Submission to the Productivity Commission Inquiry into Mental Health

April 2019

One DOOR Mental Health

Contents

Executive Summary

As a grass roots community mental health organisation providing a variety of services aimed at increasing social and economic participation for people with psychosocial disability, One Door Mental Health is well placed to provide input into the Productivity Commission's Inquiry into Mental Health. This work was prepared in consultation with our Consumer Consultative Committee, Carer Reference Group, Executive and other staff. This submission will focus on those living with severe mental illness (SMI) - those whom we have provided service to, and advocated on behalf of, for over 33 years.

Business as usual in the mental health sector is untenable. Australia is experiencing mediocre improvements in some areas of mental health (e.g. increasing awareness) and worsening in other areas (e.g. suicide rates). Consumers of the mental health system still experience inadequate access to services, variable quality of services and fragmentation that runs across all sectors that are required for an individual to maintain their mental wellbeing. The truth is we do not have a great deal of data on the impacts of mental ill-health in Australia and there is a lack of research conducted into the impact of many mental illnesses.

The burden of disease for a SMI (such as schizophrenia) including the pain, suffering, disability and death – is greater than for ovarian cancer, rheumatoid arthritis or HIV/AIDs, and of similar magnitude to leukaemia and melanoma[1]. The economic cost of SMI is estimated to be $50,000 per person per annum, but mental health expenditure is disproportionately low. Yet, the returns on investment in mental health are well documented[2]. Investment in the mental health sector also has multiplier effects including enhancement of economic output, social protection and social cohesion.

The evidence does not point towards one approach that is suitable for all consumers; there is a place for a variety of programs, across all sectors, accommodating specific needs. An individual's support needs are as individual as their circumstances, history and illness. What is clear is that those initiatives which are successful have common factors and principles such as effective mechanisms for coordination at the state and local levels, cross sector collaboration, partnerships and integrated person-centred support.

The outcomes of appropriate community-level support are clear - a relatively small investment for individuals to maintain wellness and participate in the community. As people receive support for their recovery and access services through referral pathways established by local providers; recovery, protecting a state of wellness and progress allow people living with a mental illness to think that volunteering, vocational courses and working are all possible. Establishing, re-establishing and maintaining those relationships which are most meaningful to people living with a mental illness also become possible. Healthy eating and maintaining physical health become a priority again, and consequently hospitalisations decrease, people can maintain housing and can have economic and social involvement in the community.

[1] Access Economics (2002). *Schizophrenia: costs. An analysis of the burden of schizophreniaand related suicide in Australia. Sane Australia*. http://aftercare.com.au/wp-content/uploads/2012/11/Schizophrenia-Costs.pdf. Accessed 08/03/2019.
[2] Mental Health Australia and KPMG. *Invest to Save: the Economic Benefits for Australia of Investment in Mental Health Reform.* https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf. Accessed 22/02/2019.

One of the most significant gaps that currently exists in the mental health sector in Australia are those programs that act as psychosocial supports and integrate the system. Flexible supports delivered by community psychosocial programs, with low barrier to entry, are key to maintaining people's wellness but are also able to integrate an otherwise impossibly complex and fragmented system. These remarkable and evidence-based programs, which will no longer be funded from July 2019 as the transition to the National Disability Insurance Scheme (NDIS) is completed, include Partners in Recovery, Personal Helpers and Mentors, Day to Day Living and Mental Health Carer Respite Services. While the NDIS offers a significant opportunity for those who are eligible, the impacts, particularly on those who cannot, or will not, apply for the NDIS, are likely to be significant. The Mental Illness Fellowship of Australia (MIFA) estimates a $500 million funding gap for services for those who have moderate to severe mental illness, who are not eligible or will not receive NDIS services.

Even though previous reviews have highlighted barriers and issues with the NDIS, many of which remain and continue to impact on people's wellbeing, it is important to consider the significant costs current reforms will have on the sector. For example, the mantra amongst our Carer Reference Group is: "*when you find a good support worker, stick to them like glue*", and yet no attention is being placed on the disruption and de-skilling of the workforce, and thereby the support network for those who have a mental illness, that is occurring by the introduction of the NDIS.

This submission recommends that wellbeing for many can be maintained by the enhancement of programs that act as mini-system integrators, have low barrier to entry and have an evidence-base for improved mental health and physical health outcomes. Such programs exist across the spectrum of the prevention space and include primary, secondary and tertiary prevention measures. However, with the NDIS due to roll-out in full by July 2019 (at which point many will have had supports disrupted), the urgency of these measures cannot be underestimated.

We appreciate the opportunity to provide One Door's input into the current inquiry.

Yours sincerely,

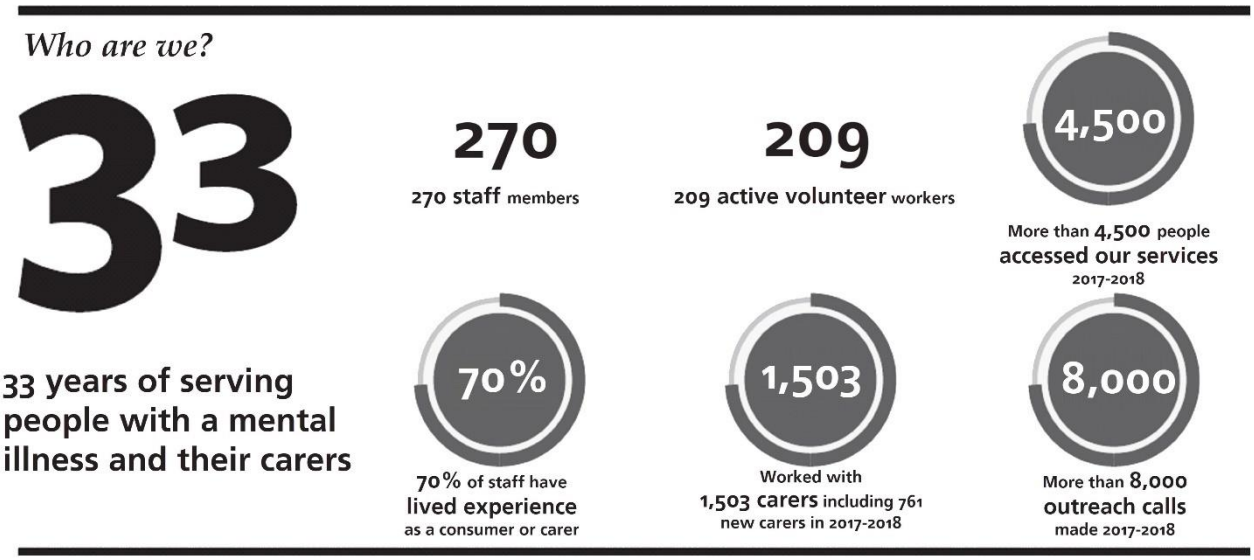
Kathi Boorman
Chief Executive Officer

About One Door Mental Health

One Door Mental Health (formerly the Schizophrenia Fellowship of NSW) is a specialist mental health recovery organisation with a 33 year history, committed to improving access to services and the circumstances of people living with severe and complex mental illness. One Door currently delivers trauma-informed recovery-oriented support through the NDIS for people with psychosocial disability.

One Door provides psychosocial community mental health programs, care coordination, housing, clinical and peer supported services. One Door has delivered services and coordinated community psychosocial care for people across silos of sectors, funding and policy through the building of relationships and trust with other providers, funding bodies and most importantly, individuals and the communities in which they live. We are committed to supporting carers and provide clinical services such as headspace, Health Care and YouInMind.

The experience One Door has in delivering this support for people with mental illness, as well as One Door's extensive experience in the psychosocial disability sector, position us well to comment on Accessibility and Quality of Mental Health Services in Rural and Remote Australia.



Answers to Selected Questions in the Issues Paper

1. Structural Weaknesses in Healthcare

Improving the Effectiveness of Reforms

Integration

In Australia, there is significant disconnect between mental health policy intent, implementation and outcomes. Continual reorganisation and reform in the mental health sector has repeatedly interrupted personal support links, the market of service provision and advocacy networks.

One of the greatest structural weaknesses Australia's mental health sector is the complexity the structure, the nexus points of funding responsibilities which are shared between state and federal governments and informational asymmetry between providers and consumers. Coordinating care in these conditions is difficult.

A good example of this poor integration is when people are discharged from a state-funded acute psychiatric facility. Targets for state-funded community mental health follow-up are as inadequate as one contact in the week following discharge[3]. It is assumed, incorrectly, that people will access community psychosocial support and housing for example, when in fact they are often discharged with no support and even into homelessness.

There is little productive collaboration between important commissioning bodies. The capabilities of different Primary Health Networks (PHNs) and Local Health Districts (LHDs) are variable and the occasions of PHNs and LHDs working together rather than in parallel are rare. Joint commissioning of services between LHDs, State Department of Health (as they also have separate Mental Health funding) and PHNs has the potential to alleviate an enormous amount of fragmentation in the system (Section 9). Joint commissioning of services also has the potential to alleviate fragmentation between sectors. This occurs successfully in the United Kingdom to overcome issues associated with government silos and lack of pooled funding[4]. This is particularly important in areas where there are high concentrations of need across sectors, which receive more funding, but which is not proportional to meet need.

Complex Needs and Navigating the System

Navigation of the mental health system and associated sectors is complicated even for those who are well or have a carer or advocate who is able to assist them with the process. Many of the recent major reforms, for example changes to the Centrelink payments and the introduction of the NDIS, ask that vulnerable and unwell people (those who are least likely to be able) to jump through increasingly more difficult hoops in order to access services. While tightening of criteria for access may be necessary to some degree, barriers are compounded by reduction in funding for supports such as individual advocacy and flexible block-funded programs, such as Partners in Recovery (PIR), that can assist an individual with the process.

[3] NSW Health. 2018-2019 KPI and Improvement Measure Data Supplement. Accessed 22/02/2019 at: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2018_048.pdf

[4] Clarke M. & Stewart J.S. (1997) *Partnership and the Management of Co-operation*. Institute of Local Government Studies, University of Birmingham, Birmingham.

While the sector experiences increasing barriers to access, there is a concurrent reduction in the aspects of the mental health system that provide low barrier to entry services, which are vital for ensuring that those who cannot, or choose not to, engage in the complex processes required, for example, to access the NDIS, have an alternative way to access support. A good example of this is Day to Day Living (D2DL) centre-based services. D2DL provides a place where consumers can access psychosocial support on a basis which suits them best; that is, when and for how long they want to or can manage, with minimum complexity of requirements to access the service. The importance of this should not be underestimated not only from an access point of view, but also the added value of the formation of a community of peers.

On the ground, organisations are developing work-arounds to overcome fragmentation. For example, one approach One Door has been taking in our Primary Integrated Care Supports (PICS) program is to develop community-based partnerships with organisations who already have the trust of and relationships with those who could benefit from the service. In PICS we have more than 20 such partnerships. With these partnerships, One Door is seeking to build the capacity of these services to support and include people living with SMI.

Lack of Outreach in the System

Support Facilitators in the PIR program, a program which will end mid-2019 due to NDIS transition, are a great example of what is required to provide outreach to people with SMI and complex needs. PIR is regarded by many in the sector as the best existing model providing specialist outreach for this population group. The value of PIR, in part, comes from the active role that Support Facilitators play 'behind the scenes', ensuring that clients can access the full range of services required, and known under the PIR model as 'systems change.'

System Responsiveness

Reforms remain slow to respond to critique from either the sector or consumers/carers once they are underway. The NDIS is a good example of this, where both providers and consumers continue to provide feedback on reforms with little impact on delivery, or changes that are too little too late.

2. Specific Health Concerns

Suicides

Intervening Before Crisis Should be a Priority

There are numerous opportunities to intervene in populations at risk of suicide who are accessing healthcare. Preventing people from getting to a crisis point where they are considering suicide, through primordial, primary and secondary prevention initiatives, is the most attractive option both from an individual outcomes point of view but also from a healthcare system perspective. However, it is a difficult task to improve whole of population mental health outcomes and with the limitations of our current system, so targeting high-risk populations should be a priority.

Among persons who died by suicide, over half have had contact with mental health care professionals during their lifetime, approximately one third in the year prior to death and about one fifth within the last month[5]. For those who are accessing healthcare it is critical that the appropriate mix of well-trained professionals are available. One key improvement in healthcare includes improving access to bulk billing psychiatrists throughout Australia. In many instances Community Mental Health Services allow people to access a bulk billing LHD psychiatrist once per year for a medication review, but this is not adequate for most people living with SMI nor to prevent people who are experiencing their first episode of mental health issues from requiring increasing levels of care.

However, it is also important to recognise that there is a large proportion, close to half, of people, who complete or attempt suicide who have not accessed mental health care. In this respect it is critical to improve the capacity of communities and community mental health services, which typically fall outside of 'mental health care', to perform outreach functions and assist those in mental health crisis who have otherwise not accessed clinical care.

An example of a model that can be adopted is the Life Span model has been adopted in some areas, based on the creation of a safety net for the community by connecting and coordinating interventions, capacity building and support people facing a suicide crisis. Life Span is predicted to prevent 21% of suicide deaths, and 30% of suicide attempts[6].

If Crisis Occurs, there are Missed Opportunities to Intervene:

i. Evidence-Based Programs to Reduce Suicide Rates for High Risk Populations - Discharge from Hospital

One of the populations at highest risk of suicide are those discharged from a psychiatric facility, despite the fact that preventing suicide following a hospital admission requires addressing issues that are well defined in the literature[7]. Best estimates of the scale of the problem is that 5-8% of all suicides occur post-hospital discharge[8,9]. Studies have shown that the rate of suicide during the first month following discharge is as high as 100 times the population rate[10] and that readmission to hospital occurs in 14.4% of cases following discharge[11]. The risk of homelessness and suicide are also heightened during this period[12,13].

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[5] Luoma, J.B., Martin, C.E. and Pearson, J.L., 2002. Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*, *159*(6), pp.909-916.
[6] Black Dog Institute. 2019. https://blackdoginstitute.org.au/research/lifespan. Accessed 22/02/2019.
[7] Crawford, M.J., 2004. Suicide following discharge from in-patient psychiatric care. *Advances in Psychiatric Treatment*, *10*(6), pp.434-438.
[8] Meehan, J., Kapur, N., Hunt, I.M., Turnbull, P., Robinson, J., Bickley, H., Parsons, R., Flynn, S., Burns, J., Amos, T. and Shaw, J., 2006. Suicide in mental health in-patients and within 3 months of discharge: national clinical survey. *The British Journal of Psychiatry*, *188*(2), pp.129-134.
[9] WA Coroner. 2019. https://www.health.wa.gov.au/publications/review/chapters/mental_health_3.2.prdf. Accessed 13/3/2019.
[10] Goldacre, M., Seagroatt, V. and Hawton, K., 1993. Suicide after discharge from psychiatric inpatient care. *The Lancet*, *342*(8866), pp.283-286; Ho, T.P., 2003. The suicide risk of discharged psychiatric patients. *The Journal of clinical psychiatry*.
[11] National Mental Health Performance Subcommittee. 2013. *Key performance indicators for Australian public mental health services*. https://www.aihw.gov.au/getmedia/f9bb1a07-a43b-458a-9b73-64ef19d8aedd/Key-Performance-Indicators-for-Australian-Public-Mental-Health-Services-Third-Edition.pdf.aspx. Accessed 13/3/2019.
[12] Tomita, A., Lukens, E.P. and Herman, D.B., 2014. Mediation analysis of critical time intervention for persons living with serious mental illnesses: Assessing the role of family relations in reducing psychiatric rehospitalization. *Psychiatric rehabilitation journal*, *37*(1), p.4.
[13] Olfson, M., Wall, M., Wang, S., Crystal, S., Liu, S.M., Gerhard, T. and Blanco, C., 2016. Short-term suicide risk after psychiatric hospital discharge. *JAMA psychiatry*, *73*(11), pp.1119-1126.

In many parts of Australia, targets for community mental health follow-up are as inadequate as one contact in the week following discharge[14]. It is assumed, incorrectly, that people will access federally-funded community psychosocial support and housing, when in fact they are often discharged with no support and even into homelessness.

Where there are evidence-based programs designed to bridge this gap between hospital and community care, known as aftercare programs, success is remarkable. For example, the Hospital to Home program (H2H) is an inexpensive peer-worker led model of community support that begins with involvement in the discharge planning process and are able to flexibly provide supports which can include assisting with issues from other sectors such as housing. Our data and other studies also demonstrate the ability of aftercare programs to prevent suicides and readmissions[15]. An independent evaluation of H2H also found an 11 day reduction in hospital utilisation per participant, representing savings of $12,034 per person based on a cost of $1094 per bed day[16]. Participants also experienced significant improvements in functional and clinical recovery. In the last quarter of 2018, participants of the program experienced a 27% increase in K10 score and a 10% improvement in RAS-DS score[17].

Key elements of this and similar programs include individualised, needs-based support, linkage with community services, communication between inpatient and community services and the use of peer workers, with their own lived experience of mental illness and recovery[18,19]. While the evidence suggests that H2H could reduce the suicide rate by 5-8% nationally, access to the program remains limited to areas where there are innovative PHNs.

ii. Emergency Departments

Another area of focus for suicide prevention should be emergency departments (ED). Those discharged from an ED following self-harm are likely to attempt self-harm again in 25% of cases[20]. There were 276,954

[14] NSW Health. *2018-2019 KPI and Improvement Measure Data Supplement*. https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2018_048.pdf. Accessed 22/02/2019.

[15] Carter, G.L., Clover, K., Whyte, I.M., Dawson, A.H. and Este, C.D., 2005. Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *Bmj*, *331*(7520), p.805., 2005; Kapur, N., Cooper, J., Bennewith, O., Gunnell, D. and Hawton, K., 2010. Postcards, green cards and telephone calls: therapeutic contact with individuals following self-harm. *The British Journal of Psychiatry*, *197*(1), pp.5-7.; Monti, K., Cedereke, M. and Öjehagen, A., 2003. Treatment attendance and suicidal behavior 1 month and 3 months after a suicide attempt: A comparison between two samples. *Archives of suicide research*, *7*(2), pp.167-174.; Motto, J.A. and Bostrom, A.G., 2001. A randomized controlled trial of postcrisis suicide prevention. *Psychiatric services*, *52*(6), pp.828-833.

[16] Scanlan, J.N., Hancock, N. and Honey, A., 2017. Evaluation of a peer-delivered, transitional and post-discharge support program following psychiatric hospitalisation. *BMC psychiatry*, *17*(1), p.307.

[17] One Door Mental Health Data

[18] Scanlan, J.N., Hancock, N. and Honey, A., 2017. Evaluation of a peer-delivered, transitional and post-discharge support program following psychiatric hospitalisation. *BMC psychiatry*, *17*(1), p.307.

[19] Carter, G.L., Clover, K., Whyte, I.M., Dawson, A.H. and Este, C.D., 2005. Postcards from the EDge project: randomised controlled trial of an intervention using postcards to reduce repetition of hospital treated deliberate self poisoning. *Bmj*, *331*(7520), p.805., 2005; Kapur, N., Cooper, J., Bennewith, O., Gunnell, D. and Hawton, K., 2010. Postcards, green cards and telephone calls: therapeutic contact with individuals following self-harm. *The British Journal of Psychiatry*, *197*(1), pp.5-7.; .; Monti, K., Cedereke, M. and Öjehagen, A., 2003. Treatment attendance and suicidal behavior 1 month and 3 months after a suicide attempt: A comparison between two samples. *Archives of suicide research*, *7*(2), pp.167-174. Motto, J.A. and Bostrom, A.G., 2001. A randomized controlled trial of postcrisis suicide prevention. *Psychiatric services*, *52*(6), pp.828-833.

[20] (Beautrais, A.L., 2004. Further suicidal behavior among medically serious suicide attempters. *Suicide and life-threatening behavior*, *34*(1), pp.1-11.; Larkin, G.L. and Beautrais, A.L., 2010. Emergency departments are underutilized sites for suicide prevention.; Owens, Horrocks, & House, 2002).

mental health-related presentations to Australian EDs in 2016–17, which was 3.6% of all presentations[21]. In many respects, EDs are ill-equipped and inappropriate places to deal with mental health presentations.

For this reason, diversions from ED are attractive. There have been a number of diversions from ED that have demonstrated positive outcomes for both providers of care and consumers that are largely unavailable across Australia. Diversion from ED into a H2H program has the potential to save lives. Other diversions include the mental health café model, originally from the United Kingdom, being trialled at St Vincent's Melbourne[22].

Comorbidities

People living with a mental illness suffer from significantly higher rates of physical comorbidities such as Type 2 diabetes, obesity and cardiovascular disease[23]. They are also more likely to have a comorbid alcohol or drug addiction than the rest of the population [24]. One systemic barrier to people living with a mental illness achieving physical wellbeing or treatment for alcohol and drug misuse is the continued segregation of treatment and management of the two issues separately.

There are a number of instruments at the disposal of policy makers to decrease the rate of comorbidities for people living with a mental illness. One of these is healthcare provider education (stigma reduction, treating only physical or mental, not both). Others include population education, change in financial incentives for providers (MBS for example), PBS listing of weight loss drugs and integration of physical health and mental health programs. For example, the MBS diabetes cycles of care provide a good example of management of a physical illness that can be replicated to achieve physical wellbeing for those living with a mental illness.

Resourcing several arms of the mental health response, including community-based services, with the resources to enhance physical health is necessary. When One Door piloted a program in 2017 to investigate the diabetes status of people living with a mental illness who were part of our physical health program New Moves, we found some striking results. Out of 12 people on the program, we identified 3 undiagnosed diabetics and 2 diagnosed diabetics with unmanaged disease[25]. This program has no ongoing funding and the pilot has not been expanded. This highlights not only the need for more physical health programs for those with a mental illness, but also the potential of mental health programs to be resourced as a point of referral for physical health issues.

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[21] Australian Institute of Health and Welfare. 2018. *Mental Health Services in Australia*. https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/hospital-emergency-services. Accessed 18/2/2019.

[22] Safe Haven Café. https://stvincentsmelbourne.blog/2018/05/17/st-vincents-safe-haven-cafe/. Accessed 18/2/2019.

[23] Dickerson, F.B., Brown, C.H., Kreyenbuhl, J.A., Fang, L., Goldberg, R.W., Wohlheiter, K. and Dixon, L.B., 2006. Obesity among individuals with serious mental illness. *Acta Psychiatrica Scandinavica*, *113*(4), pp.306-313; Osborn, D.P., Wright, C.A., Levy, G., King, M.B., Deo, R. and Nazareth, I., 2008. Relative risk of diabetes, dyslipidaemia, hypertension and the metabolic syndrome in people with severe mental illnesses: systematic review and metaanalysis. *BMC psychiatry*, *8*(1), p.84; Newcomer, J.W. and Hennekens, C.H., 2007. Severe mental illness and risk of cardiovascular disease. *Jama*, *298*(15), pp.1794-1796.

[24] Hunt, G.E., Bergen, J. and Bashir, M., 2002. Medication compliance and comorbid substance abuse in schizophrenia: impact on community survival 4 years after a relapse. *Schizophrenia research*, *54*(3), pp.253-264; Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L.L. and Goodwin, F.K., 1990. Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) Study. *Jama*, *264*(19), pp.2511-2518.

[25] One Door Mental Health Internal Data

3. Health Workforce and Informal Carers

Workforce Gaps

There are workforce shortages in many areas of the mental health system. Earlier in this submission we raised the shortage of bulk-billing psychiatrists as a significant gap in the workforce, but there are also shortages in mental health nurses and NDIS workforce.

There are significant issues emerging with the NDIS workforce in the community-managed mental health sector. While the NDIS does not directly set the amount a service provider can pay an employee, the NDIS price for services are lower than what is needed to maintain the current skill of the workforce. Provisions for basic support items allow for the employment of only minimally qualified staff. The displacement of qualified staff to other sectors is currently impacting on the ability for providers to recruit good staff and is likely to have indications for the provision of quality community mental health programs[26]. Measures have been taken to improve the situation, such as an increase in complex loading for NDIS participants with higher needs, however, the amount is below the salary expectations for the skill level of worker that was previously employed in a PIR program, for example.

Furthermore, there are alarming delays in guidelines for commissioning psychosocial supports, which will replace current community programs for those not eligible for the NDIS. These programs are due to cease June 30, 2019, at which no service will be in place for those who are not eligible. Ahead of this however, organisations have such uncertainty of funding that redundancies are necessary, and many workers are already seeking employment elsewhere as organisations are unable to provide guarantees of employment after this date.

Peer Workers

Peer workers form a fundamentally important part of the mental health workforce. Peer workers are often highly trained and skilled, however, they face the challenge of intense stigma and a sector which views their role as somewhat subordinate to other mental health workers. Workforce education should be a priority to ensure that peer workers are recognised as a legitimate and valuable part of the workforce in their own right.

Managing burnout and vicarious trauma in the mental health sector requires that appropriate supports are available and that there is a healthy culture within the organisation. In our experience and according to focus groups of our staff, a peer workforce is most effective when certain supports are in place. For example, organisations should encourage peer workers, and other workers, to create an employee care plan (ECP) if they become unwell. An ECP outlines for a manager what signs an individual considers important identifiers of when they may be becoming unwell and, in the event, that this should occur, what their preferences are for support. Another important aspect of maintaining a peer workforce is to ensure that there are multiple peer workers employed, rather than a 'token' peer worker. The support other peer workers offer each other is invaluable.

[26] Community Mental Health Australia (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. Sydney: Mental Health Coordinating Council

Carers

While caring for a loved one with an illness can be a positive experience, carers have been reported to have the lowest wellbeing of any group in Australian society- with poorer health, social and employment outcomes associated with foregoing employment and social opportunities in order to fulfil their caring responsibilities[27]. The health of a carer not only impacts on their own healthcare costs, but also their ability to care for the individual and the associated cost to the health and/or disability sector.

There have been a number of significant reforms that impact on carers in recent years, which include the NDIS and the introduction of the Integrated Carer Support Service (ICSS). One of the gaps created by these reforms is the availability of respite services, which are essential to maintain the health and wellbeing of carers.

Many Commonwealth-funded respite programs for those caring for people with a psychiatric disability, such as Mental Health Carer Respite Services (MHC-RS) and On Fire for young carers, have transitioned into NDIS funding and are no longer available (although some welcome funds for carers are still available through the State-funded Family and Carer Mental Health Program). While some carers are able to access limited funding for respite through the NDIS, in our experience this is not common-place. In many instances, carer needs are not identified, or the carer is not present to advocate for their needs. This is in contrast to the system in the United Kingdom from which the NDIS is modelled, where carers are able to apply to have their own needs addressed, outside of the needs of their loved one.

Furthermore, an additional gap has been created by the NDIS for those people who are not eligible for the NDIS or choose not to apply; their carers will also be unable to access respite funding through the NDIS.

The ICSS has been introduced to address this, providing up to $5000 in funding for respite services as well as counselling, education and referral services. However, many providers have exited the market and are no longer providing respite services, and therefore there are few services available to take referrals, particularly in regional areas. Returning a portion of block funding for services to remain in place would alleviate some of this service gap.

Services to identify and support young carers, who are particularly vulnerable to poor health, and poor social and economic outcomes, are also an area of concern. In Australia there are an estimated 2.7 million unpaid carers, with around 300 000, or 1 in 10 identified as young carers[28]. Half of all young carers are school age at under 18 years old[29]. The above statistics significantly underestimate the number of young carers by an estimated 75,000 people[30]. Part of the reason for this underestimation is that young carers are frequently not identified as such. This may be due to a lack of awareness, stigma, a fear of repercussions and cultural beliefs. Early identification of carers and supportive holistic interventions have been shown to improve

[27] Carers NSW. 2019. *Impact of Caring.* https://www.carersnsw.org.au/facts/impact-of-caring. Accessed 18/3/2019.
[28] Australian Bureau of Statistics (2015) *Survey of Disability, Ageing and Carers*. https://www.dss.gov.au/sites/default/files/files/disability-and-carers/Attachment_D_2015_Survey_of_Disability_Ageing_and_Carers.pdf. Accessed 13/3/2019.
[29] Ibid.
[30] Hill T., Smyth C., Thomson C. and Cass B.(2009), *Young carers: their characteristics and geographical distribution*, Report to the National Youth Affairs Research Scheme, Social Policy Research Centre, University of New South Wales.

education outcomes (school completion), mental health and other socioeconomic outcomes for young carers[31]. Again, however, many of the programs aimed at supporting young carers have been removed in the current reforms and what remains for this group is unclear.

It is also important to look beyond direct support of carers to address other ways in which they are disadvantaged by their caring role. For example, carer superannuation is greatly reduced by their inability, or reduced ability, to participate in paid work. Approximately 40% of primary carers are on a low income and many find it hard to cover living expenses, save money or build up superannuation[32]. Carers as a cohort experience lower labour force participation than non-carers and non-carers are two and a half times more likely than primary carers to be in full-time employment[33]. Furthermore, 56% of primary carers aged 15 - 64 participate in the workforce, compared to 80% of non-carers[34].

If we look to international examples of ways governments have attempted to address disadvantage introduced when someone is in a caring role, there are several interesting initiatives that deserve some investigation. For example, carer credits for superannuation is a concept that has been introduced in Canada, Japan and Denmark. Another important consideration is the introduction of a superannuation guarantee with the carer payment.

4. Housing and Homelessness

Housing Support is More Than Providing a House

Early intervention and prevention of both mental illness and housing insecurity are key to improving the accommodation situation for those at risk of mental ill-health. A study of Housing, Homelessness and Mental Health conducted by the Australian Housing and Urban Research Institute (AHURI)[35] identified the following key issues in the housing sector:

- There is a lack of affordable, safe and appropriate housing for people with lived experience of mental ill-health.
- Secure tenure allows people to focus on mental health treatment and rehabilitation.
- Integrated programs addressing housing and mental health are effective but do not meet demand for these services.
- Discharge from institutions poses significant risks for homelessness and mental health.
- Housing, homelessness and mental health are interrelated.
- The NDIS is reshaping the mental health system.

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[31] Twigg, J., Atkin, K. and Perring, C., 1990. *Carers and services: a review of research*. HM Stationery Office; Moore, T. and McArthur, M., 2007. We're all in it together: Supporting young carers and their families in Australia. *Health & social care in the community*, *15*(6), pp.561-568; Grant, G., Repper, J. and Nolan, M., 2008. Young people supporting parents with mental health problems: experiences of assessment and support. *Health & social care in the community*, *16*(3), pp.271-281.

[32] Australian Bureau of Statistics (2015) Survey of Disability, Ageing and Carers. https://www.dss.gov.au/sites/default/files/files/disability-and-carers/Attachment_D_2015_Survey_of_Disability_Ageing_and_Carers.pdf. Accessed 13/3/2019.

[33] Valentine., A. 2019. *Supporting Carers to Work*. Carers Australia. https://www.carersnsw.org.au/Assets/Files/Supporting%20carers%20to%20work.pdf. Accessed 18/3/2019.

[34] Ibid.

[35] The Australian Housing and Urban Research Institute. (2018). *Housing, Homelessness and Mental Health: Towards Change*. AHURI. https://apo.org.au/sites/default/files/resource-files/2018/11/apo-nid206456-1197301.pdf. Accessed 12/02/2019.

- There is a mental health service provision gap under the NDIS.
- Housing, homelessness and mental health are separate policy systems with little integration, which contributes to poor housing and health outcomes for people with lived experience of mental ill-health.

Recommendations from the report included national up-scaling of the highly successful NSW Housing and Accommodation Support Initiative (HASI) and Victoria's Doorway program. HASI and Doorway have achieved much of their success because of high-level system integration and the support of interagency collaboration[36]. The Doorway program is highly innovative, as it diverges from the predominant model of providing housing via social housing providers, in favour of the private rental market. Similarly, the lack of adequate and safe housing for these programs can be overcome through coordination with the private rental sector housing sector around mental illness and mental health provision.

Housing First is recognised as the way to help people exit homelessness which is an approach which ensures people have accommodation first, and then provide the support and services they need to re-engage and connect. From One Door's experience of where this has been implemented in NSW, Housing First is being implemented as 'housing only', with support services to help people maintain wellbeing, and ultimately their tenancy, absent. For the policy to be truly effective, implementation needs to include all aspects of the policy, which includes adequate implementation of the support services side of the policy.

People Transitioning out of a NSW Forensic Health Facility

A 'one size fits all' model for helping people transition out of a Forensic Facility does not work and housing and other supports need to be individualised. Where appropriate resources and supports have been put in place in similar initiatives, such as the Pathways to Community Living Project, the transition is successful[37].

Forensic consumers are discharged into the community often with inappropriate levels of support and to organisations who do not have the expertise to work with and manage this cohort of people who often have complex presentations and histories. While in hospital, consumers are surrounded by clinicians, allied health staff, cleaners and ancillary staff. Many have their food provided or are supported in being able to care and cook for themselves and are assisted with their daily activities. Although hospital staff do their best to prepare consumers for discharge, the reality of being out of the hospital system, frequently with limited supports, often results in relapse and readmission to a hospital facility.

Transition to the community is a highly regulated and long process. However, when a consumer is at the point of taking supervised overnight leave there is no structured programs or funding available to complete this step, leaving consumers stranded at the last stage of transition.

[36] Dunt, D.R., Benoy, A.W., Phillipou, A., Collister, L.L., Crowther, E.M., Freidin, J. and Castle, D.J., 2017. *Evaluation of an integrated housing and recovery model for people with severe and persistent mental illnesses: the Doorway program*. Australian Health Review, 41(5), pp.573-581; McDermott, S., Bruce, J., Oprea, I., Fisher, K.R. and Muir, K., 2011. Evaluation of the Mental Health, Housing and Accommodation Support Initiative (HASI) Second Report. Social Policy Research Centre, University of New South Wales.

[37] Mental Health Commission of NSW (2018). *Paving the way home: Lessons from My Choice: Pathways to Community Living Initiative: Spotlight on reform*. Sydney, Mental Health Commission of NSW

One Door is also concerned about the practice of discharging consumers into public housing where they are often surrounded by people who have unmanaged mental health or substance use problems and higher levels of criminal activity. This environment is not always conducive to a consumer's recovery journey.

5. Social Services

NDIS Service Gaps

While the NDIS is not the focus of the current inquiry, it is critical we do not overlook the remaining and emerging issues. Many of the issues advocated for in previous inquiries such as low eligibility, poor pricing and slow transition rates remain.

Of great concern is the funding gap for those who are not eligible for the NDIS, estimated to be $500 million by the Mental Illness Fellowship of Australia (MIFA) and affecting 225,000 people[38].

The original $800 million that was removed from this group through transition of funding for PHaMs, PIR and D2DL, and transferred to funding for the NDIS. Some new funding has been provided to meet that gap through Continuity of Support and Psychosocial Support Services, however there is a significant funding shortfall in this area. It is not clear who or what will be provided as PHNS are currently still waiting for guidance on these issues and no services have been commissioned. Furthermore, it may result in significant disruption to an individual who may be required to change support workers for example.

Another emerging gap is the high number of applications that have stalled in the application process and do not reach a decision of eligible or ineligible. Alarmingly, these clients will neither be eligible for continuity of supports nor the NDIS because a decision point has not been reached. This is an emerging issue of high priority, which we acknowledge the government and the NDIA are working to resolve however this is unlikely to be achieved by 30 June 2019 at which point other supports will cease.

Carer Payments and Disability Pensions

Recent changes to the Carer Payment have included a means test for eligibility. Many carers experience this process as unnecessarily difficult and burdensome. Furthermore, Social Security legislation restricts those who are working or studying more than 25 hours a week from receiving a Carer Payment, which severely limits the ability of young carers of school age to be granted this payment. Both the means testing, and study/work restrictions should be reviewed.

The notion that disability support payments for a psychosocial disability reduce the propensity of some recipients to seek employment, above the general population of disability support recipients, is incorrect. Rather in our experience, people living with a SMI have strong aspirations and want to be well enough to work. Evidence supports that mental health service users want and are able to work, even amongst those who have lost touch with the labour market over an extended period[39]. People with a SMI often require extra support in

[38] The Productivity Commission and National Mental Health Commission estimate that the number of people with severe mental illness in Australia is 690,000. Of this group, 290,000 people experience greater severity and complexity. Only 64,000 of this group are expected to be eligible for the NDIS.
[39] Secker, J. and Membrey, H., 2003. Promoting mental health through employment and developing healthy workplaces: the potential of natural supports at work. *Health education research*, *18*(2), pp.207-215.

order to achieve this. However, limitations on the amount of hours that can be worked by those receiving carer payments or disability pensions act as a significant disincentive to seek further employment.

6. Social Participation and Inclusion

True social inclusion and participation requires removal of barriers, including stigma, for people living with a mental illness and as such is a whole of government and societal issue. However, social inclusion and participation is work largely undertaken by the NGO sector in mental health.

One Door would like to bring the value of centre-based services for those living with a mental illness to the attention of the Productivity Commission. Centre-based services take many forms throughout Australia including D2DL centres (transitioning to the NDIS) and Clubhouses. The centre-based service model provides the opportunity for people living with a mental illness to form a community with peers, empowerment through joint management, the ability to gain practical skills such as pre-employment training and computer skills and all important social interaction. In fact, international research shows that Clubhouses have a 42% employment rate for members[40], reduced incarceration in the criminal justice system[41], facilitate recovery-oriented practice[42], improved education and social domain outcomes[43], improved quality of life particularly with the social and financial aspects of their lives[44]. Importantly, Clubhouses are low barrier to entry and flexible in access, as members can essentially come and go as often or as little as they want or are able to.

Centre-based services are cost effective. For example, those who attend Clubhouses for 3 days or more per week have a mean annual mental health care costs of US $5697, compared to $14,765 for those who attended less often[45] and funding of a year of holistic recovery services that are delivered to Clubhouse members costs the same cost as a 2 week psychiatric hospital stay[46].

Unfortunately, centre-based services are poorly funded and as such access is restricted to those areas fortunate enough to have one. The problem is compounded by the introduction of the NDIS and transition of funding for centre-based services. The NDIS model does not provide the financial stability required for a provider to cover fixed costs such as rent, electricity, rates and water that are necessary for a centre-based service, and the NDIS has removed the line item for centre-based services. This could be somewhat alleviated by allowing centre-based services to require a 50% deposit from an NDIS package to access the service, and then charge on a per use basis after this. However, the NDIS model is still not fundamentally compatible with the concept of a low barrier to entry service, with access available as much or as little as a person is able to.

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[40] Ibid.
[41] Ibid.
[42] Raeburn, T., Schmied, V., Hungerford, C. and Cleary, M., 2016. The use of social environment in a psychosocial clubhouse to facilitate recovery-oriented practice. *BJPsych open*, *2*(2), pp.173-178.
[43] McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W. and Lidz, C.W., 2018. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(1), pp.28-47.
[44] McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W., & Lidz, C.W. (2016). A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-20.
[45] Hwang, S., Woody, J. and Eaton, W.W., 2017. Analysis of the association of clubhouse membership with overall costs of care for mental health treatment. *Community mental health journal*, *53*(1), pp.102-106.
[46] Ibid.

7. Justice

People living with a mental illness are over-represented in the criminal justice system[47]. The reasons for this include failures of people with psychosocial disability to engage with education and employment opportunities, family breakdown, disenfranchisement, co-morbid substance abuse problems leading to crime, and social and cultural factors affecting inclusion and socio-economic status.

Certainly the justice system does not have the resources to address these broad causes. The focus must be on governments to address structural, support and pathway issues that contribute to the conflation of crime and mental illness. With that said, the justice system may contribute time or resources to early intervention programs aimed reducing the risk of criminal behaviour in young people presenting with features of mental illness. More broadly, members of the Judiciary may be informed of mental illness as a mitigating factor when sentencing, and policies of diverting people before court into treatment programs rather than prisons strengthened.

Improving the identification and management of mental illness within the justice system requires distinct change of organisational culture. In part, this cultural change will involve training current members of the Department about issues common to psychosocial disability. The aim is for staff to understand the impacts of attitudinal barriers in the provision of inclusive services.

Staff within the justice system should be made aware of the nature and consequences of mental distress and illness - its typical presentations, treatments and common prognoses. It will also involve training in strategies to deal with people with psychosocial disability experiencing mental distress or illness. This may include Mental Health First Aid training to help staff of the Department of Justice deal with people in mental health crisis. Training must focus on a positive outlook for people with psychosocial disability to help counteract embedded stigma and discrimination.

This has worked in other areas of the criminal justice system, such as NSW Police. One Door has been the official NSW Police trainer within the Mental Health Intervention Team since 2007 with impressive results[48]. Over 4000 NSW police have received increased mental health training and a Mental Health Intervention Officer is present at each police station at all times. The difference these changes have made to consumers and carers who have contact with the police are invaluable.

8. Mentally Healthy Workplaces and General Employment Support

Mentally Healthy Workplaces

One Door and others have developed frameworks and training to enable mentally healthy workplaces, particularly for a lived experience workforce[49]. The prevalence of poor mental wellbeing in workplaces means that the principles guiding the support of a lived experience workforce apply to all workplaces. A study by

[47] Butler, T., Andrews, G., Allnutt, S., Sakashita, C., Smith, N.E. and Basson, J., 2006. Mental disorders in Australian prisoners: a comparison with a community sample. *Australian and New Zealand Journal of Psychiatry*, *40*(3), pp.272-276.

[48] Herrington, V. and Pope, R., 2014. The impact of police training in mental health: an example from Australia. *Policing and society*, *24*(5), pp.501-522.

[49] Schweizer, R., Marks, E. and Ramjan, R., 2018. One Door Mental Health Lived Experience Framework. *Mental Health and Social Inclusion*, *22*(1), pp.46-52.

mental health organisation HeadsUp estimated that 21% of employees report that they have taken time off work due to feeling mentally unwell in the past 12 months[50]. Absenteeism resulting from poor employee mental health costs Australian businesses $4.7 billion per annum, equivalent to 1.1 million days' sick leave[51]. Presenteeism where people are less productive in their role due to a mental health condition, is estimated to cost Australian business $6.1 billion a year[52]. Yet despite this, the Australian Human Rights Commission reports that, despite this prevalence, nearly half of all senior managers believe none of their workers will experience a mental health problem at work[53].

Research has afforded us with a wealth of information about what works to maintain people's mental wellbeing. Mentally healthy workplaces are considered to be those which exhibit concern for, and policies to support, the mental health of their employees[54]. Maintaining a mentally healthy workforce requires support for wellbeing and robust management and human resources strategies.

Underlying stigma is a major barrier in the workplace for those already living with a mental illness. One of the unique features of One Door's workplace culture is the recognition of the need to address systemic employment discrimination that those with lived experience of mental illness face in the workplace. In 2016, One Door surveyed the level of lived experience and found that 75% of employees and more than 50% of board members identified as having lived experience of mental illness. Interestingly, at point of employment, only 50% of employees chose to identify as having lived experience of mental illness to human resources compared to 75% when asked in an anonymous staff survey. This may be indicative of a history of or perceived stigma in previous workplaces.

Increased disclosure may represent an increase in the numbers of employees experiencing workplace stressors which have been well described in the literature. These include compassion fatigue and vicarious trauma. Compassion fatigue is emotional and physical fatigue that people in the mental health industry may face or vicarious trauma[55]. However, increased workplace stressors are unlikely as employee assistance programme (EAP) use decreased 8.5 per cent and the number of EAP presentations classed as mental health related decreased 13.5 per cent from 2015 to 2016[56].

[50] Heads Up. 2019. https://www.headsup.org.au/docs/default-source/resources/bl1270-report---tns-the-state-of-mental-health-in-australian-workplaces-hr.pdf?sfvrsn=8

[51] Heads Up. 2019. *The financial cost of ignoring mental health in the workplace.* https://www.headsup.org.au/training-and-resources/news/2015/01/23/the-financial-cost-of-ignoring-mental-health-in-the-workplace. Accessed 13/3/2019.

[52] Ibid.
Price Waterhouse Coopers. 2015. *Creating a mentally healthy workplace. Return on investment analysis*. https://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf?sfvrsn=6. Accessed 29/06/2018.

[53] Hilton, M.F., Whiteford, H.A., Sheridan, J.S., Cleary, C.M., Chant, D.C., Wang, P.S. and Kessler, R.C., 2008. The prevalence of psychological distress in employees and associated occupational risk factors. *Journal of Occupational and Environmental Medicine*, *50*(7), pp.746-757.

[54] Harvey, S.B., Joyce, S., Tan, L., Johnson, A., Nguyen, H., Modini, M. and Groth, M., 2014. Developing a mentally healthy workplace: A review of the literature. *Sydney: University of New South Wales*.

[55] Newell, J.M. and MacNeil, G.A., 2010. Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue. *Best Practices in Mental Health*, *6*(2), pp.57-68.

[56] One Door Mental Health. 2016. Lived Experience Framework.

Guidelines for supporting, managing and recruitment of a lived experience workforce are widely published and similar principles apply to all workplaces without a lived experience focus. It has been reported that implementation of these guidelines result in a 10 to 1 return on investment[57].

Practically this means:

1. Supporting wellbeing:

- Providing Information on recognising the signs of burnout, compassion fatigue and compassion stress and strategies to improve wellbeing.
- An opportunity for all staff to create an Employee Support Action Plan and access to EAP and the Manager Assist Programs.
- Regular supervision.

2. Improving management strategies:

- Train management to understand the nature of mental health and illness and the impact it can have on one's ability to work.
- Support employees experiencing difficulties in a manner that respects the individual's rights by law and the philosophy of the organisation.
- Improving the skill of management to identify and take appropriate action to eliminate health and safety risks.

3. Human Resources:

- Removing stigma and negative attitudes towards lived experience through awareness and education programs.
- Provision of professional supervision.
- Clear job structures and career pathways particularly for a peer workforce.
- Supporting transition from client to volunteer or staff member.

Specific Employment Initiatives

One of the significant gaps in employment services for those living with a mental illness are programs designed to assist those who are not far enough in their recovery to be ready for Disability Employment Services or Centrelink Job services. One of the initiatives that works well in this space is the Transitional Employment Program (TEP) run by One Door's Pioneer Clubhouse.

[57] Harvey, S.B., Modini, M., Joyce, S., Milligan-Saville, J.S., Tan, L., Mykletun, A., Bryant, R.A., Christensen, H. and Mitchell, P.B., 2017. Can work make you mentally ill? A systematic meta-review of work-related risk factors for common mental health problems. *Occup Environ Med*, *74*(4), pp.301-310.

The Clubhouse model is based on non-clinical, integrated therapeutic working communities for anyone who has a history of mental illness. Membership is voluntary, without time limits and entitles an individual to both shared ownership and shared responsibility for the success of the Clubhouse.

TEP positions are time-limited, part-time opportunities, usually 6–9 months in duration. The Clubhouse develops and maintains a relationship with the employer, provides onsite training and support, and coverage by a Clubhouse staff or member in the case of an absence. TEP allows members who lack work experience, confidence or skills for open employment, the opportunity to work. This is not a subsidised employment program, rather participants receive support from Clubhouse staff to work in real jobs with real pay. The Clubhouse model also offers Supported Employment, which supports members in job seeking for employment of their choice including résumé writing, writing applications and interview preparation.

International Studies of the Clubhouse Model

The Clubhouse model of employment has been evaluated in numerous randomised control trials and cohort studies[58]. Compared to jobs specifically set aside for psychosocial disability, TEP positions had a greater number of days worked compared to persons in jobs set aside for mentally ill persons, greater workplace integration, longer tenures, more days employed and more hours worked per week[59]. Those with TEP positions had higher employment rates compared to cohorts of similar individuals not in the TE program[60].

Outside of the mental health sector there are other great examples of organisations improving their culture relating to mental wellbeing. NBN Co., in partnership with headspace and Ostara, have engaged those living with a mental illness through work readiness programs[61]. The successes for the individuals involved in the programs have been life changing, but also the change in the culture within NBN Co. with regards to workplace awareness of mental wellbeing have also been remarkable.

9. Funding Arrangements

What is Driving Costs?

Cost drivers are a function of increasing prevalence and poor access to timely and appropriate care. Cost drivers in the current and future environment include:

- ***More than half of those requiring help not seeking treatment*** as a result of inadequate services, fragmentation, stigma and lack of awareness. Inadequate services for example include a lack of bulk-billing psychiatrists.

[58] McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W. and Lidz, C.W., 2018. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(1), pp.28-47.
[59] Johnsen, M., McKay, C., Henry, A.D. and Manning, T.D., 2004. What does competitive employment mean? A secondary analysis of employment approaches in the Massachusetts Employment Intervention Demonstration Project. In *Research on employment for persons with severe mental illness* (pp. 43-62). Emerald Group Publishing Limited.
[60] Warner, R., Huxley, P., & Berg, T. 1999. An evaluation of the impact of clubhouse membership on quality of life and treatment utilization. *International Journal of Social Psychiatry*, 45, 310–320.
[61] O'Connor., A. 2016. Helping young people overcome mental health issues and find work. https://www.nbnco.com.au/blog/health/helping-young-people-overcome-mental-health-issues-and-find-work. Accessed 13/3/2019.

- ***Inadequate investment*** leading to suboptimal treatment and management and therefore long-term costs. This includes the MIFA estimated $500 million gap in community psychosocial support created by the NDIS. This also has implications for market failure in the community mental health sector and withdrawal of services from regional areas.

- **Fragmentation** resulting in poor whole of person care. For example, poorly designed housing policies drive costs in mental health.

- **Failure to access the NDIS.** A large number of people still refuse to access the NDIS, have applications which have stalled, or are ineligible to apply for the NDIS. Although psychosocial support and continuity of support measures are designed to alleviate this, the short timeframes on commissioning and implementation mean that this is likely to be suboptimal.

Improving Funding Arrangements

Joint commissioning of services between LHDs and PHNs has the potential to alleviate an enormous amount of fragmentation in the system, but this requires that there are clearly defined KPIs for each of them to carry out this intent. Additional issues from a provider's point of view include that many contracts, both historical and newly commissioned, remain on a yearly basis which makes retaining staff and infrastructure difficult.

Joint commissioning of services also has the potential to alleviate fragmentation between sectors. This occurs successfully in the United Kingdom to overcome issues associated with government silos and lack of pooled funding.

Moreover, the restrictions on ~15% contribution to overheads does not give recognition that you have to a well governed organisation to manage these services. This restriction on overheads and operating costs (service delivery 75%) drives down resources that can be used for staff training and administration. The efficiency drive to deliver the lowest cost service loses sight of the value for the people the service is meant to help.

Additional issues include that many PHN contracts, both historical and newly commissioned, remain on a yearly basis which makes retaining staff and infrastructure difficult. PHN tenders are increasingly offering provisions for overheads that are too small for many NGOs to consider.

Additional Measures of Cost

Additional measures of the cost of mental illness worth considering include workers compensation for those making claims related to mental ill-health.

10. Monitoring and Reporting Outcomes

Our best evidence in the mental health sector is simply not collected as some funding bodies are only driven by performance measures, such as hours of client service delivery/ week/ FTE. Where independent evaluation of a program is included in a tender, the level of funding embedded in the tender is often far below that which is reasonable to commission meaningful independent evaluation.

There are, however, interesting alternatives to this as demonstrated in other areas of healthcare. For example, the Palliative Care Outcomes Collaboration (PCOC) is a model of outcomes reporting that could be used as the basis to inform mental health sector reporting and benchmarking. PCOC is a voluntary national program that utilises standardised clinical assessment tools to measure and benchmark patient outcomes. Up to 80% of specialist palliative care providers across the tertiary and community palliative care sector contribute to PCOC data. As for PCOC, such a framework could be used in mental health to

- improve quality of service through benchmarking processes,
- provide validated and standardised tools to assess individual patient experiences,
- define a common language between providers to support assessment and care planning,
- facilitate the routine collection of national data
- provide regular patient outcomes reports and workshops to facilitate service-to-service benchmarking, and
- support research.

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