Uniting

23 January 2020

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

Dear Commissioners

Submission for the Productivity Commission's draft report on mental health

Uniting Vic.Tas welcomes the opportunity to provide input into the draft report on mental health released by the Productivity Commission on 31 October 2019.

Uniting Vic.Tas is the community services organisation of the Uniting Church in Victoria and Tasmania. We have worked alongside local communities across both states for over 100 years. We deliver a broad range of services in the areas of mental health, alcohol and other drugs, child, youth and families, crisis and homelessness, disability, early learning, employment and aged and carer. We work across the full spectrum of community services, intervening early to help people avoid crisis, as well as supporting those who live life at the margins.

We commend the Commission's efforts to date in developing the draft report on improving mental health to support economic participation; and enhancing productivity and economic growth. In response to the Productivity Commission's call for written feedback on the draft report, we have developed a submission that reflects our expertise and longstanding experience in supporting people impacted by mental health concerns. In the attached submission, we provide feedback on draft recommendations in the report and suggest some priority areas for enhanced focus that will help optimise the Productivity Commission's proposed mental health reforms. In line with Uniting's commitment to voice the lived experience of consumers, this submission also draws on input provided through consumer focus groups in the development of our original submission in April 2019.

Thank you for the opportunity to provide feedback to this important consultation. We would be pleased to provide further input on any of the areas covered in this submission, if requested.

We look forward to the final report being released by the Productivity Commission next year.

Yours sincerely,

Bronwyn Pike
Chief Executive Officer

Productivity Commission draft report on mental health

Submission by Uniting Vic.Tas

23 January 2020
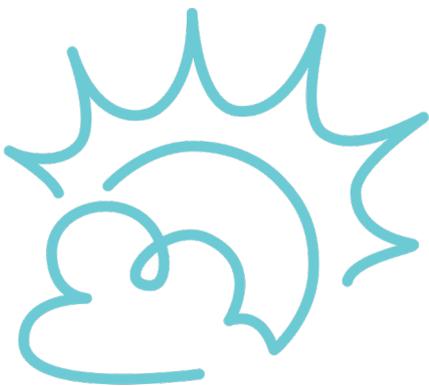
Uniting

Contents

Uniting's experience

Our experience

Uniting Vic.Tas (Uniting) is the community services organisation of the Uniting Church in Victoria and Tasmania. We have worked alongside local communities across both states for over 100 years. We deliver a broad range of services in the areas of aged and carer, alcohol and other drugs, child, youth and families, crisis and homelessness, disability, early learning, employment and mental health. We work across the full spectrum of community services, intervening early to help people avoid crisis, as well as supporting those who live life at the margins.

As a significant provider of services and programs for people experiencing mental health concerns, disadvantage, financial hardship and homelessness, Uniting is well positioned to inform the Productivity Commission about potential reform opportunities to improve mental health outcomes for Australians.

Our position

Uniting believes that every person should be able to enjoy their best possible mental health, yet mental health issues affect one in five people in any given year, and almost half of the population in their lifetime.

People experiencing poor mental health must be able to access effective and empowering medical and psychosocial support services that respond to their needs. By doing so they can feel a sense of wellbeing, undertake daily activities, participate in their communities and cope with day-to-day stress at every life stage.

Mental health is strongly shaped by social, economic and environmental factors so it is critical that strategies address causes of disadvantage such as homelessness, unemployment, family violence, trauma, physical illness, cultural and language barriers, and financial hardship.

Australia needs a more comprehensive, overarching mental health framework, with government funding commensurate to the scale of the problem, to facilitate prevention and appropriate care for people with mental illness.

Input for this submission

Our submission draws on the experiences of consumers through several consumer focus groups conducted for our earlier submission, as well as feedback from our program and service staff. The experience of our staff working in mental health, alcohol and other drug (AOD) and housing and homelessness services features strongly in this submission, given their essential role in supporting people experiencing mental health issues in Victoria and Tasmania.

Summary of Uniting's recommendations

Through our consultations we have identified some critical gaps in the draft report that we hope the Productivity Commission will resolve in the final report. We recommend the following:

1. Prevention and early intervention for mental illness and suicide attempts	**Extend Recommendation 5.1:** To address the significant barriers to accessing psychiatrists due to long waitlists and charging of large co-payments in some communities, particularly in rural and regional areas.
	Extend Recommendation 5.4: Provide interim supports for extending MBS-funded psychological support while the review is carried out, to ensure continuity of care.
	Extend Recommendation 17.1: Provide a targeted approach that enables marginalised and hard-to-reach communities to access the same level of support as the broader population, to complement proposed perinatal mental illness screening.
	Extend Recommendation 17.2: Provide greater ongoing investment in specialist paediatric mental health support in early learning settings to meet rising service demand when expanded early childhood development health checks for preschool age children identify issues.
	Extend Recommendation 17.4: Include a specific recommendation to: o Address the need for specialised trauma-informed mental health care for children and young people in out-of-home care, in order to mitigate potential trajectories into hospitalisation and juvenile justice. o Ensure that young people in, or have recently left, out-of-home care can access government support to the age of 21, no matter where they live, to lessen vulnerability to mental health issues, alcohol and other drug issues, homelessness, unemployment, early parenthood and prison.
	Extend Recommendation 20.1: Ensure the national stigma reduction strategy: o Embeds the voices of people with lived experience of mental illness through a well-resourced co-design process with the National Mental Health Commission. o Encompasses not only stigma related to experiencing mental illness but also how other issues such as discrimination and marginalisation on the basis of culture, race, religion, visa status, gender, sexuality, gender identity, disability, homelessness, alcohol and other drug issues and unemployment status can be injurious to mental health.
2. Close critical gaps in healthcare services	**Extend Recommendation 12.1:** The Fair Work Commission to review pay rates of mental health workers to ascertain if they are commensurate with other roles with similar qualifications and expectations.
	Extend Recommendation 13.1 and 13.2: Increase capacity building supports for unpaid mental health carers to provide a safe environment to deliver care in.
	Extend Recommendation 11.7: To ensure equitable access to mental health services for rural and regional communities, governments must be prepared to finance: o Travel of mental health services to undertake outreach and service delivery in rural and remote locations on a regular basis o Service partnerships and specialist outreach from metropolitan areas that delivers face-to-face clinics for rural and regional communities o Purchasing of equipment and associated training for new technologies o Rural workforce being able to attend (e.g. backfilling) and travel to training o Funding local communities of practice and place-based networks that bring together a range of services to develop local responses and reduce isolation o Targeted long-term strategies to better attract and retain qualified and experienced mental health workers in rural and regional areas.
	Extend Recommendation 23.1 and 23.3: Ensure rural and regional funding for improving access to face-to-face services features in the proposed regional pooled funding model and review of activity-based funding for mental health.

	New Recommendation: The National Disability Insurance Agency to: o Review National Disability Insurance Scheme (NDIS) pricing structures for mental health to ensure mental health supports are appropriately funded o Consider development of a recovery-focused psychosocial pathway for NDIS participants to ensure the philosophy underpinning mental health services is better reflected in NDIS design and delivery.
	Extend Recommendation 23.2: The Australian Government to review NDIS funding arrangements for mental health to deliver specialised mental health training to the NDIS workforce (e.g. Applied Suicide Intervention Skills Training).
	Extend Recommendation 23.2: Secure long-term commitment for continuity of community mental health supports for people experiencing mental illness who are not eligible for the NDIS from State and Territory Governments.
	New Recommendation: Improve access to home support workers to help fill the gap in care for people transitioning between acute services and community mental services.
3. Investment in services beyond health	**Extend Recommendation 15.1 and 15.2:** Develop an immediate strategy for addressing Australia's housing affordability crisis to help prevent people with mental illness from experiencing housing issues or losing their home over the next 2-5 years.
	Extend Recommendation 15.1: Provide the mental health workforce with additional training and information that builds their capacity to respond to the needs of people experiencing homelessness and make appropriate referrals into housing and homelessness services.
	Extend Recommendation 15.1 and 15.2: Provide housing security for people experiencing mental illness by managing demand for social and affordable housing through: o Winding back the negative gearing and capital gains tax concessions, using these savings to kickstart investment in the 500,000 new low-cost rental homes desperately needed by Australians on low and middle incomes to meet the demand for affordable housing. o Developing a National Housing Strategy to meet Australia's identified shortfall of 500,000 social and affordable rental homes, jointly funded through a revised Commonwealth-State Housing Agreement. o Increasing Commonwealth Rent Assistance by at least $20 a week to reflect the fact that rents have skyrocketed across the country. o Developing a national action plan to end homelessness. o Scaling up successful models of consumer and recovery-oriented housing for national program delivery.
	Extend Recommendation 24.3: Expedite the re-negotiation of the national housing and homelessness agreement to ensure increased funding for housing and homelessness services proposed in the draft report can occur promptly.
	New Recommendation: Enhance service capability across mental health and alcohol and other drug systems to support people with dual diagnosis: o Funding specialist AOD advisors to be placed in acute and community-based mental health services and within hospital emergency departments to build capacity to respond to people with dual diagnosis and provide specialist advice, support, secondary consultation and treatment. o Funding specialist mental health advisors to be placed in AOD services to build capacity to respond to people with dual diagnosis to provide specialist advice, support, secondary consultation and treatment.
	Extend Recommendation 16.1-16.5: Better address the health needs of prisoners with dual diagnosis of mental health and AOD issues and the need to enhance transitional support and coordination of care and for people transitioning from prison back to the community. This could occur via in-reach into prisons and improved linkages between prison and community AOD and mental health services, as well as linkages to housing support post-release.

	New Recommendation: Assist people experiencing financial hardship and help minimise the risk of already vulnerable people developing mental illness by:
	o Increasing Newstart, Youth Allowance and related income support payments and indexing these payments to wages as well as CPI to ensure they maintain pace with community living standards, as outlined in our recent evidence to the related Senate Inquiry.
	o Increasing the number of full-time employed financial counsellors to support people at risk of financial hardship, to mitigate escalating mental health concerns experienced by people managing significant debt.
	Extend Recommendation 11.4: Recognise the crucial role of peer-led and peer-facilitated groups for people experiencing mental health concerns by investing in:
	o Youth-led and youth-facilitated groups with the support of peers that build capacity and skills development, especially for LGBTIQ+ young people.
	o Peer support services for marginalised communities who face distinct challenges accessing mainstream services (e.g. through Voices Vic).
4. Assistance for people with mental illness to get into work and enable early treatment of work-related mental illness	Nil.
5. Fundamental reform to care coordination, governance and funding arrangements	**Extend Recommendation 10.3 and 10.4:** Better integrate mental health and alcohol and drug services as part of proposed single care plans and care coordination services.
	Extend Recommendation 24.4: Incentivise innovative service models that trial service integration improvements across the spectrum of a person's social and emotional needs.
	Extend Recommendation 22.3: Embed consumer and carer co-design/co-production in all aspects of proposed reforms to monitoring and reporting outcomes to ensure lived experience guides reform development.

Overarching feedback on the draft report

Disconnect between issues and recommendations

Uniting commends the work of the Productivity Commission in exploring the issues within the mental health system experienced by our consumers and service staff. The draft report covers the breadth of issues raised in our submission and that of many other individuals and organisations. However, in our view, the proposed recommendations often do not adequately address the scope of issues identified. Some examples below highlight this disconnect.

Limited focus on how poverty impacts mental health

As identified in the interim report of the Royal Commission into Victoria's Mental Health System, social disadvantage, discrimination, poor social status, family violence and physical ill-health are among the important determinants of mental illness. People experiencing socioeconomic disadvantage disproportionately experience mental illness.[1] [2] Children and adolescents in low-income families, and whose parents or carers have lower levels of education and experience higher rates of unemployment than other Australians, have higher rates of poor mental health.[3] Young people in families in the lowest income bracket have almost double the rates of mental disorders of young people in families in the highest income bracket.[4] The recommendations emphasise whole-of-population measures (e.g. universal screening and services in schools and workplaces) but generally fail to address the root causes of mental illness or the complex, interconnected relationship between mental health and disadvantage.

The recommendations need to better address the social determinants of mental health - the broader social, economic and environmental structures in which people live. While the report does recognise the need to improve some services beyond health (e.g. housing), we believe the recommendations could go further in addressing underlying drivers of mental health, such as socio-economic inequalities, stigma, discrimination, social isolation and loneliness.

Trauma-informed support for vulnerable populations

The report identifies the inequitable outcomes and challenges experienced by high-risk populations such as lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) communities, culturally and linguistically diverse (CALD) communities, people interacting with the justice system, children and young people in out-of-home care, people experiencing homelessness and financial hardship and people experiencing harm from AOD use. However, the draft recommendations provide limited actions tailored to addressing mental health inequities for vulnerable populations. While we understand the imperative of offering a universal approach that maximises early intervention and prevention efforts, we question how the reforms will create lasting impacts for our most vulnerable populations. These groups are more likely to experience mental illness due to experiences of trauma, intergenerational disadvantage, homelessness and poverty.

To illustrate this point, we urge the Productivity Commission to consider how the proposed reforms would prevent or change the trajectory for:

- A single mother living on Newstart with two children living in a rural area who cannot afford her rent and relies on emergency relief for food while trying to find employment.
- A young person in residential care who has experienced significant childhood trauma and abuse who is about to leave state care with no onward support

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[1] Allen et al (2014). *Social determinants of mental health*, International Review of Psychiatry, 26 (4), 392–407.
[2] Stewart-Brown et al (2015). *Socioeconomic gradients and mental health: implications for public health*, British Journal of Psychiatry, 206, 461–65.
[3] Lawrence et al (2015). *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Department of Health. August 2015.
[4] Lawrence et al (2015). *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Department of Health. August 2015.

- An older woman experiencing homelessness after leaving a violent partner, who is living in her car and is disconnected from mainstream services
- A young man experiencing financial hardship as a result of being estranged from his family who would not accept his sexual identity
- A family from a refugee background who experienced torture and death of family members prior to settlement, who are now navigating Australia's mental health system.

Missed opportunities for integrating alcohol and drug service responses

The draft report attempts to address the current fragmentation within the mental health system. Yet, we believe the Productivity Commission could propose further reforms to realise the potential for coordinated, effective and joined-up services for people presenting with co-occurring mental health and alcohol and other drug (AOD) needs through enhanced collaboration, care-coordination and integration across alcohol and drug and mental health services for our consumers. **We, therefore, urge the Productivity Commission to review potential opportunities throughout its entire report to incorporate AOD services in the proposed reforms.**

It is well recognised that the majority of people presenting to AOD services have co-occurring mental health needs. These co-occurring issues impact on an individual's overall health and wellbeing - AOD use can exacerbate existing mental health conditions while for others, alcohol and drugs can be one way an individual may seek to relieve some of the symptoms of anxiety, depression, trauma, Post Traumatic Stress Disorder (PTSD) and other mental health concerns.

It is also known that those diagnosed with a severe mental illness have an increased risk of developing substance use disorders compared to the broader population. This high vulnerability to AOD use among those with severe mental illness presents a myriad of problems for treating clinicians, particularly given the limitations of current treatment options for those experiencing serious mental illness alongside AOD issues.

Much work has been undertaken over the past decade to improve responses to people with dual diagnosis at both State and Commonwealth levels. In the Victorian context, this includes the upskilling of the AOD workforce to identify, assess and respond to high prevalence mental health conditions such as anxiety and depression. For example, screening questions are now embedded in the Victorian AOD Comprehensive Assessment form via the K10 and MSE. There is a large degree of expertise and confidence across the AOD workforce in supporting people experiencing high prevalence mental health conditions simultaneously with their AOD use.[5]

Yet, the most vulnerable can still face challenges in accessing appropriate and coordinated treatment and support that addresses dual needs around their AOD and mental health. Uniting would like to see more explicit mention of the important overlap between AOD and mental health and the need for investment to ensure services can respond appropriately to those experiencing dual needs. The Productivity Commission's work provides an important opportunity to address the siloed nature of service delivery and build capacity to respond to people with dual mental health and AOD needs in a meaningful way. While the specialist expertise and skills of AOD and mental health services should be recognised and maintained as distinct services systems with distinct professional knowledge and capability, there is a need to build further capacity across both sectors.

Uniting believes AOD expertise should be routinely embedded in mental health services, and other acute health settings such as emergency departments. Supporting people with dual diagnosis needs also requires mental health expertise within AOD settings. See page 17 and 19 for detailed recommendations to improve integration of mental health and AOD services.

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[5] Data drawn from: VAADA (2019), *Submission to the Royal Commission into Victoria's Mental Health System*, VAADA, Melbourne.

Implementation risks

We are concerned that the draft report's recommendations focus heavily on the development of national mental health strategies and Council of Australian Government agreements. This approach shifts responsibilities onto State and Territory Governments or other agencies such as the National Mental Health Commission without acknowledging the role of the Commonwealth Government in jointly contributing funding to services such as education, hospitals, preventive health, housing and homelessness. We note that the plethora of national and state strategies, plans and partnership agreements already in place, such as the Fifth National Mental Health and Suicide Prevention Plan (which was endorsed as recently as 2017).

While funding commitments are not within the report's remit, we see potential risk in the implementation of the proposed reforms, if a commitment to ongoing funding, at both a Commonwealth and State level, is not secured. In our experience, new intergovernmental agreements and national strategies do not always translate system reforms into meaningful changes for our consumers that provide better access to high quality, well-coordinated, person-centred mental health services.

Detailed feedback on key reform areas

In accordance with our previous submission, we have the following commentary on the draft report, grouped according to key themes across the report's five reform areas.

Reform area 1: Prevention and early intervention for mental illness and suicide attempts

a) Under-treatment of high prevalence mental health conditions

We commend the Productivity Commission for recommending access to MBS-funded mental health supports are widened through:

- Additional MBS group psychological therapy provisions (Recommendation 5.5)
- Increasing consumer choice of referrals to MBS providers (Recommendation 5.8)
- MBS-funded consultations via videoconference for psychologists (Recommendation 5.7) and psychiatrists (Recommendation 7.2)
- MBS-funded consultations between GPs and psychiatrists (Recommendation 5.1)
- MBS-funded family therapy (Recommendation 13.3).

Improving access to affordable mental health supports is a priority for our consumers. We strongly support the recommendation to evaluate the effectiveness of MBS-rebated psychological therapy and trial additional sessions (Recommendation 5.4), which we proposed in our previous submission based on guidance from our consumers. Given that the review is anticipated to take several years, we urge the Productivity Commission to consider an additional recommendation to extend psychological support provided in the interim while this review is being undertaken. This action will ensure continuity of support for people in need who have expended their MBS-rebated psychological therapy allocation of 10 sessions.

We urge the Productivity Commission to consider recommendations that address the significant barriers to accessing psychiatrists due to workforce shortages for psychiatrists in some communities, particularly in rural and regional areas where waitlists can be up to 12 months and affordability issues as large co-payments can be requested.

We also note the trend towards online treatment models (Recommendation 5.6, 6.1, 6.2) and urge the Productivity Commission to consider such services as complementary to rather than a substitute for face-to-face services.

b) Early intervention approaches for those most at risk

Targeted screening for perinatal mental illness
We strongly support the Productivity Commission's recommendation on universal screening for perinatal mental illness (Recommendation 17.1). As with all universal programs, we see a need for a targeted approach that enables marginalised and hard-to-reach communities to access the same level of support as the broader Australian population. We know that some populations, for example, CALD and Aboriginal and Torres Strait Islander communities, have lower rates of access to maternal and child health services[6], so a more tailored response is required such as through outreach, home visits, drop-in services and multidisciplinary clinics.

Early intervention for children in early learning settings
We welcome the proposed recommendations which recognise the role of early intervention in child mental health. As the largest early learning service provider in Victoria and Tasmania, we understand the importance of early intervention for children and families in preschool settings. However, we advise the Productivity Commission to consider the broader context of early learning workforce training, recruitment and remuneration. The additional measures proposed by the Productivity Commission (Recommendation 17.2) to support and enhance social and emotional development in early learning settings (e.g. through parenting education programs)

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[6] See the Victorian Auditor General's Office report on this issue:
https://www.audit.vic.gov.au/report/effectively-planning-population-growth?section=32565--audit-overview

must be appropriately resourced if they are to be effective. Reforms based on revising guidelines, regulations and quality standards alone is not enough to effectively implement expanded early childhood development checks for preschool age children. There is also a critical need for greater ongoing investment in specialist paediatric mental health support to meet rising service demand when these health checks identify issues.

Social and emotional learning in schools

We support recommendations for social and emotional learning programs in the education system and wellbeing leaders in schools to oversee policies, coordinate services and assist teachers and students, as well as improve data collection (Recommendation 17.3, 17.5, 17.6). We note that revisions to data and guidelines alone may struggle to achieve long-term impacts without resourcing for teacher training and development. Further, universal approaches must be complemented by more targeted programs for high-risk groups of children and young people with well-documented trajectories associated with trauma and abuse (such as LGBTIQ+ communities, children and young people in out-of-home care, victim/survivors of family violence and sexual abuse, CALD communities including refugees and people seeking asylum).

The lack of targeted interventions articulated by the Productivity Commission for children and young people in out-of-home care is striking, given the greater risk they experience for a range of mental health issues, including post-traumatic stress disorder, depression and anxiety due to violence, neglect or abuse.[7][8] When considering the connection between child protection and mental health presented by the Royal Commission into Victoria's Mental Health System (below), the need for targeted efforts to achieve equitable mental health outcomes is clear.

Figure 12.7: Proportion of people accessing public specialist mental health services utilising other Victorian Government services, 2017–18

Legend:
- Proportion of people accessing Victorian public specialist clinical mental health services also using another Victorian Government service
- Proportion of entire Victorian population using the Victorian Government service
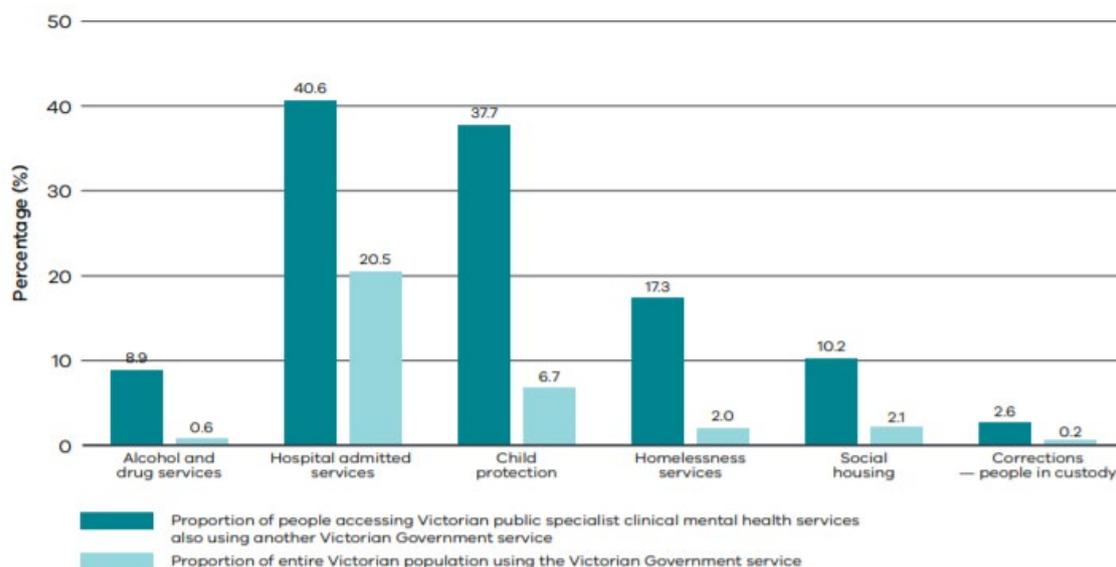
Source: Commission analysis of Department of Health and Human Services, Integrated Data Resource. Client Management Interface/Operational Data Store, State Alcohol and Drug Treatment Service Utilisation Data Collection Victorian Admitted Episodes Dataset, Child Protection - Case Management, Victorian Homelessness Services Collection, Victorian Housing Register, E-Justice, 2015–16 to 2017–18

This estimate only considers service use amongst people accessing the public specialist clinical mental health service and other service systems in 2017–18. It does not account for people who a) may be accessing private mental health services or b) may have a mental illness but are not accessing the public specialist clinical mental health service in 2017–18. Child Protection refers to children in contact with the system, not parents.

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[7] Australian Institute of Family Studies (2014). *Effects of child abuse and neglect for children and adolescents*. Available from: https://aifs.gov.au/cfca/publications/effects-child-abuse-and-neglect-children-and-adolescents

[8] Commission for Children and Young People (2019). '*In our own words': Systemic inquiry into the lived experience of children and young people in the Victorian out-of-home care system*. Available from: https://ccyp.vic.gov.au/upholding-childrens-rights/systemic-inquiries/in-our-own-words/

The draft report identifies the need for education support for children with mental illness, particularly reviewing the Disability Standards for Education, evaluating disability funding structures and reviewing funding for student outreach services (Recommendation 17.4). However, the recommendations fail to address the well-documented link between mental health and trauma experienced by children and young people, especially those in out-of-home care. As a matter of priority, we urge the Productivity Commission to include a specific recommendation in its final report that:

- Addresses the need for specialised trauma-informed mental health care for this population, in order to mitigate potential trajectories into hospitalisation and juvenile justice
- Ensures that young people in, or who have recently left, out-of-home care can access government support to the age of 21, no matter where they live in Australia.[9] Improving access to care and early intervention will reduce young people's vulnerability to homelessness, mental health issues, AOD issues, unemployment, early parenthood and prison.[10]

Young adults in the tertiary education system
We broadly support the recommendations on to improve student mental health and wellbeing strategy in tertiary education institutions (Recommendation 18.1, 18.2, 18.3).

Supported online treatment for CALD communities
We note that the Productivity Commission is considering recommending the expansion of supported online treatment to cater for people from CALD backgrounds. We see some limited potential in this proposal, particularly for people who come from a cultural background where there is stigma around mental health or substance misuse, however this form of treatment could be equally useful for people who reside in remote areas or experience barriers to attending face-to-face appointments or appointments within business hours.

We believe that online treatment is likely to be better than no treatment but is less effective than face-to-face services that offer a better opportunity for practitioners to build rapport and ensure the most culturally appropriate support is provided.

c) Addressing stigma

More education and training for health professionals, as well as for family/carers, to improve their understanding of and response to some mental health conditions such as Borderline Personality Disorder was a key recommendation of our previous submission.

We welcome the Productivity Commission's proposal to develop a national stigma reduction strategy (Recommendation 20.1). We expect that the strong ethos of embedding lived experience across all aspects of service design and delivery put forward by the Royal Commission into Victoria's Mental Health System would also be reflected in the Productivity Commission's approach. As such, we believe this recommendation would be strengthened by specifying that the national stigma strategy embeds the voices of people with lived experience of mental health through adoption of a well-resourced consumer co-design process with the National Mental Health Commission.

Based on our experience with peer support groups, we know that the impacts of stigma on mental health do not only relate to experiencing a mental health condition, but can be derived from experiences of discrimination and marginalisation on the basis of a person's culture, race, religion, visa status, gender, sexuality or gender identity, disability, homelessness, unemployment status and other co-occurring health issues such as AOD use. We envisage that the national stigma reduction strategy would encompass the intersectional nature of mental health and identity, particularly recognising that those with co-occurring health conditions such as AOD use, can experience compounded stigma.

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[9] See the Home Stretch Campaign at http://thehomestretch.org.au/
[10] Deloitte Access Economics. Raising our children: Guiding young Victorians in care into Adulthood. Socioeconomic Cost Benefit Analysis. 2016. Available from:
https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-guiding-young-victorians-in-care-into-adulthood-anglicare-220816.pdf

d) Suicide interventions

We endorse the recommendations to reduce suicide deaths and intentional self-harm through universal access to aftercare, empowering Indigenous communities to prevent suicide and a national mental health and suicide prevention agreement (Recommendation 21.1, 21.2, 21.3).

Reform area 2: Close critical gaps in healthcare services

a) Mental health workforce strategies

Improving remuneration of mental health workforce
Uniting commends the Productivity Commission on the proposed update to the national mental health workforce strategy, proposals to increase psychiatrist and specialist mental health nurse workforce and increase training and specialisation for doctors (Recommendation 11.1, 11.2, 11.3, 11.5, 11.6). We also welcome the recommendation that the Australian and State and Territory Governments extend the funding cycle length for psychosocial supports from a one year term to a minimum of five years (Recommendation 12.1). Extending the contract length of psychosocial supports was a recommendation from our previous submission, to improve job security and enhance the attraction and retention of staff, especially in rural and regional areas. In implementing this recommendation, we propose that Fair Work Commission should review pay rates of mental health workers to ascertain if they are commensurate to other roles with similar qualifications and expectations.

Support for unpaid carers
We welcome the proposal to reduce barriers to accessing income supports for mental health carers (Recommendation 13.1), improving employment support for mental health carers (Recommendation 13.2) and more family-centred and carer inclusive practice (Recommendation 13.3). We envisage that capacity building supports for mental health carers, such as adequate and appropriate training and information, would help provide carers with a safe environment to deliver care in. We therefore ask that the Productivity Commission also include a specific recommendation to build the capacity of unpaid carers.

b) Improving hospital care

We support the proposed improvements to people receiving care in hospitals (Recommendation 7.1, 8.2, 8.3) that aim to ensure that consumer needs reflect their treatment. In addition, we reiterate the need to appropriately remunerate rural and regional acute inpatient beds and specialised community mental health bed-based care.

c) Rural and regional gaps

As a significant provider of rural and regional services across Victoria and Tasmania, we actively advocate for better funding arrangements for rural, regional and remote community organisations to appropriately remunerate travel and service delivery in rural and remote locations, and support for use of new technologies. In our view, the draft recommendations go some way to improving rural and regional service access through proposing:

- Expanding online platforms, videoconferencing and telehealth to support people in rural and regional areas (Recommendation 5.7)
- Increasing psychiatry training placements and supervisors (Recommendation 11.2)
- Attracting a rural workforce by greater use of videoconferencing and expanding initiatives such as the Rural Locum Assistance Program to fund visiting health professionals to temporarily stand in for rural and remote health workers while they attend professional development activities, meetings and conferences and take leave (Recommendation 11.7).

In principle, rural and regional communities should be able to access the same level of supports as people living in metropolitan areas. As such, we believe the proposed recommendations to provide audio-visual mental health services should be positioned as a complementary service, not as a substitute for face-to-face services in rural and regional areas. To ensure truly equitable access to mental health services for rural and regional communities, governments must be prepared to finance:

- Travel of mental health services to undertake outreach and service delivery in rural and remote locations on a regular basis
- Service partnerships and specialist outreach from metropolitan areas that delivers face-to-face clinics for rural and regional communities
- Purchasing of equipment and associated training in how to use new technologies
- Ensuring rural workforce being able to attend (e.g. backfilling) and travel to training
- Funding local communities of practice and place-based networks that bring together a range of services to develop local responses and reduce isolation of professionals
- Developing targeted long-term strategies to better attract and retain qualified and experienced mental health workers in rural and regional areas.

We also suggest that rural and regional funding for improving equitable access to face-to-face services should feature prominently in the proposed regional pooled funding model and associated review of activity-based funding for mental health (Recommendation 23.1, 23.3).

d) NDIS gaps in mental health

The NDIS is an integral part of the mental health service system which aims to improve choice and control for people with psychiatric disability. If mental health outcomes are to be realised through the Productivity Commission's work, then the NDIS should feature more prominently in the draft recommendations for reforming the mental health system. While some issues of the proposed actions may resolve some challenges of NDIS implementation, other issues remain outstanding, as outlined below.

NDIS pricing structure for mental health
In our earlier submission, we recommended that the Productivity Commission consider reviewing the current pricing structure of the NDIS to better incorporate mental health services. Given this issue remains unresolved, we urge the Productivity Commission to consider the need to review NDIS pricing structures for mental health in their final report.

NDIS workforce training and specialisation in mental health
We note that the draft report does not respond to issues with mental health training for the current NDIS workforce. We previously recommended that the Australian Government review NDIS funding arrangements for mental health to invest in upskilling NDIS staff to better address mental health issues. This action would involve the Australian Government providing dedicated funding to deliver essential specialised mental health training, such as Applied Suicide Intervention Skills Training (ASIST), to the NDIS workforce. We recently recommended similar actions through our submission and hearing appearance to the Joint Standing Committee on the NDIS.

State-funded psychosocial service gaps for people not eligible for the NDIS
We strongly support the Productivity Commission's recognition of the need to guarantee continuity of psychosocial supports to ensure that anyone who requires psychosocial support is able to access it, including former participants of Australian Government-funded psychosocial supports such as Personal Helpers and Mentors (PHaMs), Partners in Recovery (PIR) and Support for Day to Day Living in the Community (D2DL) (Recommendation 12.2). We also welcome the long-term recommendation for participants to either be transitioned onto the NDIS, if appropriate, or access the replacement psychosocial support when the National Psychosocial Support Measure is phased out.

We support the proposal for State and Territory Governments to take on long-term responsibility for psychosocial and carer support services (Recommendation 23.2). Yet we also stress the *urgent need* for a similar long-term commitment for continuity of state-funded community mental health supports for people experiencing mental illness who are ineligible for the NDIS, particularly in Victoria through (former) Mental Health Community Support Services. Improving access to home support workers would also help fill the gap in care, or "missing middle" for people experiencing mental illness who are transitioning between acute services and community mental health services.

An NDIS recovery-focused psychosocial pathway
In our previous submission, we proposed the development of a recovery-focused psychosocial pathway for NDIS participants to ensure the philosophy underpinning mental health services is better reflected in NDIS design and delivery. We welcome the proposed improvements to the National Disability Insurance Agency's approach to psychosocial disability (Recommendation 12.3) including evaluation of the psychosocial disability stream trial and incorporating lessons learnt from the Independent Assessment Pilot into the NDIS access and planning process. We stress the urgency of resolving implementation issues for NDIS participants.

Reform area 3: Investment in services beyond health

a) Housing and homelessness services

Housing security for people with mental illness
We welcome the draft recommendation to support people to find and maintain housing (Recommendation 15.2) through directing State and Territory Governments to:

- Provide mental health training for social housing workers in the medium-term (2-5 years).
- Review social housing policies to reduce risk of eviction for people with mental illness in the medium-term (2-5 years).
- Ensure that tenants with a mental illness who live in the private housing market have the same access to tenancy services as the general population and those in social housing by meeting unmet demand for these services, in the medium-term (2-5 years).
- Monitor impacts of reforms to residential tenancy legislation in the long-term (5-10 years).

These recommendations align with research and policy advice from the Australian Housing and Urban Research Institute (AHURI).[11] However, we are concerned about the lack of recommendations to develop an *immediate strategy* for addressing Australia's housing affordability crisis in the draft report, given this will not help prevent people with mental illness from experiencing housing issues or losing their home over the next 2-5 years.

In our experience, the fundamental challenge of addressing the links between housing, homelessness and mental health is Australia's current inability to meet demand for social and affordable housing. Implementing housing models that support people experiencing mental health concerns cannot be addressed in isolation from broader housing policy and will, thus, require substantial investment to address the challenges facing the housing sector.

Some unaddressed actions that would help manage demand for social and affordable housing[12] and, thereby, ensure housing security for people experiencing mental health concerns include:
- Winding back the negative gearing and capital gains tax concessions, using these savings to kick start investment in the 500,000 new low-cost rental homes desperately needed by Australians on low and middle incomes to meet the demand for affordable housing.
- Developing a National Housing Strategy to meet Australia's identified shortfall of 500,000 social and affordable rental homes, jointly funded through a revised Commonwealth-State Housing Agreement.
- Increasing Commonwealth Rent Assistance by at least $20 a week to reflect skyrocketing of rents across the country, as called for by Australian Council of Social Services.
- Developing a national action plan to end homelessness.
- Scaling up successful models of recovery-oriented housing for national program delivery.

Finding and maintaining housing
We support the draft report's proposed actions to ensure housing and homelessness services have the capacity to support people with severe mental illness to find and maintain housing in the community (Recommendation 15.2) over the next two years, including:

- A nationally-consistent formal policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and prisons.

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[11] See ARUHI's (2019) policy analysis on mental health and housing: https://www.ahuri.edu.au/policy/policy-analysis/mental-health-and-housing
[12] See Everybody's Home campaign for more details at https://everybodyshome.com.au/

- Comprehensive mental health discharge plans for people with mental illness who exit institutional care, to integrate care coordination and access to accommodation.
- Review of the Specialist Disability Accommodation strategy to encourage development of long term supported accommodation for NDIS recipients with severe mental illness.
- Meeting the gap in the number of supported housing places for those individuals with severe mental illness who are in need of integrated housing and mental health supports.
- Meeting the gap for homelessness services among people with mental illness in their jurisdiction, including increasing existing homelessness services, as well as scaling up longer term housing options (e.g. Housing First programs).

In developing the final report, we ask the Productivity Commission to consider how actions, such as a formal policy of no exits into homelessness, will be practically implemented and costing the level of resourcing required by governments to ensure their success.

Uniting welcomes the Productivity Commission's recognition that these actions require governments to invest in homelessness services. We particularly support the recommendation to increase Australian Government funding for State and Territory Government-provided housing and homelessness services through the next negotiation of the national housing and homelessness agreement (Recommendation 24.3). However, we note that the current agreement is not due to be re-negotiated for several years.

Referral pathways from mental health to housing and homelessness services
While enhanced referral pathways and mental health training are recommended for housing and homelessness services (Recommendation 15.1), we also see a corresponding need to extend this recommendation to ensure the mental health workforce gain additional training and information that builds their capacity to respond to the needs of people experiencing homelessness and make appropriate referrals into housing and homelessness services.

b) Integration with alcohol and other drug services

As expressed in our previous submission, we hope these reforms will clarify the roles of Commonwealth, state and territory governments, private organisations and the community sector across primary care, community-based services, alcohol and other drug treatment, specialist and clinical mental health services and the NDIS, in order to help people navigate and access joined-up services.

There is a need to build further capacity across both mental health and AOD sectors. To this end, we would like to see AOD expertise routinely embedded in mental health services, and other acute health settings such as hospital emergency departments. Supporting people with dual diagnosis needs also requires mental health expertise within AOD settings. As such, we urge the Productivity Commission to consider a new recommendation for:

- Specialist AOD advisors to be placed in acute and community-based mental health services and in hospital emergency departments to build capacity to respond to people with dual diagnosis and provide specialist advice, support, secondary consultation and treatment.
- Specialist mental health advisors to be placed in AOD services to build capacity to respond to people with dual diagnosis to provide specialist advice, support, secondary consultation and treatment.

c) Interaction with the justice system

Uniting welcomes the recommendations about developing additional justice inclusion approaches for improving mental health care in correctional facilities and on release (Recommendations 16.1, 16.2, 16.3, 16.4, 16.5), adequately resourcing legal aid services to assist people appearing before mental health tribunals (Recommendation 16.6) and non-legal advocacy for people subject to involuntary treatment (Recommendation 16.7).

While the draft report recognises the need for mental health care at all stages of the justice system, Uniting believes this inquiry provides an important opportunity to address a range of inequities for those people in the criminal justice system with co-occurring AOD and mental health concerns. The draft report recognises the overrepresentation of people with mental

illness in every part of the justice system. Dual diagnosis of mental health and AOD issues is the norm for people in contact with the criminal justice system. In addition, people in prison often have co-occurring physical health needs, histories of abuse and trauma, limited or interrupted education histories and limited employment histories. There are significant limitations to the health services offered to people in prison, particularly those experiencing AOD and mental health issues, and significant gaps for people transitioning out of prison back to the community.

Recently-released prisoners are at increased risk of harm and death from suicide and overdose. People released from prison with mental health and AOD issues are particularly vulnerable to these preventable causes of death.

We urge the Commission to consider the health needs of prisoners with dual diagnosis of mental health and AOD issues and the need to enhance transitional support and coordination of care and for people transitioning from prison back to the community. This could occur via in-reach into prisons and improved linkages between prison and community AOD and mental health services as well as linkages to housing support post-release.

d) Addressing the impact of financial hardship and disadvantage

Mental health is strongly shaped by social, economic and environmental factors. Through our services for people experiencing financial hardship, Uniting has witnessed the huge impact financial difficulties can have on a person's mental health and, correspondingly, how mental health concerns can cause financial difficulty (e.g. inability to work and/or inability to manage finances and communicate with creditors). In our CareRing program, for example, mental health issues are consistently named as one of the top five vulnerabilities faced by people experiencing financial stress.

Any mental health reforms need to address the interconnected causes of disadvantage, vulnerability and marginalisation that contribute to mental illness such as homelessness, unemployment, family violence, trauma and financial hardship. The absence of recommendations that consider the broader context of disadvantage faced by many people with mental health concerns on a day-to-day basis are a critical gap in the report

Living on income support payments has profound impacts on people's mental health, emotional wellbeing and ability to engage socially. Our consumers report struggling to afford their ongoing psychiatric treatment or medication. Research suggests that nearly half (48.6%) of Newstart recipients report mental or behavioural problems, compared with 21% of wage earners.[13] Yet, the draft recommendations do not consider the adequacy of Newstart, Youth Allowance or related income support payments in helping people financially through challenging times. We question why this issue is not considered, given the draft report also states that only 17% of Newstart Allowance recipients with a recorded psychological or psychiatric condition receive an exemption on this basis.

The draft recommendations do propose improvements to employment support assessment measures (Recommendation 14.1) and greater flexibility in mutual obligations requirements for people with mental health concerns (Recommendation 14.4). Yet, in our view, there are several additional actions that the Productivity Commission could propose to assist people experiencing financial hardship and help minimise the risk of already vulnerable people developing mental illness. Some priorities, as identified in our submission and hearing appearance for the Senate inquiry into Newstart and related payments, include:

- Increasing Newstart, Youth Allowance and related income support payments and indexing these payments to wages as well as CPI to ensure they maintain pace with community living standards, as outlined in our recent evidence to the related Senate Inquiry

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[13] Collie A, Sheehan L & McAllister A. (2019). *The Health of Disability Support Pension and Newstart Allowance Recipients: Analysis of National Health Survey Data.* Insurance Work and Health Group, School of Public Health and Preventive Medicine, Monash University. Retrieved from: https://www.dspstudy.com/dsp-health-study

- Increasing the number of full-time employed financial counsellors to support people at risk of financial hardship, to mitigate escalating mental health concerns experienced by people managing significant debt.

e) Improving social participation and inclusion

We commend the Productivity Commission on seeking to strengthen the peer workforce (Recommendation 11.4) through developing national peer workforce guidelines, establishing a professional organisation for peer workers, educating health professionals about peer workers and commissioning a national review of peer worker qualifications and training.

In our view, this recommendation could also recognise the crucial role that peer-led and peer-facilitated support groups play in supporting people experiencing mental health concerns to engage in self-help strategies. Feeling connected to peers can help build people's confidence to seek further support from outside services that are perhaps not known as being an affirming or inclusive place. In particular, we stress the critical need to invest in:

- Youth-led and youth-facilitated groups with the support of peers that build capacity and skills development, especially for LGBTIQ+ young people.
- Peer support services for marginalised communities who face distinct challenges accessing mainstream services (e.g. through Voices Vic).

Voices Vic shows the value of peer support services

Voices Vic is an award winning and research-supported network of professionals, carers and voice hearers that work together to reduce the distress which can be associated with hearing voices. Voices Vic was established by Uniting in 2009, after successfully running Hearing Voices groups since 2005. We work in partnership with other Australian and international Hearing Voices Networks. We offer a range of peer-support services such as one-on-one and community groups with trained professionals who have experienced, or still experience, hearing voices themselves. Research on peer support groups within the Hearing Voices Network demonstrates the effectiveness of peer support services in helping people feel understood, reducing isolation, improving self-esteem and hopefulness about the future, improving coping strategies and reducing hospitalisations and need for emergency assistance (Beavan, Jager & Santos, 2016).

Reform area 4: Assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

Uniting broadly accepts the recommendations proposed by the Productivity Commission to support mentally healthy workplaces such as workplace psychological health and safety law (Recommendation 19.1), codes of practice on employer duty of care (Recommendation 19.2), lower premiums and workplaces initiatives (Recommendation 19.3), no liability treatment for mental health related workers compensation claims (Recommendation 19.4) and disseminating information on workplace interventions (Recommendation 19.5). These recommendations are best analysed by other relevant organisations with expertise in workplace relations.

Reform area 5: Fundamental reform to care coordination, governance and funding arrangements

a) Enhancing service coordination and integration

Missed opportunities to integrate AOD services

In our previous submission we called for greater clarity of the respective roles of Commonwealth, state and territory governments, private organisations and the community sector across primary care, community-based services, AOD treatment, specialist and clinical mental health services and the NDIS, to help people navigate and access joined-up services.

The proposed reforms to information exchange and referral between consumer phone lines, online navigation platforms to support referral, single care plans and care coordination services (Recommendation 10.1, 10.2, 10.3, 10.4) align with our previous advice to adopt joint case planning models to improve coordination and continuity of care. While we commend the draft report for addressing current mental health system fragmentation, we also suggest that these reforms should extend to AOD services to improve integrated and holistic care for consumers.

The critical role of integrated, place-based services that address local needs

In our previous submission, we highlighted the importance of promoting the design and delivery of innovative integrated services. We know that other social services have developed place-based services models similar to our St Kilda 101 Engagement Hub that provide person-centred services in an integrated and holistic way. Yet, the draft report misses the opportunity to incentivise integrated, place-based approaches that provide a holistic response to mental health within the broader context of an individual's situation. The emphasis of the draft report appears to be heavily focused on joining-up mental health services but fails to recognise that most people seeking mental health support require a range of other social services.

The draft report recommends incentivising more innovative payment models through establishment of a Mental Health Innovation Fund to trail innovative system organisation and payment models (Recommendation 24.4). However, this action appears specific to mental health regional commissioning bodies, rather than seeking to drive integration across the breadth of social services that people with mental illness engage with on a regular basis. We recommend broadening Recommendation 24.4 to incentivise innovative service models that trial service integration improvements across the spectrum of a person's needs.

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St Kilda's 101 Engagement Hub provides holistic care

The 101 Engagement Hub in St Kilda provides social connections and pathways into secondary health services for people with mental health conditions that would otherwise face isolation. The Hub acts as a one-stop-shop for people experiencing mental illness, homelessness, disadvantage and marginalisation by promoting meaningful social connections, reducing stigma, mitigating risks of interactions with police and justice systems and helping connect people into mainstream mental health and primary health services. The Hub currently welcomes a community of around 450 vulnerable people and sees around 90 people per day. It provides psychosocial supports and is commonly cited by these consumers as drastically reducing feelings of social isolation and loneliness.

The Hub was not developed as a mental health service, yet, without its operation, these people would not have a space to engage in meaningful social interaction and feel a part of the local community. Many of the people attending the Hub would likely be on the street with nowhere to go, increasing their susceptibility to developing a mental illness and engaging in socially challenging behaviours that would have negative flow-on impacts on local residents, businesses and other services (e.g. police, hospitals).

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b) More effectively monitoring and reporting outcomes

We commend the Productivity Commission's position that monitoring and reporting should be focused on outcomes for consumers and carers and broadened beyond the health portfolio, as well as filling data gaps and building a stronger evaluation culture (Recommendation 23.1, 25.3, 25.4). For Uniting, consumer co-design and engagement of people with lived experience as *equal partners* in the development of indicators is a key factor of success.

The recommendation to enhance consumer and carer participation (Recommendation 22.3) expresses a desire to provide consumers and carers with the opportunity to participate in the planning, design, monitoring and evaluation of government policies and programs. However, when viewing this recommendation in the context of other recommendations on performance targets, national agreements and strategies it is difficult to see how consumers and carers would be meaningfully engaged, when national agreements (Recommendation 22.1), whole of government mental health strategies (Recommendation 22.2) and performance targets are

determined by the Council of Australian Governments (Recommendation 22.4) and programs are to be evaluated by the National Mental Health Commission (Recommendation 22.5). The Royal Commission into Victoria's Mental Health System, by comparison, deeply embeds consumer and carer co-design/co-production in all aspects of their proposed reforms.

c) Reforming funding arrangements

Long-term sustainability of funding arrangements

In our previous submission, we outlined how more sustainable funding arrangements for mental health services which focus on outcomes and reflect the need for longer term treatment for many mental health conditions would support best practice. As such, we support the recommendation to extend contract lengths for psychosocial supports from 1 year to a minimum of 5 years for both Commonwealth and State Governments (Recommendation 12.1).

Regional funding models

The proposed structural reforms to provide the mechanisms to enhance regional control and responsibility for mental health funding (Recommendation 23.3, 24.1) and flexible and pooled funding arrangements (Recommendation 23.4) are ambitious. We support the need for this structural reform, in principle, and the opportunity to enhance regional integration of mental health services including AOD services.

We would urge the Regional Commissioning Authority to consult with local service providers on establishing regional funding arrangements, and ensure consistent contact with stakeholder agencies to ensure funds are being equitably allocated. Given the ambition of this reform, we would also caution that many people working in the mental health sector have 'change fatigue', and care will need to be taken to adequately manage this change

Performance-based funding

The Productivity Commission has shown a commitment to reforming funding arrangements and to more effective monitoring and reporting. While Uniting supports the need for both, we would strongly caution against potential perverse incentives that would be created if funding was linked to reporting outcomes.

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