How do you Measure a Contributing Life?

Australia's First National Report Card on Mental Health and Suicide Prevention

Speech to the National Press Club, Canberra, 1st August 2012

By Professor Allan Fels AO

Chair, National Mental Health Commission

It's a great responsibility to be the Chair of Australia's first National Mental Health Commission. In fact it's the greatest responsibility I've ever had and let me tell you why as both an economist and carer.

This is important business.

Mental illness can have a devastating effect on individuals and families – I know – and, while I believe that Australia has a good health system by international standards, it has two profound weaknesses: mental health and Indigenous health, to which mental health is a very significant component. Mental health needs to be a higher priority for governments and the community at all levels.

The National Mental Health Commission is a new, independent body established to tell the truth about mental health services in Australia – the good and the bad, the gaps and the shortcomings. And it's of great significance that we are located in the Prime Minister's portfolio. The Commission is the first of its kind to have a national whole-of-government scope, and a whole-of-life view – from health to employment to housing to stigma and discrimination. This signifies a commitment at the highest level to our mandate, hopefully ensures we meaningfully engage with COAG on its Ten Year Road Map for Mental Health and gives us an opportunity for the Commission to provide independent advice, showcase successes and make a case for improvement to the highest level of government.

Most of us value our health and wellbeing and that of our families and loved ones above all else. And I include in wellbeing – economic wellbeing.

However, there is no health and wellbeing without mental health. And there is no mental health without a view of the world that is wide and inclusive.

You don't achieve mental health by relying only on the health care system. I know that both intellectually and in my heart, as I'm the carer of my daughter who has schizophrenia. I've seen up close the impact of mental illness on the material basics of life that many of us consider as fundamental - perhaps even as human rights - such as accommodation, education, employment and social connectedness.

You can't achieve effective investment in mental health and wellbeing without your starting point being the person with mental illness and those around her or him. We're talking about all of life – end to end and side to side.

And that's enshrined in the National Mental Health Commission.

I sometimes wonder if people get what is really meant by this whole of life approach. Because it's essential, evidence-based and, I believe, indisputable.

I'll use schizophrenia as an example although labels in mental illness don't matter as much as outcomes.

There is a myth that people with schizophrenia don't recover.

They *do* recover: in fact anywhere from 20-40% live fulfilling lives, often with jobs.

But a focus on just the health care system gets you only so far:

Medications for people with chronic psychosis have made a huge difference. They reduce disordered thinking and harm very significantly, and make it easier for people to live in the community, but medications by themselves don't affect recovery rates much at all - and by recovery I mean people leading the lives they aspire and wish to.

How come?

Well, it's because no drug or hospital bed is going to repair people's lives – the isolation caused by this condition, the demotivation and the potentially crippling loss of social skills.

For recovery to occur, you need somewhere decent, stable and safe to live, you need education and rehabilitation, you need physical health and ideally you also need a job. And while I chose schizophrenia as my example, this multi-faceted approach is true for major depression and bipolar disorder.

Those are tasks for every part of government not just the bailiwick of the Ministers for Health and Mental Health. And that is why we urge COAG to

develop its promised Ten Year Roadmap for Mental Health with meaning, direction, commitment and accountability.

Mental health conditions are the third leading cause of burden of disease in Australia. They are the leading burden of disease for women, and suicide is the tenth leading cause of death for men. And it is worse in Aboriginal and Torres Strait Islander communities.

This devastating impact on individuals and our society, culture and economy means we must realign our thinking, ask more of non-health sectors and at the same time better integrate service and support systems.

The establishment of the Commission on 1 January 2012 marked a major shift in the view of mental health and suicide prevention. The Commission's job is to observe, listen and then – with *fierce* independence – report and advise on what needs to happen – based on the lived experience of consumers, carers, families and the community.

My fellow commissioner Janet Meagher puts it well:

> *"People with mental health problems," she says, "want the same things as everyone else. Even the most disadvantaged should be able to lead a 'contributing life' – whatever that means for them – and this simple goal will be our touchstone and yardstick."*

When I talk about a “contributing life”, it is what I hope for my daughter Isabella. I think of a life where people can do satisfactory and potential activities, participate in work if appropriate, take part in family, develop relationships and achieve a good proportion of their potential.

But how can you have a contributing life if you’re in poverty, isolated and struggling to re-learn social skills - despite wanting to work or do a satisfactory activity?

Be under no illusion – if you’re unemployed for a long time - you and your children are either poor already or will become poor. Many people with mental illness in Australia want to work but find themselves less likely to find a job.

The personal and national economic impact of mental health conditions is enormous and, to a large extent, preventable. There’s no amount of welfare that can replace the economic impact of having a job. Work integrates us into the community; work drags us out of poverty; work gives us independence; work helps to define us, and having a job contributes to the productivity of the nation.

Employment, in my view, must be judged as a prime outcome of our investment in mental health.

Preliminary research shows that Australian businesses lose over $6.5 billion each year by failing to provide early intervention and treatment for employees with mental health conditions.

A conservative estimate from the International Labour Organisation puts the cost of mental ill health at 3-4% of gross domestic product in the European Union and there is no reason to assume we're different.

A new report by the Inspire Foundation in Australia has found that mental illness in young men costs the Australian economy $3.3 billion a year.

According to a US study, workers with a mental disorder have a 50% higher likelihood of involuntary job loss, and a 30% increased likelihood of voluntary job-quits.

Let's take the mining industry as an example.

An estimated average of between 8,000 to 10,000 employees in the mining industry experienced a common mental health illness like anxiety, depression or substance abuse over a 12 month period and that's spread across all mining employment categories, from managers and professionals through to machinery operators and drivers.

Estimated costs to the industry including lowered productivity are between $320 million to $450 million per year.

And the mining industry is not alone.

Recently, we've seen reports about mental health within the legal profession, among teachers, young doctors, nurses, members of the

media, members of the defence forces, veterans, footballers, refugees, to mention but a few.

The solutions include more knowledge in the workplace about mental illness and less fear and stigma so that people in distress can be helped as quickly as you'd expect with a physical illness.

We believe in, and act on, prevention and early detection in heart disease and diabetes - why not mental health conditions?

Groups like beyondblue and Sane Australia have innovative workplace programs but we need every workplace to be supported.

Adequate, timely and well integrated supports will require co-operation and coordination – at different times and in different ways – of employment services, health services, education institutions and benefit authorities.

Given that the majority of people with mental ill health are in work - a lot more needs to be done to ensure that workers retain their jobs. It comes back to the crucial role of good-quality jobs, good working conditions and, in particular, good management.

Data shows that job discrimination based on a person's mental health still occurs, meaning it's harder to get a job and harder to keep one.

This is a measure of our wellbeing as a nation.

There are places in the world where they achieve higher employment rates for people with mental illness than we do. According to the OECD for instance, Switzerland achieves a 66% employment rate for people with serious mental illness whereas we're down at 48%. That is significantly fewer Australians being productive, feeling fulfilled and who have more money in their pockets and are more self reliant.

The potential for persons with so called "common mental disorders", episodic depression for instance, to get and hold jobs and be more productive in the workplace is even greater – it is immense.

I can announce that we intend to hold an Industry Leaders' Roundtable to share our views and seek solutions. I have already held productive discussions with the CEO of the Business Council of Australia, the CEO of the Council of Small Business Organisations of Australia (COSBOA) and others about how we might collaborate to trigger more attention to this matter.

To sum up on this point, the area of the employment of person's with mental illness is capable of great change. Business leaders – and agencies like Treasury – are very interested in seeing how real innovative and productive change can be achieved.

This example of how we can act as a catalyst for positive change is just one of several set out in our new, three year *Strategies and Actions* document – which I'm pleased to announce - is today live on our website.

How can you have a contributing life without a home?

People with mental health problems are far less likely to be homeowners and far *more* likely to live in unstable environments. A SANE Australia survey found that 94% of respondents with a mental illness had been homeless or without suitable housing at some point.

This is something I know a lot about given the difficulties my daughter has had finding stable accommodation.

Haven

Let me tell you that story briefly. In 2003 following the ABC TV Australian Story program about my daughter's schizophrenia (a factor in my retirement from the ACCC), a group of carers, including my wife, got together concerned about finding secure and stable accommodation for their children, all of whom suffered from high impact mental illness, all very vulnerable, that required them to have support, care and accommodation on a long term basis even beyond the time we could care for them.

We approached the Catholic Parish of South Yarra which had a disused convent. Instead of selling the valuable property for a high price, that parish provided the convent at very low rent as part of its social commitment. These carers (all of them women incidentally) then drew up a

model of accommodation, care and support. I know my way around government better than many and, after much negotiation and some pressure, our project received generous housing funding and generous and adequate staffing funding from the Victorian Government. Even with my heavy personal involvement, the process took 8 years.

It is really hard for most people; both to get the resources and to break through the many hurdles there are, to involve families and carers properly.

Most people could not possibly have achieved this outcome yet the outcome has been one that meets a really important unmet need in our community. We have 14 people who will otherwise be in hospital or high intensity care or, at the other end of the spectrum, homeless or in temporary accommodation before relapse and reentry into hospital, at the Haven. We have a very high degree of family, carer and consumer involvement in the conduct of the management of the unit which we do in conjunction with the Prahran Mission. There is a huge waiting list.

Isabella was lucky that I was able to raise money for special housing. But that is a one off solution and not a system wide answer. Housing authorities and governments need to do more than provide indifferent hostels where people languish without hope.

Housing is in the Commission's sights as a core right and a critical foundation for recovery.

How can you have a contributing life if you're physically unwell and die young?

The physical health of people with mental illness is a scandal that receives almost no attention. According to research from the University of Western Australia and other evidence, the life expectancy gap is around 15 years at least. That is, people with mental illness live 15 years less – maybe 20 years less – than the rest of us. We die in our 80s, they die in their 60s.

Suicide is only one cause, not the main one. People are dying young of heart disease, cancer and diabetes.

People with serious mental illness have 2.5 times the risk of developing cancer than the general population. This is probably due to late diagnosis and/or lack of access to treatment.

There is a significantly higher risk of heart disease in people with schizophrenia than the general population. In other words they are more likely to get heart disease and less likely to be treated for it.

Depression according to some cardiac researchers is as potent a risk factor for heart disease as cholesterol. Stress is a significant risk factor for heart attacks.

It works both ways: mental health services may be ignoring physical illness or attributing it to mental illness symptoms and tolerate high levels of

smoking and unhealthy lifestyles; while GPs and others may not be attending to the physical needs of their mentally unwell patients.

There are many reasons as I just said, but the health care system is perfectly capable of stigmatizing people with mental illness. The result can be that people with severe mental illness metaphorically or literally are put in the corner to die. This is often called the overshadowing effect. If I see a health professional about my illness, it is treated. If I am perceived by that professional person to be mentally ill, this overshadows their view and causes them to discount, down play or not treat the illness

This is an area that the Commission intends to illuminate and understand better.

How can you have a contributing life if you want to take your own?

Suicide is an important part of our brief.

Suicide – at least according to officially reported statistics, which the ABS states, are under-estimates - represents a quarter of male deaths between the ages of 15 and 40 and 20% of female deaths in their early 20s. Scandalously, we don't know the true rates in Aboriginal and Torres Strait Islander communities but it is at least 2.5 times higher. And for every completed suicide, there are up to 50 attempts.

Suicide is complicated and not always directly related to mental illness. Dislocation, drug use, isolation and discrimination all play a role.

Obviously they all play a role but we shall be trying to understand what is happening and the reasons – again building up from the community and individual stories.

The Commission's job is to observe, listen and then report and advise on what needs to happen.

It isn't there to fix things itself.

That is the job of us all: State, Federal and Territory governments, non-government organisations, the professions, the community, the education sector and employers. We are – and this is deliberate - a small agency which doesn't hold funds. We're there to shine a light on what is working and what isn't and indicate and influence better directions.

We are also not the usual group of bureaucrats that make up a Commission. There are two family members, one person with lived experience, a welfare provider from an NGO, an indigenous psychologist and academic, a business woman with mental health interests especially concerning indigenous people, and two excellent professors and a former Health.

If you're expecting the National Mental Health Commission only to dump on the system, you're going to be disappointed. We shall point out and

celebrate the successes because they are the foundations for future improvements.

There is excellence.

The Commonwealth is funding Queensland and New South Wales to build on their experience of several years, to develop a nationally consistent service planning framework which could bring us closer to more predictable and uniform services for people with mental illness no matter where they live.

There are many laudable organisations – and you always hesitate to pick out a few, but I'll do it anyway - such as YouthReach in WA, The Personal Helpers and Mentors Program - PhaMs, the Housing Accommodation and Support Initiative in NSW and many others providing world beating solutions.

Australian researchers have pioneered online mental health services that are the envy of the world; where people can work at their own pace – with professional support – to learn how to deal with their difficulties; where the tyranny of distance and the fear of being seen walking into a "mental health service" in a small town can be overcome.

In beyondblue, we have a world leading organisation advocating and providing for people with depression and anxiety.

Professor McGorry and colleagues are world leaders in early intervention – another matter that needs high priority.

National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is very welcome. I have three comments:

- First, it is critical that it not only applies to persons with physical disability but also to persons with significant and enduring psychiatric disability. After some debate, the Productivity Commission recommended this and I believe the Government broadly supports this. It is a key need for the mental illness agenda. We are conscious there will be pressure to reduce costs by restricting the scope of the program. The NMHC will closely watch to ensure that current policy is maintained.

- Second, I welcome the bipartisan support for the NDIS. Obviously the big issue is the funding and resourcing. This problem needs to be resolved in one way or another. The NMHC has no views on the funding mechanisms but one must be found.

- Third, the NDIS at best covers only a small proportion of the population with mental illness. There are many other persons with mental illness outside the proposed NDIS who need care, treatment, support, accommodation, employment and other services.

Health Reforms

I want to now deal with an issue that can't wait till our first Report Card comes out.

It is about avoiding untoward consequences from National Health Reforms, chiefly the Activity Based Funding one.

Under the reforms the Commonwealth would soon be paying 50% of the increase in state and territory hospital expenditure. This will give states major incentive to move mental health into hospitals. This reverses the work of many years in which we have been trying to keep people with mental illness out of hospitals wherever possible and supported to stay well in the community. Years of effort in moving to contemporary and innovative practice threaten to be undone.

We believe it is better for people to be treated in their community, very often by excellent non-government organisations, with links to services such as rehabilitation, housing and employment, rather than in hospital beds in a clinical or hospital setting except in acute cases. They can also be with or near their families and friends. Costs are usually lower. This is a people centred approach that considers their whole life, not just health aspects.

The ABF focus on public hospital services also artificially slices up an ideal system of integrated, cross sector, community based support which should

focus on what the person wants and needs, not where the money comes from.

Moreover, there are claims in the mental health community that mental health spending already has an undue bias towards hospital spending. Especially where there are expenditure cuts, many believe the first thing to go is community services and the last thing to go is hospital services, causing further imbalance. All of this makes the reforms of great concern.

Our concerns are compounded by the national pricing system reforms.

Under Activity Based Funding, funding flows to hospitals on the basis of the average cost of each service. This works well for many health "transactions" such as a standard knee operation, where operating theatre and bed times and other costs are often standard and undebatable.

While the Commissioners broadly support the pricing reform agreed by the Council of Australian Governments – COAG – which tries to match dollars to need and demand and outcomes, we're worried about the application to mental health and you need to know about it.

First, it is unpredictable as to how long treatment can take. It may take a day, it may take 6 months. It is difficult to run an average pricing system in this setting. In addition, although a pricing system provides some powerful incentives for hospitals to work efficiently, there can also be some undesirable effects – undue pressure to get patients out of hospital quickly,

even in standard clinical matters, gaming, and so on. Those undesirable side effects can be magnified with patients with mental illness.

If governments get the design of Activity Based Funding and its associated pricing wrong for mental health, it could drive investment and activity back into hospitals – going against the trend of the last decades – and seriously undermine effective and efficient care.

This, I believe, isn't consistent with the spirit of the COAG agreement; with evidence based best practice models or the most efficient use of highly sought after mental health funds.

The Independent Hospital Pricing Authority has issued their pricing framework and do seem to have heard us, as have the Government, which is very gratifying and we are pleased to be on their mental health working group.

But we are still concerned about how this will roll out and will continue to be an active participant so that good decisions are made.

Our pushback on pricing and our willingness to work with governments for a better system is the first example of what a National Mental Health Commission can do uniquely.

Every Australian deserves to know how the 'mental health system' is performing and the contribution other sectors are making to people's lives.

Later this year the Commission will produce its first Report Card. It is a short timeframe from our inception but the careful development of the Report Card will help us to understand how Australia is meeting people's needs, creating a baseline to track performance year on year. Over time the Report Card will create a case for change and continuous improvement.

So here is the challenge: if you were in our shoes, how would you measure a "contributing life"?

We have a tonne of statistics on mental health and services in Australia. But they're numbers. They're necessary but say little about whether they've helped people with mental illness achieve the life they hope for themselves and their loved ones.

We've been asking a large number of people with lived experience: families and carers, workers at the front line of many industries, professional groups, bureaucrats and members of the general public, how they think we should be accounting for our efforts in mental health.

We've also been looking for hidden sources of data which might hold up a better mirror.

We've met with over 300 individuals and groups, done close to 60 detailed consultations with governments, services and professional and consumer groups.

We've performed a month-long, widely distributed and promoted on-line snapshot survey which has generated several thousand responses.

We've also done nearly 200 paper-based surveys, and I'd like to thank our partner, the Mental Health Council of Australia, for allowing us to piggy back on their own national roadshow to hand out these forms and obtain this input.

In the online survey, the majority either had personal experience of a mental health condition or worked in mental health.
Carers and family members accounted for 15% of online survey respondents. Three quarters of the respondents were female and over half were living with partners.

We've conducted large scale face to face consultations with groups of first responders, system leaders, Aboriginal and Torres Strait Islander peoples and community based organisations.

And here are some of our preliminary findings:

No matter who responded, the answers as to what mattered were remarkably consistent:

- Timely Access to high quality, integrated services;

- Reduced discrimination and increased community knowledge;
- Stable, permanent homes,
- A focus on recovery;
- Support for families and carers;
- Good employment (and remember employment is a good proxy for recovery);
- Overwhelmingly people want better social and emotional wellbeing.

It is easy to say how the system is to be judged. It is tough to figure out how to measure some of those things but we're already uncovering untapped sources of data.

Just one example.

We've found that a unique source of information is police and other 'first responders'.

They know how many calls they get to help people in crisis. The police know about these people's social and disability status, their lack of housing, low educational attainment and low income.

Police forces know how many officers are involved in each call-out and how long it takes them to find care for the person in distress.

There are a lot of police hours away from crime control and too many hours for people in mental anguish not gaining access to care. I hope the Report Card will publish data on this.

We intend to work closely with frontline workers in many sectors to see if their data can help illuminate aspects of mental health care in this country and also help build the case for smart investment in innovation and the things that work.

I can't say too often that the National Mental Health Commission believes that there is no substitute for reporting on the lived experiences of people with mental illness and the people around them. A major part of our Report Card will be stories from people themselves. We intend that this qualitative data will be a feature from day one, and to build its veracity over time through good research, meaningfully aggregated.

We convened 18 discussion groups with Australians in their own homes to talk about the issues of mental illness and suicide. They were held across the country in all mainland states and the Northern Territory, in capital cities and regional towns.

In addition to Anglo-Celtic Australians, the groups included people from all backgrounds including Indigenous people, first and second generation migrants, members of various CALD groups, gay, lesbian, transgender and intersex people.

Many of the participants afterwards expressed their thanks for being given ‘an excuse’ to talk about these issues. They believed that we need to make more space in our conversations with friends for these important issues. They felt that because we’re reluctant to have these conversations, we’re deprived of some of the most basic understanding of what mental health/illness really is. They reported that they’re unable to recognise symptoms in others as well as in themselves. What this suggests is that a good number of us may have difficulty knowing when to get help for ourselves as well as for others.

We have a pent up desire to talk about this issue and no shortage of personal experiences to share.

There is no point in providing services for services’ sake to make it look as though we’re doing something if people’s lives aren’t improving materially, psychologically and socially.

We are consulting with and listening to Aboriginal and Torres Strait Islander communities. They are telling us what is wrong, what is right and what is needed.

We will also hear from other groups that don’t have a sufficient voice, such as culturally and linguistically diverse, people who are severely ill, the homeless, children, youth and people who are gay, lesbian, bisexual, transsexual or intersex.

What I’ve given you today is a flavor of our thinking.

Our first National Report Card will be highly targeted to action and outcomes. Our sole purpose is to improve people's lives and experiences.

I've no intention of wasting my time, the time of my fellow independent Commissioners, or taxpayers' money on just another government commission.

The National Mental Health Commission is going to make a difference and if it doesn't, I'll be the first to call for it to be shut down.

But make a difference we shall, and that will be because we've kept true to our aim of grounding ourselves in the experiences of ordinary people whose lives have been affected by their or their loved one's mental health.

Thank you.

Australian Government
National Mental Health Commission

PROFESSOR ALLAN FELS AO
NATIONAL PRESS CLUB ADDRESS
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Unless otherwise stated, all Australian statistics cited in
NMHC Report of the National Review of Mental Health Programmes and Services

CHECK AGAINST DELIVERY

INTRODUCTION

I would like to acknowledge the Ngunnawal people who are the traditional custodians of this land on which we are meeting and pay my respect to the Elders of the Ngunnawal Nation both past and present. I extend this respect to all Aboriginal and Torres Strait Islander peoples in attendance today.

I also would like to pay my respects to people with lived experience of mental health issues, their families and other supporters. My topic today is: Time to aim higher and why mental health must be part of Australia's economic and social reform agenda.

The Commission completed a national review of mental health programmes and services last December.

The vision for our review is highlighted in the title – Contributing Lives, Thriving Communities. Our review is based on the Contributing Life Framework – a whole-of-person, whole-of-life approach to mental health and wellbeing. It recognises that if we enable people to live contributing lives – to have relationships, stable housing, and to maximise participation in education, employment and the community more broadly – we will help build economically

and socially thriving communities, and a more productive Australia.

Sadly, a contributing life can seem unattainable for people living with mental illness. The review found that Australia's mental health programmes and services are not maximising the best outcomes from either a social or economic perspective.

As an economist, I want to emphasise that mental health is a significant problem for our economy – as significant as, often more significant than, tax or microeconomic reform. Many people do not get the support they need, and governments get poor returns on substantial investment. The economic or GDP gains from better mental health would dwarf most of the gains – often modest ones – being talked about in current economic reform debates.

This is starting to be recognised internationally.

The world's leading economic commentator, the *Financial Times*' Martin Wolf, has concluded mental ill health is the developed world's most pressing health problem. He said:

> "Given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves."

Recognition comes also from *The Economist* magazine which has just published a special report on the growing incidence and costs of mental illness and the Economist Intelligence Unit has done the same.

From Davos, the World Economic Forum has warned finance ministers and economic advisers that they need to react to the 'formidable economic threat' posed by non-communicable diseases, including mental health disorders.[1]

The OECD estimates the average overall cost of mental health to developed countries is about four per cent of GDP. In Australia, this would equate to more than $60 billion or about $4,000 a year for each person who lodges a tax return or over $10,000 per family. The costs include the direct costs of treatment; the indirect costs e.g. disability support pensions, imprisonment, accommodation and so on; the costs of lost output and income and finally costs to carers and families, not to mention that their workforce participation is held back by caring demands.

Reducing this cost – even by a fraction – would generate sizeable gains. I'll come back to this.

Treasury looks at economic growth through the three Ps: population, participation and productivity. I will address each in turn.

POPULATION

The population affected is huge, with as many as 20 per cent of the adult population affected by mental ill-health in any given year. In fact, one in two Australian adults will experience mental ill-health at some point – this is 7.3 million Australians (aged 16-85). And the issue is greatest for our young Australians, those who should be participating in the education system and

[1] Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl, A.B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A.Z., & Weinstein, C. (2011).
The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum

embarking on their working lives. One in four 18-24 year olds experience a mental ill-health problem every year.

To reinforce the point about the size of the problem, I note that mental illnesses are the leading causes of the non-fatal disease burden in Australia – they account for about a quarter of the total burden. Mental illness also accounts for about 13 per cent of our total burden of disease (including deaths).

Unlike other diseases, a major impact of mental illness on our economy is due to lost income from unemployment and expenses to support an illness that begins when we're young and lasts many years – this is what makes this economic burden so great.

PARTICIPATION

Labour force participation is the second major variable in economic growth. The higher the number of people working, the higher the rate of economic growth. Mental illness is responsible for a very significant loss of potential labour supply and output.

Today 37.5 per cent of people affected by mental ill-health are either unemployed or not in the labour force. This compares to 22.3 per cent of people without mental health conditions. And our performance is low by the standards of the leading OECD countries.

The World Economic Forum estimates the cost of lost output and income as being about 1.75 per cent of GDP.

This is not good enough and there is a clear productivity cost. Many people with mental illness want to work but find it difficult to find a job, also impacting on families, carers and other support people. We need to provide better support for people living with mental illness to get into the workforce and stay in it, not only for the benefit of individuals, their families and support people but also for the benefit of the whole population.

There are many very specific measures that can be taken that would have a substantial economic impact. For example, specific measures to get young people from school to post-school education and employment; greater individual support for those in trouble; and other market mechanisms to encourage sustained employment and skill development during this period.

PRODUCTIVITY

The third variable is productivity. Mental ill-health generates considerable absenteeism and presenteeism (on the job productivity loss). Those with mental health difficulties are both more likely to take time off from work and to accomplish less than they would like to when they are on the job.

Mental health conditions result in around 12 million days of reduced productivity for Australian businesses each year.[2] And given one in six people in employment experience a mental health issue each year, even small businesses are likely to employ people with a mental illness, which requires proper support.

[2] PwC PricewaterhouseCoopers Australia, Creating a mentally healthy workplace: Return on investment analysis, 2014. Available from www.headsup.org.au

Mental health and wellbeing is recognised as a serious workplace matter. That's why at the Commission we have formed a collaboration with a very interested business sector, the mental health sector and government through the Mentally Healthy Workplace Alliance.

The Alliance is made up of important entities including the Business Council of Australia, the Australian Chamber of Commerce and Industry, COSBOA, Australian Industry Group, Comcare, Australian Psychological Society, Safe Work Australia, SuperFriend, the Black Dog Institute, beyondblue, Mental Health Australia, SANE, and The University of New South Wales.

To quote Jennifer Westacott, who chairs Mental Health Australia and is CEO of the Business Council of Australia, the business case for change in mental health is "not only morally and socially compelling, it is economically fundamental".

THE COSTS

Our Review identified that the direct costs of Commonwealth expenditure alone on mental health and suicide prevention programmes are about $10 billion a year (2012-13).

This gives rise to another set of important economic questions: the allocation of spending – is that expenditure effective and efficient?

- Are scarce resources being used cost-effectively to achieve identified objectives?
- Are decisions on what programmes and services the Commonwealth invests in resulting in maximising net benefits to the community?

From the limited evidence available, the Commission's view is that much of the funding from the Commonwealth is neither effective nor efficient.

An indicator of this is that a very large amount of spending occurs in downstream programmes engaged in income support and crisis responses, as well as in other benefits and activity-related payments – $8.4 billion or 87.5 per cent of Commonwealth funds is spent in five major programmes:

- Disability Support Pension
- Carers Payments
- Payments to the States and Territories for hospitals
- Mental health related Medicare Benefits Schedule payments (including Better Access)
- Pharmaceutical Benefits Scheme payments

Much of this is payment for failure, payment for failure to treat the problems early and cost effectively.

I believe this heavy expenditure could be reduced with a greater emphasis and investment in prevention, early detection, a focus on recovery from mental ill-health and the prevention of suicide.

THE REVIEW

Our Review – Contributing Lives, Thriving Communities – highlighted that mental health is not just an issue for governments. It touches every industry, every workplace, the vast majority of families and is everyone's responsibility.

We heard from many people with lived experience, their families and supporters, and people who work in the sector.

We found many examples of wonderful innovation and that effective strategies do exist for keeping people and families on track to participate and contribute to the social and economic life of the community.

Fundamentally, the approach we recommend calls for the system to be realigned from a focus on service providers, to a focus on people, where those with lived experience, their families and support people are engaged and involved at all levels —"nothing about us without us".

Central to this are person-centred design principles, where through an integrated stepped care model, services are designed, funded and delivered to match the needs of individuals and particular population groups. This involves a participative and inclusive approach, focused on achieving better outcomes for individuals, their families and communities – not on the role of providers and what activity they produce, though they are indispensable and valuable players.

Importantly, the right approach requires a holistic focus on people, taking into account all of their needs – their mental health and fitness, social and emotional wellbeing, physical health, and other determinants such as culture and a sense of belonging.

We need to shift the focus from downstream to upstream services – from income support and crisis responses, to early intervention, prevention and support for recovery-based community services, stable housing and participation in employment, education and training.

We have to catch people before they fall.

Our Review shows that we have a once-in-a-generation opportunity to create a system that will support the mental health and wellbeing of millions of individuals to enable them to live contributing lives and participate in thriving communities. What's more, the Review shows this is achievable and sets out a blueprint on how we can get there.

We have identified measures that will enable the Commonwealth to maximise value for taxpayers by using its resources as incentives to leverage desirable – and measurable – results.

We need to start that change now.

STEPPED CARE FRAMEWOK

Key to this is a stepped care framework as outlined in the Review.

This means that there is a range of options that vary in intensity according to an individual's level of need or functional impairment.

People's needs vary dramatically across the spectrum of mental illness. Of the 3.7 million estimated to have mental ill-health problems in any given year, the majority, or 3 million, have a mild to moderate condition, such as anxiety or depression.

Another 625,000 have a persistent complex and chronic illness such as schizophrenia or severe depression. And 65,000 people have severe illness and suffer from a psychosocial disability.

Stepped care services would range from no-cost and low-cost options for people with the most common mental health issues, through to support and wrap-around services for people with severe and persistent mental illness. It includes a greater range of services being available according to need and functional impairment – for example:

- a graduated range of services from self-help and prevention
- a strengthened primary health care approach
- non-clinical psychosocial support within the community, and
- a variety of options between specialised community mental health services and acute hospitalisation – for example, step-up/step-down services where, for example, people can leave costly hospitals and go to less restrictive accommodation with adequate levels of care
- more generally, we need to build community capacity and rely less on new hospital beds – in both the public and private sector.

The overarching aim is to enable all to participate as much as possible within their families and communities, and to lead contributing lives.

Easy to access service delivery models such as e-mental health have an important role to play in assisting people and those who care for them. This would in turn enable more cost effective use of the time and skills of clinical and other professionals.

A fundamental element of a stepped care approach is prioritising the delivery of care through general practice and the primary health sector.

International experience shows countries that have strong primary health care infrastructure have healthier populations and lower overall costs for health care than countries that focus more on specialist and acute care.

NEW SYSTEM ARCHITECTURE

Our report recommends new system architecture, with a focus on the needs of particular population groups.

In particular, it recommends a stronger focus on the early years and a healthy start to life, to build resilience in children and families, reduce childhood trauma which can have an intergenerational impact, and protect those who are vulnerable.

The most important years in a child's development are those that occur by the age of three.

We also recommend that agreement be reached on the respective roles of the Commonwealth on the one hand, and the States and Territories on the other. Our view is that the Commonwealth should focus on national leadership and programmes, and that their other key role should be in enabling a much better coordinated, joined up system at a regional and local level.

The current system is too fragmented and with too many siloed services, meaning that the more functionally impaired you are the harder it becomes to navigate the system.

PRIMARY AND MENTAL HEALTH NETWORKS

Right now, organisations are rolling out across the country that could spearhead this change to a more regional, localised approach.

For example, July 1 saw the formation of 31 Primary Health Networks covering the entire country. These provide the ideal architecture to better target mental health resources to meet population needs on a region by region basis.

We propose renaming these as Primary and Mental Health Networks and providing them with bundled funding for planning and purchasing mental health programmes, services and integrated care pathways for mental health that are tailored to individual needs and different communities.

We envisage these Primary and Mental Health Networks will engage with local services, with people with lived experience and with their families and support people to identify local priorities and local responses.

We see it as vital that mental health and wellbeing is identified as intrinsic to primary health care – Australia cannot take a person centred, holistic approach to better outcomes for individuals and communities unless we deal with both the physical and mental health of populations and people's overall wellbeing.

Some of the most disturbing findings of our review related to the physical health of people with a mental illness and in particular the failure of the system to recognise the physical clinical deterioration of people with a mental illness. Few people probably realise that people with psychosis die on average earlier than the general population with the causes being the side-effects of antipsychotic

medications, high, increasing rates of smoking and the fact that many people with a mental illness do not get good treatment of their physical illness.

SUICIDE

A good example of what we mean in relation to a regional or local approach is in the area of prevention of suicides and suicide attempts.

In our country seven people die every day from suicide, approximately double the road toll. But while the number of deaths on our roads has diminished substantially, there has been no major reduction in the suicide rate over the past decade.

In particular, death from suicide among Aboriginal and Torres Strait Islander peoples is twice that of non-Indigenous Australians.

There are excellent examples of suicide prevention, treatment, follow-up and postvention in Australia.

However too often services are not joined up, too fragmented, lack sufficient focus and operate from too small a resource base to achieve a meaningful impact.

A new approach is needed and there is some evidence about a range of strategies that work.

Suicide is not just about mental health and nor is it about any one sector. What we need are locally organised and properly coordinated or joined up responses to this major problem.

So we have proposed that the Commonwealth use its resources as incentives to drive the development of community partnerships which co-create solutions at a local level for suicide prevention. These partnerships should encourage buy-in (including financial or in-kind contributions) from local communities, including health services, schools, NGOs, businesses, local government, media, community organisations and clubs, and in particular from families and communities, to all play a part in developing local solutions which provide comprehensive strategies based on local knowledge.

And we want to commence this approach with 12 regions as the first wave of nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

REGIONAL CHANGES

We need to acknowledge diverse regions have different needs and to plan appropriately, and that there is significant regional variation in need, and in access to services and regional equity. A one-size-fits-all approach cannot be applied across metropolitan, regional, rural and remote Australia.

We need to think about the local health landscape and consider the prevalence of mental health concerns as well as demographic, environmental, socioeconomic, cultural and other factors.

A regional approach provides the opportunity to improve service equity for rural and remote communities through place-based models of care.

We know that the further away you get from major cities the harder it is to access mental health specific services.

Our view is that changing this will require national leadership combined with local responses.

On a per capita measure, for example, when compared to remote or very remote areas, major cities have almost four times as many psychiatrists, three times as many registered psychologists and twice as many mental health nurses.

Because access to Better Access services funded under Medicare is dependent on the availability of providers rather than demand for the service, people in rural and remote communities are less able to use services under this programme.

Although Mental Health Services in Rural and Remote Areas (MHSRRA) has helped improve the workforce situation, the service deficit in rural and remote locations remains significant and the lack of psychiatrists and psychologists is particularly acute.

The lack of rural incentives under Better Access appears to be an anomaly when compared with other programmes where there is a rural loading—for example, for GPs, practice nurses and mental health nurses**.**

We therefore have made recommendations for the Commonwealth to consider changes to the Better Access program that would encourage a more equitable geographical distribution of psychological services.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Finally, in recent weeks, we have seen news coverage that has further amplified areas of crisis in indigenous mental health, social and emotional wellbeing and suicide. In 2011–12, 30 per cent of Aboriginal and Torres Strait Islander adults had high or very high levels of psychological distress. That's almost three times the rate for other Australians.

In 2012–13, the annual suicide rate for Australians generally was 10.3 deaths for every 100,000 population – for Aboriginal and Torres Strait Islander peoples it was 21.4 deaths per 100,000.

The system as it stands is tragically ill-equipped to help.

This must change. Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing must become a national priority.

There is a strong Aboriginal and Torres Strait Islander presence which flows throughout our review recommendations, with many of the system changes we recommend expected to have a positive impact on Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing. However, there are two specific recommendations which I want to draw to your attention:

Recommendation 5: Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional CoAG Closing the Gap target for mental health:

- Establish a new and dedicated National Aboriginal and Torres Strait Islander mental health plan

- Implement the National Strategic Framework for ATSI Peoples' Mental Health and Social and Emotional Wellbeing 2014–2019, the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, National ATSI Suicide Prevention Strategy 2013 and National ATSI Peoples' Drug Strategy

What that Closing the Gap target should be needs to be worked out with the Indigenous community – it may be there need to be two, one on social and emotional wellbeing and the other on suicide prevention.

Recommendation 18: Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations, linked to Aboriginal and Torres Strait Islander specialist mental health services.

- Ensure through contractual performance requirements that general population mental health services are accountable for better Aboriginal and Torres Strait Islander mental health outcomes.

- Train and employ the Aboriginal and Torres Strait Islander workforce needed to close the mental health gap.

CALL TO ACTION

The Commission would like to thank the many in the mental health sector who have supported our reform plan, some of whom are in the audience today. We know we are a dedicated sector that wants to work collectively to make change happen.

Together, we are determined not to let this opportunity for change pass us by.

In this context, I want to quote from the response of the Mental Illness Fellowship of Australia to the Review report:

> "It's not perfect. We could argue with some of the detail. But our own experiences with mental illness and the mental health services tell us that it seems to be about right on all the big issues. Most importantly, it gives us all a framework that we can get started on as the first part of a ten year plan. Let's argue the detail **after** we get started on implementation."

Whether we measure the cost of mental illness in terms of individual misery or the burden it places across society, it is clear we are currently paying too high a price for a system in urgent need of reform.

We have had successful reform programs in the past. The National Competition Reforms that kicked off in the mid-1990s and took ten years are credited with a two per cent improvement in GDP.

If we can improve the mental health system by 25 per cent, we can deliver a 1 per cent improvement in GDP. That would be a huge contribution. To put it another way for every 10 per cent gain in mental health, GDP would rise by 0.4 per cent.

There is much scope for addressing the three Ps of economic growth – reducing the impact of mental illness on a large population; improving participation; and improving productivity at work.

In fact, as I hope this address and our report makes clear, there is immense scope for significantly reducing the high costs of mental illness and improving

the outcomes for individuals whose quality of life can be so damaged by mental illness. In short, the costs of mental health to the economy are high. They can be greatly reduced.

I get some comfort from the fact that, at last month's leaders' retreat, the Prime Minister and the State and Territory leaders agreed to focus reform on health, education, infrastructure and housing.

When it comes to chronic care, they recognised that mental health requires particular attention and included a new focus on primary care and keeping people out of hospital.

We welcome this recognition and urge our political leaders to continue to look beyond health costs to the full burden of mental illness in our society and to give mental health the priority it needs.

So let's set in place a world-leading mental health system while we have that appetite for change. It will pay dividends for decades and generations to come.

It will not only improve the lives of many individuals and families. It will make us a more productive society, reduce the numbers of those in need of support, increase the numbers of those who are contributing and help secure future economic growth.

The Commission delivered on time last December a major report with major reform proposals based on the fullest consultation.

Government – and that includes State Governments – needs to act on it as soon as possible to demonstrate commitment to the millions of people in the mental health sector.

Australian Government
National Mental Health Commission

Professor Allan Fels AO
National Press Club Speech
Tuesday 25 July 2017

Good afternoon.

I acknowledge the Ngunnawal people, the traditional custodians of the land and pay my respects to their Elders past and present.

I'd also like to pay my respects to people with lived experience of mental health issues, their families and other supporters.

I also thank the National Press Club for its continuing support for speakers about mental health.

Mental health is the weak point of Australia's generally good health system. Today I am going to talk about one of the more visible, and, to a degree, fixable parts of mental health - the poor physical health and wellbeing of those with mental illness.

And in doing so on behalf of the National Mental Health Commission, I am proud to launch *Equally Well – the National Consensus Statement on improving the physical health and wellbeing of people living with mental illness,* a statement of over 50 major organisations concerned with mental health.

About the NMHC

A quick overview of the National Mental Health Commission.

It plays a key role in mental health reform in Australia.

How?

First, we monitor and report on the performance of the mental health system.

Second, we engage with all stakeholders in the mental health system (especially people with a lived experience and their carers).

Third, we also provide advice to the governments and the community, particularly about evidence-based ways to improve outcomes for people living with mental illness.

I'd like to single out two significant contributions the National Mental Health Commission has made:

- First, it has promoted the concept of a contributing life. Essentially, this asserts that people living with a mental health difficulty should be able to expect the same rights, opportunities and health as the wider community. Simply put, it means having a stable and secure home (not a temporary one), meaningful work, opportunities for education and training, good healthcare and support when needed, and connections to family, friends and community, all without experiencing

discrimination due to having a mental health problem. In short, it embodies a life where people with mental illness are thriving, not just surviving!

- This concept highlights the need for a whole of government approach to reform – that is, reform cannot just come from within health departments alone, or housing departments, or employment or education departments for that matter. Rather, to achieve the contributing life vision, we need a wider approach - a whole of government approach - to the strategy and governance of reform. Sadly, that is not what we currently have in Australia. We need to have an approach at national and state level that involves all parts of government not just health departments. We need leadership from the top.

- Second, in 2014 the Commission reviewed the mental health system as a whole. We found that whilst there is a substantial level of investment in mental health related services in Australia, the service system is fragmented, siloed, hard to navigate and with too little spent on investment and especially on prevention and early intervention

- In 2015, the government announced major mental health reforms drawn from our recommendations.

- These reforms aim to fundamentally change the way services are planned and delivered, and focus on delivering a more person-centred, locally-based, stepped-care approach to mental health and suicide prevention services.

Reflecting the value they place on the role of the National Mental Health Commission, the Coalition Government made a commitment prior to the last election that it would strengthen the Commission. We look forward to an announcement about that - I believe it is imminent.

The need to embrace *Equally Well*

Today, I want to discuss the physical health and wellbeing of people living with mental illness.

It's shocking that even now – in the 21st century - with all our capabilities and one of the best health systems in the world - people with a mental illness have poorer physical health outcomes than those without mental health issues – particularly those with a chronic mental health condition.

What is most distressing is that, on average, people with a serious mental illness die younger – between 14 and 23 years earlier – than the general population.

And of great concern the gap seems to be widening rather than narrowing over the past three decades.

There are some alarming statistics to consider.

Firstly, four out of every five people living with a mental illness have a co-existing physical illness.

Compared to the general population, people living with mental illness are:

- two times more likely to have cardiovascular disease;
- two times more likely to have respiratory disease;
- two times more likely to have metabolic syndrome;
- two times more likely to have diabetes;
- two times more likely to have osteoporosis;
- 65% more likely to smoke; and
- six times more likely to have dental problems.

They comprise around one third of all avoidable deaths.
People living with severe mental illness are particularly at risk.

They are:

- five times more likely to smoke;
- six times more likely to die from cardiovascular disease, even if aged between 25 and 44 years;
- four times more likely to die from respiratory disease;
- more likely to be diagnosed with diabetes or have a stroke under the age of 55 years;
- 90% more likely to be diagnosed with bowel cancer if they have schizophrenia; and
- 42% more likely to be diagnosed with breast cancer if they have schizophrenia.

Why do people with mental health problems have poorer physical health and excess mortality?

It is not suicide – it only makes a small contribution.

Medications can, in many instances, lead to weight gain, obesity, cardiovascular disease, metabolic syndrome and type 2 diabetes. Often no action is taken to actively prevent or manage these damaging side effects despite clinical guidelines to the contrary partly because it is unclear who is responsible – the physical or mental health people.

Poor access to services also contributes. That can be due to a lack of knowledge or ability or motivation to locate or access or travel to appropriate services. New models of proactive integrated screening and health care would address these concerns.

Affordability of high out-of-pocket costs can also limit access to screening, investigations, medication or other prescribed treatments.

Stigma and discrimination which is still widespread, particularly towards those with serious mental illness, can also discourage an individual from seeking help.

And health professionals still all too regularly demonstrate stigma and discrimination against those with mental illness - by ignoring them or by dismissing or diminishing the symptoms they report, by not investigating as frequently or by not treating as assertively as they otherwise might if the person did not have a mental illness.

There is so called ‘diagnostic overshadowing’. In simple terms if I have a sore back then I am taken more seriously than a person with mental illness with the same complaint with the consequence

that physical conditions can go undiagnosed and untreated which can prove fatal.

The quality of care can also suffer because health professionals do not feel comfortable in knowing how to relate to persons with mental illness or how to explain treatment options or medications in a way that maximises understanding and compliance with treatment.

Adding to that, physical health teams may struggle to help people with mental illness whilst mental health professionals may not pay enough attention to physical health care.

Of particular concern is evidence of the inequalities in access to treatment in some of the most critical areas of health care, with individuals with schizophrenia at most disadvantage. For example, some patients with serious mental illness and diabetes are less likely to receive standard levels of care for their condition, just as patients with mental illness and cardiovascular disease are the least likely to receive specialised interventions and some medications. This differential can extend into the surgical realm as well, with studies demonstrating that people with serious mental illness have higher rates of postoperative complications and higher postoperative mortality.

So called ‘health risk behaviours’ are particularly high amongst those with mental disorders. Known risk factors such as smoking, alcohol and drug use, poor nutrition, higher sedentary behaviour and lower levels of physical activity contribute to poorer physical health.

We know that when someone with a mental illness smokes, there is often no effort made to encourage them to stop smoking. This may be due to a view - perhaps well-intentioned but misinformed - that you should not expect too much from people with mental illness. Sometimes it is because smoking is perceived to be their only pleasure in life. In my view however, this is yet another form of discrimination – not offering a treatment that could improve health and wellbeing and increase life expectancy simply because someone has a mental illness is unacceptable.

There are many other factors that also contribute to poorer health outcomes as well – inadequate housing, lack of education, social exclusion, low income, unemployment, exposure to violence and abuse, and intergenerational trauma – to name a few.

Is it inevitable that people with mental illness will have poor physical health? The answer to that is a very big and clear “No” - because we know that much of the link between mental illness and poor physical health is preventable. We just need to do more to prevent it!

Health and wellbeing is a basic human right and it is being denied to many in our community because they have a mental illness.

The disparities in health outcomes for people living with mental illness that I have detailed to you today – with lower life expectancy and higher rates of physical ill-health – are unacceptable.

That's why the Commission aided by 53 mental health organisations and countless individuals - many here today – and whom I want to thank - led the development of *Equally Well – the National Consensus Statement*.

We are all committed to putting health care for people living with mental illness on an equal footing to that of people without a mental illness.

Now if we are to achieve improved health outcomes for people living with mental illness, it clearly will require a change in how the system works.

The *Equally Well Statement* calls for better collaboration and coordination between governments, professional bodies, social and community services and other leaders in mental health to make the physical health of people living with mental illness a national priority, and to address the many factors that place people living with mental illness at risk.

One of the core reforms we have called for is person-centred care rather than provider-centred care. If that is done it will be easier to combine physical health care as well as mental health care.
The *Equally Well Statement* challenges the low expectations that pervade the health system in terms of health outcomes for people with serious mental illness. Not only can people with mental illnesses benefit from evidence-based interventions, just like everyone else, but more fundamentally, they have the same right to high-quality appropriate health care as everyone else.

Our Statement sets out practical approaches to addressing the problem of poor physical health of the mentally ill including better prevention services, early treatment, better equity of access, improved quality of health care, care coordination and better integration across physical health, mental health and other services.

Aboriginal and Torres Strait Islander

Regarding Aboriginal and Torres Strait Islander mental and physical health I make three points:

1. The life expectancy of Aboriginal and Torres Strait Islander people with mental illness is much less than for Aboriginal and Torres Strait Islander people without mental illness;

2. The emotional social and wellbeing framework stemming from Aboriginal and Torres Strait Islander culture is holistic and brings together physical and mental health in a way mainstream approaches don't;

3. I want to mention a passion of mine: that the Council of Australian Governments (COAG) ‘closing the gap’ targets should include mental health targets.

Economics

The OECD estimates the average overall cost of mental health to developed countries is about four per cent of GDP.

There is scope for more or better investment in, and for much improvement in the operation of, the mental health system.

Martin Wolfe, the world's leading economics commentator has said that "Given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves."

As to the total cost to the Australian health system of physical illness for people living with severe mental illness it has been estimated at $15 billion per annum (about 1 percent of GDP). That includes the cost of health care, lost productivity and other social costs.

I would like reform of mental health to be seen as an important part of the economic reform agenda. The potential economic gains dwarf most of the gains that might be made from standard reforms being discussed currently and is more politically achievable. Last week a start was made. The Australian Conference of Economists made it a keynote session.

There is a strong case for a reference to the Productivity Commission to get mental health on to the economic agenda.

The importance of carers

I would also like to highlight the incredible contribution that carers of people with mental illness make.

An estimated 240,000 Australians care for an adult with mental illness but are not registered to receive carer benefits.

According to a recent study by Mind Australia it would cost $13.2 billion to replace informal mental health care with formal support in Australia.

The Fifth National Mental Health and Suicide Plan

There is not time to discuss the forthcoming Fifth National Mental Health and Suicide Plan except for one observation.

One of my great disappointments at the NMHC over 5 years has been the slowness and resistance by governments to give enough priority to the production of measures of performance or outcomes in relation to the mental health system recommended by us since 2012.

One exception namely the collection and recent public reporting on rates of seclusion, has seen a reduction in this restrictive practice – it shows the value of publishing data.

It is also important for the National Mental Health Service Planning Framework to be publically available. The reticence to publish this framework has held back public and political understanding of what is needed to address mental health.

More broadly, we in the mental health community know that sadly, when push comes to shove, that when budgets are made, mental health, the poor cousin of health and social welfare, does not get

the priority it needs. What I find especially disappointing, however, is the failure to publish data and information that lets the community know the truth about mental health and that could help make it a higher priority.

National Disability and Insurance Scheme (NDIS)

The NDIS is a good thing, and mental health should be included.

There is early anecdotal evidence that for many people with severe and persistent psychosocial disability, participation in the NDIS is resulting in more effective services and supports, better tailored to the diverse and specific needs of individual consumers.

The Commission, however, has heard from multiple stakeholders across Australia of many very serious issues and concerns expressed about its implementation.

Today I refer to two issues.

First, there is concern about the estimated number of people with mental illness and psychosocial disability who will not be eligible for support under the NDIS.

Bear in mind that the Australian Bureau of Statistics (ABS) data show there are about 700,000 people with severe or psychotic mental illness.

The initial estimate was that 64,000 people with psychosocial disability would qualify to receive Individually Funded Packages

(IFPs) by full rollout in 2019-20. The Department of Health has estimated that it's more like 92,000 people.

However, the Commission thinks that both of these figures vastly underestimate the number of individuals with mental illness who need psychosocial support, and that there may be up to or more than 200,000 people who will miss out on much needed psychosocial support because they will be deemed as not eligible under the NDIS.

Incidentally I discount claims that current enrolment numbers show the estimates were on target. The Victorian submission to the Productivity Commission shows why.

More people need to get in. Equally worrying is the fate of large numbers of people who are deemed to qualify at best for a lower tier of support. There are grave fears as to whether they will receive any significant support at all and we deeply fear many people will fall into a big hole between the NDIS scheme and mental health schemes.

The Commission has raised this discrepancy with the Government. We were pleased that a funding commitment of $80 million was given in the Federal Budget to help bridge this gap.

The $80 million is a good start. But it may not be sufficient to meet the need and it still needs to be matched by states and territories, who in some instances appear to have been withdrawing funding for psychosocial disability services as part of the transition to the NDIS.

It's not just the NDIS we have to worry about. It is also the capacity of mainstream mental health service systems to support and complement the NDIS. If the NDIS is too restrictive there will be a flood of people needing mental health services at great cost to federal and state governments.

The second big and related issue is the assessment process for determining eligibility. The NDIS is principally designed for people with a physical or intellectual disability. Assessing their level of disability and the supports they require is relatively straightforward. In contrast, assessing the eligibility of people with a mental illness and their level of psychosocial disability and the supports they require is frankly proving to be a major problem for an assessment process dominated by physical and intellectual disability. The assessment process requires radical review.

Just to take one problem. Many prospective participants are not able to collect the evidence required to complete NDIS access and review processes. People with severe mental illness (particularly those on compulsory treatment orders), the homeless, people with a dual disability, and those with little informal support network, are often unable or reluctant to engage with formal service systems or have no treating health professional.

For individuals with mental illness and an associated psychosocial disability there is a need for additional effort and outreach to help them access, understand and provide the information necessary for them to participate.

Despite the NDIS trials commencing over three years ago, there is still no published eligibility criteria for people with psychosocial disability. Added to that, anecdotal reports indicate that the outcomes from the assessment process are somewhat unpredictable and seem quite variable for people with similar levels of psychosocial disability.

All of these point to a need for the scheme to build much better the specialist skill capacity needed to deal with people with mental illness, and also to consider whether a special gateway is required for people with mental illness to facilitate their entry to the scheme. At the moment the big risk is that mental health becomes the poor cousin of the scheme, and is squeezed between an imperfect NDIS and a contracting mental health system.

I also believe the NDIS fails to adequately address the housing support needs of people with a mental illness despite provision in some cases for payment of so called 'user cost of capital' - which makes a limited contribution in this area.

Equally Well

In this speech I will not go into detail of our action plan but I want to acknowledge there is some promising and substantial work in this area from groups that are with us here today.

To pick two from many there is the Healthy Active Lives Programme (the HeAL Programme) developed by Dr Jackie Curtis and others at the Bondi Psychosis Programme.

The Royal Australian and New Zealand College of Psychiatrists has also produced an excellent report *Keeping Body and Mind Together*.

On behalf of the National Mental Health Commission, I am honoured to officially launch *Equally Well* and in doing so to thank all stakeholders who have been involved in its development and all organisations that have shown early support for it.

I would like to acknowledge members of the *Equally Well* Implementation Committee who are here with us today. The Committee will be co-chaired by Associate Professor Russell Roberts from Charles Sturt University and Elida Meadows the Carer Co-Chair of the National Mental Health Consumer and Carer Forum. They are joined by representatives from key stakeholders in the private, public and community sectors.

We also call on individuals and organisations across Australia to take action in your area of influence.

Equally Well truly is a national statement of consensus. Today, there are 53 logos on the website showing the support that already exists from the Australian Government, all State Governments, all Mental Health Commissions, PHNs, professional colleges and many high profile mental health sector organisations.

In launching *Equally Well,* we wish to inspire a commitment to putting health care for people living with a mental illness on an equal footing with people with physical problems.

Thank you.

3523 words