WAAMH

Western Australian Association for Mental Health

SUBMISSION PRODUCTIVITY COMMISSION MENTAL HEALTH DRAFT REPORT 2019

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About WAAMH

The Western Australian Association for Mental Health (WAAMH) is the peak body for community health in Western Australia. Our membership comprises community-managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. We also engage with a wide network of collaborative relationships at a state and national level with individuals, organisations and community members who share our values and objectives.

WAAMH influences community attitudes, mental health priorities, policy and practice through mental health promotion, systemic advocacy and sector training and development, so Western Australians have the rights, resources and support needed for mental wellbeing, recovery and citizenship. Our vision is that as a human right, every one of us with have the resources and support needed for mental wellbeing, recovery and citizenship.

This submission is in response to the Productivity Commission Draft Report into mental health published 31 October 2019.

The views represented in this submission are WAAMH's and WAAMH takes responsibility for any inaccuracies therein.

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Executive Summary

The Productivity Commission Draft Report[1] (Draft Report) into mental health in Australia acknowledges the urgent requirement for reform of mental health services in Australia and identifies contributing factors to the unacceptably high proportion of Australians experiencing mental health concerns and those at risk of experiencing mental health concerns and suicide if these factors are not addressed. The Draft Report acknowledges that the mental health system has not kept pace with needs and expectations of what is required to treat and support the needs of people with mental health concerns or promote wellbeing through prevention and early intervention.

The Draft Report proposes five key reform areas:

1. Prevention and early intervention for mental illness and suicide
2. To close critical gaps in services and provide alternatives to hospital emergency departments by expanding services
3. Investment in services beyond health such as the provision of long-term housing to people with severe mental illness
4. Assistance for people to get into work and enable early treatment and support for workplace related mental ill health including compensation and
5. Care coordination, governance of funding arrangements to ensure genuine accountability, clarify responsibilities and ensure consumers and carers participate fully in the design of policies and programs that affect their lives

The five key reform areas overlook the importance of lived experience in the mental health sector, despite this being recommended throughout the report, in addition to the need to fill the gaps for funding for people with psychosocial disability who are not eligible for the National Disability Insurance Scheme (NDIS). The Draft Report does not satisfactorily contribute to how reforms might be actively implemented and thus achieved.

The Draft Report acknowledges that clinical health models continue to form the basis of the mental health system; that treatment and support for people with mental ill health has been 'tacked on' (Draft Report, Vol. 1, p. 2) to a system designed to treat physical illness and that this has not been an effective or adequate approach in achieving good outcomes for mental health.

Emergency and acute inpatient services are reported as not working for people with mental illness due to the environment being unsuitable for people already experiencing

[1] Australian Government Productivity Commission, 2019, *Mental Health Draft Report*. Available at: https://www.pc.gov.au/inquiries/current/mental-health/draft (Accessed 10/12/2019).

distress (Vol 1, p. 303). Consumer perspectives are presented with regard to the delivery of mental health care through emergency and inpatient services:

> *I wasn't treated with the respect and dignity I deserved nor are many MENTALLY ILL patients in the Emergency Room. As it is not the place for us. It is designed for PHYSICAL ILLNESS.* (Vol 1, p. 304).

This quote succinctly captures the underlying problem; mental illness is being responded to by models of health care that are not sufficient. The Draft Report, despite identifying that there are gaps and reforms needed to take place, generally recommends the expansion of existing models of interventions that occur in primary and tertiary care settings or emanate from them via Primary Health Network (PHN) processes, plus a range of ancillary changes or reforms. The Draft Report recommends alternative settings and services but suggests they be provided by existing services largely operated by health professionals.

These limitations are evident in the proposed stepped care model, which h\sets out steps to access clinical services, with little integration of the Commission's concerns about social determinants and consumer focused outcomes.

However, changes cannot occur by merely tweaking the system. Broad systemic change needs to occur that rebalances the service mix, instates mechanisms for innovation and is coproduced by consumers and family members/carers who are qualified to provide leadership on what works for them.

Recommendations

1. The final report should include a greater focus on building long term system improvements and develop service planning frameworks that are based on wellness and recovery outcomes; this will necessitate being underpinned by a balanced system model and the social determinants of mental health. These outcomes and frameworks should be coproduced.
2. The final report should base its discussion of prevention and early intervention on the social determinants of mental health.
3. The Draft Report's recommendation for suicide after care should include funding and legislation or policy development to support its implementation.
4. The Commission should review the recommendations made by the submission to the inquiry by Suicide Prevention Australia and consider whether combining suicide prevention uniquely with mental health under the National Mental Health Commission provides the level of leadership and expertise that it needs because it is not uniquely a mental health issue.
5. The final report accord housing, homelessness and supported accommodation issues greater primacy and urgency with clearer language around this being a primary priority and include shorter timeframes for the recommendations.
6. The final report recommend stronger incentives, such as tying funding to consumer outcomes in housing and supported accommodation.
7. The final report include specific recommendations that require commissioning agencies to increase investment in supported accommodation services.
8. The final report include greater clarity about what community and psychosocial supports are, who would benefit, the system impacts, and the funding required to achieve these.
9. The final report include community and psychosocial support earlier in a stepped care model, to incorporate it as a complementary support, a support in its own right, and in recognition of its role as preventing and reducing the need for sub-acute, acute, emergency mental health and/or forensic and justice services.
10. The final report explicitly recommends increasing funding for psychosocial and community supports to meet the needs of the missing middle and consumers with severe and persistent mental health issues, and to ensure adequate and equitable access across all regions of Australia, rather than relying on incentives for commissioning bodies.
11. The psychosocial, community support and peer workforces are included as priority workforces for development in the final report's workforce initiatives.

12. The final report recommends mechanisms to build a stronger evidence base for community support, through innovation initiatives, research, co-design labs, stronger outcomes-based reporting and evaluation of existing programs.
13. The final report recommends specific mechanisms for building consumer and family member/carer capacity including: clarification of which government is primarily responsible; the development of capacity building programs, tools and frameworks including training and leadership development; and the establishment of a Centre of Excellence to develop, implement and evaluate initiatives.
14. The final report recommends the rebuild model for commissioning authorities, with funding to be controlled by a commissioning body at the State or Territory level.
15. The final report recommends funding arrangements that tie commissioners to investing in a balanced system and improved outcomes. These could compel commissioning bodies to evidence their investment in the suite of services that comprise an optimal and balanced system, evidence outcomes rather than activity, and report in much greater detail to improve transparency.
16. The final report's funding formula account for the additional costs of rural and remote service delivery.

1. Introduction

1.1 Submission objectives

WAAMH's Vision: *As a human right, every one of us will have the resources and support needed for mental wellbeing, recovery and citizenship.*

Towards this WAAMH has four change priorities to achieve its vision:

1. *Progress the 10 Plan target for balancing the system towards prevention*
2. *Progress the 10 Plan target for balancing the system towards community support*
3. *Influence NDIS implementation in WA to ensure its responsive for people with psychosocial disability*
4. *Uphold the human rights and hear views from those most disadvantaged by the mental health system*

The Better Choices, Better Lives, The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 - 2025[2] (the Plan) is an initiative that provides the roadmap to achieve balancing the system; the Plan includes in its principles, "a primary focus is on rebalancing services between hospital-based and community-based: moving services to the community where clinically appropriate" (the Plan p. ii). However, despite intentions to prevent mental health problems before they start, successive governments have failed to substantially invest in this area. While mental health has received additional spending overall, Government has focused these resources on acute and sub-acute services, continuing the existing structure of a system unable to keep people well or respond to the thousands of Western Australians seeking support in the community each year.

This submission's purpose is to inform the Productivity Commission that balancing the system to adequate investment in prevention, social determinants and psychosocial and community support will improve mental health outcomes for Australians. Sound, robust and strategic governance, commissioning and lived experience leadership, and policy implementation will be required to address the increasing social and economic burden of mental health and suicide on the nation.

1.2 Systemic change; reform needed to balance the system

Based on extensive research and consultation, the Plan estimates the optimal level of services to meet 100% of demand of the needs of people with severe mental illness in Western Australia. The Plan accords with national and international frameworks

[2] Mental Health Commission, 2015, *The Better Choices, Better Lives, The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025*. Available at: https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf (Accessed 10/10/2019).

evidencing the need for a new balance in mental health services with a greater focus on prevention, early intervention and community or psychosocial support. These policies all agree that the current approach is overly oriented around a system designed to support people who are acutely unwell; a new and balanced system must be developed to support people to live well in the community, optimising their rights, wellness, community contribution and productivity, and reducing unnecessary system costs

Tables one and two represent the current inefficient mix of services and the optimal mix of services (the Plan, 2015, p. 21)

Table 1. Current inefficient mix of services (2012-13)

Prevention	5%
Community Support	8%
Community Treatment	43%
Community Beds	6%
Hospital Beds	38%

Table 2. Optimal mix of services (2025)

Prevention	7%
Community Support	19%
Community Treatment	38%
Community Beds	10%
Hospital Beds	26%

The Better Choices, Better Lives, The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025 Update 2018[3] (the Plan Update) reports an increase in expenditure in hospital-based services of 29% (the Plan Update 2018, p.61). During the same time period, expenditure for clinical community treatment increased by 19%, expenditure for community bed-based treatment increased by 20% while expenditure in community support serviced decreased by 7% and prevention decreased by 9% (the Plan Update 2018, pp. 36-55).

Overall, the target to reduce hospital-based services and community treatment, and increase prevention and community-based services has to date not been achieved and the worrying trend of increased presentations to Emergency Departments, high and repeated use of inpatient services, and interaction with the justice system continues.

> *In the absence of suitable alternatives, there remains a shortfall in supply in community-based services, and hence hospital services are currently*

[3] Mental Health Commission, 2018, *The Better Choices, Better Lives, The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025 Update 2018*. Available at: https://www.mhc.wa.gov.au/media/2830/plan-update-2018.pdf (Accessed 10/12/2019).

experiencing higher demand. Hospital services will not experience excessive demand if all elements of the mental health and AOD service system are in balance and at reasonable levels relative to the optimal levels. While expanding services that focus on prevention, community-based care and supported accommodation will ultimately reduce the use of higher cost hospital-based services, responding to the increased demand remains a challenge within the context of a fiscally constrained environment. Reducing hospital-based services to re-allocate funding to the community services is not feasible in the current circumstance where demand already exceeds supply of hospital-based services. As more community-based services are established, demand will even out across the services, and hospital services will not experience excessive demand. (Plan Update 2018, p. 7)

The Draft Report fails to recommend a significant reform agenda that would embrace genuine lived experience leadership, change the way the mental health system is structured and funded, and enable better outcomes to be achieved.

1.3 A Failure of Implementation

The Western Australian Office of the Auditor General's (OAG) Report *Access to State-Managed Adult Mental Health Services 2019*[4] (AOG Report) concluded that implementation of the plan has not been realised, with many actions and targets not met or completed. It found a lack of accountability for implementation of the Plan and a lack of allocated funding to implement the Plan the reason why targets have not been met.

The Plan is not attached to any statutory authorisation or allocated funding for its implementation. It cannot be implemented without leadership and investment of adequate funding to support its implementation.

The Western Australian Department of Health (DoH) Annual Report 2018/19[5] demonstrates the current lack of parity of funding between health and mental health with the current proportion of the Western Australian Health budget allocated 8% of the budget to mental health services. Lack of adequate funding is the major obstacle to the implementation of mental health policies. In the current commissioning context, the MHC purchases public and NFP service providers.

Experts agree that we should aspire to achieve parity between health and mental health, both in terms of perception and expenditure. While recognising the financial and

[4] Office of the Auditor General, 2019, *Access to State-Managed Adult Mental Health Services*. Available at: https://audit.wa.gov.au/reports-and-publications/reports/access-to-state-managed-adult-mental-health-services/auditor-generals-overview/ (Accessed 11/09/2019).

[5] Department of Health. (2019). *Annual Report 2018-2019.* Available at: https://www.health.gov.au/sites/default/files/documents/2019/10/department-of-health-annual-report-2018-19_0.pdf (Accessed 22/01/2020).

political complexity of parity of expenditure and the unlikeliness of this in the current political and economic climate, we must nonetheless hold it as an ideal. Parity between health and mental health in terms of perception is about stigma reduction that prevents people experiencing mental health concerns seeking help.[6]

The final report must grapple with the long history of ineffective policy implementation in mental health; comments on this are included in section 7 which addresses governance and commissioning.

[6] Dingle, S. (2019) *The politics of mental health* [Podcast]. 22 July. Available at https://www.abc.net.au/radionational/programs/bigideas/the-politics-of-mental-health/11735904 (Accessed 28/01/2019).

2. Limitations

2.1 Snapshot

The Draft Report presents a snapshot of the mental health of the nation, the estimated costs associated with mental ill health and suicide and the estimated cost of addressing mental health and suicide prevention in Australia. The narrative reflects concern and a genuine effort to address mental health concerns and suicide in Australia.

It undertakes a review of the current context of mental health in Australia, but it does so with a particular lens and that lens influences the entire Draft Report and its recommendations. This lens limits its capacity to engage meaningfully with the submissions or to interpret them adequately for the level of analysis that is required to understand mental health and suicide in a broader context; a context outside of that which is quantifiable or measurable.

The Draft Report refers to the emotional cost of mental health and suicide, but it does very little to examine it or to reflect the pain, suffering and frustration of lived experience in its narrative. In doing so, the Draft Report repeatedly contradicts itself and offers piece-meal solutions to very complex issues relying on existing evidence bases and existing service structures, most of which have been tacked onto health, rather than promising genuine reform.

With the understanding and acknowledgment that mental health and suicide are complex issues to address, the Draft Report is long, inconsistent and structured poorly. For example, some aspects or determinants of mental health that intersect are discussed separately in the report such as social determinants, justice and housing and homelessness is not discussed in relation to prevention and early intervention. The Draft Report is difficult to navigate due to this and it hampers accessibility and analysis.

A stronger focus on the context of State and Territory funding for NFP community support is required than what is discussed in relation to the impact of the transition to the NDIS for psychosocial support.

However, it must also be noted that some areas were given sound attention and productive analysis and recommendations such as Chapter 13 on carers and families and the importance and NFP community supports in this area. Similar attention would have been appropriate to the psychosocial and community support needs of consumers specifically; existing services that meet need as well as the requirement for service expansion to meet the unmet needs referred to in Chapter 12 on psychosocial support.

2.2 Lived experience: a human rights perspective

The Commission has asked WAAMH for insight on how to capture the voice of lived experience during a teleconference dated 21 January 2020. The Commission claims that it has tried to integrate a consumer perspective into the Draft Report; however, while the Draft Report includes some powerful consumer quotes, it has failed to reflect a lived experience focus.

The Commission appears to have assumed that its principle of being consumer centred will be clear and understood, however this is not the case in mental health which has a long history of subjecting consumers to a system designed around services, which privileges the views of clinicians, and for many consumers subjects them to involuntary treatment. This principle needs to be clearly specified in the report, and evidence provided in how the lived experience voice has shaped the commentary and recommendations.

People experiencing mental health concerns have the same human rights as everyone else and it is often the experience of many people with lived experience that they are not treated with the respect and access to supports and social determinants that reflects their human rights are met, including the right to dignity outlined in Article 1 of the Declaration of Human Rights[7].

Article 25(1) of the United Nations Declaration of Human Rights[8]:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The following quote is from a consumer who presented to an Emergency Department:

> *I have a MENTAL ILLNESS that I have managed since my diagnosis, I have learned to understand it. Hence what I KNEW EXACTLY WHAT I NEEDED FOR TREATMENT. TWO MEDICATIONS. TWO MEDICATIONS! I didn't even take up a bed, I slept on the couches in the "meeting room" with my mother being forced to 'watch me' as the hospital was short staffed.* (Vol 1, p. 304)

This quote is described in the Draft Report as reflecting the challenges of delivering health care through emergency and in-patient services (Vol 1, p. 304). The lens of the Draft Report views the challenge to be in delivering what they describe as health care; an alternate lens might view the challenges experienced by the person left waiting while

[7] https://www.un.org/en/universal-declaration-human-rights/ (accessed 22/01/2020)
[8] https://www.un.org/en/universal-declaration-human-rights/ (accessed 22/01/2020)

their needs, which were known to them, were ignored and which caused clear distress for consumer and family member/carer.

The following quote from a young woman demonstrates the difference that even the smallest act of human contact and a more person-centred approach can make:

> *In late 2016 I was taken to hospital via ambulance after trying to end my life. My experience in emergency was incredibly confusing, frightening and overwhelming.*
>
> *Whilst I was in hospital, I remember a man coming and speaking to me about what had happened, he was wearing a white button up shirt and a black jacket, I deduce that he was a Doctor, but I don't recall him telling me this.*
>
> *There were many other staff members who treated me over several hours, most of them would come into the room, monitor something, maybe ask me a question about my physical state and then bustle away. This was my first time in emergency, and my first time in hospital for mental health issues. I had no idea who each person was or what they were doing, and this added to my distress and my shame.*
>
> *Another staff member entered the room to monitor me, before she could do anything I said quietly "I'm sorry, but can you please tell me who you are and what you're doing? I have no idea what's going on" at this point she stopped and looked me in the eyes and said "sorry, I'm your nurse", she proceeded to introduce herself and explain what she was monitoring.*
>
> *She then sat on my bed, this nurse was only in my room for 3-5 minutes, but we spoke about what had happened, about why I had made my attempt and how I had attempted. She was then able to explain the medical complications that could arise in the future from making such an attempt. I had no idea.*
>
> *I didn't see this nurse much more over my short stay in hospital.*
> *But from that moment on, I felt more calm, compliant and empathetic.* (Hayley Harris[9])

Ms Harris now works as a peer support worker for the Mental Illness Fellowship of Western Australia, which is a NFP organisation that provides non-clinical support to consumers, carers and families.

[9] Hayley Harris, Lived experience peer support worker, email, 23/01/2020.

This quote also demonstrates that a key shift that needs to occur: reform needs to be about change management and cultural shift in mental health services, as much as changes to structures and services.

2.3 Recovery-oriented practice

The Draft Report language and description of the mental health system, mental 'illness' and the reforms needed reflect clinical framing of mental health issues and lack contemporary understandings of recovery. The content of the report based on the submissions calls for person-centred, trauma informed, recovery-oriented care in the community and for lived experience leadership.

The Draft Report states that from the point of view of people needing care that person-centred care that accommodates individual needs is missing; it recognises that implementing person-centred care consistently across the mental health system will be a 'significant cultural shift' (Draft Report, Vol. 1, p. 17), yet the recommendations do not reflect this.

The separation of psychosocial support and social determinants as being outside the mental health system risks perpetuating the current disjointed system and retaining social and peer-based interventions as merely an optional add on to a clinically led and clinically oriented system.

The Draft Report's support of a stepped model of care believes it would allow for the mental health system "…to focus more on a recovery-oriented approach – rather than dealing with crisis" (Draft Report, Vol. 1, p. 346).

The term recovery-oriented features seven times in the two volumes of the Draft Report, however no description of what recovery-oriented practice entails is provided. The Draft Report references *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers 2013* in its bibliography, which describes recovery-oriented practice as:

> *Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations. (A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers 2013, p.2)*

A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers 2013[10] (p.2) describes recovery as a transformative concept

[10] Australian Health Ministers' Advisory Council, 2013, *A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers*. Available at:

that gives primacy to the insights of people with lived experience and their families; that it was conceived by and for people with mental health concerns to "…affirm personal identity beyond the constraints of their diagnosis".

It is difficult to ascertain how this aligns with a stepped model of care, currently comprised of clinically focused services that offer very little choice, are embedded in a power dynamic that puts clinicians above their patients and at times compromises human rights through coercive or involuntary interventions, and require a cultural shift to provide person-centred care.

The various components of the stepped care model are focused on clinical services delivered in clinical settings, however in their current mode these settings and services offer few opportunities to support individuals to identify their personal recovery goals. These settings also struggle to properly grapple with and support consumers towards improved outcomes such as homes, jobs, relationships, community belonging, choice and control (Mental Health Outcomes, p. 5). Finally, as the Draft Report repeatedly identifies, interfaces with other service systems (e.g. housing, justice) remain complex and fractured, limiting the ability of the stepped care model (or any mental health system focused model) to support consumers effectively in their recovery.

The MHC Mental Health Outcome Statements, 2012[11] (p. 5) describe the elements of recovery that people hope to achieve on their recovery journey:

> ***Outcome: Health, Wellbeing and Recovery***
> *People enjoy good physical, social, mental, emotional and spiritual health and wellbeing and are optimistic and hopeful about their recovery.*
>
> ***Outcome: A home and financial security***
> *People have a safe home and a stable and adequate source of income.*
>
> ***Outcome: Relationships***
> *People have enriching relationships with others that are important to them such as family, friends and peers.*
>
> ***Outcome: Recovery, learning and growth***
> *People develop life skills and abilities, and learn ways to recover that builds their confidence, self esteem and resilience for the future.*
>
> ***Outcome: Rights, respect, choice and control***

https://www1.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf Accessed 17/01/2020.

[11] Mental Health Commission, 2012, *Mental Health Outcome Statements*, Available at: https://www.mhc.wa.gov.au/media/2788/mental-health-outcomes-statements-1-1.pdf. (Accessed 29/01/2020).

People are treated with dignity and respect across all aspects of their life and their rights and choices are acknowledged and respected. They have control over their lives and direct their services and supports.

Outcome: Community belonging
People are welcomed and have the opportunity to participate and contribute to community life

2.4 Recommendations

- The final report should include a greater focus on building long term system improvements and develop service planning frameworks that are based on wellness and recovery outcomes; this will necessitate being underpinned by a balanced system model and the social determinants of mental health. These outcomes and frameworks should be coproduced.

3.Prevention and early intervention

The Draft Report discusses prevention throughout its two volumes in relation to various aspects of mental health but has dedicated chapters for prevention and early intervention in Volume 2, Part IV, divided into five chapters:

- Chapter 17: Interventions in early childhood and school education
- Chapter 18: Youth economic participation
- Chapter 19: Mentally Healthy Workplaces
- Chapter 20: Social participation and inclusion
- Chapter 21: Suicide Prevention

The discussion of prevention in these chapters oscillates between primary, secondary and tertiary prevention strategies, reflecting a lack of understanding of how prevention is conceptualised in public health and the mental health sector.

These five areas merit attention, but these areas and the elements discussed in association with them, could have been integrated into a broader discussion about the determinants of mental health and suicide. Many of the determinants of mental health and suicide sit outside of the mental health sector; income, employment, workplaces, education, justice, housing among others. The Draft Report fails to grapple with concepts like family recovery and the needs of children of parents with mental illness; initiatives working with these groups contribute to prevention.

The Draft Report states that "…there are many other government services beyond health that can contribute to better mental health and wellbeing…" and that taking "…a coordinated approach that prioritises people's needs will enable these services to provide a comprehensive set of services focused on prevention and early intervention" (Draft Report, Vol. 1, p. 183). Part I, Chapter four (Draft Report, Vol. 1, pp. 183-200). This statement offers a broader, more substantive and appropriate discussion of prevention and early intervention and captures the importance of a holistic approach and agency and sector integration.

3.1 Comments on Part IV recommendations

Chapter 17: Interventions in early childhood and school education

The Draft Report's recommendation for wellness leaders in school is inadequate in addition to placing a further burden on an already overburdened system. Help needs to be available when required outside of a school setting, within which contact to children and families is limited to the school context. The Draft Report Chapter 13 - 'Carers and Families' (Draft Report, Vol. 1, p. 492) discussion about the success of Emerging Minds and COPMI and NFP services for families and carers could have been incorporated in

Chapter 17 and the Commission's recommendations alongside the development of new approaches to support family recovery.

Chapter 21: Suicide Prevention

Draft Recommendation 21.1 (Draft Report, Vol. 2, p.863) recommends Australian, State and Territory Governments 'should' offer universal aftercare to anyone who presents to a hospital, GP or other government service following an attempt from the moment of discharge for up to a period of three months. However, it offers no mechanisms as to how this might work or recommend the allocation of funding to pay for this service, which would involve significant investment to be effective.

Suicide Prevention Australia (SPA) in its submission (submission 523[12]) to the Productivity Commission says that there are thousands of Australians working collaboratively to achieve a meaningful reduction of suicide in Australia. SPA recommends a public health and wellbeing approach to suicide prevention that should be based on a broader perspective than "…a public health based, holistic view of mental health and well-being can offer rather than only focusing on diagnosing an illness and providing treatment for that illness" (SPA submission, p. 6). SPA assert that similar methods can be employed, and investment made in a similar way this occurs in relation to the prevention of accidents and avoidable deaths in other contexts.

SPA recommends "…*appointment of a Federal Minister for Suicide Prevention to champion a whole-of-government approach*" (SPA submission 523, pp. 7-8).

3.2 Broad holistic approach to prevention and early intervention

The Commission promotes the need for psychosocial services to support people to live in the community, better systems navigation, co-ordinated care, consumer empowerment, inclusive culturally appropriate practice, strengthening systemic advocacy, through organisations that represent lived experience and strengthening a lived experience and cultural peer workforce (Draft Report, Vol. 1, pp. 189-200). WAAMH supports these approaches.

In the context of Aboriginal and Torres Strait Islander (ATSI) mental health, the Draft Report refers to '"…the holistic and whole-of-life definition of health held by ATSI Peoples…" in accordance with nine principles outlined in the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017-2023 (Draft Report, Vol. 1, pp.901-902).

The Plan (p. ii) refers to a holistic approach as "…acknowledging the impact of the social determinants of mental health and wellbeing such as housing, education and

[12] Suicide Prevention Australia, *Submission to Productivity Commission Inquiry into the Social and Economic Benefits of Improving Mental Health*, Available at: https://www.pc.gov.au/__data/assets/pdf_file/0005/242429/sub523-mental-health.pdf (Accessed 14/01/2020).

employment. In the context of mental health, holistic care is about treating the whole person by considering all of the factors that contribute to wellbeing." The Draft Report applies this concept of holistic care to ATSI Peoples but fails to properly recognise and integrate the importance of a holistic approach to mental health for everyone at risk of or experiencing mental health concerns; this should be better addressed in the Final Report.

The final report would benefit from the application of the its approach to ATSI Peoples to the mental health of the broader population.

3.3 Recommendations

- The final report should base its discussion of prevention and early intervention on the social determinants of mental health.

- The Draft Report's recommendation for suicide after care should include funding and legislation or policy development to support its implementation.

- The Commission should review the recommendations made by the submission to the inquiry by Suicide Prevention Australia and consider whether combining suicide prevention uniquely with mental health under the National Mental Health Commission provides the level of leadership and expertise that it needs because it is not uniquely a mental health issue.

4. Staged rollout of individual placement and support model

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to potentially all State and Territory Government community mental health services, involving co-location of IPS employment support services.

WAAMH wholly supports the draft recommendation to implement IPS across all Government community mental health services.

The rollout of IPS would allow Australians experiencing mental health issues access to equitable, sustainable and meaningful ongoing employment as part of their wellness and recovery journey.

In rolling out IPS across mental health services it is important to note that the services involved will need to be supported through an implementation phase to ensure the model is understood and accurately provided to the consumers in the service. Ongoing technical support, assistance with outcome data collection and evaluation via fidelity reviews should be a mandatory requirement to deliver the model to ensure adherence to and integrity of the model.

It would also need to be considered how IPS would be implemented i.e. via a partnership model with a Disability Employment Service (DES) or via an integrated model where the government community mental health employs a vocational specialist directly into their team.

An integrated funding model would allow for a vocational specialist to be employed directly into a clinical team and follow the core practice principles of IPS without any restrictions from an already existing employment service provider. An integrated service would allow a vocational worker to be solely dedicated to the role of IPS. It would mean the specialist could adhere to core practice principles and ensure the service was following zero exclusion as there would be no requirement for the consumer to want to work a minimum benchmark hours, nor be deemed eligible to work via a job capacity assessor.

The IPS vocational specialist is currently a very valued role within the mental health service, however, is also an incredibly fragile position reliant on DES provider adherence and funding. Having an IPS worker directly employed into the clinical team changes the landscape of community mental health services, highlighting employment as part of an individual's recovery journey and as a tool to recovery, creating financial freedom, opportunities for stable housing, and mental wellbeing rather than as an afterthought once someone is "well".

In considering this option it would be imperative that the federal government deemed participation in this service as meeting the requirements to continue to receive income

support payments rather than the consumer also having to be engaged with a DES or jobactive provider.

As such, employment of a vocational specialist directly into mental health teams is the preferred model. It could be funded via several avenues. For example, in Western Australia a preferred model would be the WA MHC restructuring current IPS funding. Instead of being an advocacy and promotion role to support community mental health services to take on IPS and then rely on a fee for service from the DES provider, the MHC funding could instead be directed to the independent reviewer providing the necessary training, technical support and fidelity reviews to successfully operate an IPS program. Additionally, the Department of Health / Health Service Providers could provide an in kind IPS coordinator which could sit under a community development role, as previously seen in the Stirling catchment. Finally, the Department of Social Services could provide funding for the vocational specialist role; this would be possible if some of the current funding for DES-ESS and DES-DMS was scaled back.

If a partnership model was to be undertaken which we have seen used in the community mental health setting an expression of interest to the local Disability Employment Service providers would need to be undertaken and a recruitment phase occur. It is important to note that often DES providers feel that the lower caseload numbers associated with IPS will reduce the income stream and affect star ratings. A recommendation would be to create a stream alongside the DES framework where a providers IPS program was funded and assessed separately to all other programs operating in their service.

In doing this it would be imperative that DES providers are subject to engaging with a specialist unit such as the IPS WORKS unit within WAAMH to ensure implementation support, ongoing technical advice was followed, outcome data collection was occurring and that the provider was engaging in independent fidelity reviews. This would ensure adherence to the model and allow the quality of outcomes creating a separate IPS funding stream would achieve to be clearly reviewed.

In either option it is imperative that an independent specialist IPS service such as the IPS WORKS unit within WAAMH be funded under the rollout to provide the direct expertise and support to facilitate implementation, the day to day operation of the program, technical assistance such as data outcome collection training and independent fidelity reviews.

4.1 Recommendations

- Implement IPS across all Government community mental health services via an integrated model where the mental health service employs a vocational specialist directly into their team.
- The final report recommend independent specialist IPS services be funded under the rollout to provide the expertise and support to facilitate consistent implementation.

5.Housing and supported accommodation

WAAMH endorses the Commission's recognition of safe stable housing and supported accommodation services as fundamental to prevention, recovery and wellbeing and an important condition for an effective mental health system.

In 2019, WAAMH completed a report for the WA MHC on barriers to supported accommodation access in Western Australia including discharge, transition, and flow through to lower level supported accommodation places and private rental. Our consultation with more than 200 consumers, family member/carers, public mental health service staff, and NFP service providers identified the issue is at crisis point, including in metropolitan areas but especially in regional areas.

The report, still in draft, outlined in depth a range of extensive and entrenched barriers to addressing these issues. These include:

- Inadequate supply of affordable social housing and private rental options
- Lack of investment in mental health supported accommodation options
- Limited data to assess and quantify need
- Fragmented service landscape
- Difficult access and entry points (wrong doors)
- Lack of consistency in program delivery, combined with a lack of data to assess program impact and effectiveness
- Service gaps particularly for young people, people with multiple unmet (complex) needs, Aboriginal and Torres Strait Islander people and people with co-occurring mental health and alcohol and other drug issues.

We welcome the Commission's proposal that State governments should commit to comprehensive mental health discharge plans, and services available in the community to meet the needs identified in the plans.

The Draft Report presents data (Draft Report, Figure 15.4, page 564) suggesting there is already sufficient supported accommodation services in Western Australia, however this is not supported by Western Australian data. The MHC 2019 Mental Health Inpatient Snapshot Survey[13] (p. 2) reported that 27.1% of consumers occupying mental health beds could be discharged if appropriate accommodation, usually with linked support, was available. This has repeatedly been identified as an urgent issue in Western Australia over many years, as a major contributor to longer than necessary hospital stays and readmission rates and is a current investment and development priority for the MHC. The final report should more accurately reflect the Western

[13] Mental Health Commission, 2019, *Mental Health Inpatient Snapshot Survey*, Available at https://www.mhc.wa.gov.au/reports-and-resources/reports/mental-health-inpatient-snapshot-survey/ (Accessed 24/01/2020).

Australian need for these services, outlined in the MHC's draft A Safe Place supported accommodation strategy, the 2019 Inpatient Snapshot and the Plan.

While we agree that state governments should close the gap in supported accommodation places and homelessness services, we are concerned about the lack of urgency this issue is given, reflected in the Draft Report's wording that governments should 'work towards meeting the gap', with the majority of the recommendations being placed in in the medium and long term, rather than the short term. In comparison, many recommendations have clearer wording and shorter timeframes, such as Draft recommendation 10.4 care coordination services. While WAAMH acknowledges that this may be due to the high cost of initial investment in these developments, it is short term thinking to push these investments out to later years and an example of where the Draft Report doesn't properly prioritise prevention, early intervention and recovery.

We also welcome the Commission's discussion of homelessness prevention and tenancy supports, including proposed reforms such as tenancy support schemes, reforms to private tenancy laws, review of policies governing 'anti-social' behaviour in social housing, and no discharge into homelessness.

The Draft Report's call for increased investment and Australian Government support across the range of programs and services needed are welcome but need to be more specific. As with prevention and community support, the Productivity Commission's principle that outcomes-based incentives or the clear presentation of pressure points and worthwhile investments will be sufficient to achieving increased investment in the range of services, supports and sector and workforce development required, is unrealistic. The Draft Report and proposed recommendations lack recognition of the range of entrenched historical, structural, budgetary and political imperatives that impede efforts to invest in tenancy support, social housing and mental health supported accommodation.

The final report should recommend stronger incentives, such as tying funding to consumer outcomes in housing and supported accommodation. Please see section 7.4 for more discussion on commissioning incentives to address these barriers.

5.1 Recommendations

- The final accord housing, homelessness and supported accommodation issues greater primacy and urgency with clearer language around this being a primary priority and include shorter timeframes for the recommendations.

- The final report recommend stronger incentives, such as tying funding to consumer outcomes in housing and supported accommodation.

- The final report include specific recommendations that require commissioning agencies to increase investment in supported accommodation services.

6. Balance the system towards community support

The Draft Report identifies, to some degree, the need for a shift towards community-based care, citing COAG:

> *COAG: The vision…is for a mental health system that: a) enables recovery; b) prevents and detects mental illness early: and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.* (The Draft Report, p.899)

This statement supports a shift towards earlier intervention and increased investment in lower cost community-based services. The Draft Report discusses psychosocial services and also includes a section on deinstitutionalisation and the limitations of what has been achieved:

> *However, there is widespread agreement that these [community based] alternatives failed to keep up with the pace of deinstitutionalisation. Rather than receiving the care they needed to live in the community, many people fell through the cracks, entering homelessness or the justice system (or both).* (Draft Report, Vol. 1, p. 544)

However, the Draft Report is limited in its description and analysis of community and psychosocial support and fails to make strong recommendations that would drive reform in this area.

6.1 A shift to community support

Community supports are person centred, recovery-oriented and should be developed in association with consumers to ensure design meets their needs. A holistic approach to care and integration of services can lead to good outcomes based on well-developed programs.

Across Australia and the world, communities, experts and governments agree we need to establish a new balance for mental health systems so that problems can be prevented, and people can find and access the support they need before reaching crisis point. International models demonstrate how to organise mental health services that respond to need where and when it is most needed, through increasing self and

community-based care, and reducing over-reliance on hospitals and specialist services[14].

The COAG vision - which includes community support - is supported by state, national and international policy which recommends a balanced system that prevents mental health issues, intervenes early when they occur and provides effective and adequate community support to reduce demand for hospital based and emergency department interventions.

To achieve the best outcomes, increased investment in community support is required. The Plan's optimal service mix would increase community support to 19% of mental health expenditure by 2025, up from 8% (2013).

6.2 Defining psychosocial/community support

A key problem with the Draft Report is that it conflates psychosocial and community support and contains no clear definitions.

The Plan describes community support as:

> *Community support services provide individuals with mental health, alcohol and other drug problems access to the help and support they need to participate in their community. Community support includes: programs that help people identify and achieve their personal goals, personalised support programs (e.g. to assist in accessing and maintaining employment/education and social activities), peer support, initiatives to promote good health and wellbeing, home in-reach support to attain and maintain housing, family and carer support (including support for young carers and children of parents with a mental illness), flexible respite, individual advocacy services and harm-reduction programs.* (The Plan, p. 36)

While the definition of community support outlined in the Plan is specified as being for people who have a severe and persistent mental illness, it is a broad concept based on the knowledge that recovery is possible and hope empowering. In contrast, the term 'psychosocial' is usually associated with supporting people with the impact of a disability, which is considered a permanent condition. In the context of the NDIS, the term 'psychosocial disability' has been widely criticised as being the antithesis of recovery-oriented support. A permanent disability connotes a narrower target group and a narrower system benefit.

This problematic conflation is reflected in the Draft Report which positions psychosocial support as a last option in its stepped care model:

[14] World Health Organization, 2018, *The Optimal Mix of Services: WHO Pyramid* Framework, Available at http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf (Accessed 19 October 2018).

> "***Even with the best clinical treatment***, episodic or persisting mental illness can result in the need for psychosocial and other supports, such as stable accommodation, income and vocational support, to assist the person to live as independently as possible in the community" (emphasis added).(Draft Report, Vol. 1, p. 25)

In recent years the two terms have increasingly become blurred and interchangeable. For example, the Draft Report describes both the past Personal Helpers and Mentors Service (PHaMS) and current Individualised Community Living Strategy (ICLS) as psychosocial supports. However, eligibility criteria for neither program (Mental Health Commission, 2018, pp. 4-5[15]) required evidence of disability, rather being based on support *need*. The interchangeable use of the terms, and perhaps their association with government commitments around mental health program changes and the NDIS, appears to be contributing to earlier and broader understandings of community support becoming lost.

There is a similar confusion of terms in relation to community support, community-based services and community treatment. In some data sets, community support means public mental health services delivered in the community (e.g. Australian Institute of Health and Welfare data); in contrast in the Plan these are called community treatment. Additional clarity of the terms used is required in the final report.

The Commission used the National Mental Health Service Planning Framework, which is a tool designed to help plan, coordinate and resource mental health services to meet population needs, to estimate the need to specific types of clinical and psychosocial support services needed (Draft Report, Vol. 1, p. 133). However, this data does not distinguish between public health service providers and NFP service providers and therefore the data is unhelpful in identifying the role of NFP service providers plays in the provision of services to meet estimated needs.

WAAMH is concerned that the Draft Report's lack of a clear definition of psychosocial supports will limit understanding of the system benefits of community support, the estimates of the numbers of people who need it and result in continued lack of strong recommendations.

A narrow need estimation risks perpetuating the same high bar for access currently in place under the NDIS, which has resulted in loss of services and reports of increased pressure on state funded community support services, which were already unable to meet demand. It might limit investment in community supports, restricting consumer choice and access. The benefits of community support as an earlier intervention to keep people living well in the community and reduce admission and readmission may not be

[15]Mental Health Commission, 2018, *Individualised Community Living Strategy Program Service Program Guidelines*, Available at https://www.mhc.wa.gov.au/media/2791/guidelines-individualised-community-living-strategy-guidelines-2018.pdf (Accessed 22/01/2020).

realised. This is the case in Western Australia, where limited access to community-based services has been clearly identified as a driver of high demand and long hospital stays (OAG Report).

This seems to be perpetuated in the Draft Report, which discusses the need to provide psychosocial support services for the "missing middle" in several places (e.g. Section 7.2), but also fails to put forward clear recommendations to address this need.

Additionally, the Draft Report positions psychosocial support as separate from mental health care and the mental health service system, despite national and international policy placing it as an integral part of an effective and balanced mental health system. This positioning risks exacerbating the siloed service approaches that the Draft Report rightly recognises as a significant problem.

6.3 The role of the not-for-profit sector

In 2009, the Productivity Commission undertook an inquiry into the role of the NFP service sector in Australia, recognising mental health as an area within which there was a strong NFP presence. The final report has not been published on its website, but the draft report identified the NFP sector as being cost effective, outcomes driven and innovative with "…improving efficiency and effectiveness in addressing social and environmental problems…" as core business for the not-for-profit sector. (Productivity Commission, 2009, p. 9.3[16])

It is disappointing that the Commission in its Draft Report has not also examined the important role that the NFP community support sector plays in the provision of services to consumers in any depth, except in the psychosocial and carer chapters. While it refers to several NFP driven programs, there is little discussion about the contribution the NFP sector makes to consumers more broadly and that with increased capacity, it could exponentially improve mental health outcomes in Australia by offering alternative models that address people's holistic needs, rather than such strong emphasis on the current failing clinical care model.

The introduction of the NDIS and resultant loss of services in some jurisdictions, along with weak market conditions for NDIS psychosocial services have contributed to a sector under strain and struggling with sustainability. While the recommendation to extend psychosocial contract lengths to five years is certainly welcomed, it is disappointing that the Draft Report appears limited to considering contracting mechanisms rather than examining sector sustainability in sufficient depth. An example of where this is evident in the Draft Report is in the lack of inclusion of the NFP workforce in the Commission's workforce recommendations. Strategic commissioning could enhance sector sustainability; this is discussed in section 7.3.

[16] https://webarchive.nla.gov.au/awa/20100123113249/http://www.pc.gov.au/projects/study/not-for-profit/draft (accessed 16/01/2020).

Poor commissioning and governance by commissioning bodies has meant that there isn't a clear national picture of the size and extent of the sector, the services it provides, and the outcomes attained. For example, the Commission cites an absence of publicly available evaluation of carer support programs run in Australia resulting in a lack of clarity as to whether the service mix here is effective and aligns with best practice (Draft Report, Vol. 1, pp.481-483). A lack of evaluation is also evident in other community supports, with some notable exceptions in employment and supported accommodation services.

6.4 Carers and family members

The Draft Report examines the current role of the NFP mental health sector in providing services to support carers, lists a range of services provided and cites a reference list of Australian and international studies that demonstrate the positive impact.

The Draft Report suggests that a substantial proportion of carers have unmet needs, and described participants responses to the inquiry identifying barriers to accessing carer support services, such as "…poorly coordinated services and fragmented funding, difficulties navigating service access, and insufficient funding and services available to meet community need (Draft Report, Vol. 1, pp. 485-486). The impact of the NDIS was also examined, and while new services have been commissioned the report expresses doubt that it is too soon to know if they will meet the needs of mental health carers (Draft Report, Vol. 1, p. 484).

As with community and psychosocial support, the Draft Report recommends that funding for services be allocated from State and Commonwealth Governments and that State and Territory Governments take policy responsibility for these services; (Draft Recommendation 23.2, Vol. 1 p. 103). However, it fails to recommend targeted funding to support this for research, development and evaluation of services to facilitate the innovation of contemporary service models and expansion of community support services for carers.

6.5 Governance, funding and innovation

WAAMH agrees that current roles and responsibilities for psychosocial/community support overlap, are unclear and require clarification. WAAMH supports the Draft Recommendation that the primary responsibility for psychosocial/community support lies with state governments yet remains concerned about the lack of detail in the about funding arrangements. To date, funding has been a shared responsibility with both levels of government significantly under-investing in these kinds of services.

Without this specification, a continuing underinvestment in community and psychosocial supports is likely; a lost opportunity for enhancing mental health outcomes and productivity benefits. This is discussed further in section 7.5 regarding funding.

The Draft Report lacks detailed recommendations for community support, in contrast to other sections, such as carers and families where detailed recommendations are present. WAAMH's understanding is that the Commission has identified a lack of data and evidence on which to base recommendations; this presents an opportunity for the Commission to recommend ways in which governments, commissioning bodies, researchers and service providers can and should build the evidence base.

This highlights the need for the commissioning bodies set clear outcomes targets, evaluate the services they commission and shift reporting requirements from metric measures of hours of activity to outcomes. This shift requires adequate funding for reform of commissioning practices and sector development to acquire and apply sound evaluation tools and to work alongside consumers as trusted partners in the establishment of these mechanisms.

New kinds of funding arrangements and innovation mechanisms are needed to foster the genuine shift to community supports in ways that meet consumer needs:

> *This kind of service needs to be organised and funded locally, and to conform with the evidence supporting interdisciplinary, integrated care. This will need new models of funding, beyond the existing fee-for-service arrangements, which exist under Medicare, probably with providers working in new collaborative organisations. Most of all, this kind of new thinking needs local, real-time feedback on consumer and carer mental health outcomes, to monitor and shift resources to better reflect individual and local needs.* (Rosenberg, 2019[17]) https://www.smh.com.au/politics/Commonwealth/latest-mental-health-productivity-data-reveals-scale-of-reform-ahead-20190208-p50wlz.html, accessed 9/12/2019)

6.6 Recommendations

- The final report recommend stronger incentives, such as tying funding to consumer outcomes in housing and supported accommodation.
- The final report include specific recommendations that require commissioning agencies to increase investment in supported accommodation services.

[17] Rosenberg, S. 2019, *Latest mental health productivity data reveals scale of reform ahead*, Available at: https://www.smh.com.au/politics/federal/latest-mental-health-productivity-data-reveals-scale-of-reform-ahead-20190208-p50wlz.html (Accessed 12/12/2019).

- The final report include greater clarity about what community and psychosocial supports are, who would benefit, the system impacts, and the funding required to achieve these.
- The final report include community and psychosocial support earlier in a stepped care model, to incorporate it as a complementary support, a support in its own right, and in recognition of its role as preventing and reducing the need for sub-acute, acute, emergency mental health and/or forensic and justice services.
- The final report explicitly recommends increasing funding for psychosocial and community supports to meet the needs of the missing middle and consumers with severe and persistent mental health issues, and to ensure adequate and equitable access across all regions of Australia, rather than relying on incentives for commissioning bodies.
- The psychosocial, community support and peer workforces are included as priority workforces for development in the final report's workforce initiatives.
- The final report recommends mechanisms to build a stronger evidence base for community support, through innovation initiatives, research, co-design labs, stronger outcomes-based reporting and evaluation of existing programs.

7. Governance, commissioning and consumer leadership

7.1 Clarity and responsibility

WAAMH welcomes the Draft Recommendation 22.1 to develop a National Mental Health and Suicide Prevention Agreement. Noting that previous strategies and COAG agreements have failed in implementation, clear governance responsibilities and transparency will be required particularly to resolve interface challenges with state agencies such as justice and housing.

We note that the lack of clarity for responsibility for psychosocial and community support remains an impediment to progressing reform and improving access, which the Draft Report acknowledges and should be addressed in the proposed Agreement.

We further note that local governments have a significant role in creating inclusive communities, suicide prevention, stigma reduction and linkages to services. In Western Australia local governments are legislatively required to develop local public health plans to support improved health outcomes for their communities, with consideration of mental health (WALGA)[18]. Their role should be considered in governance arrangements and the development of new mental health and suicide prevention agreements, along with the requisite resourcing.

7.2 Consumer leadership

We particularly welcome the inclusion of consumers and carers as key partners in developing this agreement and in the development of other processes and activities such as agreed mental health outcomes by COAG. Recommendations for contractual mechanisms to strengthen the contract stability of peak bodies and reporting mechanisms to improve funding transparency are welcomed. However, the Draft Report does not identify sufficient mechanisms to build consumer and carer capacity to powerfully engage in coproduction processes and to inform the policy and system design also recommended in the Draft Report.

[18] Western Australian Local Government Association, *Public Health Advocacy Plan*, Available at: https://walga.asn.au/Policy-Advice-and-Advocacy/People-and-Place/Health-and-Wellbeing/Public-Health (Accessed 24/01/2020).

WAAMH recommends additional specific mechanisms for building consumer and family member/carer capacity be identified in the Final Report including clarification of which government is primarily responsible and the development of capacity building programs, tools and frameworks including training and leadership development. A Centre of Excellence is one mechanism that could be funded to innovate, trial, research and evaluate what works to advance consumer and family member/carer participation, codesign and coproduction. This Centre of Excellence could also drive focus on developing and expanding the peer workforce and conduct innovation trials to test and evidence best practices for developing and including peer support in a range of service environments, measuring the impact of mental health outcomes.

7.3 Commissioning authorities

WAAMH supports the Commission's starting point that commissioning authorities should hold all funds to improve continuity of care and create incentives for earlier intervention. Additionally, as the Draft Report points out, effective interfaces with physical health, housing, education and justice are critical to improving mental health. While there are some interfaces that are with Commonwealth government, most notably income and employment and the NDIS, most of the interfaces are with other state agencies.

The Commission proposes the 'rebuild option' (the Draft Report's preferred option for mental health system commissioning):

> *The 'rebuild option proposes that most mental health funding is held in regional funding pools controlled by each State and Territory Government under arrangements approved by the COAG Health Council and administered by Regional Commissioning Authorities (RCAs). The purpose of the RCAs is to create a seamless mental healthcare system that offers continuity of service and fills gaps in service provision. RCAs would overcome unnecessary and inefficient care discontinuities, duplication and gaps that would otherwise persist between Australian Government and State and Territory Government responsibilities.* (Draft Report, Vol 1. P.199)

The Commission is not entirely clear on what it means by 'Regional' Commissioning Authorities. WAAMH supports the current commissioning context in Western Australia with a central State Government commissioning body so if this aligns with the rebuild option then WAAMH supports that option and the notion that a single State based authority be responsible for the commissioning of all State and Commonwealth funded mental health services.

Greater clarification on how these commissioning bodies would link with and report to the proposed strengthened role of the National Mental Health Commission and to COAG should be provided in the final report.

As such, broadly WAAMH supports the Rebuild model to develop or retain and strengthen regional commissioning bodies, provided this model retains and strengthens the WA Mental Health Commission.

We do not support the Renovate Model of embracing current cooperation efforts between Primary Health Networks and Local Hospital Networks/Health Service Providers. PHNs hold only a very small proportion of mental health budgets and have no direct authority over, and little experience of state funded mental health services. To develop this expertise and authority is a significant task and one that we would be concerned would hold back reform. Current efforts by PHNs to develop Joint Regional Plans highlight the limitations of a minor commissioning body influencing a much larger commissioning body and Health Service Providers, and the ways in which the commissioning structure retains and potentially reinforces existing siloes in mental healthcare.

7.4 Commissioning incentives

The Draft Report's assumption that the benefits of investment in earlier intervention will be a sufficient incentive to commissioning bodies is not evident in Western Australia, where spending on acute services has increased significantly, while investment in prevention and community support has gone down. Current resistance to changing the service mix is evident in some stakeholders, with recent efforts in Western Australia to seek return of mental health budgets to health departments. The strategic approach needed to turn the system around is not aligned with government terms and requires solid bipartisan support and long-term commitment.

Funding arrangements that tie commissioners to a balanced system are required. These could compel commissioning bodies to evidence their investment in the suite of services that comprise an optimal and balanced system, evidence outcomes rather than activity, and report in much greater detail to improve transparency. Outcomes should be focused on consumer and family member/carer recovery and wellbeing (e.g. community inclusion, employment) and system benefits (e.g. contracted to deliver outcomes of reduced demand for hospital services) and must be coproduced.

7.5 Funding arrangements

We would like to understand more about the suggestion that funding be linked to Medicare funding per person on mental health services across Australia. We are concerned that basing future funding on current usage in areas where services are extremely limited and service access is lower would be a problematic approach to rural and remote service delivery and funding. As outlined in earlier section on psychosocial and community support, funding should be based on need rather than current service access. A future funding formula must account for the additional costs of rural service

delivery, as evidenced in various reports on the NDIS including salary and living costs, transport, infrastructure, lack of other series to connect to, distance etc.

7.6 Recommendations

- The final report recommends specific mechanisms for building consumer and family member/carer capacity including: clarification of which government is primarily responsible; the development of capacity building programs, tools and frameworks including training and leadership development; and the establishment of a Centre of Excellence to develop, implement and evaluate initiatives.
- The final report recommends the rebuild model for commissioning authorities, with funding to be controlled by a commissioning body at the State or Territory level.
- The final report recommends funding arrangements that tie commissioners to investing in a balanced system and improved outcomes. These could compel commissioning bodies to evidence their investment in the suite of services that comprise an optimal and balanced system, evidence outcomes rather than activity, and report in much greater detail to improve transparency.
- The final report's funding formula account for the additional costs of rural and remote service delivery.