of potential NDIS applicants who are being deemed ineligible for the scheme. This appears to be far higher than expected, with initial estimates indicating an ineligibility rate as high as 50%. This will likely have a significant impact on budgetary and other considerations for the provision of support to non-NDIS registered people with a psychosocial disability.

MHCT refers the Productivity Commission to the Joint Standing Committee on the NDIS *Inquiry into the provision of services under the NDIS for people with a psychosocial disability related to a mental health condition*, 2017, for information and recommendations made in relation to the NDIS. MHCT strongly endorses those recommendations and urges the Productivity Commission to encourage the Australian Government to formally accept, respond to and implement them as soon as possible.

6.4 Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?

MHCT wishes to acknowledge and thank its Submission partner TasCOSS for providing the answer to this question.

The Issues Paper acknowledges the associations between 'psychological distress' and indicators of disadvantage such as unemployment, low income and low social connectedness.[69] TasCOSS, however, wishes to make a far stronger statement about these relationships, which is that poverty and inequality

[68] For further information, please refer to MHCT, 2018, p.5.
[69] https://www.pc.gov.au/inquiries/current/mental-health/issues/mental-health-issues.pdf, p. 4

are both a consequence and a determinant of poor mental health. According to the World Health Association (WHO):

> *Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk. It is of major importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages, and through to older age. Action throughout these life stages would provide opportunities for both improving population mental health, and for reducing risk of those mental disorders that are associated with social inequalities*.[70]

Findings from the last ABS General Social Survey highlight the link between mental ill-health and financial stress, physical and social isolation and ability to access services.[71] In the findings from Tasmania, people with a mental health condition made up almost 25% of the survey's respondents, but were:

- 39.8% of those who could not raise $2000 in a week;
- 49% of those who had experienced difficulty paying bills 8 times in last 12 months;
- 78% of people who took 4 dissaving actions in the previous 12 months, including:
    - Reducing their loan repayments
    - Drawing down on savings or term deposits
    - Increasing the balance on their credit cards
    - Borrowed from family or friends
    - Sold household goods or jewellery
- 40.9%-61% of people who sometimes/often had difficulty getting to where they needed to go;
- Four and a half times more likely to say they could not find someone to help out when needed as someone with no mental health condition;
- Twice as likely to report cost as a barrier to accessing services as someone with no mental health condition.

The links are further illustrated in the following quotes from recent TasCOSS consultations:

"I am on the Disability Support Pension as I have more than one mental illness and a physical condition… It's important to balance my necessities and treats, payment by payment. I am able to manage some months easier than others. I worry about the financial future."

"People in the community…are struggling financially, which results in struggling emotionally, mental health issues."

"I was diagnosed with a terminal illness/disability [but was not granted the DSP]. I was on Newstart, and kept applying for jobs as required, but always knowing that as an over 50 I would be too old to be successful. I contemplated ending my life when the combination of poverty, unemployment, end of my lease – homelessness, terminal disability, yet no way to get my superannuation - all got too much for me."

The Australian Institute of Health and Welfare report on mental health services 2016-17 also shows a disturbingly clear link between socio-economic status and mental health status. Contact with mental health services were almost universally (with the exception of the ACT and NT) more frequent for people in the most disadvantaged quintile, with the rate reducing as the quintiles increase. In Tasmania,

[70] World Health Organisation, *Social determinants of mental health,* 2014, p.9 https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf;jsessionid=0E8A094C0BA9D298F6A457542EF632C8?sequence=1

[71] ABS General Social Survey 2014, https://www.abs.gov.au/ausstats/abs@.nsf/mf/4159.0

the rate was 318 per 1000 people in the lowest socio-economic quintile; in the highest, least disadvantaged quintile, the rate was 148 per 1000 people. Australia-wide the rates were 448 per 1000 for the lowest quintile and 272 per 1000 for the highest quintile.[72]

The discussion above demonstrates the need for the approach recommended by WHO and also endorsed by TasCOSS and MHCT: the need for early intervention and prevention that is community-based, multi-faceted and addresses the social determinants of health across the life course. An excellent example of this is the Trieste model, discussed in more detail elsewhere in this submission, because it places people experiencing mental ill-health at the centre of a health care system that encourages and promotes their full social and economic inclusion.

Access to appropriate payments

While people suffering episodic or ongoing mental health conditions can require a variety of supports, it is vital that support includes an income adequate to their needs. Unfortunately, this is not always the case. A steady restriction of the eligibility for the Disability Support Pension (DSP) has seen more people with mental health conditions shifted onto Newstart.[73] (Recent research shows the majority of appeals to the Administrative Appeals Tribunal ended with the applicant being awarded the DSP.[74]) At about $275 a week - more than $100 per week below the poverty line[75] - this payment only entrenches poverty and disadvantage. This is particularly so for people with mental health conditions who often have only a partial capacity to work – they are competing against jobseekers with full capacity to work, adding to the difficulty of obtaining and retaining employment that allows them to cover essentials including food, housing, transport and medical costs.

Those who are able to work in a limited capacity while continuing to receive Newstart face the added challenge of navigating the harsh income tests enforced by Centrelink. A person who is casually employed often needs to give Centrelink an estimate of what their income might be for the reporting fortnight, which leads to errors and inadvertent under- or over-payments. This is notoriously difficult – hence the scandal over Robodebt, when thousands of Australians were unduly penalised for breaches they never committed.

To address this issue, ACOSS has proposed that people receiving an unemployment payment have access to an 'income bank', similar to that introduced in 2017 for people engaged in seasonal horticultural work. That system allows Newstart recipients to earn $5000 from seasonal horticultural work that is at least 120km from their usual place of residence (a criterion introduced to address the shortage of seasonal workers) without their Newstart payment being affected. The $5000 could then be 'banked', giving recipients an income to draw on after they complete their seasonal work. ACOSS's proposal is set out in more detail at Appendix 1. TasCOSS and MHCT encourage the PC to consider mechanisms such as this to better address the needs of people whose incomes fluctuate over time.

[72] AIHW, Mental Health Services in Australia, March 2019, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/data
[73] According to ACOSS, successful claims dropped from 63% in 2010 to just 25% in 2015/16. https://www.acoss.org.au/media_release/disability-support-pension-cuts-bad-news-for-people-affected/
[74] https://probonoaustralia.com.au/news/2019/02/disability-groups-weary-dsp-appeals-skyrocket/
[75] https://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0010/2844487/Poverty-lines-Australia-March-Quarter-2018.pdf

ACOSS Income bank Proposal[76]

To make reporting of income easier and increase the real incomes of people in low paid casual work, ACOSS proposes that people receiving an unemployment payment have access to an "income bank", similar to that available to students or Age Pensioners. Both allowances have a working credit system that operates, on the face of it, like an income bank, but in reality is complicated and inconsistent with income test thresholds.

For Newstart Allowance, a working credit accrues by up to $48 per fortnight if earnings are less than $48 per fortnight (which bears no relation to the income-free threshold of $52 per week). The maximum amount of working credit a Newstart recipient may accrue is $1,000 and Youth Allowance (Other) is $3,500, which are relatively small amounts and take extended periods of time without paid work to accrue under current policy settings.

An income bank of $4,000 for Newstart and Youth Allowance (Other) that accrues in full over six months without work would ease transitions into employment and enable people who secure on temporary or casual employment to increase their real incomes. It would be easier to understand than the current working credit system and better enable people to track how much they can earn before their payments reduce. It would also likely reduce the incidence of debts arising because of estimated earnings that may naturally differ from their actual earnings (as discussed above).

In the Mid-Year Economic and Fiscal Outlook, a $27.5 million income bank pilot was announced to encourage Newstart and Youth Allowance (Other) recipients to do seasonal agricultural work. The measure commences 1 July 2017 and will allow Newstart recipients to earn $5,000 from seasonal horticultural work that is at least 120 kilometres away from their usual place of residence without their payment being affected. This pilot acknowledges the problems faced by people undertaking insecure seasonal or casual work because of the potential loss of income support without the certainty of future employment.

ACOSS's proposal, while not as generous, would extend this pilot to all Newstart and Youth Allowance (Other) recipients regardless of the paid work they carry out, in recognition that the problems for people regarding seasonal agricultural work apply to short term, insecure, casual work generally.

Disability-related payments should go to all who need it

It is the resolute view of TasCOSS that the disability support pension, carer payment and carer allowance should be paid to people who need it; we reject the implication in a question in the Issues Paper that payments should go only to those who 'need it most'.[77] Such an approach leads to a crisis-driven response rather than a prevention/early intervention approach, because people who need help to prevent a situation getting worse do not receive it. By the time they reach the system threshold, they are usually in crisis.

[76] https://www.acoss.org.au/wp-content/uploads/2017/02/ACOSS_Budget-Priorities-Statement_2017-18-FINAL.pdf
[77] p. 21

TasCOSS Recommendations on income support

6. **Ensure that everyone who needs DSP receives it**
7. **Independent oversight and regular monitoring of DSP rejections**
8. **Increase the rate of Newstart so that people, with or without a mental health condition, are not left destitute**
9. **Federal funding for education programs targeting employers to hire people with disability**
10. **Introduce an income bank for all people receiving social security payments whose income fluctuates due to casual or insecure work**

6.6 How could mental illness-related income support payments better meet the needs of people whose capacity to work fluctuates over time?

Please refer to discussion in the response to Question 6.6 above.

Social participation and inclusion

7.4 What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?

Basic indicators of social participation and inclusion that are easily measured are rates of participation in education (for school-aged children) and employment (for people aged 18-65). Participation in education and in the workforce requires a relatively high level of functionality in terms of a person's mental health. Therefore, a basic benchmarking framework for mental health outcomes could be built from these measures.

Child safety

9.2 What, if any, alternative approaches to child protection would achieve better mental health outcomes?

MHCT partnered with TasCOSS in 2018 to provide the Tasmanian State Government with information relating to the Out of Home Care (OOHC) Monitoring Program. The following information is drawn from that work and relates specifically to the experiences of Tasmanian children in OOHC and how their mental health outcomes might be improved.[78]

[78] For complete submission, discussion and referencing, please refer to MHCT/TasCOSS, 2018, pp. 3-10.

Young people in OOHC typically experience worse mental and physical health outcomes than their peers. This can often be attributed to adverse experiences prior to or during OOHC, insufficient mental health and wellbeing support in care and the ongoing impact of exiting OOHC.

Tasmania has a Charter of Rights for Children and Young People in OOHC (The Charter) that stipulates that all children and young people have the right to receive health care when needed. This includes access to a comprehensive health check when they first enter care. In contrast to the National Standard, however, The Charter does not list targeted timelines. The process is subject to lengthy delays, with some children going up to 12 months without a paediatric assessment. A formal mental health diagnosis is required before children and young people can access specialist mental health supports and funding. This means that many children wait years before gaining access to support, a failure that can have significant and long-term negative impacts for the child.

To address this issue, it is proposed that the OOHC system assumes a trauma history in every child who enters the system and provides immediate support at entry to address any past trauma and to support the transition into OOHC, which in itself is frequently traumatic. Early assessment and support for trauma will support stable placements, which in turn are associated with better mental health outcomes for children and young people in care.

Further, it is proposed that providers of allied health services for children in OOHC, particularly dentistry and immunisation, should take a trauma-informed practice approach. This would have a protective effect on children in OOHC and lower the risks of re-traumatisation. All government-preferred allied health providers should receive training and assistance to implement a trauma-informed approach.

Recommendations on child safety

6. **Provide assertive, wraparound therapeutic support for children in OOHC, particularly around complex trauma, to begin immediately and removed only if the support is assessed as no longer needed**
7. **Support all preferred providers to receive training in trauma-informed care**
8. **Support carers to receive additional trauma-related training, as required**
9. **Assign priority status for healthcare to children in OOHC**
10. **Provide all children and young people in OOHC with regular and meaningful opportunities to be active participants in decisions that affect their lives.**

Regulation of workplace health and safety

14.2 What workplace characteristics increase the risk of mental ill-health among employees, and how should these risks be addressed by regulators and/or employers?

Intrinsic workplace risk

Some workplaces carry intrinsic risks for the mental health of employees due to the nature of the work that is undertaken. These workplaces are usually characterised by inbuilt exposure to traumatic stressors.

In Australia, examples of 'intrinsically risky' workplaces are:

- Armed forces on active deployment
- First responders (police, firefighters, paramedics)
- Any workplace in which workers, in the course of their daily duties,
  - face a real or perceived threat to their own life;
  - are exposed to the sight of or aftermath of violent death;
  - may be required to threaten others' lives or physical integrity.

While such workplaces cannot protect workers from exposure to traumatic stress, it is possible to mitigate its impacts by intensive post-exposure management and support.

The scale and level of risk to workers in 'intrinsically risky' workplaces is still being investigated. The recent Senate Report, *The People behind 000: mental health of our first responders* provides baseline investigation of this issue in an Australian context.[79]

In Tasmania, amendments to the Workers Compensation Act are planned which will provide presumptive compensation to Tasmanian public sector workers who are diagnosed with PTSD. The primary focus of this legislation appears to be first responders (Tasmania Police, Ambulance Tasmania, Tasmanian Fire Service), however, the application of the legislation to all Tasmanian public servants has been contemplated in Parliament by the Minister for Workplace Relations. The legislation is due to be introduced in the 2019 Autumn session of Parliament. If passed, this would be the first Australian example of presumptive legislation to formally recognise, and provide compensation for, mental illness that is incurred due to workplace exposure to significant mental health risks.

[79] *The People Behind 000*, 2019

Extrinsic workplace risk

Many other Australian workplaces pose mental health risks to workers that are not connected to (or *extrinsic* to) the nature of the work being undertaken. This could include any workplace at which workers are:

- subjected to harassment, bullying or intimidation
- treated unfairly and where conflict resolution or mediation is poorly handled
- rostered on to shifts that affect the worker's sleep patterns over long periods of time
- fly-in, fly-out (FIFO) workers

In workplaces where risks are extrinsic to the work environment, the focus should be on preventing or limiting exposure as far as possible. It must be noted, however, that some strategies that are protective for workers could have negative impacts on the mental health of consumers and others. For instance, a 'zero tolerance of violence' policy at a high school may be protective for staff, but result in students at risk of mental illness being excluded from school, with negative impacts for their educational attainment, sense of self-worth and identity.

MHCT also refers the Productivity Commission to the new *Clinical Guideline for the diagnosis and management of work-related mental health conditions* published by Monash University and approved by the National Health and Medical Research Council in late 2018.

Recommendations on regulation of workplace health and safety

- **Urgently prioritise research to create an evidence base for first responder workplace mental health risks**
- **Consider implementation of national standards to ensure best-practice trauma recovery practices are in place to help protect all Australian workers, especially first responders, from the harmful effects of intrinsic workplace risks**

Coordination and integration

15.2 To what extent do current governance and institutional arrangements promote coordination and integration of mental health services and supports across health and non-health sectors and different levels of government?

Current Australian governance and institutional arrangements for mental health services are poorly coordinated and integrated across sectors and levels of government. Federal and state government funding channels tend to act as information silos; the services and supports provided by (for instance) federal government are clearly visible to staff within federal government agencies, but less so to state government agencies. Community-sector services may be visible at a high level within state government agencies, but this visibility may not extend to service-level staff within state-funded organisations such as public hospitals.

If service-level staff are not aware of services offered through other channels, they are unable to coordinate their own service with complementary services. For instance, in Tasmania, a community-sector service provider offers a suicide prevention service specifically tailored to people who have

recently been discharged from inpatient psychiatric care. The service has poor intake despite relatively high numbers of inpatient psychiatric discharges. When the service questioned why intake was so low, it emerged that very few of the hospital staff managing the discharge process were aware of the service's existence and hence did not make referrals. The few staffers who were aware of the service often referred people to it, indicating that the issue was a knowledge gap rather than a deliberate veto.

In relation to coordination of services across health and non-health sectors, historically, Australia's public service structure has worked to channel information upward to secretariat or ministerial levels; coordination between agencies is usually arranged via meetings of Cabinet or of department secretaries or both. If mental health services are to be coordinated with inter-agency services, broader cross-portfolio governance and management structures will be necessary to guide information flow and ensure appropriate integration of services provided by each agency.

15.3 What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?

Barriers to the closer coordination of health, mental health and non-health services were articulated during a recent evaluation of the Floresco integrated care model currently operating from the Floresco Centre in Ipswich, Queensland. The evaluation revealed specific themes that presented particular challenges to the implementation of integrated care:

- Information sharing;
- Staff recruitment and retention;
- Integrating with the public (clinical) mental health service;
- Responding to higher than anticipated demand, and
- Complexity related to operating integrated services within a consortium model.[80]

The evaluation also highlighted 'opportunities for improvement', indicating areas of potential weakness where additional work was needed to support coordination of health, mental health and non-health services. Not surprisingly, these were strongly correlated with the barriers that had been identified:

- Funding to be increased and made more flexible;
- Stronger clinical governance to be provided;
- Governance of the model to be more strategic;
- Staff induction into the vision, model and underpinning philosophy of Floresco to be further developed; and
- Greater focus to be given to staff retention.

The Floresco evaluation indicates that the degree of integrated service delivery was dependent to a large extent on staffers who had good contextual knowledge and worked collaboratively with other co-located program staff (information sharing, staff knowledge and retention). Issues of matching supply to demand also need to be considered in provision of community-based preventive integrated mental health service delivery in a context where there has previously been relatively little preventive care available, as population demand for these services is often underestimated.

[80] Diana Beere et. al., *Floresco Service Model Evaluation: Final Report*, 2018 (available here)

Funding arrangements

16.1 What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?

Please refer to discussion in response to Question 2.1.

16.5 How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?

Changes currently being contemplated to the Medicare Benefits Scheme include removing the 10-visit per annum cap on Mental Health Plans. The on-ground effect of this change would be that a person who is referred to a specialist mental health care provider such as a psychologist under a Mental Health Plan will be subsidised to attend an uncapped number of visits per annum to that specialist (currently a Mental Health Plan provides a maximum of ten subsidised visits per annum, although additional visits in the same year may be approved separately on the recommendation of the specialist and the issuing of an extension to the Plan). The contemplated move to uncap the number of subsidised mental health consultations has been widely discussed in the mental health sector; no clear consensus view has emerged.

MHCT believes that this change may not provide people with the best mental health treatment options. There is no substantive evidence that increasing the number of repeat consultations with a single mental health professional is the most effective way of managing mental illness. Indeed, the available evidence indicates the best treatment for mental illness is an individually-tailored combination of therapeutic interventions. These might, for instance, include group therapy, physical therapy, psychotherapy and skills-based training to support emotional regulation, such as dialectic behavioral therapy (DBT) and cognitive behavioral therapy (CBT).

Further, it is unlikely to be cost-effective; the comparatively high cost (an additional $2 billion) will likely be unevenly distributed, disproportionately advantaging comparatively wealthy metropolitan areas in capital cities, where take-up of the existing scheme is highest. This apparent ‘targeting’ is an unintended consequence of the high concentration of, and easy accessibility to, mental health practitioners in metropolitan areas. The concentration of take up in capital city metropolitan areas acts against the original intent of the scheme, which was to make mental health care more affordable to people in lower socio-economic groups.

In that regard, Tasmania is particularly unlikely to derive benefit from the planned uncapping of the per annum number of mental health consultations, since its small, decentralised population makes service provision less cost effective, which in turn limits accessibility. Uncapping the number of mental health visits would likely have the unintended effect of making waiting lists longer, a significant problem given that it is common for newly-referred people to wait up to three months for an initial consultation.

MHCT believes, therefore, that the estimated $2 billion per annum cost of uncapping the number of specialist mental health consultations provided in current Mental Health Plans may be more effectively used to increase accessibility to a broad range of preventive and early intensive mental health supports and services targeted to areas of greatest need.

Monitoring and reporting outcomes

17.5 What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?

To address this question, MHCT sought the views of mental health consumers through member organisation Flourish: Mental Health Action in our Hands Inc. Flourish works with mental health consumers to ensure that their rights, responsibilities and opinions are heard and respected.

Flourish consumer volunteer advocates workshopped the question and provided MHCT with detailed comments and responses. Consumers addressed all parts of the question in detail.

Participation

Consumers pointed out that increased participation levels would result in greater empowerment for consumers and carers. They noted that greater participation and empowerment of consumers through mental health support groups could help to manage mental ill-health and thereby lower the rate of psychological crisis presentations at emergency departments:

> *Participation needs to be improved at all levels to empower consumers and carers. Empowering consumers is an essential way to increase population mental health and productivity. Going to peer support groups can help consumers to stay well and prevent presentation in mental health hospitals … When consumers and carers are involved, it can improve resilience and decision-making capacity, not just for individuals, but also for the wider community.*

In relation to consumer participation and representation in mental health contexts, there is a need for greater cultural and age diversity:

> *We need more young people and people from culturally and linguistically diverse backgrounds to provide consumer/carer input.*

Participation and representation in health care contexts was considered both important and useful; however, payment equity issues could be problematic. While lived experience perspectives were critical in health care contexts, it was equally important that this work was appropriately valued and remunerated:

> *Consumers and carers working with professionals deserve the same financial reward for the work they do - appropriate financial compensation for time/effort.*

Issues with Tasmania's peer workforce were also noted, indicating that consumer peer work may need greater on-ground support:

In rural areas, the peer workforce model hasn't been designed properly which has led to high turnover rates for peer workers. A decrease in carer support has led to distress in the home.

Economic growth

Consumers felt that Australia's economic growth in past decades had not resulted in increased economic benefit to mental health consumers. Economic growth had not brought any increased opportunities to enter (or re-enter) the workforce. Workforce re-entry was desired, but hard to accomplish without specialised support:

Economic growth has not translated into increased employment for mental health consumers. The Employment Assistance Program is not always available for people with lived experience - this is a real barrier for consumers to go back to the workforce, with very limited support.

Consumers identified that support payments to mental health consumers and carers had not kept pace with Australia's economic growth in recent decades. This was a significant failure of Australia's 'safety net':

Economic growth has not flowed through to benefit payments to consumers and carers. Therefore, we need to look at the ratio of capital growth measured against consumer and carer benefits.

It was noted that the effects of economic growth on the housing market in Tasmania was especially negative, since it had led to a steep rise in residential rents which disproportionately affected low-income earners:

Availability of affordable housing decreased majorly in Tasmania – this can lead to serious impacts on people's mental health, which needs to be measured.

Productivity

In relation to the question, 'What does improved productivity mean for consumers and carers?', consumers flatly stated that productivity was a poor measure of population mental health. Instead, it was suggested that indicators such as the national suicide rate, hospital admission rates for mental illness presentation, re-admission rates, and employment participation rates were more useful. Further, they suggested that these indicators could be cross-referenced with financial indicators to model the effects of indexation and inflation on population mental health:

All the improvement in productivity has not led to a decrease in the suicide rate. The suicide rate, the ratio of people in employment, hospital admission rate, re-admission rate need to be measured with annual income indexation.

Summary

Flourish's mental health consumer advocates were very supportive of participation-based outcomes as a measure of effectiveness in mental health. There was a clear view that increased participation had a positive impact for the person participating (for instance, re-entering the workforce was viewed as highly positive although hard to achieve without support). Participation in peer support groups or in lived experience workplace roles could benefit other people as well as the person participating.

However, there was concern about the lack of support for workforce reintegration; consumers felt that more was needed to assist people to return to work after mental illness or, in the case of peer workers, more may be needed to support them to stay in their roles.

Consumers noted that economic growth and productivity were not useful as indicators of population mental health, pointing out that decades of strong economic growth and high national productivity had not led to increases in consumer and carer benefit payments or to greater employment opportunities. Indeed, economic growth has adversely affected housing affordability and stability for consumers and carers, and concern was expressed about the compounding effect of this issue on mental ill-health.

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