Samaritans

Compassion Integrity Justice

Response to Productivity Commission Draft Report – Mental Health October 2019

Prepared by Samaritans Foundation

Date: 23 January 2020

Response to Productivity Commission Draft Report – Mental Health

Samaritans welcomes the opportunity to respond to the Productivity Commission's draft report on Mental Health. The Commission has recognised many of the significant challenges facing people who are trying to navigate the mental health system and access necessary non-health services that have a direct impact on their mental health. The Commission has also acknowledged the great distance we still need to travel in order to have a system in place that adequately supports those people and addresses gaps in service delivery.

Samaritans offers below some additional feedback regarding some of the specific recommendations, requests for information and findings of the Commission. Additionally, Samaritans asks that the Commission considers several items that could be strengthened in the final report and recommendations to be released in May.

Specific Comments

ADDRESSING THE LACK OF SUPPORT FOR PEOPLE WITH CO-MORBIDITIES – SUBSTANCE ABUSE AND MENTAL ILLNESS

The Commission acknowledges the gaps in service delivery for **PEOPLE** with co-morbidities, the need to improve service coordination and the issues with people being turned away from both mental health services and alcohol and other drug (AOD) services. However, Samaritans is concerned about the lack of explicit recommendations addressing the issues for people with co-morbidities.

In the draft report, the Commission explains:

> *"Substance use comorbidity is common for individuals with some types of mental illness, and <u>where relevant care plans will need to cover drug and alcohol issues</u>* [emphasis added]*. Further, a large proportion of people who present for substance use treatment display symptoms of mental disorders (while not meeting the full criteria for a diagnosis of a disorder). For <u>effective treatment there should be an alignment</u>*

> *between mental health and alcohol and drug policies.* [emphasis added]"[1]

And:

> *"There are opportunities to improve coordination of services to better assist people with comorbidities and meet previously unmet treatment needs (Victorian Government, sub. 483, p. 19). In particular, it is important to close service gaps to avoid people falling between the cracks and build the capacity of providers to address people's comorbidities* within *the different service sectors.* [emphasis added]"[2]

While the draft report acknowledges these issues, there are no recommendations made to specifically address them. Instead, the draft report refers to several recommendations made in Chapters 5-8, 10, and 11 as relevant to improving service coordination for people with comorbidities. Samaritans believes this still leaves the potential for many people to not get the help they need, either because they haven't previously been identified as having complex mental health care needs, haven't previously sought help, or are undiagnosed for either a mental illness or substance abuse issue. These recommendations also do not directly address the issue of services turning people away because of comorbidities.

Samaritans recommends that the Commission's report be updated and strengthened to specifically address these issues. Updates and recommendations should include:

- Commissioning bodies to fund both AOD and mental health services.
- Commissioning bodies to monitor community need for AOD services and set appropriate standards to ensure services are meeting those needs.
- Training for police, ambulance, housing and other relevant services to include AOD as well as mental health.

[1] Productivity Commission Draft Report Mental Health - Volume 1, page 26
[2] Productivity Commission Draft Report Mental Health - Volume 1, page 330

- Provision of additional specialist services for people with comorbidities. This should also include services for those with low to moderate needs.
- Specialist care coordination services available to people with high-complex comorbidities.
- Correctional facilities to offer specialist services for people with comorbidities.
- Addressing skill shortages specifically in relation to AOD.

ADDRESSING AND REDUCING COMPLEX TRAUMA

The Commission has recognised the impacts of various forms of trauma throughout the draft report, however the draft findings and recommendations make very few mentions of trauma or specific interventions. Samaritans recommends that evaluations be conducted on a range of programs that prevent and address trauma to identify and implement the most appropriate interventions. This should include programs that target various key areas including:

- Aboriginal and Torres Strait Islander communities
- Culturally and linguistically diverse communities
- Family education and support
- Childhood trauma
- Emergency service personnel
- Victims of domestic violence and other crimes
- Peer workers.

General Comments

DRAFT RECOMMENDATION 5.3 — ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE

The Commission's recommendations assume that service levels in the regions where headspace operate are at a level high enough to service young people with medium and complex mental health issues. The severe shortage of services specifically for young people, acknowledged by the Commission, mean that they are often diverted to services such as

headspace that were never originally intended to cater to cohorts with higher support needs.

Currently, headspace centres are underfunded for the volume and intensity of referrals they receive. The Samaritans operates headspace Maitland, provides services for many rural and low socio-economic communities where there is greater demand for high intensity supports because of the higher population of vulnerable people. Subsequently, headspace Maitland supports many more young people with medium and complex mental health issues than ever expected or accounted for in the funding.

This coupled with a lack of alternative services and long waiting lists mean that high-intensity supports are prioritised, resulting in greater wait times for young people with low-intensity mental health issues.

Samaritans agrees that headspace centres must continue to be held accountable for delivering services that are appropriate and meet a need in the regions they operate. However, this should not be based on meeting targets for low-intensity services. It should instead be assessed individually by commissioning agencies and be solely dependent on the characteristics of young people in the region and demand for services.

It would be expected that as other reforms are implemented to meet the identified gaps in high intensity supports for young people, the characteristics of headspace centres' clients would change. Commissioning agencies should therefore have the flexibility to modify targets periodically based on updated regional data.

DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

The Commission recommends that State and Territory Governments provide additional alternatives to hospital emergency departments for people with acute mental illness. Samaritans agrees with this and suggests that this

recommendation might be strengthened by explicitly including people with co-morbidities.

DRAFT FINDING 10.1 — DIGITAL RECORDS WOULD FACILITATE INFORMATION SHARING

The Commission found that service delivery and benefits to consumers are improved using a range of approaches to improve collaboration between service providers and clinical health services. However, this benefit is not addressed in any of the recommendations. Samaritans recommends that commissioning agencies undertake evaluation of best practice approaches to co-location and collaboration, including the merits of favouring/encouraging these models in their tendering processes.

DRAFT RECOMMENDATION 10.3 — SINGLE CARE PLANS FOR SOME CONSUMERS AND DRAFT RECOMMENDATION 10.4 – CARE COORDINATION SERVICES

Samaritans is very supportive of the introduction of care plans and care coordination services.

Samaritans recommends that these be expanded to address gaps which would potentially cause people with comorbidities to fall through the cracks. The recommendations should allow for alternative entry points with identified service providers and others (such as police) to make initial contact and referral to a clinician who would then oversee the care plan. This would ensure that people who have not previously sought help or are undiagnosed would at least receive a referral to an appropriate person for assistance.

All care plans and care coordination services should have the ability to support people in other areas influencing their mental health, such as social security, justice, housing, employment and community. The Commission recommends that the MBS include a specific item to compensate a clinician to oversee a single care plan. It is unlikely a clinician would have the breadth of knowledge required to assist a person to coordinate across all these areas, so there must be systems and/or alternative mechanisms in

place to support clinicians with accurate information and enable referral to and collaboration with other services.

INFORMATION REQUEST 14.1 — INDIVIDUAL PLACEMENT AND SUPPORT EXPANSION OPTIONS

The Commission seeks additional information about the pros and cons of two options for expanding the Individual Placement and Support (IPS) model of employment support. Samaritans believes that the second option presented by the commission, to have an Australian Government-administered contract for IPS providers, would be a preferable option as it would better allow IPS providers to be integrated into existing services in community hubs or co-located with complementary services.

INFORMATION REQUEST 14.2 — INCENTIVES FOR DSP RECIPIENTS TO WORK

Samaritans is supportive of changes that make accessing and maintaining the DSP less stressful for people with mental illness. The Commission is seeking additional information about the costs, benefits and risks to increasing the income threshold and the value of the taper rate for the Disability Support Pension (DSP), and increasing the hourly limit above which no DSP is payable.

Recent research published by Monash University supports changes to the way applicants are assessed and monitored:

> *"Health, and particularly mental health, can also be improved by reducing the burden of engaging with government. The process of applying for welfare benefits and complying with obligations often required by benefit regimes can be stressful, has been linked with adverse impacts on the health of benefit recipients with illness and injury and a reduction in the ability to participate in employment. People with cognitive, intellectual or psychological conditions and those with less education, smaller support networks or other vulnerabilities are more likely to be adversely affected. Actions such as simplifying benefit application processes or funding services that*

can support people with disabilities to engage with Centrelink are likely to reduce these potentially adverse psychological impacts."[3]

Samaritans believes that both options presented for feedback by the Commission will improve the ability of people with chronic mental health conditions to re-enter and remain in the workforce. To further support people, Samaritans also recommends that:

- Centrelink staff are provided with training to assist them to better understand mental illness.
- The application and assessment process should be simplified, and applicants should be supported through the process by trained Centrelink staff.
- Application processes be simplified even further for people who have previously been in receipt of the DSP, so their payments can be reactivated if they find themselves unable to work after working over 30 hours per week for 2 years. This might include shorter forms, reduced evidence requirements and shorter wait times.
- Eligibility criteria is revised so that people are eligible to apply even if they are able to work over 15 hours per week.

These measures go some way to recognising the variable nature of mental illness and will reduce the stress involved in the application process. This level of flexibility will also provide a level of security for people who are able to work but whose mental illness impacts the consistency with which they can work.

[3] Collie, A., Sheehan, L., & McAllister, A. (2019). *The health of disability support pension and newstart allowance recipients: Analysis of national health survey data.* Insurance Work and Health Group, School of Public Health and Preventative Medicine, Monash University.

DRAFT FINDING 16.1 — PREVENTION AND EARLY INTERVENTION TO REDUCE CONTACT WITH THE CRIMINAL JUSTICE SYSTEM AND DRAFT FINDING 16.3 — COURT DIVERSION PROGRAMS

The Commission has found that "There is some evidence that investment in prevention and early intervention is a strategy that can reduce offending"[4] and notes that further research and evaluation would improve these initiatives.

The Commission also found that the success of court diversion programs in reducing recidivism rates and in some cases improving mental health is well evidenced but again suggests that further research and evaluation would improve the success of these programs.

While the draft report has recognised the success of these types of programs and encourages further research and evaluation, the Commission has not made any recommendations to this effect. Samaritans recommends that evaluations be conducted of national and international prevention and early intervention programs and court diversion programs with a view to identifying and implementing a best practice model that incorporates a suite of suitable programs.

DRAFT RECOMMENDATION 16.1 — SUPPORT FOR POLICE

In addition to supporting police by embedding mental health professionals as advisors in police communication centres, police training should include appropriate content on mental health, complex trauma and AOD. For the existing police workforce, training rollout should be staged commencing with areas that have high instances of suicide, complex mental illness and substance abuse.

INFORMATION REQUEST 18.2 — WHAT TYPE AND LEVEL OF TRAINING SHOULD BE PROVIDED TO EDUCATORS

All teaching staff should be provided with awareness training in the following areas:

[4] Productivity Commission Draft Report Mental Health - Volume 1, page 603

- Youth specific mental health first aid,
- Trauma informed care,
- Social and emotional development,
- Sexual health, sexuality and gender.

Additionally, State and Territory departments of education should develop a program for more comprehensive teacher training which can be deployed as required. This training should be available to areas identified as having higher levels of mental illness, suicide and substance abuse. The program should consider thresholds that would trigger a rollout to particular schools or regions (including anomalies such as a spike in youth suicides), and other influencing factors such as high rates of absenteeism among students, high youth crime rates, high rates of domestic violence.

INFORMATION REQUEST 23.1 ARCHITECTURE OF THE FUTURE MENTAL HEALTH SYSTEM

Samaritans believes the first option presented by the Commission (renovate) would be preferable as it avoids the introduction of additional bureaucracy. Under the renovate model, Primary Health Networks (PHN) could be given the same responsibilities and resources as those proposed for the Regional Commissioning Authorities.

In order to improve service delivery to people with comorbidities, Samaritans also recommends that PHNs hold funding for, and commission, alcohol and other drug services.

INFORMATION REQUEST 24.1 – REGIONAL FUNDING POOLS

MBS rebate volumes will not provide a complete picture with which to determine funding for a region. MBS rebates will typically be accessed by people with higher levels of education or mental health literacy, greater access to services and encountering fewer disadvantages. This means that MBS rebate volumes will likely not include many people from marginalised groups, those without a diagnosis and others whose access to services or

health literacy is lower. Funding should be based on population need and should consider indicators of the social determinants of health.

DRAFT RECOMMENDATION 24.2 — REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING

The headspace brand is strong across Australia and is recognised as a cost-effective model for youth specific services. headspace centres are placed in areas with high need for youth specific services and centres are required to report on KPIs to headspace national. Additionally, headspace centres are accountable to their funding PHN for ensuring that local needs are being met. headspace Maitland meets quarterly with the PHN to discuss current population issues that are to be addressed in service provision going forward.

The process of evaluating regional need, tendering for new centres and ongoing KPI monitoring should continue. headspace centres should be subject to appropriate review for their effectiveness, as should other specific service providers. headspace centres are well structured to adapt as community needs change and funding models should allow for this to occur through ongoing monitoring of population data.

Ensuring that funding is available specifically for youth mental health services is an important step in addressing the early onset of mental illness and reducing the long-term effects to improve quality of life as young people grow into adulthood.

Authorised by: Brad Webb – Chief Executive Officer
Authored by: Emma Granger – Executive Officer
Contributors: Felicity Scott – Community Services Manager