JOINT SUBMISSION

Response to the draft Productivity Commission report into mental health

Contents

WHO WE ARE

Mind Australia Ltd

Mind Australian Limited (Mind) is one of the country's leading community-managed specialised mental health service providers. We have been supporting people who are dealing with the day-to-day impacts of mental ill-health, as well as their families, friends and carers for 40 years. Our staff deliver a range of services and supports to people challenged by mental ill-health. In the last financial year, Mind provided over 400,000 hours of recovery focused, person centred support service to over 9,000 people, including residential rehabilitation, personalised support, youth services, family carer services and care coordination. Mind also operates as a provider of services and supports to individuals who have NDIS funding packages in multiple locations across Australia.

We also work with people to address poverty, housing, education and employment. It is an approach to mental health and wellbeing that looks at the whole person in the context of their daily life, and focuses on the social determinants of mental health, as they play out in people's lives. We value lived experience and diversity and many of our staff identify as having a lived experience of mental ill-health.

Mind significantly invests in research about mental health recovery and psychosocial disability and shares this knowledge, developing evidence informed new service models, evaluating outcomes, and providing training for peer workers and mental health professionals. We also advocate for, and campaign on basic human rights for everyone; constantly challenging the stigma and discrimination experienced by people with mental health issues.

Neami National

Neami National (Neami) is a not-for-profit Community Managed Organisation providing specialist, community-based mental health services. Neami has over 31 years' experience supporting people along the continuum of mental health need, with a focus on those people experiencing severe mental ill-health and the most complex needs. We support over 9,000 people nationally each year across a range of services including:

- Community-based support
- Community and group programs
- Service coordination
- Step Up Step Down
- Intake and assessment
- Housing and homelessness
- Residential rehabilitation
- Early intervention
- Suicide prevention and postvention
- Clinical support services
- National Disability Insurance Scheme (NDIS) services

Neami's overarching vision of *full citizenship for all people living with a mental illness in Australian society* underpins an emphasis on social inclusion and community connection in the way we collaborate with people and work to our mission of *improving mental health and wellbeing in local communities*. We use a collaborative recovery approach, which is informed by current research and backed by over three decades of experience in the community managed mental health sector.

We value and strive to provide:

- Evidence-informed collaborative recovery support
- Safe and high-quality services
- A great consumer experience
- Participation and co-design of our service models and evaluation
- Support to improve physical health
- Peer support
- A commitment to diversity and inclusion

Wellways

Wellways was established in Victoria in 1978 and employs over 2,100 staff across over 100 offices throughout Australia's eastern states: the Australian Capital Territory (ACT), New South Wales, Queensland, Tasmania and Victoria. There are over 240 people working in peer support roles and 189 volunteers contributing over 14,000 hours of work each year, servicing thousands of people.

Wellways Australia is a provider with over 40 years' experience. We specialise in mental health and disability support. We dedicate resources to advocacy, to ensure systems are responsible and equitable, and society is inclusive. To us recovery means all Australians lead active and fulfilling lives in their community.

We work with individuals, families and the community to help them imagine and achieve better lives. We provide a wide range of services and assistance for people with mental health issues, disabilities and those requiring community care. Peer work is at the heart of many Wellways programs, from our peer support Helpline to social and housing support.

Wellways Vision is for an inclusive community where everyone can imagine and achieve their hopes and potential. The four pillars of our work are:

1. Community inclusion is as important as treatment;
2. We create opportunities for connection with a diverse range of people;
3. We ensure community supports are accessible to everyone; and
4. We challenge barriers to inclusion, such as poverty, discrimination and inaccessible environments.

This philosophy underlies the many direct services we deliver to thousands of people each day across the Australian eastern seaboard.

SANE Australia

SANE Australia is a national mental health charity working to make a real difference in the lives of people affected by complex mental health issues. SANE's vision is for an Australia where people affected by complex mental health issues live long and fulfilling lives, free from stigma and discrimination.

Founded in 1986 in Melbourne as the Schizophrenia Australia Foundation, SANE Australia's focus is on supporting the approximately four million Australians affected by complex mental health issues. This includes adults aged 18 and over living in Australia who identify as having a complex mental illness or an experience of complex trauma or are experiencing very high levels of psychological distress. For every person living with a complex mental health issue, there is a network of additional people impacted, including carers, family, friends and colleagues who often play a critical role in supporting their recovery.

SANE's work includes promoting mental health literacy, destigmatising poorly understood mental health issues, online peer support and information, specialist helpline support, research and advocacy. Established in 1999, SANE Australia's StigmaWatch program pioneered stigma-reduction through tackling media representation of mental illness and suicide. The Dax Centre and the Anne Deveson Research Centre (ADRC) also form part of the SANE Australia group.

Language used within the submission

Mind, Wellways, Neami and SANE (hereafter referred to as the Sector Partners) recognise that language is important in relation to mental health. We acknowledge that there are differing terms used in the mental health sector and we support the right of all people to choose the language they want to describe themselves, their experiences, thoughts, feelings and behaviours.

To align with the Productivity Commission, we have used the term consumer throughout the submission to refer to those people who access mental health and/or psychosocial support services, including online self-help resources.

We have also adopted the Productivity Commission's definition of mental ill-health to refer to diminished mental health from either a mental illness/disorder or a mental health problem.

INTRODUCTION

Mind, Wellways, Neami and SANE (hereafter referred to as the Sector Partners) jointly present this submission to assist the Productivity Commission to prepare its final report.

We have combined our experiences, practice wisdom and research into this one submission to present a united view on where we believe the final report can be strengthened so that it best addresses the needs of all Australians, including consumers, their carers and the workforce who support them. Our four organisations have over 120 years combined experience in supporting people affected by severe and complex mental health issues.

The Sector Partners congratulate the Productivity Commission on its draft report into mental health and the consultative manner in which the inquiry has been conducted. We wholeheartedly agree with the Productivity Commission's starting point that substantial changes are needed in order to set Australia on a path to the sustainable long-term reform of its mental health system to improve the outcomes for people affected by mental health ill-health.

The Sector Partners are encouraged by the Productivity Commission's intention to design an all of population mental health system architecture that covers the spectrum of mental health needs. We are also heartened that there is recognition within the report of the importance of the social and emotional model of mental health care that includes 'non-health' components of mental ill-health, such as poor housing, education, training and labour market participation.

To strengthen the report, the Sector Partners believe that it would benefit from a far greater focus on the role of psychosocial supports and clearer plans to reform and expand the community mental health service (CMHS) sector. In fact, the Sector Partners contend that the most significant and pressing gap within the Draft Report is the omission of the role of the community mental health workforce.

The following submission will not attempt to respond to every recommendation made in the Draft Report. Rather, it will specifically address those aspects where the Sector Partners can add value to the Productivity Commission's deliberations and where we believe additional information is required to strengthen and better enable its vision for reform. This includes those areas where the Productivity Commission has made requests for further information, either contained in the report or made by Commissioners directly to the Sector Partners in hearings, presentations and meetings.

This submission will follow the structure set out in the overview document of the draft report. For clarity, we have structured individual sections of this submission into 'where the Sector Partners support the Productivity Commission's approach' and 'where the Sector Partners believe more work is needed'. The latter includes some specific recommendations for the final draft of the Commission's report.

We welcome the opportunity to contribute to the Productivity Commission's final report into mental health.

Australia's current bushfire crisis

Although initially outside the scope of the Commission's inquiry, we cannot proceed without making comment about the impact that climate-related natural disasters can have on mental health and wellbeing, both for those directly affected as well as others in the community.

Australia is facing an unprecedented bushfire crisis with significant loss and trauma experienced across multiple communities. The ripple effect of these events has been felt nationwide. The impact of this crisis will require additional mental health resources, and an integrated and ongoing support package to respond to the needs of people affected by this and future disasters. These resources should respond to those experiencing post-traumatic stress disorder in wake of crisis, but also those affected by complex mental health issues who may require additional support as a result of these events.

The Sector Partners recommend that:

- The Commission explores options for increased and sustained funding for mental health organisations to respond to bushfires and other natural disasters ensuring they can mobilise quickly
- An appropriately funded model is developed (e.g. MBS) to provide ongoing care for people who develop complex mental health issues, or whose complex mental health issues are exacerbated by these natural disasters beyond this initial two-year phase

RESPONSES TO THE DRAFT REPORT

Part II Reorienting health services to consumers

The Sector Partners strongly support the Productivity Commission's approach to reorienting health services to better support consumers. Consumers should be able to access a range of quality treatment options regardless of where they live or their socioeconomic status that allows them timely access to culturally safe and appropriate mental healthcare at the right level for their condition.

Healthcare access

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support evaluating and reforming MBS-funded psychological therapy, as set out in draft recommendations 5.4 and 5.5, to enable more people to access this treatment, particularly those with more complex needs.

The Sector Partners are encouraged by the Productivity Commission's intention to examine the out-of-pocket costs of mental health care (information request 3.2). This significant issue is seldom examined in a reform context, despite the fact that it is a major concern for consumers.

In consultations that Wellways and Mind undertook for the Royal Commission into Victoria's Mental Health System, consumers said they were delaying psychological treatment due to costs and becoming more unwell as a result. This is also supported by SANE's work on understanding the needs of people affected by Personality Disorder which found that specialist programs are only available privately with significant out of pocket costs. A number of consumers reported having to maintain private health insurance in order to meet their support needs, despite the significant financial burden of doing so.

As the Productivity Commission has highlighted, the limitations of 10 publicly funded consultations with a psychologist are not providing enough time for consumers with complex mental health needs to develop a relationship with their psychologist. A number of people discussed the difficulties of trying to find a psychologist that bulk billed. The Commission should examine the introduction of a scheme to pay gap fees in health services for those on lower incomes and advocating for those with a psychosocial disability in the NDIS to be able to access psychological therapy as part of their support needs.

In relation to Information Request 3.2, other issues related to the financial cost of accessing mental health services included:

- Not being able to access medicines that are not on the Pharmaceutical Benefits Scheme
- Needing to travel to access services, especially for people from outer suburban, regional and rural areas
- The difficulty of receiving treatment from clinicians without private health insurance, especially for those who have complex or low prevalence disorders
- Consumers having to maintain private health insurance to access services such as trauma specific therapists, despite the significant costs
- Needing to forgo paid work to participate in therapy or other activities to support their wellbeing.

Out of pocket costs to access mental health care are particularly onerous for those on income support such as the Disability Support Pension, Newstart and Carer Payment. The Productivity Commission has not addressed the inadequacy of government-funded social security and we believe this should be examined.

The Sector Partners recommend that:

- A scheme is introduced to ensure people on low incomes are able to access evidence-based psychological therapies
- The adequacy of government funded income support for people experiencing mental ill-health is examined
- The Productivity Commission examine the possibility of enabling people with psychosocial disability to access psychological therapy as part of their NDIS-funded supports.

Where the Sector Partners believe more work is needed

The changes proposed by the Productivity Commission to reorient care so that more attention is paid to those experiencing moderate to complex mental health issues are positive, however the Sector Partners believe what has been proposed is insufficient. We believe the report remains clustered around the types of support that specifically address people's medical and clinical needs.

The Draft Report explains the importance of the social determinants of mental ill-health, and includes them within the proposed stepped model of care. However, we note that the important non-health supports identified by the Commission are graphically presented below the clinical and medical supports and are largely unintegrated in the model of stepped care. While we understand that service integration is complex, a far greater interface between the mental health system and social determinants could be achieved by adopting a more explicit recognition of the importance of psychosocial supports provided by CMHS providers. This component of the mental health system is, at present, largely absent from the Draft Report.

The Draft Report would benefit from greater clarity and specific recommendations to address psychosocial supports and a far greater explanation that psychosocial supports should be available to all people experiencing mental ill-health. The Sector Partners suggest that there are three dimensions to this, which will be explained throughout this submission:

- The definition of psychosocial supports and what they are designed to achieve
- The nature of the workforce needed to provide psychosocial supports and how it can be better supported
- Where psychosocial supports fit in the current mental health service configuration.

Addressing the definition issue, the term 'psychosocial' refers to the interaction between psychological and social/cultural components of life. This recognises mental ill-health can affect a person's ability to take part in day-to-day activities. Engagement (or lack of engagement) in these activities, in turn, also has an impact on mental health.

Mind, Wellways and Neami are experts in delivering psychosocial supports and offer this further information to assist the Productivity Commission with its deliberations. Furthermore, SANE advocates for psychosocial needs and is leading a program of research to understand how stigma and discrimination might limit a person's opportunity across a range of psychosocial domains.

Psychosocial supports can be categorised in two distinct ways:

1. Psychosocial disability support
2. Psychosocial rehabilitation

Psychosocial disability support

Psychosocial disability[1] support refers to processes, interventions and services that aim to support an individual to maintain their current level of independence across a range of social interventions.

This commonly means that workers complete and support specific tasks with and for the consumer when that person is unable to complete the tasks themselves. These supports are tailored to the individual, which requires an appropriately skilled person to deliver them. Supports can include, but are not limited to:

- Assistance in rebuilding and maintaining family connections
- Managing daily living needs
- Financial management and budgeting
- Tenancy and creating a home
- Educational and training goals
- Maintaining physical well-being, including exercise
- Assistance to manage drug and alcohol misuse
- Building broader life skills, including confidence and resilience
- Assistance to deal with trauma, particularly related to precursors in childhood such as violence, abuse and neglect, especially when these are intergenerational, and which can lead to poorer functional outcomes
- Social skills and to build friendships and relationships

Psychosocial rehabilitation

Psychosocial rehabilitation aims to enhance and increase skill development, maximise potential to manage everyday life, participate in the community and increase independence. This commonly means working with individuals to support them to develop skills in these areas.

In much the same way that someone who is physically injured requires some form of long-term physical rehabilitation to help them to recover, those recovering from mental ill-health may have impairments in terms of emotional, cognitive, practical and social skills that require supports to mend and rebuild. It is worth noting that these losses can be deep and wide ranging,[2] and can include:

- Cognitive functions (attention and memory)
- Emotional functions (depression, anxiety stress)
- Energy and drive (motivation, apathy and fatigue)
- Activities and participation (relationships to others and employment)
- Personal health and self-care
- Limitations to an individual's ability to take part in social activities

In other words, they help consumers to develop/regain the skills necessary be able to fully participate in society – the core rationale underlining the Productivity Commission's inquiry.

Disability support and rehabilitation are both critical supports to assist an individual's quality of life, and the need for these services and interventions must be considered based on individual need. Purposeful and targeted psychosocial disability support, which assists a person to maintain their life in the community is just as important as a rehabilitation intervention, which assists an individual to acquire skills and build capacity.

The Sector Partners believe that part of the confusion with psychosocial disability support and rehabilitation also derives from positioning them only in terms of the severity of need within the

[1] This terminology refers to the support being provided, rather than a labelling of the mental ill-health that is being experienced.
[2] See presentation by Lisa Brophy, *Supporting people with psychosocial disability - the evidence, opportunities and challenges - an update*, Psychosocial Support Services (national psychosocial support measure) Murray Primary Health Network Forum, April 2019. Bendigo. Invited Speaker

stepped care model. Psychosocial supports should be available to all consumers, regardless of the severity of their symptoms.

Psychosocial interventions are critical for people with low to moderate clinical mental health need to assist them to regain skills lost during a period of being unwell. Furthermore, failure to intervene with appropriate psychosocial interventions may result in an individual with low to moderate mental ill-health becoming more unwell. This situation can result not only in the symptoms of mental ill-health becoming more serious, it can impair an individual's ability to think and function, which can impact a range of areas, including family relationships, being able to hold a job or maintain stable accommodation.

In recommending more psychosocial interventions in the broader mental health service system, the Sector Partners want to emphasise that we are not proposing that psychosocial interventions should be delivered in place of clinical interventions. Access to appropriate psychosocial interventions needs to take place alongside clinical care, at whatever stage of mental ill-health this is required. In addition, people need access to social, legal and other long-term social and supporting services.

The Sector Partners believe in a system of specialised treatment and care delivered through models that integrate and coordinate clinical, psychosocial and social supports for people with the most serious and persistent forms of mental ill-health. For example, through the existing Step Up Step Down services. These provide a service intervention of up to 28 days, which can include clinical service, one on one and group support psychosocial supports, as well as assistance to access and navigate a range of other services, with the aim of supporting consumers to transition to independent living and improved mental health.

There is a strong evidence base for the success of targeted psychosocial interventions in promoting recovery, particularly if they are applied early. To cite just one of these, a comprehensive literature review commissioned by Mind and undertaken by the Melbourne University Centre for Mental Health in 2016, confirmed strong evidence that people offered psychosocial interventions of the type noted above can make significant gains in their capacity to engage in social and economic participation.[3] "Interventions identified in this review have the potential to reduce the experience of impairment and provide early assistance that maximises people with psychosocial disabilities' potential to work, improve their relationships with their families and others, gain new skills, stabilise their housing and self-manage."[4]

The Sector Partners believe that an increased focus in this area will not only assist the Commission to achieve its stated reform aims in relation to the mental health system, but ensure these changes are more sustainable in the longer term. We will address other areas relating to psychosocial interventions throughout the submission.

The Sector Partners recommend that:

- The final report includes a clear statement and associated graphic that ensures psychosocial supports are available for every person experiencing mental ill-health.

[3] Laura Hayes, Lisa Brophy, Carol Harvey, Helen Herman, Eoin Killackey and Juan Jose Tellez, *Effective, evidence-based psychosocial interventions suitable for early interventions in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery,* The Centre for Mental Health, Melbourne School of Population and Global health, 2016.
[4] Ibid, 19.

Online treatment

Where the Sector Partners support the Productivity Commissions approach

The Sector Partners support the Productivity Commission's acknowledgement of existing service gaps and the opportunity for online navigation and services.

In 2014, Young and Well Cooperative Research Centre provided advice to the National Mental Health Commission regarding 'Technologies in e-Mental Health'.[5] The advice highlights the impact of piecemeal funding, sector uncertainty and a lack of a coordinated strategy as driving forces behind the service fragmentation that people accessing online information, support and treatment experience. The paper makes the case for the development of shared technology platforms, integration across different types of services, and longer-term consideration of other social service domains to truly provide person-centred care.

Tele-web services, such as online peer support forums and telephone-based help centres provide much-needed support to those unable to access other forms of treatment, however, they need to exist alongside quality in-person assessment and care, particularly for those affected by complex mental health issues who require specialist care and support. A lack of adequate funding for rural mental health services contributes to difficulties accessing appropriate services and other tragic outcomes, such as the higher suicide rates in rural and remote areas. Mental health services should be available to all, regardless of where you live, with accessible pathways available for those living in remote locations or in areas where there are other barriers to access.

Existing services could be extended to explore options for online triage and initial assessment to appropriately link people with a service that meets their needs. The Sector Partners agree with the Commission's finding that supported online treatment can also serve as an adjunct to mental health services, in some instances functioning as a way to maintain engagement between face-to-face interactions. As highlighted above, an overarching strategy and point of coordination is required to direct future integration of online mental health treatment and support services.

SANE's Online Peer Support Forums and Help Centre are the only services of their kind available to people affected by complex mental health issues. To increase reach, SANE's Online Peer Support Forums are also syndicated with 75 other partner organisations' websites, with this integration funded by the Federal Government.

Mary

Mary describes her family as "bushies in a very rural area, two hours travel away from the hospital."

Mary's 23-year-old daughter was recently diagnosed with Schizoaffective disorder with Bipolar 1 and her family felt scared and in need of more information to best support her.

After visiting SANE's Online Forums and reading some of the recent personal stories shared Mary said she "gained more information here in an hour or so reading than we have in the over two weeks since our daughter was admitted from the Doctors currently treating her."

[5] Young and Well Cooperative Research Centre, Advice on Technologies in e-Mental Health: Briefing Paper for the National Mental Health Commission. Abbotsford. October 2014.

As per recommendation 5.9, expansion and reconfiguration of mental health services should allow people to access support at a level that suits their treatment needs, that is timely and culturally appropriate, and accessible in a format that meets their needs, including to provide continuous and ongoing support following discharge from clinical services. The Sector Partners support recommendation 6.1 to integrate and expand online treatment options.

The Sector Partners believe the expansion of online treatment should also be inclusive of text-based services to cater for service users who prefer this medium.

The Sector Partners support the recommendation 5.6 encouraging commissioning agencies to implement Practitioner Online Referral Treatment Services to improve the accessibility and effectiveness of online mental healthcare treatment options. In addition to an online referral pathway, many practitioners require further information as to the services available as highlighted in recommendation 6.2 (*Develop an information campaign to promote supported online treatment*).

The Sector Partners support recommendation 6.2 to develop an information campaign to promote supported online treatment. This initiative should promote services for all types of mental health presentations, and occur in conjunction with anti-stigma and health promotion activities. While the Sector Partners support this recommendation, it is felt that an information campaign would best be executed by a mental health non-government organisation/s to ensure it is independent, with mental health expertise.

The Sector Partners recommend that:

- The proposed information campaign to promote supported online treatment is developed and delivered by a non-government mental health organisation or alliance of mental health organisations
- Online treatment is explored as an adjunct to Step Up Step Down services.

<u>Where the Sector Partners believe more work is needed</u>

The Sector Partners also support recommendation 10.1 to ensure better exchanges of information between providers by optimising digital records. Although the Productivity Commission has indicated *My Health Record* may be an appropriate platform to store information, many people have opted out of the scheme and other strategies are required to facilitate transfer of information between service providers. This recommendation could also be expanded to include a long-term goal of better integration of health services with online treatment services.

Improving mental health system navigation will improve the experience of people affected by complex mental health issues. The Sector Partners support recommendation 10.2 to ensure service providers have access to online navigation platforms offering information on pathways into the mental health system. Although the Commission has proposed PHNs or RCAs may elect to develop such platforms individually, a collaborative approach is more likely to reduce fragmentation and confusion for service users.

Furthermore, currently under the Disability Discrimination Act 1992 service providers are required to ensure information and services are provided in a non-discriminatory accessible manner. The majority of service providers would operate their online services compliant to Level A of the Web content accessibility guidelines version 2.0 - external site (WCAG 2.0) standard. However, the Sector Partners believe service providers should be encouraged to upgraded to Double A compliance over a two to five-year period. In some cases, content should be accessible to Level Triple A.

The Sector Partners recommend that:

- The proposed online navigation platforms is developed collaboratively to minimise duplication and maximise the accuracy of information on pathways and entry to the mental health system
- Resourcing is made available for an integrated national online, telephone and peer-to-peer support service for people affected by complex mental health issue that can operate as a standalone service or as an adjunct to other adult mental health services including Adult Community Mental Health Centres
- Service providers should be encouraged to upgrade their online services to comply with the Level Double A of the Web content accessibility guidelines version 2.0 - external site (WCAG 2.0) standard over a two to five-year period.

The Productivity Commission has requested further information on the provision of online treatment for culturally and linguistically diverse (CALD) communities (information request 6.1). All mental health services should consider cultural appropriateness and responsiveness in service delivery. People from culturally and linguistically diverse communities who have English as a second language may have lower health literacy, which can impact their help seeking behaviour, management and understanding of mental health issues.[6] Different communities have different understandings and approaches to help-seeking behaviour. The Sector Partners acknowledge the importance of ensuring that services including online treatment and support are appropriate for CALD communities. Working with communities to develop culturally appropriate and conceptual translations of content requires significant funding and support from governments. While there are resources and guidelines available to understand the needs of CALD communities (such as Embrace Multicultural Mental Health) more investment and support is needed to ensure services can effectively implement them.

The Sector Partners recommend that:

- Funding is made available to mental health organisations to work with CALD communities to develop conceptual translations of online mental health information, referral and support services.

[6] Australian Bureau of Statistics (2009), *Health literacy. Australian Social Trends*, accessed at https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features20June+2009

Improvements for people receiving care in hospitals

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support the intent of the Commission's reforms to improve the experience of people receiving care in hospitals. This includes ensuring that the supply of public acute mental health beds in hospitals, specialist mental health community treatment services and sub-acute/non-acute mental health bed-based services meet need on an ongoing basis (draft Recommendation 7.1). We also strongly support the Draft Report's long and short-term draft recommendations in relation to providing "more and improved alternatives to hospital emergency departments for people with acute mental illness" (draft recommendation 8.1).

As the Draft Report makes clear, presentations to emergency departments (EDs) have increased, despite them being an inappropriate place for intake and response for those experiencing mental ill-health. The lack of appropriate entry points to the mental health system see consumers stuck in EDs for long periods and subjected to treatments such as "restraints, seclusion and lengthy periods of sedation."[7] We are also aware of complaints from consumers and carers regarding the unpleasant physical configuration of EDs for someone in serious mental distress and poor training on the part of ED staff in relation to mental health presentations.

Where the Sector Partners believe more work is needed

The Sector Partners encourage the Commission to examine a role for the peer workforce in making EDs a better intake point for consumers. Even with the reforms proposed in the Draft Report, the reality is that EDs will continue to act as a key point of entry to the mental health system. The negative impacts for patients and staff could be considerably ameliorated by the introduction of mixed teams of peer/community mental health workers in EDs. The role of peers within these teams could include:

- Reducing consumer stress, deescalating potentially difficult situations, conflict resolution and liaising between consumers and staff
- Minimising the traumatic aspects of ED treatment for the consumer, by explaining to consumers what is going on and what is available in terms of treatment, reducing stigma and educating ED staff about mental health, and assisting in admission to in-patient care or referrals to other service.

Such teams would obviously need to be supported by EDs and work closely with staff. This entails changes in hospital procedures and clinical culture, which while significant, are nonetheless in line with the cultural shift envisaged by the Commission as necessary to implement a person-centred care across the mental health system.

The Sector Partners recommend that:

- Recommendation 8.1 is strengthened by clearly stating that all new ED builds and re-builds are undertaken with people with lived experience to ensure that they are safe, trauma informed and therapeutic
- The Productivity Commission investigates employing, training and supporting peer workers in EDs as part of its recommended expansion of peer workers.

[7] Australasian College for Emergency Medicine, 'Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions,' February 2018, 1.

Whilst we applaud Commission's acknowledgement of the importance of sub-acute residential mental health services in providing an effective alternative to hospital in-patient treatment for consumers, the Sector Partners believe that more work is needed to identify the optimal model for sub-acute services. The position of the Sector Partners is informed by our direct experience delivering psychosocial support for consumers in partnership with clinical teams in sub-acute settings nationally over the last decade.

Sub-acute services are typically operated by hospital-based clinical services with CMHS providers providing holistic psychosocial support. Consumers are able to access both Step Up support, where they are seeking to manage their mental health and avoid an inpatient admission, and Step Down support, where they require continued treatment in a supportive environment to further stabilise symptoms and recover from an acute episode before transitioning back into the community.

Traditionally funded through the hospital system, practice experience of the Sector Partners indicates that there is an increasing imbalance between the mix of clinical and psychosocial interventions that underpin the function of sub-acute services. The need to maintain bed throughput for hospital mental health inpatient units in response to increased demand results in downward pressure on sub-acute facilities to operate more frequently in a Step Down capacity, accepting higher acuity consumers who are being discharged earlier from inpatient units.

In turn, the increase in Step Down referrals reduces the capacity of sub-acute services to provide Step Up prevention support for people seeking to manage their mental health and avoid an inpatient admission. The capacity of CMHS provider staff to provide an effective level of psychosocial support is diminished due to the more immediate clinical needs of higher acuity consumers engaged with the service.

The Sector Partners encourage the Commission to investigate sub-acute models that allow for the separation of Step Up and Step Down care to ensure the accessibility of Step Up services for people wishing to stabilise their mental health without the need for a hospital inpatient admission. These models could include sub-acute services run directly by CMHS providers, to balance the pressure these services currently face to expand their Step Down functionality, at the expense of providing Step Up services. In the latter example, Step Up services would be operated by CMHS providers with a strong emphasis on a lived experience workforce and with clinical input. This would potentially decrease the stigma associated with accessing Step Up support, allowing a more homelike environment, and would increase the likelihood of Step Up beds being available for consumers.

In addition to the clear economic benefits of reducing hospital admissions provided by adequate provision of Step Up interventions, there is increasing evidence for the efficacy of community-managed sub-acute services, where community sector organisations employ and manage all staff, including clinical staff, within a service that has a strong recovery orientation. An evaluation by the University of Western Australia (UWA) School of Medicine of Neami National's Western Australia Mental Health Commission funded Joondalup Mental Health Step Up Step Down model[8], now being replicated across Western Australia, found that people accessing the Joondalup service:

- Reported significant reductions in psychological distress and significantly increased general self-efficacy, work and social adjustment, at service exit compared to service entry;
- Reported a high level of satisfaction with their stay overall, with at least 75% of the respondents to an Exit Questionnaire providing a rating of "Satisfied" or "Very Satisfied";
- Benefited from a reduced hospitalisation rate and risk, shorter hospital length of stay, and reduced risk of presenting to hospital emergency departments; and

[8] Ngo, H. and Geelhoed, E., *What Can Be Learned from an NGO-managed Step-up Stepdown Mental Health Prevention and Recovery Service from a Systems Impact and Service User Recovery Experience?*, University of Western Australia School of Medicine, August 2017 (Final Report, currently being prepared for publication)

- Experienced a death rate just over one-quarter of that among other similar/matched psychiatric patients who did not access Joondalup's service.

The economic analysis accompanying the evaluation demonstrated that the community-managed Step Up Step Down service model is of good value. On average, one year of sub-acute service saved approximately $516,111 for the Western Australian health system, related primarily to the cost savings of a reduced number of hospital bed days, whilst also saving around 0.28 potential years of life for each individual engaged.

The outcomes delivered through the Joondalup service model provide an example of how sub-acute services, essential to the provision of holistic, community-based mental health support that covers the spectrum of community need, could be aligned to better deliver the outcomes they were created to provide. In part, the community management of the facility acts as a check on Step Up services being diminished in favour of the Step Down component of the model by clinical operators needing to ease pressure on hospital inpatient units. We would be happy to provide any additional information in support of this assertion, including the currently unpublished University of Western Australia Final Report in relation to the evaluation of Joondalup Mental Health Step Up Step Down, as required.

The Sector Partners recommend that:

- The proposed regional service planning in relation to subacute mental health bed-based services include evaluation of service models that effectively demarcate Step Up and Step Down interventions, ensuring consistent accessibility of Step Up support for consumers across regions.

Healthcare workforce

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support the recommendation in the Draft Report to ensure that the forthcoming update of the National Mental Health Workforce Strategy aligns health workforce skills, availability and location with the need of mental health services (draft recommendation 11.1). We also agree that there is a requirement for improved mental health training for doctors (draft recommendation 11.5), for governments and specialist medical colleges to take further steps to reduce the negative perception of, and to promote, mental health as a career option (draft recommendation 11.6), and for governments to do more to attract a rural workforce (draft recommendation 11.7).

The Sector Partners congratulate the Commission on its peer workforce recommendations (draft recommendation 11.4). This recommendation shows that the Commission has recognised and accepted evidence of the vital role those with lived experience can play all levels of our mental health system.

Where the Sector Partners believe more work is needed

The most significant and pressing gap within the draft report is the omission of the community mental health workforce. The lack of attention paid to the community mental health workforce (CMHWF) is most obvious from the fact that none of the community mental health roles are represented in Box 11.1, 'Health professions most relevant to people with mental ill-health' on page 368-369 of the Draft Report. In addition, while the Draft Report contains an analysis of what is termed by many the 'missing middle' of service provision, we believe the conclusion it draws in terms of workforce planning and development – increasing the number of psychiatrists (draft recommendation 11.2) and mental health nurses (draft recommendation 11.3) – will reinforce the narrow, clinical focus and does not go far enough to ensure consumers are supported to deal with the emotional, practical and social impacts of mental health in order for them to fully participate in society.

The Productivity Commission has requested additional information on the nature and scope of the CMHWF. The following comments will focus on describing the skills and aptitudes required in a workforce that can deal with the complex social determinants of mental ill-health, how our workforce is structured, the challenges it faces, and what can be done to better support its ongoing viability.

1. The roles within our workforce

The Sector Partners employ skilled professional mental health workers that deliver different types of services within their discipline and scope of practice. Many of our staff have lived experience, which enables our organisations to draw upon their expertise to inform and deliver our services.

The below table provides a guide to the Productivity Commission of the main employees of these organisations, the minimum qualifications and experience required to work in these roles and the key responsibilities they have. These roles should be included within the Productivity Commission's description of the mental health workforce. Collectively, we have referred to them as community mental health workers.

Job title	Minimum qualifications and experience	Key responsibilities
Service Manager/ Senior Practice Lead (Neami) Practice Leaders or Team Leaders (Mind and Wellways)	• Relevant degree qualification in human services, Social Work, Occupational Therapy, Psychology and/or Mental Health Nursing or equivalent experience • Experience in clinical services, dual disability, dual diagnosis and/or mental health	• Service planning • Service coordination including supervision and mentoring of staff • Practice development and improvement • Partnership development • Day to Day management • Report writing • Incident Management on the ground • Recovery and Transition Planning
Community Mental Health Practitioner (Mind) Recovery Support Worker (Wellways) Community Rehabilitation Support Worker (Neami)	• Certificate IV in Mental Health • Experience in mental health services work and/or drug and alcohol issues, recovery oriented practice, psychosocial rehabilitation support, working with people from Aboriginal and Torres Strait Islander Communities, CALD and other diverse groups	• Individual support and group recovery programs • Support independent skills development through day-to-day supervision of daily life activities including meal planning, meal preparation, tenancy maintenance, budgeting and self-care • Support goal setting and goal attainment personalised to the consumer • Care coordination • Provides trauma-informed support • Involves family and carers • Assistance with social and community participation
Peer Support Worker (all organisations)	• Lived experience • Certificate IV in Mental Health	• Using lived experience of recovery as an intentional and purposeful way to support others in their journey • Support individual and group recovery programs • Support independent skill development through day to day supervision of daily life activities including meal planning, meal preparation, tenancy maintenance, budgeting and self-care • Support participation in community services • Contribute to consumer progress reviews

Please note: There are slight differences among the organisations in the minimum qualifications and experience required and sometimes flexibility is afforded in particular circumstances.

It is important to note that our workforce consists of many people who have an allied health degree. In some cases, these people are employed as Community Mental Health Workers and paid as such under our classification structures. In other cases, they are employed as allied health workers (such as Occupational Therapists, Mental Health Nurses) and will be paid under that classification.

2. The work of our specialised staff

The work that is undertaken by the community mental health sector is a specialised service, which cannot be replaced by another profession.

The support they provide is flexible and personalised, provided at various intensities as per intensive and moderate, to enable capacity building of individual and family/carer. There are parallels with other sectors, such as Family Violence workers and housing support staff.
It often involves:

- Goal setting and attainment – assisting consumers to identify personal goals and assisting clients to achieve them
- Promoting positive risk taking – otherwise known as dignity of risk. Enabling clients to take calculated risks to learn and grow, as part of their recovery journey
- Care coordination – referring and assisting clients to access services such as clinical care, housing, employment etc.
- Recovery-oriented assessment
- Motivational interviewing
- Trauma-informed practice - involves staff being honest, calm and predictable, building trust, having non-judgemental attitudes while modelling tolerance and acceptance, seeing challenging behaviours as a client's best efforts to solve problems and supporting active engagement in recovery goals

The nature of the therapeutic relationship with the client cannot be underestimated as it is an essential element that enables recovery-oriented rehabilitation practice. Positive relationships between community mental health workers and consumers inspire, motivate and lead to increased self-esteem, self-management and involvement in the rehabilitation process. Consumer-centred practice is characterised by collaborative and partnership approaches to practice that encourage and respect a person's autonomy, control and choice and support their right to enact these choices.

The Sector Partners believe consumers must be an active participant in the planning, assessment, implementation, evaluation and modification of their recovery goals and the rehabilitation processes that support them. A genuine, effective and active working relationship between consumer and worker that is built on trust, respect, honesty, that looks to possibilities and celebrates the individual's uniqueness means that service providers are more likely to gain the depth of understanding that truly assists with the collaborative development of the individual's plan. This includes understanding a person's motivations, interests, goals, strengths, barriers, habits, roles, possibilities, current capacity and how well the individual believes they perform tasks within their environment. A safe respectful relationship between the consumer and service provider is vital in nurturing a safe environment in which both parties can exchange feedback, discuss recovery goals and possibilities and assist the person's self-efficacy and self-determination.

The below case studies may help to explain how these roles work in practice.

Libby

Libby is a 29-year-old woman who was diagnosed with bipolar disorder and has been in and out of mental health facilities since her late teens. When transitioning from an inpatient unit in hospital to a Step Up/Step Down facility, community mental health workers work with her to identify skills and steps for her recovery journey.

Libby identifies a number of goals including living a healthier lifestyle, rebuilding the relationship with her family and exploring opportunities to participate more in the community, as well identifying strategies for wellbeing and how to maintain this when she exits the Step Up/Step Down facility.

Libby is allocated several sessions with a Family Engagement worker to meet with Libby and work with her and her family to restore her relationship and Libby's parents are provided with relevant information and details of local Carer Support groups they can contact for additional support.

A community mental health worker meets with Libby two to three times a week to initially to assist her in designing the actions required to meet her goals, including (but not limited to):

- Developing her meal planning and preparation skills, focusing on healthy eating
- Wellness planning
- Identifying and connecting Libby with activities that align to her interests, such as community groups
- Libby recognises that she needs to do more physical activity to achieve her goal of being healthier. The community mental health worker explores local options and supports Libby to join the local leisure centre and attend a weekly exercise class.
- Developing strategies to address any barriers in reaching her goals

Upon her exit from the service, Libby is better connected with her natural supports, local services and the community and has an improved resilience and capacity to self-manage and seek help with regard to her mental and physical health.

Rick

Rick is a 24-year-old young man who has a diagnosis of drug-induced psychosis, auditory hallucinations, and a mild intellectual disability.

Rick moved into a supported accommodation service two years ago. Prior to this, he had lived in 37 different types of accommodation and been evicted from all of these. As a child, Rick suffered abuse and neglect, which means he finds it very difficult to regulate his emotions. This leads to disruptive behaviour and sometimes property damage.

When Rick entered the service, he was allocated a community mental health worker who had a passion for working with people with significant trauma backgrounds. The worker recognised that Rick's disruptive behaviour were a result of him feeling shame. This shame could be a result of his needs not being met and his inability to communicate this effectively. Equally, the shame could also be about Rick feeling disempowered, unvalued and less a person than others around him.

The community mental health worker used her practice experience to develop trust and rapport with Rick over a few week period. The worker was given the scope to spend lots of time with Rick so they could get to know one another. As the relationship grew, the worker worked collaboratively with Rick so he was able to identify and communicate important goals for him. These were:

- Maintaining safe, secure and affordable accommodation
- Understanding the impacts of his mental illness on his life and finding ways to better manage this
- Developing positive relationships and having love in his life

The worker observed how Rick responded positively to her strengths based approach and supported Rick to reframe his experience of shame.

In the first nine months of Rick's stay, there were many incident reports submitted because of Rick's disruptive behaviour. However, the worker knew she would have to be patient and persistent and continue to walk alongside Rick on his journey, always there with him and never judging his reaction to things and helping him to understand reframe his experiences. Two years into Rick's time at the service and incident reports are rare; he has found love in his life and has maintained safe, secure and affordable accommodation. Rick is a valued member of the community who cares for others and helps people whenever he can. He has discovered much joy in caring about others.

3. Issues the community mental health workforce faces

a) Workforce retention:

Short contracts, uncertainty of job security due to tender processes and the introduction of the NDIS are leading to higher turnover rates.

It costs about $30,000 to replace an employee in terms of advertising, recruiting, training, on boarding and providing a shadow shift to a new staff member. There can also be the cost of paying a casual for the period between which the position becomes vacant and is filled. Funding instability, the combination of commissioning models, short-term contracts, delays in contracting and short-term notice periods for the end of contracts, are a key factor underlying staff turnover.

While we recognise that the CMHWF will benefit from the extended funding cycle for psychosocial supports proposed in draft recommendation 12.1, workforce retention will remain a significant issue given the multiple funding streams at Commonwealth and state level that CMHS providers have to deal with. It is also not clear how funding instability will be dealt with as part of the Commission's proposal to introduce regional funding pools (information request 24.1).

b) *Growing acuity:*

CMHS providers are now required to respond to a growing level of acuity caused by sustained system access barriers and increase co-morbidity with substance misuse. This affects staff stress and burnout, and mental health workers experiencing trauma vicariously through their work with clients with complex needs. The effects extend beyond the individual service worker. In a residential facility, for example, it may mean staff are required to spend more time with a person with complex needs at the cost of spending less time with other members, affecting one-on-one service provision.

c) *The transactional nature of service delivery:*

CMHS providers are struggling to cope with problems resulting from the increasingly transactional nature of mental health service delivery. This is where the cost of delivery is calculated on the principle of an 'efficient price' for transacting the support provided, without counting the true cost of what it means to provide that service. This includes the capabilities and time required to deliver the service, provide care coordination, and the emotional and mental labour, which is inherent in providing psychosocial disability support and rehabilitation. These features of service provision still occur but are unfunded, adding to service staff's workloads and emotional burden. This is also true of the kinds of liaison necessary between workers in different organisations and across service systems to ensure that support for any given individual is effective and contributes to positive outcomes.

The Sector Partners believe this is a major deficiency in the Commission's report to reform the mental health sector. In addition to its impacts on CMHS providers, failure to deal with this issue will undermine implementation of the Commission's sound proposals. The constraints imposed on service workers by low funding levels, 'efficiency' prices, tight commissioning frameworks, and the prioritisation of other economic variables at the expense of vital relational work, are often what is behind many negative experiences with the mental health service system.

The increasingly transactional and commercial nature of mental health service provision comes from a number of areas:

- PHNs: the administration of PHNs has seen small amounts of funding dispersed over large geographical areas with relatively tight timeframes, low overheads, and very tight KPIs
- NDIS pricing: the Sector Partners are aware of evidence that pay price points and the pricing of NDIS supports are having a serious impact in terms of the CMHWF. There are indications some providers are hiring more workers on lower Certificate II qualifications and on lesser pay and conditions than those on the SCHADS award. Despite increases in the NDIS 2019-20 Price Guide, which has made the delivery of core supports more viable for CMHS providers, it is our understanding that many providers are still unable to deliver core supports without

cross subsidisation from cash reserves. This will not deliver sustainable quality service provision, ultimately impacting negatively on consumers
- State-based funding is increasingly being diverted to hospitals who then contract services back to providers. Due to their own efficiency targets, they often require the same level of service at a cheaper rate.

The increasingly commercial nature of service provision favours providers with a lean business model based on rapid throughput and staff qualifications below Certificate IV skill levels. This situation is also leading to much higher rates of casualisation and staff turnover, which negatively affects care continuity, trust and rapport between client and worker, all of which are vital for effective psychosocial interventions.

4. Measures to address our workforce issues

The Community Mental Health Workforce is under considerable strain and is not being valued for its vital work.

This must be addressed by the Productivity Commission in its final report. The National Mental Health Workforce strategy must include our workforce and the community mental health sector must be consulted to develop this strategy.

The Sector Partners recommend that:

- As a matter of principle, Community Mental Health Worker, or similar term, is included in the description of the mental health workforce contained on pages 368 to 369 of the draft report
- Recommendation 11.1 is strengthened by recommending the forthcoming update of the National Mental Health Strategy must include the community mental health sector. This includes:
    - Mapping the workforce in the sector and determining the right mix of skills and experience required to deliver psychosocial supports both now and in the future
    - Support for advanced training to upskill and develop our staff to service the increasing level of acuity among our clients
    - Arrangements to support a mixed community managed mental health sector, covering allied health, peer workers psychosocial disability and rehabilitation.
    - Support for innovative strategies to build a sense of diverse, long-term career path with CMHS providers. This could include placement opportunities in both clinical and non-clinical roles
    - Quantify the future supply of community mental health workers
- The community mental health sector is consulted on the forthcoming update of the National Mental Health Strategy.

The Sector Partners also suggest a number of measures to strengthen draft recommendation 11.4. We believe these measures are vital to ensure the peer workforce is properly supported and therefore sustainable.

In addition to the Productivity Commission's proposal to implement work standards for particular areas of practice, the national guidelines on peer workers must include firm KPIs. There are already frameworks that cover peer workers, including the Victorian Department of Health's 2011 *Framework for Recovery Oriented Practice*, and the 2014 Federal Department of Health *National framework for recovery oriented mental health services*. A key reason there has been slow uptake from clinical services of these guides is the lack of enforceable KPIs. At a minimum, KPIs should include:

- Numerical targets for peers employment by the service/organisation
- Training and career paths
- The inclusion of peers in management roles
- Appropriate workplace accommodations to support employees

The inclusion of clear KPIs will help ensure the importance of peers is embedded in organisations providing mental health services. In the longer term, the Sector Partners believe there is also a need for accreditation standards to ensure peer workers are adequately trained and remunerated. The administration of this could potentially sit within the remit of the national organisation to represent peers recommended by the Commission.

The Sector Partners supports the intent of recommendation 11.4 that state and territory governments should develop a program to educate health professionals about the role and value of peer workers in improving outcomes and to improve workplace culture for peers. We would suggest, however, that this needs to occur in the short term rather than medium term, so it can immediately support other measures in draft recommendation 11.4.

The Sector Partners recommend that:

- Recommendation 11.4 is strengthened by:
    - The inclusion of KPIs in national guidelines on peer workers
    - Considering a national accreditation program to reinforce the role of peer workers and ensure adequate support and remuneration
    - The development of a program to educate health professionals about the role of peer workers to occur in the short, rather than long-term

Part III Reorienting surrounding services to people

Care integration and coordination

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners agree with the need to reorient surrounding services to people experiencing mental ill-health. This includes:

- The Commission's recommendations to expand and improve consumer assistance phone lines services (draft recommendation 10.1)
- The expanded use of digital records in mental healthcare – provided they are subject to robust privacy provisions (draft finding 10.1)
- Improved and more effective access to online navigation platforms to support referral pathways (draft recommendation 10.2) and
- The use of co-location, alliances and networks to improve service delivery and overcome barriers to service collaboration (draft finding 10.2)

The Sector Partners particularly support the Commission's proposals around improved care coordination for those with serious and persistent mental ill-health. The Sector Partners believe that the introduction of single care plans (draft recommendation 10.3) and the Commission's suggestions for improved care coordination services (recommendation 10.4) have the potential to deliver much better outcomes for consumers. One of the most significant and persistent complaints by mental health consumers and their carers and families, relates to poor continuity of care.

Where the Sector Partners believe more work is needed

Building on our earlier comments on the important role of psychosocial support services and the importance of the CMHS sector in providing these, the Sector Partners recommend three areas in which more work needs to be done to ensure the success of the Commission's recommendations.

The first relates to our previous statements on the transactional nature of service delivery. It is important to stress that improved collaboration is not just a matter of encouraging greater coordination between providers and platforms. It also means dealing with the overly transactional nature of service delivery in the mental health sector that has been discussed previously in this submission.

Memorandums of Understandings "to create clear accountability structures and overcome barriers to collaboration," (draft recommendation 10.2) already exist between service providers at all levels of the mental health system. However, there is an opportunity to improve this collaboration through clear recognition that partnership development and maintenance must be resourced properly.

The second area relates to the recommendation to develop single care plans for consumers. According to the wording of draft recommendation 10.3, these appear to be exclusively focused on the clinical aspects of care and the responsibility of a clinician. The Sector Partners urge the Commission to reconsider these aspects. Consideration should be given to non-clinical supports such as psychosocial supports, as well as physical support, including those that are delivered by the NDIS. This is in line with our previous comments on the importance of understanding the lived experience of mental ill-health as one that encapsulates clinical need but also difficulty undertaking everyday life and community tasks. The final report also needs to include more detail on proposed single care plans, including consideration of how they will be funded and what role carers will provide. Of crucial importance is ensuring that consumers are able to exercise choice and control over their care plans. This has not been explained within the draft report. Consumers should be able to choose who manages their single care plan, including self-management.

The provision of skilled care coordinators, who are able to undertake elements of case management and facilitation, system navigation, and support, will be vital to the success of single care plans. While the Commission recognises this in the Draft Report, ideally this should be subject to a formal recommendation in the final version. These care coordinators must be highly skilled people, able to work at the top of their scope of practice (and be paid accordingly), who are conversant with psychosocial supports as well as being able to liaise with clinical services.

The third area concerns the Commission's draft recommendations around psychosocial supports. As previously noted, we welcome recommendations to extend the contract length of psychosocial support services, guarantee the continuity of psychosocial supports and improve NDIS support for people with a psychosocial disability.

Part of the solution is a more comprehensive and assertive outreach on the part of the mental health service system, which underlines the intent of draft recommendations 12.2 and 12.3, and the development of a national benchmark for care coordination services (draft recommendation 10.4), although this alone is not enough. The Sector Partners suggest that what is needed is the introduction of a tiered response that provides people, including those with single care plans, access to psychosocial services (with an early intervention focus), first for a period of up to five years. Those with ongoing support needs beyond this time would automatically be eligible for the NDIS. This is an inversion of the current approach were people are asked – required in some jurisdictions – to apply for NDIS first and can only be considered for eligibility for other programs – for example, those being commissioned through PHNs), if they are deemed ineligible.

This should be administered based on a no wrong door approach, i.e., by GPs, clinical services and CMHS providers.

Ideally, in the medium term, this also needs to be part of a more coordinated, integrated and targeted system of care, underpinned by a nationally consistent and standardised approach to assessment available to anyone whose needs cannot be met by the MBS system or unable to self-manage their condition, including for psychosocial support needs. This would comprise:

- An assessment service available to anyone with mental health issues who is also showing signs of reduced functional capacity that would provide a 'red flag' or alert that a greater level of service may be required
- The use of standardised assessment tools implemented by multidisciplinary teams
- Holistic assessment undertaken over time, in the individual's regular living context, with the opportunity for the individual to identify and communicate their needs
- The collection of standardised outcomes measures and satisfaction data.

Combined with the Commission's proposals around better care coordination services and continuity of psychosocial supports, this approach would not only result in better outcomes for consumers, but more effective targeting of resources, with less waste and duplication of publicly funded services.

The Sector Partners recommend that:

- There is explicit recognition of the importance of skilled care coordinators who are able to undertake elements of case management and facilitation, system navigation, and support.
- Draft recommendation 10.3 is amended to:
    - Ensure single care plans include all aspects of a person's care, including psychosocial supports
    - Provide consumer control by allowing consumers to choose who manages their plan, including the opportunity to self-manage
- A tiered response is introduced that gives people, including those who have single care plans, access to psychosocial services for a period of up to five years, before assessing eligibility for the NDIS
- In the medium term, a more coordinated, integrated and targeted system of care is developed and underpinned by a nationally consistent and standardised approach to assessment available to anyone whose needs cannot be met by the MBS system or unable to self-manage their condition, including for psychosocial support needs.

Carers and families

The Sector Partners appreciate and support the Productivity Commission's focus on carers and families within the Draft Report and its understanding of the unique challenges mental health carers face that are distinct from other carers. We support many of the recommendations proposed and if adopted, believe they will go a long way to addressing the needs of carers and families. However, there are recommendations that could be strengthened, particularly in regard to family and carer inclusive practice.

In addition to these comments, some of the Sector Partners have made substantial contributions to other organisations' submissions who promote the rights and needs of carers, such as Mental Health Carers Australia. Mind is the coordinator of *Caring Fairly*, an Australian campaigning coalition led by specialist community organisations and peak bodies that support and advocate for carers' rights. SANE is also a member. *Caring Fairly* has provided a standalone submission to the inquiry and we support the recommendations of that submission.

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support the Productivity Commission's appreciation of the differences mental health carers face that other carers don't. We note and support the Commission's detailed discussion of these differences and wish to reiterate it is the constant demands of providing emotional support that is often the defining characteristic of this relationship, alongside the episodic and unpredictable nature of mental ill-health. Carers of people with mental health issues report poorer health and mental health themselves than any other group of carers, despite being more likely to access supportive services.[9] In this context, it is therefore important to consider that in many families, the relationship between carer and consumer is interchangeable. Carers can become consumers of mental health services, and in fact, their loved one who they have been caring for, can start to assume caring responsibilities themselves.

The roll out of the new Integrated Carer Support Service (Carer Gateway) and the provision of carer support services across Australia, including carer support planning; tailored support packages; in-person counselling, peer support and coaching; and emergency respite care will benefit all of Australia's unpaid carers.

Wellways is the single largest provider of carer support services under the Australian Government's new Integrated Support Service (Carer Gateway), delivering supports to carers in Queensland and the New South Wales regions of South West Sydney and Nepean Blue Mountains.

Carer Gateway services have been designed based on evidence provided by carers, service providers and peak bodies to improve the quality of life of carers. New services to be delivered by Wellways include:

- Carer support planning — to help carers identify what areas of support will best help them in their caring role and to develop a simple plan for ongoing support and service
- Assistance with navigating federal, state and local government and non-government schemes, including the NDIS, My Aged Care and palliative care
- Tailored financial packages — either a one-off payment for an item to assist a carer in their caring role, or ongoing practical help, such as respite or transport, over a twelve-month period.
- In-person counselling — for one-on-one support with a professional counsellor if a carer feels stressed or overwhelmed
- In-person peer support — where carers can meet with people in similar caring situations and share their stories, knowledge and experience

[9] Timothy Broady, '"How Can I Take a Break?" Coping Strategies and Support Needs of Mental Health Carers', *Social Work in Mental Health*, vol. 13, no. 4, 2015, p318-335.

- In-person coaching – where carers can work one-on-one with a qualified coach to gain skills and resilience to help them as a carer. Carers can reflect on how they are going, how they would like things to be, and how they might take steps towards making things happen
- Emergency respite care – to make sure the person carers care for will be looked after if an urgent or unplanned event stops the carer from being there.

Through the Carer Gateway, carers will be provided, for the first time, with opportunities to access a range of tailored supports and services to help them manage their daily challenges, reduce stress and plan for their future. The new services will focus on providing carers with access to early-intervention, preventative and skill building supports, to improve their own well-being and long-term outcomes, in their own right, no matter whom they are caring for. The Sector Partners not only support the Productivity Commission's recognition of differences mental health carers face from other carers, but also agrees with the Commission's Draft Recommendation 23.2, in particular the continued role of the Australian Government in administering the Carer Gateway's service navigation, information and provision of support for all carers.

The Sector Partners support Draft recommendation 13.2 in its current form, and we thank the Productivity Commission for this recommendation.

Where the Sector Partners believe more work is needed

Family and carers need to be included more within our mental health system. To this end, we are generally supportive of Draft Recommendation 13.3 to enable more carer-inclusive practice and thanks for the Productivity Commission for considering these steps.

However, we think the report could be considerably strengthened by a stronger statement of the important role that families and carers have in their loved one's recovery journey. Following on from this, it would also benefit from a clear assertion that there must be collaboration between the mental health professional, the consumer and the carer.

The Triangle of Care, as developed by the UK Carers Trust,[10] re-printed in *A Practical Guide For Working With Carers Of People With A Mental Illness* (the Guide)[11] and pictured below, clearly demonstrates the model we are striving towards; where consumers, carers and service providers work together in a partnership model.

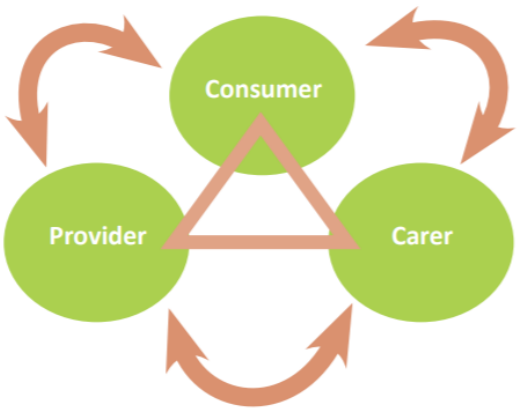

Diagram: Triangle of Care model

[10]See:https://professionals.carers.org/sites/default/files/thetriangleofcare_guidetobestpracticeinmentalhealthcare_england.pdf
[11] *A practical guide for working with carers of people with a mental illness*, March 2016, Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network (Australia), Mental Health Carers Arafmi Australia and Mental Health Australia.

To implement this model, the Sector Partners believe that carer inclusive practices and tools based on the Guide are mandated. The Guide has been developed and endorsed by Mind, Helping Minds, Mental Health Australia, Private Mental Health Consumer Carer Network (now Lived Experience Australia) and Mental Health Carers Australia. It was developed to assist staff across service settings in Australia in recognition and support of carers, to enable them to continue in their role as partners in recovery.

We thank the Productivity Commission for understanding and explaining in detail the important part the Guide plays in providing staff additional skills to work effectively with carers. However, despite organisational support and implementation of this guide, there is still a lack of carer inclusive practices within mental health services.

Mind has been running a pilot to embed the Practical Guide into all areas of practice, operations and governance through co-designed approaches with consumers and carers. The pilot has found that while a number of the technical elements of the Practical Guide are in place to meet standards of the Guide, further work is needed to embed an understanding of broader definitions of carers and families, how carers and families can best be supported to have a role within the support team and what carer and family inclusion means in practice – from a carer and family perspective. Meeting the standards of the Practical Guide consistently requires attitudes, practices and policies that support it at all levels of organisations; reflection on approaches to carer and family inclusion in traditionally individualistic models of care; and the active participation of carers and families in key decisions, design processes and evaluation of outcomes.

The Sector Partners believe that many mental health practitioners intend to work with families and carers, however, when resources are stretched and practitioners are time-poor, it is often families and carers who are forgotten.

While we support the suggestion in draft recommendation 13.3 to routinely collect responses to the Carer Experience Survey, we believe that this is the second step to improving carer inclusive practice, as it would merely provide feedback on how services are including carers and provide incentive to improve. The first step is to increase carer inclusive practice within services, and we believe that this would be best achieved through mandating practices based on the Guide.

The Sector Partners broadly support draft recommendation 13.1 to reduce barriers to accessing income support for mental health carers. However, we believe this recommendation could be strengthened in regard to the ‘25 hour rule’ as we believe this inquiry provides the opportunity to abolish the ’25 hour rule’ entirely. For a detailed discussion of the reasons for this recommendation, please see the *Caring Fairly* submission.

The Sector Partners wish to reiterate that there must be a greater focus on ensuring that workplaces are carer inclusive as well. In accordance with the recommendations of the *Caring Fairly* submission, we believe unpaid carers need tailored employment support services. As noted above, while recommendation 13.2 is welcome, it is unlikely to be sustainable without workplaces implementing practices at the senior level to enable carers to maintain employment in their chosen profession.

Caring Fairly advocates for a National Framework for Carer Inclusive Workplaces to specifically address the needs of carers. This would assist to inform and educate workplaces about the unpredictability of mental ill-health and enable a greater understanding of how workplaces can assist carers at work.

A National Framework for Carer Inclusive Workplaces could involve the Department of Social Services, together with the Department of Employment, Skills, Small and Family Business, the National Mental Health Commission and the Department of Health (or associated departments) investing and co-designing a framework, informed by sector representatives.

The Sector Partners disagree with the timeframes recommended by the Commission in regard to the Productivity Commission's Draft Recommendation 13.3. The Sector Partners believe family inclusive practice should be introduced as soon as practicable. Those with lived experiences of mental health issues generally have much better mental health outcomes when family support is available and present. This requires families to be involved in care. When we address the impacts of mental health in a family relationship context this in turn supports greater holistic benefits both to the family unity and to the individuals involved.

Inclusion of individuals, carers and families in relation to improving people's experience with mental healthcare should be the starting point. The Sector Partners believe the Productivity Commission's final report needs to further consider families and carers across all key reform areas.

Family and carer inclusive practice and consultation should be the rule, not the exception. Culturally appropriate approaches that account for various cultures and flexibility to work with varying family structures and dynamics should also be considered. Models exist that can be implemented sooner, rather than later.

The Sector Partners also wish to reiterate comments made in the *Caring Fairly* submission about gender inequality among carers. While the Productivity Commission has identified the gendered nature of caring, we are concerned there are no recommendations to specifically assist women to continue in their caring role without facing further economic and social disadvantage.

The Sector Partners recommend that:

- The '25 hour rule' is abolished
- Recommendation 13.3 is strengthened by mandating carer inclusive practices, based on the Practical Guide to Working with Families and Carers, as a matter of priority
- A National Framework for Carer Inclusive Practice is implemented and developed by a cross-departmental group working with carers
- The gendered nature of caring is recognised and addressed through:
    - The Government reinstating a formal government commitment to producing annual gender budget analyses to examine the effects of tax, spending and economic policy on women
    - The Workforce Gender Equality Agency is involved in any policy decisions, which affect carers' participation in the workforce
    - Investigations into the economic benefits of providing the superannuation guarantee to carers on the Carer Payment.

Income Support

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support the Productivity Commission's appreciation of the differences mental health consumers face from other people requiring employment support. We acknowledge and support the Commission's detailed discussion of these differences and the specific barriers to attaining employment faced by people experiencing severe and more moderate forms of mental ill-health.

Specifically, we strongly support the inclusion of Draft Recommendation 14.3 and the call for a staged national rollout of the Individual Placement and Support (IPS) model. Implementing a system that works to get people employed and to stay employed is an essential component of the mental health system. The IPS model provides positive outcomes for individuals and families, as well as significant potential savings for all levels of government as identified in the Draft Report.

The Sector Partners support Draft Recommendation 14.4 and the increased flexibility sought for Newstart and Youth Allowance recipients experiencing barriers to employment due to the challenges associated with mental ill-health. In combination with Draft Recommendation 14.3 and the call for a national rollout of employment support predicated on the IPS model, we agree that these measures will result in positive outcomes for consumers and carers through better alignment of income and employment support with the experience of mental ill-health.

Where the Sector Partners believe more work is needed

In relation to Information Request 14.1, the Sector Partners prefer direct employment of IPS employment specialists by CMHS providers. CMHS providers are uniquely placed within the Australian mental health system, maintaining a large, experienced workforce practiced in the engagement of people across the continuum of mental ill-health. The CMHS provider workforce has a specialist understanding of the recovery context in which employment activities are conducted.

In this context, we suggest the direct employment of IPS specialists within established CMHS programming. Given the value ascribed in the Draft Report of aligning employment opportunities to the employment preferences of individuals, the person-centred, relational engagement approaches employed by CMHS provider staff offer significant value for the IPS model, predicated as it is on rapid job search and strong working relationships between individuals, IPS specialists, clinical teams and employers.

With a focus on supporting individuals to identify the personal strengths and values that underpin their recovery, CMHS provider staff efficiently develop the interpersonal connection with consumers crucial to establishing an individual's employment preferences and perceived barriers. The CMHS sector also offers a broad range of community-based programming tailored to the needs of people experiencing mental ill-health, ensuring that the vocational support provided by IPS employment specialists is situated within a targeted recovery context.

IPS employment specialists situated within these programs benefit from the skills, experience and support of multi-disciplinary program staff. Importantly, this option also mitigates the need for individuals to re-tell their story when accessing a separate IPS employment service and streamlines shared care processes, with other program staff able to support individual consumers in the event the IPS employment specialist is unavailable.

Embedding IPS specialists within CMHS sector programming in this manner provides continuity of care for individual consumers through leveraging established organisational and individual care team relationships, as employment support is situated within an established care structure. Working with an IPS employment specialist, consumers receive flexible, tailored support that promotes the recovery benefits of social inclusion and that is closely integrated with a range of other support services.

Researchers at the University of Sydney and La Trobe University have evaluated the outcomes achieved by one example of this type of arrangement, Neami National's WorkWell program. The study found that WorkWell appears to support positive employment outcomes, including sustaining employment beyond 13 weeks.[12] The emergent findings of the evaluation present promising opportunities for further exploration into how the integrated CMHS/IPS approach can be optimised to enhance open employment placement rates across Australia.

The Sector Partners recommend that:

- Any staged rollout of the Individual Placement and Support model prioritise direct employment of IPS employment specialists by community mental health services to ensure that consumers benefit from the skills, experience and support of multi-disciplinary program staff and established service relationships and structures.

As highlighted by Information Request 14.2, more work is needed to assess how to best incentivise the uptake of employment opportunities for recipients of the Disability Support Pension (DSP) experiencing mental ill-health. Of particular interest to many consumers engaged with CMHS providers is the impact of current income threshold and taper rates on their capacity to enter into paid CMHS and other consumer participation opportunities.

The issue of paid consumer participation is unique in that these opportunities, essential to the development of effective mental health programming, are generally offered at rates well above the minimum wage. The reasons for this are acknowledged by the Commission in the discussion of co-design principles on page 908 of Volume II of the Draft Report and are consistent with the approach taken by the Sector Partners when offering paid co-design opportunities to consumers: the desire to provide remuneration consistent with the value ascribed to the input of consumers as the experts in their own experience and as representatives of consumers as the fundamental drivers of service design and delivery.

In this context, it is not uncommon for consumers to be paid $40-50 per hour in recognition of their expertise and the crucial nature of the insights and knowledge they provide. Rates of pay thus respect the dignity and expertise of consumers engaged in work and acknowledge the additional barriers they must overcome when providing their time and expertise.

The reality faced by consumers, as well as the services seeking their engagement through paid consumer participation, is that many people who would like, and are able, to work decline to do so through fear of losing all or part of their DSP due to the income threshold. Mental health policy demands meaningful co-design and the involvement of people with lived experience at all steps of service design, delivery and evaluation and that dignity and value of consumer participation is recognised with financial reward. However, income support policy penalises people for their contribution and participation within a system which is difficult and stressful to navigate where people have variable income.

Given the benefits of employment for people experiencing mental ill-health, the Sector Partners wish to highlight the benefits that increasing the DSP income threshold would have on the capacity of DSP recipients to accept opportunities for paid consumer participation. Although consumer participation makes up a small proportion of employment opportunities overall, they are of immense value to consumers as they represent a tailored employment opportunity that reflects the episodic nature of mental ill-health, as opportunities are generally project-based and/or cyclical and seek to utilise and build on the strengths and experiences of people in a way most other employment opportunities are unable to match.

[12] Scanlan, J.N., Feder, K., Ennals, P., & Hancock, N. 2019. 'Outcomes of an individual placement and support programme incorporating principles of the collaborative recovery model' *Australian Occupational Therapy Journal*.

At the current DSP income threshold of $174 per fortnight, people wishing to accept a consumer participation opportunity at $50 per hour who are unwilling to risk any impact to their DSP would be restricted to contributing 3-hours of their time over a two-week period. This hampers service system efforts to engage people more fully and acts as a disincentive to consumers unwilling to disrupt their daily lives for such a limited scope of engagement.

An increase to the income threshold would go some way to addressing these concerns in the context of paid consumer participation, allowing the greater social and economic participation so important to improved mental health outcomes. In addition, the Sector Partners suggest that an extension of this component of the Commission's enquiry include greater emphasis on how the DSP model could allow for the switch between full-time work, when people are well and receiving industry awards, and the DSP when people are episodically unwell and unable to generate income. Along with supporting consumers and the mental health system to take better advantage of co-design opportunities, it is suggested that such an approach would allow a much greater number of consumers to enter the workforce, with the DSP acting as financial security and encouraging increased participation.

The Sector Partners recommend that:

- An increase to the DSP income threshold and greater flexibility within the DSP is provided to align DSP income security with the episodic nature of mental ill-health and the periodic capacity of consumers to engage in paid employment currently outside the scope of permitted income levels.

Housing and homelessness

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners welcome the substantial focus in the Draft Report on homelessness and housing issues and their links to mental ill-health and recovery, as housing is the foundation for mental health.

We strongly support the context and direction of the proposals for action contained in draft recommendation 15.1 and 15.2.

Where the Sector Partners believe more work is needed

The Sector Partners believe there are some distinct areas where the Commission could sharpen its focus on housing and homelessness issues.

1. Social housing stock

The chronic underinvestment in social, including public and supported housing, in Australia is widely recognised, including in the Commission's own report and by numerous other commentators.[13] While we acknowledge that reversing this trend is a long-term task, which must be tackled on many levels, we believe the draft recommendations regarding stock in 15.2 need to be strengthened to make it clear that state and territory governments should increase social housing expenditure across the board.

The reality is that without more stock, many of the recommendations in the Commission's report simply will not work. To offer one example, the Sector Partners agree there is merit in governments committing to a nationally consistent policy of no exits into homelessness for people with mental ill-health who are discharged from institutional care, including ensuring that these people receive a comprehensive mental health discharge plan (draft recommendation 15.2). This already occurs in most services that accommodate those with mental ill-health for any period of time.

From our experience, staff in services such as Step Up Step Down, Community Recovery Programs, Community Care Units and youth residential care, spend a considerable amount of time on discharge planning, of which post-discharge accommodation is often a central focus. Detailed discharge planning sometimes begins from the moment the consumer enters the service. There are also a range of relationships in place with a wide range of service providers, including housing and homelessness services, to ensure no exits take place into homelessness.

There are indications, however, that despite the best efforts of staff, consumers leaving services do exit to secondary (moving between short term accommodation options) and tertiary homelessness (private boarding houses and private, low services congregate care setting such as supported residential services as they are known in Victoria).

A nationally consistent policy of no exits to homelessness may, indeed, prevent services from discharging individuals into homelessness but the accommodation that is provided is often only temporary, i.e., a couple of nights in a motel, after which the client may become homeless. Indeed, it may also create perverse outcomes as some short-term mental health accommodation services may exclude admissions directly from the homelessness service system as they fear they will be 'stuck' with the responsibility for housing the individual upon discharge. While there are a number of factors underlining this situation, which is particularly serious in regional areas, a key issue is a lack of social housing stock.

[13] To cite just one of numerous pieces on commentary to this effect see, 'Australia needs to triple its social housing by 2036. This is the best way to do it,' Julie Lawson, Hal Pawson, Laurence Troy, Ryan van den Nouwelant, *The Conversation*, November 15, 2018.

2. People experiencing mental ill-health who require housing + support

Mind has invested significantly in research to understand the links between mental health and housing, by partnering with the Australian Housing and Urban Research Institute to develop *Trajectories: the interplay between mental health and housing pathways.*

The report includes 130 interviews with families and carers, which, as far as we are aware, is the largest body of lived experience knowledge on mental health and housing in Australia. The report will be launched on 19 February and Mind would be pleased to provide a copy to the Commissioners to assist in preparing the final report. Initial findings from the research suggests that people experiencing mental ill-health and housing difficulties benefit from circuit breakers which enable them to stabilise and recover.

Since 2011, Wellways has delivered the Doorway Program funded by the State Government assisting people who are homeless with serious mental illness to access the private rental market. The Doorway program embeds a Housing First approach, ensuring people gain a home as the primary intervention with participant directed support embedded thereafter. The Doorway Program works in partnership with four major hospitals in Victoria and real estate agents in the community.

The interventions in draft recommendation 15.1 aimed at preventing people experiencing mental ill-health from losing their home are an important intervention. This includes that each state and territory government offer and encourage the use of mental health training and resources for social housing workers. There is also an urgent need to ensure tenants experiencing mental ill-health who live in the private housing market have the same ready access to tenancy support services as those in social housing.

The Sector Partners acknowledge that the issue of homelessness is complex and multifaceted, therefore a flexible and individually tailored responses are required to meet service demands, including interventions such as Private Rental Access Program (PRAP) and PRAP Plus to effectively assist people to sustain a home in the private rental market. Additionally funding is needed to provide targeted outreach support where tenancies are at risk. Targeted housing and recovery support is essential to assisting people to maintain a tenancy in the community, without support, evidence suggests higher rates of tenancy arrears and evictions.

Subsidised housing models have shown efficacy in supporting individuals with mental ill-health to secure and maintain a home in private rental, this is reflected in individuals increased participation in their community and reduction in clinical hospital service utilisation (Nous, 2014). The Sector Partners support further extensions to PRAP funding and similar arrangements across Australian Government and State and Territory Governments to provide on-going rental subsidies to people living in private rental thereby reducing the demand on social housing and increasing accessibility and sustainability to tenancies in the community.

The shortfall in NDIS accommodation for those experiencing mental ill-health and the underinvestment in social housing mean that for a large number of individuals experiencing moderate to severe mental ill-health, the private rental market will be a key, if not for many of these people, the only housing option available. While brokerage funds of the type suggested in draft recommendation 15.1 and explored at length in the Draft Report are a vital part of the support that needs to be provided, the Trajectories study suggests private rental interventions also need to take into account of a number of other factors, including:

- How they relate to the provision of housing in a location that is meaningful and safe for the consumer
- How interventions are connected to a trusted worker who is able to engage in more than a transactional level of service provision and can assist in issues beyond managing medication and symptoms of mental ill-health
- The importance of housing design and configuration.

The Sector Partners also recommend the Commission explore the possibility of extending draft recommendation 15.1 to include mental health training for private sector real estate agents and landlords. It is the experience of many of the people who use our services that stigma and discrimination towards those experiencing mental ill-health on the part of landlords and real estate agents is a very significant issue.

The Sector Partners would advocate that each State and Territory Government, with support of the Australian Government engage with their relevant Real Estate Institute to commission community organisations to deliver mental health training to real estate agents, and in addition, increase private rental access for people on a low income. For example, expansions to National Rental Affordability Scheme. In addition, we would encourage governments to work with property developers in designing quality rental properties and a fixed proportion of these new builds must be allocated to social housing, and this must be income tested for access. To further support people, he Sector Partners support the provision of 12-18 months support to these individuals to assist the person at risk and the landlord.

The recognition of the urgent need to review the NDIA's Specialist Disability Accommodation (SDA), which could substantially help this group, is welcome. There is a strong perception SDA is not applicable for those with psychosocial disability. We understand that of the 348 participants with a primary psychosocial disability who receive SDA funding nearly 72% (250) have come from one psychiatric institution in NSW. Excluding those from this one institution, this leaves only 148 participants with a primary psychosocial disability that receive SDA funding. This demonstrates that SDA funding is not being included in NDIS plans for people with severe and persistent mental ill-health who need long-term accommodation.

The Sector Partners recommend that:

- There is a clear recommendation that states that all States and Territories must immediately increase social housing stock
- Recommendation 15.1 is strengthened by ensuring mental health training and resources are provided to private rental agents and landlords
- There is a greater focus on design and configuration for people who need a medium-term intensive housing response that combines accommodation and support
- There is focused funding to provide targeted outreach support where tenancies are at risk
- Homelessness and housing program commissioners should allocate funding on evidence-based models, including but not limited to Housing First.

3. Efficacy of By Name Lists in Responding to Homelessness

Page 583 of Volume I of the Draft Report notes that "There is scope to supplement the current suite of homelessness services with specialised programs that have been shown to be effective at improving housing outcomes for (people with severe and complex mental illness)", that "homelessness services that are well coordinated with mental health and other services (such as drug and alcohol or family and domestic violence services) are more effective at supporting people who are homeless", and that "in many cases, the agencies providing these services work independently from each other." The Commission also highlights "a need to better coordinate or integrate housing, homelessness, mental health and other services."

In this context, the Sector Partners suggest that the call for a national response to homelessness and an increase of existing homelessness services contained in Draft Recommendation 15.2 could be improved by acknowledging the national and international efficacy of *By Name Lists* in promoting improved service coordination and housing outcomes for people experiencing homelessness.

Although not specific to people experiencing mental illness, the use of *By Name Lists* for addressing homelessness, in particular primary homelessness and rough sleeping, is supported by Australian and international experience and evidence. One of the Sector Partners, Neami National, leads the South Australian Department for Communities and Social Inclusion funded Street to Home program, a housing-first approach to supporting people rough sleeping in the Adelaide CBD to find and maintain sustainable housing. Street to Home coordinates cross-sector collaboration that provides assertive street outreach, clinical street outreach and post-crisis support for people rough sleeping.

As one element of this lead role, Neami National is a core partner of the Adelaide Zero Project (AZP), coordinated by the Don Dunstan Foundation. The AZP is a collective action approach to achieving 'functional zero' in relation to people rough sleeping in Adelaide's CBD. Functional Zero street homelessness is demonstrated when the number of people rough sleeping is no greater than the housing available in that month, and this can be consistently proven with data. The AZP is situated internationally within the broader Institute of Global Homelessness (IGH) – A Place to Call Home initiative, with Adelaide and Sydney becoming the first Australian cities to commit to achieving functional zero as part of A Place to Call Home. To date, the IGH initiative has resulted in three communities achieving functional zero in the US alone.

Essential to the AZP, as well as the Sydney-based equivalent and the international IGH initiative, is the development of a *By Name List* that:

- Gives services the opportunity to know the names of individuals sleeping rough and to provide tailored support, rather than people simply being a number in a wider system
- Provides a picture in real time of people experiencing homelessness / rough sleeping in the inner city of Adelaide and
- Affords a mechanism to assess the housing or support intervention required by each person to exit homelessness permanently.

Adelaide's *By Name List*, developed and coordinated by Neami National, is officially accredited by Community Solutions, a US based organisation promoting the use of quality data to address social issues and helping communities around the world end homelessness. The By Name List has proven effective in providing services with information on the complexity of need experienced by people and their potential need for post-crisis support once housed, making it possible to allocate the highest intensity of support to people with the highest needs, with lower intensity or episodic support provided to people whose self-management skills are more advanced. Analysis of By Name List data also identifies common tipping points into homelessness, allowing upstream services across sectors to understand and support prevention and early intervention initiatives within a seamless and collaborative response across the continuum of housing need.

The application of the *By Name List* approach to supporting people with mental illness experiencing homelessness is underlined by Adelaide *By Name List* data indicating that 81.6% of rough sleepers reported mental health issues.[14] Other *By Name List* data analysis reveals that:

- 76.7% of rough sleepers reported physical health issues
- 79.2% of rough sleepers reported substance misuse
- 54.9% of rough sleepers report experiencing a simultaneous combination of physical, mental and substance misuse
- 59% of rough sleepers report homelessness being influenced by a relationship breakdown
- 74% of people on the BNL were living with friends or family, or in their own house prior to rough sleeping
- 35% were in secure housing, 39% were staying with family and friends temporarily.[15]

[14] Data from the community-owned Adelaide Zero Project By Name List

[15] Ibid

In combination with other functions of the *By Name List*, including transparency and insight around multiple service usage by individuals and the capacity to monitor failed exits from homelessness through people returning to the *By Name List*, the Sector Partners suggest that the implementation of such an approach in communities across Australia would provide a significant improvement in the quality of data relating to people with a mental illness experiencing homelessness. In turn, this would allow a more coordinated and effective suite of interventions at both a community and national level, with data and analysis from each community made available to support efforts in other parts of the country.

The Sector Partners recommend that:

- The proposed investment to increase homelessness services include a provision to develop *By Name List* data in each capital city in the short term and across regional and rural areas in the longer term to ensure improved service coordination and housing outcomes for people experiencing mental ill-health.

4. Creation and implementation of a National Housing Policy in Australia

The Sector Partners believe there must be a federal housing policy in Australia that drives housing and homelessness service improvements across the health sector. This policy should articulate the importance of service collaboration and integration between all health based services, and provide flexible responses for people experiencing homelessness, or risks to tenure. It must ensure that there is a 'no wrong door' approach and that organisations who are commissioned to deliver service to this population group are delivering evidence-based interventions, such a Housing First models. In addition, funding models should be designed to work fluidly across these sectors to aid better service integration and delivery to the end user.

For example, Canada have implemented a National Housing Strategy that focusses on a holistic approach to homelessness investing $55 billion to building stronger communities and increasing Canadians access to safe and affordable housing through private and social housing methods. We must have a National Housing Policy in Australia that operates from the premise that all Australians have the right to safe and affordable housing, and that a multi-agency approach is taken to assist people to achieve this. It is also essential to understand the social determinants of homelessness when driving such policy and for these considerations to be actions in funding models. For example, the impact of poverty on homelessness - those living on a Centrelink income simple cannot access the private housing market without assistance due to the cost of living outweighing benefits. This Housing Policy should also look for opportunities to increase private and social housing stock, aligning to scattered site models that are evidenced to be most effective to supporting people with mental health issues to live within a community of their choice and live a good life.

The Sector Partners believe there must be improved service integration between housing, community and clinical services to support effective service delivery to reduce the silos within these sectors. In addition, that specialist homelessness programs are delivered in collaboration between these services. Where this occurs, the most effective models of care integrate housing and mental health support roles within the one position for a streamlined approach to care.

In addition to scaling up Housing First programs in jurisdictions to support individuals whom have experience long term homelessness, the Sector Partners would advocate that services are funded to deliver Assertive Outreach Team responses to engage with people who have experienced long term homelessness offering brokerage packages to meet individuals immediate health needs, whilst also linking them to housing as a priority response.

For individuals exiting institutional care, in addition to creating policy for no exits into homelessness and formalised discharge plans, there must be Housing and Mental Health support staff co-located in these organisations to facilitate the transition for individuals from care into the community. A 'no exit into homelessness' policy will not be enough without dedicated staff to fulfil this work and housing stock to assist. These support roles should be commissioned to community organisations and should

assist people to secure longer-term accommodation plans (18-24 month), and connections to services in the community alongside their discharge plan. The Sector Partners would suggest a CMHS provider is funded to in-reach to institutions to assist people whom clinical service and prisons identify as being at risk of homelessness, and work alongside the care team to support the individual into a planned service and accommodation discharge plan, and this worker would then transition them into the community providing longer term care.

The Sector Partners recommend that:

- A federal housing policy in Australia is established to drive housing and homelessness service improvements across the health sector. This policy should articulate the importance of service collaboration and integration between all health based services, and provide flexible responses for people experiencing homelessness, or risks to tenure.

Justice system

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support Draft Recommendation 16.3, in particular the focus on information sharing and continuity of care for individuals experiencing mental ill-health.

Where the Sector Partners believe more work is needed

We also strongly support the Commission's focus on transition support for people being released from correctional facilities, as outlined in Information Request 16.1. Transition support is an essential component of care for people treated by the Prison Mental Health Service (PMHS), safeguarding any gains made by individuals in relation to their mental health whilst in prison and ensuring that individuals released from prison have in place those things that support ongoing recovery, including stable housing, opportunities to connect with the community and service referrals equal to the complexity of support needs. The Sector Partners deliver services that speak directly to this issue and that may inform the Commission in the context of Information Request 16.1.

Individual Recovery Support – Transition from Correctional Facilities Program

Among the broad range of community mental health programming delivered by the Sector Partners are services involved in the effort to address this gap. The Individual Recovery Support – Transition from Correctional Facilities Program (IRS-TCFP), funded by Queensland Health and delivered in Cairns and Townsville by Neami National, provides support for individuals experiencing a severe mental illness and about to be released to the community from a Queensland adult correctional facility. Referrals originate from the PMHS.

In the ACT the Detention Exit Community Outreach (DECO) Program, delivered by Wellways and funded by ACT Health, supports people with diagnosed mental health issues to transition back into the community after a period in detention. Guided by Wellways' Well Together model, community outreach workers provide participants with intensive case management and psychosocial support, helping them manage their mental health, build or rebuild relationships with friends and family, and find employment.

Both the IRS-TCFP and DECO programs offer a range of non-clinical, psychosocial wraparound supports to an individual prior to release from the correctional facility (where the date is known) and for up to 12 months post release. Initial support under the IRS-TCFP is offered at a high intensity and frequency for a period of up to three months, followed by a period of up to nine months access to non-clinical supports at a lesser intensity and frequency.

Supports through the IRS-TCFP are informed by the Transition Plan developed by PMHS in collaboration with the community mental health service and the individual prior to the individual's release. Once the individual is in the community, any changes to the Transition Plan occur with guidance from the relevant clinical team. PMHS stay involved with an individual for up to two weeks post release and clinical responsibility is mostly handed over to the community mental health team.

IRS-TCFP and DECO Service Findings

The Sector Partners agree with the conclusion of the Draft Report that coordination between PMHS and community-based mental health services is inadequate or lacking. The Neami IRS-TCFP service experience highlights some areas of focus that would promote better mental health support for people transitioning from a correctional facility:

- Access to out of hours emergency accommodation to augment transitional housing options
- Access to individual brokerage as part of a release package; the package could include bus passes, toiletries, grocery vouchers, clothes vouchers and support with other basic needs that underpin an individual's capacity to engage in mental health recovery
- Psychologist referrals as a way of strengthening continuation of support

- Greater emphasis on developing elements of the Transition Plan whilst people are in prison to ensure timely access to services upon release; an example is Department of Housing applications, often held up on release due to insufficient identification documents, all of which could potentially be progressed whilst the individual is incarcerated
- Greater definition of the roles and responsibilities of each service involved in the transition process and the streamlining of the currently complex bureaucratic processes that hamper continuation of support; a lack of clarity often occurs with which service is doing what – for example, a Transition Plan may be developed by one service only to find out that another service has also created a plan, leading to confusion for services and disruption for the individual, PHMS and community-based services
- Increased collaboration between all services involved in the individual's transition into the community; Draft Recommendation 10.4 provides one example of how this might be effectively introduced
- Clearer communication of release dates and associated information to assist community-based services with transition planning; currently, little to no advance notice of a person being released – frequently just before close of business hours on a Friday - results in limited resources and availability of services, hampering release efforts and the smooth transition from the corrections facility
- Additional resources targeted at following people who identify as Aboriginal and/or Torres Strait Islander through to their community

Since 2015, of those who have participated in the Wellways delivered DECO program, 93 percent have not reoffended. The DECO program's success rate stands in stark contrast to broader recidivism rates. Data from a comparative study undertaken by the Productivity Commission highlighted almost 40 percent of ACT adults released from prison returned to jail with a new sentence within two years. The DECO program further encourages and promotes social inclusion, along with increasing participant access to meaningful employment and/or education and training opportunities. It also links them with third party support services to ensure they are receiving the support and assistance they require to achieve their individual goals and plans.

Both the IRS-TCFP and DECO programs provide long-term cost saving and social benefits for authorities with the reduction in recidivism, the broader community and of course, the individual concerned.

Part IV Early intervention and prevention

Workplaces

Where the Sector Partners support the Productivity Commission's approach

People experiencing mental health conditions are three times more likely to be unemployed than the general population – this ratio is among the highest in the Organisation of Economic Co-Operation and Development (OECD), based on an OECD 2015 report examining evidence to practice in mental health and work.[16] The Sector Partners support the Productivity Commission's appreciation of the importance of the links between employment and mental health. We appreciate the acknowledgement that workplaces can both help a person's recovery and, in poorly designed workplaces, can undermine the mental health of employees.

We believe that a mentally healthy workplace is one that protects and promotes mental health as equally important as physical health and empowers people to seek help for their mental health issues, for the benefit of the individual, organisation and community.

We support many of the recommendations proposed and if adopted, believe they will go a long way in creating mentally healthy workplaces that give mental health the same priority as physical health. However, we believe some of the recommendations can be strengthened.

The Sector Partners support Draft recommendation 19.4 in its current form.

Where the Sector Partners believes more work is needed

The Sector Partners broadly support Draft recommendation 19.5 regarding dissemination information on workplace interventions. However, we believe that this can be strengthened through Workplaces Health and Safety (WHS) regulators and CMHS providers sharing evidence and coproducing resources on how to build and maintain mentally healthy workplaces.

The Sector Partners broadly support Draft recommendation 19.2, to develop codes of practice on employer duty of care. However, we believe this can be strengthened in several ways.

The Productivity Commission draft report mentions stigma as one of the organisational risk factors to workplace mental health, but we believe a greater focus on reducing stigma and discrimination is needed. Draft recommendation 19.2 can be strengthened by explicitly stating the importance of creating inclusive workplaces that are free from mental health stigma.

This recommendation should also encourage managers and human resource professionals to work collaboratively with the employee and their treating practitioners to develop return to work plans & stay at work plans, that better support employees with psychological health issues, and facilitate psychological safety at work. There should also be a focus on ensuring that all employers have an Employee Assistance Program that provides psychological support services to all employees.

The Sector Partners believe the report can be strengthened by including a stronger focus on the importance of creating inclusive workplaces free from stigma and discrimination, and that support people with existing mental health issues in joining or returning to the workforce and staying at work.

A mentally healthy workplace is not only a workplace that recognises and manages workplace related risks, but also supports people with existing mental health issues and works to reduce the stigma surrounding mental health issues. The ongoing management of mental health issues that are not

[16] OECD 2015, *Fit Mind Fit Job: From Evidence to Practice in Mental Health and Work*, https://read.oecd-ilibrary.org/employment/fit-mind-fit-job_9789264228283-en#page12

triggered by a workplace risk is an important component of creating mentally healthy workplaces and is intimately linked to mental health stigma and discrimination in the workplace.

Stigma and discrimination around mental health issues can make it less likely that people will stay in long- term employment and have access to promotions. It can affect their interaction with colleagues and influence employers' hiring and promotion decisions. These factors can thus make it more difficult for employees to reap the social and economic benefits conferred through employment.

Mental health-related stigma and discrimination pose significant barriers to participation in the workforce. This means tackling stigma and discrimination and developing a culture where employees feel able to talk openly about their mental health issues should be a priority within every workplace. This will not only facilitate psychological safety but also cultural safety within a workplace.

This requires workplaces ensuring that mental health stigma reduction is part of their organisational and workforce strategies. Explicit workforce strategies that reduce stigma, facilitate an inclusive, and thereby a psychological safe workplace, need to be developed along the employee life cycle. This includes how we define jobs, write position descriptions, how we recruit, how we work with disclosable outcomes arising from National Police Checks, through to how we manage attendance, performance and behaviour matters.

Any workplace awareness campaigns need to focus on the full spectrum of mental health issues, not just high prevalence conditions and must include a consideration of how mentally healthy workplace supports families and carers (discussed in the Carers and Families section).

The Sector Partners recommend that:

- Recommendation 19.5 is strengthened through greater integration and coordination between organisations
- Recommendation 19.2 is amended to strongly state that mental health stigma and discrimination reduction is part of their organisational and workforce strategies.

Stigma

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners welcomes the Productivity Commission's focus on the impact of stigma and acknowledge the central role stigma and discrimination play in causing distress for people affected by complex mental health issues, as well as its role in some of the design challenges facing our current system.

Australians affected by complex mental health issues experience unacceptably high levels of stigma and discrimination. Stigma and discrimination are pervasive and experienced within many settings, sectors and systems and manifest in a multitude of ways including self-stigma, perceived stigma, public stigma and structural stigma and discrimination. It adversely impacts wellbeing by worsening psychological distress, inhibiting help seeking and treatment adherence, limiting personal relationships and reductions in the ability to achieve educational and vocational goals.[17]
Areas of stigma and discrimination identified as problematic for the people we serve include:

- Self-stigma
- Stigma within the health sector and system broadly and inclusive of stigma demonstrated by mental health professionals and other health professionals (through hierarchy of diagnosis and diagnostic overshadowing)
- Stigma within workplaces affecting job attainment, satisfaction and promotion, personal wellbeing
- Structural and systemic discrimination as demonstrated within the insurance industry
- Community ignorance/lack of awareness perpetuating public stigma, including inaccurate or irresponsible media reporting
- A sense of burdensomeness, particularly for those who experience suicidal thoughts
- Diverse communities, such as CALD communities, people who identify as LGBTIQ+ and Aboriginal and/or Torres Strait Islander peoples.

SANE Australia is currently undertaking a National Stigma Report Card project, conducted in partnership with the Melbourne School of Psychological Sciences at the University of Melbourne, with the generous support of the Paul Ramsay Foundation. The project includes the 'Our Turn to Speak' survey will explore the experiences of 5,000 people affected by complex mental health issues across 14 different life domains. This sample represents approximately 1 percent of Australians living with complex mental health issues and is the largest survey of its kind conducted in Australia to date. The survey was conducted online, in person and via telephone.

The project's Interim Report summarises the development and implementation of the survey and presents interim findings from an analysis of the first 1,000 survey responses. The domains in which participants frequently identified that they had experienced stigma and discrimination related to their experience of complex mental health issues are mental healthcare services, relationships with friends and family, and employment. In each of these areas, experiences of stigma and discrimination in the previous 12 months were observed to be frequent and impactful. Participants commonly reported anticipation of future stigma and discrimination, and withdrawal from opportunities in these areas of life because of stigma and discrimination. Preliminary findings regarding other intersecting sources of stigma and discrimination, as well as examples of positive treatment in these three domains, are also described.

Data from the survey is expected in the second half of 2020 and will provide critical data to inform the development of a holistic national stigma reduction campaign.

[17]Corrigan, 2004; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Wells, Robins, Bushnell, Jarosz, & Oakley-Browne, 1994.

In 2019, Wellways Australia launched #StampedeStigma, an ambitious campaign to end the stigma and discrimination faced by people who experience mental health issues. A first for Wellways, #StampedeStigma is a multi-year campaign focused on high-profile anti-stigma messaging targeting workplaces in its first year of operation and expanding to provide educational resources to support young people and marginalised communities to change attitudes towards mental health. The campaign does not isolate high prevalence or low intensity mental health issues but seeks change attitudes on all mental health issues.

For many Australians it's hard enough to experience mental health issues, without having to face the judgement, shame and isolation that often surrounds them. Using subtle humour in its promotion, and a Zebra, the intention of #StampedeStigma is to remove the awkwardness and fear that stops many people talking about mental health.

#StampedeStigma is supported by an Inclusive Language Guide and workshops designed to assist employers explore how to respond to the specific mental health needs of their employees and how they can build a more welcoming and inclusive environment for everyone. The workshops, along with a self-audit tool to help guide internal change making towards more inclusive workplaces, were initially funded by an NDIS Informational, Linkages and Capacity Building (ILC) grant.

The Sector Partners welcomes the Commission's recommendation 20.1 to develop a National Stigma Reduction Strategy focussing on "poorly understood" or low prevalence disorders. The proposed focus of this Strategy is health professionals, but general population initiatives, including employers and media outlets, are required as articulated under The Fifth National Mental Health and Suicide Prevention Plan. This could be explored either through this strategy, or the proposed Whole-of-Government Mental Health Strategy. Any Strategy should be multi-faceted, informed by evidence, and learn from other jurisdictions who have implemented similar strategies including Scotland, Ireland, New Zealand or Canada. SANE is part of the Global Anti Stigma Alliance with these global partners.

<u>Where the Sector Partners believes more work is needed</u>

Addressing structural stigma and discrimination, including in the workplace, is required to ensure that all people affected by complex mental health issues have the opportunity for a long and fulfilling life. Awareness raising campaigns are just one tool required to eliminate stigma and discrimination and education efforts should be accompanied by mechanisms to eliminate structural stigma and discrimination across all tiers of our community.

We cannot afford to have short term and short-sighted plans to change the community's attitudes and behaviours. Public mental health awareness campaigns must be sustainable and seek to create a social movement working to change the way we all think and act about mental health issues.

The Sector Partners recommend that:

- The National Stigma Reduction Strategy is expanded to include well-resourced, whole-of-population, tailored stigma reduction initiatives
- The National Stigma Reduction Strategy includes initiatives to eliminate structural stigma and discrimination through legislative or regulatory amendment, where required
- The National Stigma Reduction Strategy is inclusive of all low prevalence mental health conditions.

Part V Pulling the reforms together

Governance, responsibilities and consumer participation

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners are supportive of much of what the Productivity Commission is proposing in the area of mental health governance and accountability.

We support the proposal for COAG to develop a National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) and note it also corresponds to the first principle of Mental Health Australia's *Charter 2020*, which The Sector Partners support. This can play an important role of clarifying governance and funding arrangements for mental health. We hope, however, that the recognition of "non-health supports in meeting consumer and carer needs, particularly psychosocial supports," means that the Agreement will take into consideration of the wider economic and social determinants of mental health. We also support the draft proposal for a new whole-of-government mental health strategy (draft recommendation 22.2), and the measures to enhance consumer and carer participation (draft recommendation 22.3).

We support draft recommendation 22.4 regarding establishing targets for outcomes. University of Sydney academics, Sebastian Rosenberg and Ian Hickie, maintain that one of the reasons past reform efforts have largely failed is because of the limited data available to make comparisons and measure progress, which has rendered Australia "largely outcomes blind."[18] While we note the Commission's desire that any targets "reflect an appropriate balance of ambition and reality," the Sector Partners believe it is crucial that they are not purely clinically focused and encompass targets related to the economic and social determinants of mental ill-health informed by people affected by mental ill-health.

Where the Sector Partners believe more work is required

As discussed in great detail at the start of the submission (and continued below), a significant gap in the report is clear recommendations to address the issues the CMHS sector faces in relation to delivery psychosocial recovery supports and rehabilitation.

A new whole-of-government mental health strategy must include a detailed and comprehensive plan, which clearly maps the sector's current state and provides a plan to address it.

The Sector Partners recommend that:

A psychosocial community mental health strategy is developed, which features:

- An understanding of the current psychosocial needs of people living with mental health issues
- An understanding of the current state of the community mental health sector
- Methods to ensure that psychosocial interventions are available to all people who experience mental ill-health, not just those who experience severe mental illness or have a psychosocial disability
- The urgent expansion of community mental health services to all people at all stages of mental ill-health.

[18] Sebastian Rosenberg and Ian Hickie, 'No gold medals: Assessing Australia's international mental health performance,' *Australian Psychiatry*, Vol 27(1), 2019, 36-40.

Funding

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support, in principle, the draft funding recommendations (recommendations 23.2 - 24.4) proposed to incentivise investment in mental health services that best meet the needs of Australians with a lived experience of mental health issues, their families and carers, and the promotion of more efficient use of taxpayer funds.

We believe every person accessing mental health services deserves the highest quality care and support, and the maximum opportunity to influence how that support is arranged and managed. To meet this ambition there needs to be a greater focus on high-quality commissioning to achieving good outcomes for people with a living experience of mental health, using evidence, local knowledge, skills and resources to best effect. This will require commissioning agencies working in partnership across the varying Australian Government, State and Territory mental health systems to promote good mental health and wellbeing, and prevent, as far as is possible, avoidable mental-health related hospital admissions.

Our Sector Partners believe effective commissioning plays a central role in driving up quality, enabling people to meaningfully direct their own care, facilitating integrated service delivery and making the most effective use of the available resources. As commissioning has been delegated to zoned or regional Australian Government, State and Territory Government authorities, and activated on a cyclical basis, it is critical to the success of commissioned programs that the needs of the local population in need of care and/or support services are considered. As commissioning authorities design, deliver, monitor and evaluate those services, the service user/support recipient – those with a lived experience of mental health should be engaged at each stage to ensure appropriate outcomes.

Where the Sector Partners believe more work is needed

Draft Recommendations 23.2 and 23.3 endorse defining roles and responsibilities to either the Australian Government or the States and Territories. The Sector Partners fully support Draft Recommendation 23.3 that the Australian Government and the State and Territory Governments should work together to reform the architecture of Australia's mental health system. However, the Sector Partners believe effective commissioning cannot be achieved in isolation and is best delivered in close collaboration across all responsible authorities and agencies and remain a constituent part of the greater health system. We are of the collective view that commissioning should be inclusive, person-centred and outcomes-focused, well-led and delivers a sustainable mental health sector.

Inclusivity should lie at the heart of any structural reform of the mental health system. Good commissioning starts from an understanding that people using services, their families, carers and their communities are experts in their own lives and are therefore essential partners in the design and development of services. Good commissioning creates meaningful opportunities for the leadership and engagement of people, including carers and the wider community, in decisions that impact on the use of resources and the shape of local services.

The Sector Partners support Draft Recommendation 24.1 to transition to flexible and pooled funding arrangements to allow primary allied mental healthcare services to better respond to people's needs. However, these arrangements must ensure commissioning from pool funding is person-centred and outcomes-focused and considers the views and experiences of service users. This will allow services to better tailor care packages to the needs of the individual. This should also include streamlined reporting and monitoring requirements to ensure consistency of funding requirements and relieve any administrative burden on resource-constrained service providers.

Person-centred and outcomes-focused commissioning promotes health and wellbeing, including physical, mental, emotional, social and economic wellbeing. This includes maximising people's capabilities and support within their communities, commissioning services to promote health

wellbeing, preventing, delaying or reducing the need for services, and protecting people from abuse and neglect. It must take into account the social determinants of mental health. Person-centred and outcomes-focused commissioning also delivers social value. This includes value for the whole community not just the individual, their family and their carers, the service provider or the program commissioner.

Reform should be undertaken through positive engagement with all providers of care and support. Whether the Productivity Commission's final recommendation is to rebuild or renovate, the Sector Partners believe future systems and commissioning should be engaged in as a shared endeavour, with commissioning authorities working alongside service providers and people with care and support needs, their family members, carers and the public to find shared and agreed solutions. Any solution should promote equality of opportunity and focus on reducing inequalities in health and wellbeing between different people and communities.

Mental health should be given the same priority as physical health. The Sector Partners expect parity of esteem between mental and physical health services. Successive Australian Governments and State and Territory Governments have expressed their intention to improve existing services for people with a lived experience of mental health issues and tackle the wider underlying causes of mental health issues. However, they have not clearly articulated how this would be delivered locally to give people better outcomes.

Structural reform must include clear direction for those in leadership roles; the senior leaders and commissioners of services. Leaders should be required to consistently demonstrate the values of the mental health system and ensure that commissioning is underpinned by the principles of co-production, personalisation, inclusion, integration and the promotion of health and wellbeing. Leadership should be demonstrated through a whole system approach, ensuring the best use of all resources in a given local area through joint approaches between the public, not-for-profit and private sectors.

In commissioning programs, authorities should demonstrate evidence about what works and utilise a wide range of information to promote quality outcomes for people, their carers and communities, and to support innovation.

The Sector Partners do not have a firm view on Draft Recommendation 24.4, however, we share the Productivity Commission's opinion for greater need for innovation and incentives to encourage commissioning agencies to invest and trial new services, under the proviso that they have them independently evaluated and share the findings.

The Sector Partners recommend that:

- Commissioning bodies adopt outcome-based flexible and pooled funding to drive better outcomes for people and reduce administrative burden and waste at service level
- Commissioning from pool funding must be person-centred and outcomes-focused and considers the views and experiences of consumers
- Mental health should be given the same priority as physical health, establishing a parity of esteem between mental and physical health services.

Monitoring, reporting and evaluation

Where the Sector Partners support the Productivity Commission's approach

The Sector Partners support, in principal, the draft Monitoring, Reporting and Evaluation recommendations (specifically recommendations 25.5 – 25.6) proposed to improve transparency, accountability and potentially service quality.

The Sector Partners fully support the Productivity Commission's Draft Recommendation 25.6. To ensure a vibrant, diverse and sustainable market able to deliver positive outcomes for citizens and communities, there needs to be a harmonisation of compliance and reporting requirements placed upon service providers by commissioning agencies. The adoption and use of different methods and reporting outcomes, which impose considerable limitations on baseline comparability across mental health interventions, should be avoided. We believe transparent provision of data at the service provider level is an essential ingredient in creating a people-oriented mental health system and improving service outcomes for those for whom services exist; those with a lived experience of mental ill-health, their families, carers and their communities.

Where the Sector Partners believe more work is needed

Ensuring diverse, sustainable and quality programs across the mental health sector is critical to sector reforms. Cost-effectiveness evaluations, as proposed under the Productive Commission's Draft Recommendation 25.8, are necessary to support government decision-making on what mental health interventions to fund. However, the Sector Partners believe commissioning authorities utilise cost-effectiveness evaluations without accounting for the long-term sustainability of their service providers. We believe further investigation is required by the Productivity Commission into the sustainability of mental health service providers.

CMHS providers are not funded adequately enough to meet demand and the nature of short-term funding arrangements creates challenges for employee retention, which ultimately impacts on continuity and quality of service. Service providers are required to direct significant resources to apply for funding for well-established and needed programs servicing our community, creating unnecessary and repeated uncertainty and redirecting resources away from core business. In many cases services providers have become more adapt at tender writing than their core business of providing services.

The Sector Partners appreciates that due to the nature of commissioning, Australian Government, State and Territory Government funds are placed in the hands of commissioning authorities to purchase services in accordance with local community needs. Devolved, or third-party purchasing, as such arrangements are known, are well described internationally and are used to improve the quality and appropriateness of services for specific populations. The Sector Partners have each been successfully in providing services to numerous specific cohorts funded by commissioning authorities, including the Australian Government's Primary Health Network.

To this end, successful commissioning requires a clear policy framework of national and regional priorities, which define agreed roles, responsibilities and targets for commissioning. The Sector Partners further appreciates that nationally standardised performance measures and data requirements need to be built into contracts, with ongoing monitoring and evaluation mechanisms.

However, achieving the balance between competitive tendering associated with contracting and the costs required for service delivery is becoming a major challenge for all CMHS providers participating in commissioning tender processes, perhaps more so for service providers seeking to build relationships with commissioning authorities while operating in smaller geographical areas.

The Sector Partners are concerned that we are seeing increasing reference within commissioning tender specifications and criteria to 'Administration overheads' incorporating items that should be included in the cost of delivery of a service (operational costs) but are now viewed as administration

costs. These include, but are not limited to cars, mobile phones, mobile IT (e.g. a tablet or laptop), as well as the rent of premises. Most worrying for service providers is the increased pursuit by commissioning authorities to keep 'direct' costs to within a cap (the majority of PHNs have imposed a 15 per cent cap). There is serious concern that for many service providers applying for tenders is no longer viable, affecting the long-term sustainability of CMHS providers.

We are seeing more and more funding envelopes from commissioning authorities (including PHNs) that do not support the expected outputs. Where there is both Australian Government and State/Territory Government jointly funding a service, we are seeing administration or corporate levies multiplied, diminishing the amount of money left for service delivery.

The following is a recent real example (de-identified) from a PHN tender for a suicide response service. In this instance, funding from the program comes from both the Commonwealth and State governments. Before the funds were put to tender, both the PHN and the Health Service charged a corporate levy as follows:

Corporate Contract Governance Costs PHN & Hospital Service					
Funding Source	*Total Funding*	*Funded Agency*	*Corporate Levy*	*Corporate Charge*	*Available Service funding*
Commonwealth	580,958	PHN	8.8%	51,124	529,834
State	586,560	Health Service	15%	87,984	498,576

An NGO would charge, e.g. a 13% Corporate Levy and on their portion of the funding (13% of $808,410 equating to 9% of total funding). This means 32.8% of the funding will have been used for corporate overheads.

The Sector Partners recognise the need for commissioning authorities to seek value for money, as the Productive Commission highlights in Chapter 25. However, we believe this should be achieved by identifying solutions that ensure a good balance of quality and cost to make the best use of resources and achieve the most positive outcomes for people with a lived experience of mental health issues and their communities.

The Productivity Commission rightly observed in Chapter 12 of the Draft Report of the existence of roadblocks creating issues in the coordination and cooperation of service providers as they compete for funding. However, the Sector Partners respect the need for some level of competition between service providers and supports the Productivity Commission's view that tender processes managed by commissioning authorities should encourage innovation and the system must be flexible enough to allow for this, including the potential for bids by consortia. We agree with the Productivity Commission's view that while the aspect of competition should not be removed completely from the tender process, there must be care taken to manage it so that it does not interfere with the ability of service providers to cooperate with each other.

To engender good commissioning, it is essential commissioning is undertaken by competent and effective authorities and facilitates the development of an effective, sufficient, trained and motivated mental health workforce. Commissioning authorities should be concerned with sustainability, including the financial stability of providers, and the coordination of traditional mental health and peer workforce planning as recommended in Draft Recommendation 11.4.

The Sector Partners recommend that:

- A clear policy framework is developed which sets out national and regional priorities and defines agreed roles, responsibilities and targets for commissioned services.
- A percentage cap is placed on handling fees, administrative changes and levies taken by commissioning authorities from pools of funds targeted for services.
- Further service funding and supporting arrangements between tiers of government and commissioning agencies are streamlined to reduce the burden of responding to tenders and contractual compliance.