Merri Health
Healthcare that moves with you

4th April 2019

Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601
Submitted via on line portal

Submission to the Productivity Commission Issues Paper – The Social and Economic Benefits of Improving Mental Health

Merri Health welcomes the opportunity to provide a response to the Productivity Commission Issues Paper – The Social and Economic Benefits of Improving Mental Health dated January 2019.

Merri Health creates healthy, connected communities through local health services for people at every age and stage of life.

We know that at different times, health needs change. That's why we support people throughout life, with a range of wraparound services available all through the one local network.

Our approach addresses the medical, social, environmental and economic aspects that affect health, with services spanning across:

- children and families
- young people
- carer support
- management of chronic conditions
- dental
- mental health
- disability services
- health and wellness
- aged care

We've been the trusted health service of local communities for over 40 years. As a not-for-profit organisation, our focus is on partnering with people, responding to local needs, and strengthening the health of entire communities.

Merri Health provides the following responses with regard to the specified questions of the inquiry:

2. Questions on Structural Weakness in Healthcare

- ***Why have past reform efforts by governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness? How would you overcome the barriers which governments have faced in implementing effective reforms?***

Many of the structural weaknesses in healthcare for people with a mental illness can be attributed to the following factors:

1. **Underfunding.**
   Despite past attempts by governments to reform the sector, all efforts have largely remained underfunded relative to the needs of people living with mental illness across Australia. Due to this underfunding, services have not been able to engage and support all those who are in need of a healthcare response. Without the appropriate amount of funding being allocated to healthcare service responses for people living with mental health issues, the sector has remained unable to meet need, therefore resulting in a system which is ineffective in meeting its healthcare aims.

2. **Lack of cohesion between State and Commonwealth funding.**
   One of the main factors that has impeded past reform efforts is the lack of cohesion between service responses provided by the State and Commonwealth governments. Service responses are often developed in isolation, leading to a service system that can be fragmented and lacking a whole-of-government direction/vision. We advocate for a more structural reform across the service system that addresses this fragmentation for the benefit of a more integrated approach to service delivery that encompasses a whole of health approach, and recognises the social determinants of health as a key influence of the burden of disease in mental health.

3. **Funding limitations.**
   Some of the ways in which mental health funding has been structured has also impacted on the effectiveness of government reform. For example:

   i. Ongoing stability of funding- many programs are funded with short term contracts (e.g. 12 months at a time) meaning that organisations don't have the necessary time to build and develop their service offerings. This instability may impact on the willingness for people experiencing mental health issues to engage in a service that is unable to provide consistent and long term support. This short termism also impacts organisations having a stable workforce with the challenge to retain experienced staff.

   ii. Flexible service delivery- many of the programs that have been previously funded have had quite rigid service delivery guidelines, therefore limiting service providers from being able to provide a flexible service option that supports and encourages engagement with the healthcare system and doesn't support client centric approaches.

   iii. Transition to the National Disability Insurance Scheme (NDIS) - ever-changing service system - over the past few years there has been significant and ongoing changes in mental health service delivery. The most significant of these has been the transition to the NDIS. This significant change in service delivery modality has meant that many people experiencing mental health issues have either been denied access to this system (through being found ineligible) or who have found the transition too daunting and have stepped away from the service system all together. Whilst this transition has occurred, other State and Commonwealth services have begun to wind down, therefore creating significant gaps in the service delivery options for people living with mental health issues. Our experience has seen increasing prevalence of mental health conditions in these clients.

4. **Fragmented and complicated service system.**
   For people living with mental health issues, the healthcare system can be incredibly daunting. In general, it is very difficult to navigate, lacks integration and is difficult to access. Past reform attempts have just contributed to a service system that is already overstretched, fragmented and difficult to engage with but have not addressed the fundamental structural challenges of the system. Promoting integration and ease of accessibility is a key factor to ensuring that future reforms are able to meet need.

- ***What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments? How should they be addressed and what would be the improvements in population mental health, participation and productivity?***

Some of the key structural weaknesses in healthcare are not being specifically targeted in the most recent and foreshadowed reforms by government; the main one of these being the fragmented and complicated service system. A number of new programs have been initiated in an effort to tackle the service gaps generated by the NDIS; however, the addition of these new services has the potential to further add to the existing fragmentation and confusion around how to access appropriate services. One potential way of addressing this would be to streamline how these programs are tendered and then launched. Wherever possible, small pieces of funding should be combined into more substantial funding options, thus minimising the confusion around the number of programs, what they are offering and their access points.

3. Questions on Specific Health Concerns

- ***Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?***

The lack of funding in mental health for genuine primary prevention contributes to the ineffectiveness of the system, as we are currently mostly seeing people when they are already in crisis and intervention is complex, intensive, and not always fully successful. The way prevention is referenced in the issues paper does not reflect the true definition of primary prevention, which is working with individuals before the onset of illness occurs. In contrast, the reference in the issues paper refers to primary prevention as "*cognitive behaviour therapy for young people who have a parent with a diagnosed depressive order (prevention)*". The definition also limits "healthcare" to specific services, and doesn't fully recognise the role that complementary government policies and programs can play in preventing poor ill-health, nor does it reflect the fact that a range of organisations can deliver primary prevention "healthcare".

The current structure of healthcare isn't holistic and doesn't appropriately acknowledge or resource key settings for primary prevention such as schools, early years, local government, and workplaces. For example, the Australian Government Department of Social Services (DSS) currently funds community cohesion and social inclusion initiatives that aim to improve harmony and belonging across diverse communities. This is considered a primary prevention approach to mental wellbeing, by increasing social connections, social capital, fostering a sense of belonging, feeling valued, and connection to community. These are all protective factors for positive mental health which aren't appropriately considered in the issues paper.

- ***Which forms of mental health promotion are effective in improving population mental health in either the short or longer term? What evidence supports this?***

VicHealth has a strong evidence base around mental wellbeing and resilience in young people which can be found here https://www.vichealth.vic.gov.au/media-and-resources/publications/mental-wellbeing-strategy. It's also important to acknowledge the influence of discrimination and social exclusion on mental wellbeing, and the subsequent costs to the healthcare system. Beyond blue has evidence to support this link https://www.beyondblue.org.au/docs/default-source/policy-submissions/stigma-and-discrimination-associated-with-depression-and-anxiety.pdf as does VicHealth and Deakin University https://www.deakin.edu.au/__data/assets/pdf_file/0005/229469/Mental-Health-Impacts-summay-report.pdf

- ***What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?***

The best way for the healthcare system to respond to specific mental health issues such as suicide (prevention and aftercare) and co-morbidities amongst people with mental illness, is to enable a service response that:

- Is flexible and able to tailor service delivery to the needs of consumers;
- Has a skilled workforce who are able to work with complex needs, including crisis level responses;
- Is connected with other service systems for example, the disability sector, acute care (ie.hospitals) alcohol and other drug services.

By providing services in this way, mental health support needs are met in an integrated, cross-sector manner that allows for a responsive and tailored service delivery response. By providing care in this way, people experiencing mental health issues are more likely to receive high quality support that is integrated across the service sector and responsive to their range of needs. This, in turn, is likely to have positive impacts on mental health, participation and productivity, as people experiencing mental health issues are more likely to receive appropriate and integrated care which will allow them to remain connected and engaged with the community.

- ***What healthcare reforms do you propose to address other specific health concerns related to mental ill-health? What is the supporting evidence and what would be some of the benefits and costs?***

Addressing the correlation between poor physical health and mental ill-health is a key health concern that needs to be built into any healthcare reforms. There is much evidence that demonstrates the significant and detrimental impact that mental ill-health can have on physical health outcomes. Examples of this impact include a reduction in life expectancy and increased risk for serious physical health concerns, such as cardiovascular disease, diabetes and metabolic issues due to medication. The Mental Health Commission of New South Wales released a document in 2016 titled 'Physical Health and Mental Wellbeing: evidence guide' which documents the serious physical health issues that are facing people living with mental illness.

Some of the key ways in which this health concern can be addressed is through service models that provide holistic care and education. Holistic care is central to ensuring that all aspects of an individual's health - both physical and mental - are considered and support provided around all elements of well-being. The necessity for service providers to work in this way should be embedded into funding and service delivery requirements, to ensure that all service provision works from this framework. Addressing physical health, from both a prevention and intervention level within the healthcare system, will have significant impacts on the economic and social participation of people living with mental health issues. Individuals who are healthier, both physically and mentally, are more likely to engage in broader economic, social and community domains, which is beneficial both at an individual and family level and also at the broader societal level.

4. Questions on Health Workforce and Informal Carers

- ***Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity?***

The professional health workforce working with people experiencing mental health issues needs to be highly skilled, experienced, agile and flexible. The mental health sector has a strong history of a workforce who are both passionate about the work they do and skilled in providing client-centred, responsive and high quality service. As the sector transitions into the NDIS, this workforce is being lost as NDIS pricing does not allow for tertiary qualified and experienced staff. This is a great concern and is likely to have a negative impact on the participation and productivity of people living with mental health issues. Access to skilled and appropriate staff is central to the provision of high quality care, which in turn generates positive outcomes around economic and social participation.

Another change that needs to be made to the configuration of the mental health workforce is the inclusion and valuing of peer workers/staff with a lived experience of mental health

issues. Utilising peer workers within the workforce is shown to have positive impacts on the engagement of people living with mental health issues, thus enhancing participation and productivity. The inclusion of peer workers is becoming a lot more common across the service sector and should continue to be encouraged and supported.

- ***What could be done to reduce stress and turnover among mental health workers?***

Stress and turnover amongst mental health workers is an issue that needs to be addressed in order to ensure that the service system continues to provide high quality care and support. A number of factors impact on the stress experienced by workers, and need to be addressed in order to minimise turnover rates. The following issues are important to consider:

- Funding instability. Job security is a key element in maintaining the wellbeing of staff, however the current situation in the mental health sector does not provide workers with any stability or sense of security about their ongoing work. Providing stable and long term funding of programs would go a long way to mitigating this source of stress.

- NDIS model. The shift to delivering services under the NDIS has been a great source of stress and discontent within the existing workforce. The current NDIS model does not value skilled and qualified staff which leads staff to either leave the mental health sector or feel undervalued. Similarly the shift to a market- driven model has taken the focus away from providing collaborative, community focused work- which has long been the attraction to this field of work.

- Demand exceeding resources. Another source of stress for staff is the level of work that is required in order to meet demand. Current levels of resourcing/funding do not match the level of need within the community, therefore staff are under pressure to try and meet demand with limited resources. Adequate funding of the sector would work to alleviate/minimise this source of stress.

- ***How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?***

Support mechanisms inclusive of systems and processes are essential to support the workforce to undertake training and professional development opportunities. This needs to be a key consideration in funding models. Current funding models, inclusive of the NDIS, do not support staff to access training opportunities and this encapsulates both time and cost. Consideration also needs to be given for less costly models of peer learning where professionals and peer workers have the opportunity for peer reflection and case consultation.

- **What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?**

Carers need access to a range of services at different points in time in order to continue in a caring role and still have a rewarding and contributing life of their own. Respite opportunities are very important for mental health carers and often difficult to access or locate. Carers are frequently unable to have holidays or even spend extended time away from their loved one for a quick break. NDIS packages for carer recipients do not include any consideration of the carers needs and the assumption seems to be that if the care recipient is receiving NDIS support there is no significant carer burden. Currently if a care recipient is in receipt of NDIS support the carer is not eligible for Commonwealth Respite Support and this is a major issue for mental health carers. Even if there are services and access available, the carer recipients often will not accept or respond to a general respite worker and need access to someone they have established a credible and trusting relationship with. The cessation of the Commonwealth Flexible Mental Health Respite program has also taken access to flexible, short term respite options away from carers. This leads to considerable carer distress and fatigue and leads to an increasing isolation of carers and greatly reduced social, and at times, economic participation of carers.

A major gap is access to short term crisis respite facilities as the Emergency Departments at local Hospitals do not provide any real options for people in crisis unless this is at a level where it is clearly and presently life threatening. This is made even more difficult when, as is often the situation, the person with a mental illness abuses alcohol and the acute system is frequently unable or unwilling to provide support. These situations are devastating for the family and carers, and particularly for working carers as the time lost attempting to negotiate and locate support impacts significantly on their ability to maintain employment. Better access to short and medium term respite and treatment or short term secure accommodation could be a key measure to address this.

6 Questions on Social Services

- ***Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?***

There is currently a significant fundamental issue for people with a psycho-social disability accessing the NDIS. The majority of people currently accessing government funded mental health services do not meet the access and eligibility requirements for the NDIS and as a result, have been left with very limited options for services.

The current options available include:

- **Acute Mental health Services** – this is only for acute episodes, and symptoms need to be severe to access these services. This does not support people to manage their mental

health but rather assists when a crisis point is already reached. Due to limited resources and funding, acute mental health services are unable to take a pro-active and recovery based approach.

- **Community Health Organisations** – waiting lists can be long and all Victorian and Commonwealth funding is transitioning to NDIS which has left a significant portion of people with psycho social disability without any mental health support services available to them, putting them at significant risk and placing a greater burden on the acute mental health system.

- **Medicare subsidized visits** under mental health care plan or chronic disease management (allied health other than Psychology) – people with a psychosocial disability may not be able to pay the gap in payment for these services, or have the motivational/organisation skills to seek out these services and be able to leave their place of residence to visit these services at various office locations in the community.

- **Private health insurance & fee for service** – this is only an option for those who have the financial means which is far more unlikely for people living with significant and complex psychosocial disability as this most often affects their ability to participate in paid employment.

- ***What continuity of support are State and Territory Governments providing (or plan to provide) for people with a psychosocial disability who are ineligible for the NDIS?***

  In Victoria, it remains unclear as to what the CoS arrangements will look like in the longer term. Although the Commonwealth government has recently committed to providing continuity of support arrangements via block funding from the Primary Health Networks, this grants process is still in transition so the outcomes and how much of the significant gap this will be able to fill is yet to be known. Even more uncertainty remains around the Victorian State Government Continuity of Support arrangements as Victoria was the only state to dismantle its community based mental health services and handover all of it's funding to the NDIS under the bilateral agreements, which has posed a significant issue.

- ***Are the disability support pension, carer payment and carer allowance providing income support to those people with a mental illness, and their carers, who most need support? If not, what changes are needed?***

  Carer Payments and the Carer Allowances provide a degree of support but are not well tailored for Carers of someone with a mental illness. The often episodic nature of the impact of mental illness means that carers may not meet the criteria for the Carer Allowance/Carer Payment but still impose a heavy burden on many carers of people with a mental illness. Some consideration could be given to schemes such as the Carer Support Fund in Victoria which is a flexible small grant program to assist carers in various ways. The program is limited to and delivered through Case Workers in Mental health Clinical Services but could be modified to make assistance more generally available for people outside the direct

clinical services. Most people with mental illness are outside the formal Clinical Services and are treated via their GP's and supported in the community by their families and peers.

The Disability Support Payment (DSP) provides a good economic support for those who receive the payment but is also very restrictive and does not appear to take into account sufficiently the impact of mental illness and its symptoms on a person's social function, and as a result, many people with long term mental illness are found to be ineligible for the payment. In the past all applications for Invalid Pension/DSP had a mandatory Department of Social Services/Centrelink social work psych-social assessment provided as part of the assessment. This helped identify the actual impacts on the persons functioning and need for longer term needs.

- ***Is there evidence that mental illness-related income support payments reduce the propensity of some recipients to seek employment?***

Anecdotal evidence from our work within mental health support would indicate that mental illness-related income support payments do not reduce the propensity of recipients to seek employment. From our service delivery experience, people living with mental health issues do want to be contributing members of the community and are often interested in being supported to seek employment. However, the nature of their illness often makes it difficult to engage in regular work, with fluctuations in mental state affecting their ability to maintain ongoing or full time work. Flexible options for engagement in employment are vital for people experiencing mental health issues.

It should also be noted that the ability for people with mental health issues to access mental illness-related income support is a vital safety net; as it allows for economic security whilst also allowing for employment options to be explored without the fear of losing all access to income if they become unable to work due to their mental health issue.

7. Questions on Social Participation and Inclusion

- ***In what ways are governments (at any level) seeking to improve mental health by encouraging social participation and inclusion? What evidence is there that public investments in social participation and inclusion are delivering benefits that outweigh the costs?***

All levels of government play a critical role in addressing social inclusion and participation which is reflected by the current Commonwealth Department of Social Services Strong & Resilient Communities funding, and Victorian Multicultural Statement and initiative. Local governments in particular are well positioned to drive social inclusion and participation at the community level, however are often hampered by resourcing, capacity, and their core role in supporting all residents, constituents and rate-payers, regardless of whether certain communities experience greater need.

Social participation and inclusion are principles that are embedded within Commonwealth funded programs, such as PHaMs and Day to Day Living (D2DL). As a group based program, D2DL programs are focused on enhancing connection between people experiencing mental health issues and the broader community. Group-based programs facilitate this connection, and seek to increase social participation and enhance the inclusion of people living with mental health issues into the broader community.

By investing in programs such as these, we are able to foster the creation of healthy and connected communities that are then able to support themselves, separate from the service system. Developing skills and providing opportunities for social engagement and participation is essential in minimizing social isolation and creating healthy and vibrant communities. Services such as D2DL can therefore be seen as offering both intervention and prevention work. At an intervention level they are providing services that work to build skills, confidence and social participation in people experiencing mental health issues, however it is this very work that is then able to reduce the need for more ongoing work as those we have supported are able to utilize the skills and social connections they have developed to manage their mental health into the future. Therefore, the benefits of these programs far outweigh the costs involved in delivering the service.

- ***What role do non-government organisations play in supporting mental health through social inclusion and participation, and what more should they do?***

Non-Government Organisations (NGOs) and Community Health networks can also play a strong role in addressing social participation and inclusion and can often more easily navigate prioritising marginalised communities than local governments can. In order to be effective it's critical for NGO's to be integrated with local networks and partners, and to have strong connections with local communities. In order for NGO's to be most effective in this space, greater funding and stronger links with the primary health care and acute systems are also necessary.

NGOs are heavily involved in promoting social inclusion and participation, both generally through their work in the community but also through the specific mental health programs they may have been funded to provide. At a grassroots level, this is often the core business of NGOs, particularly Community Health Services and is often work that is done unfunded as it benefits the community. With adequate and specific funding more work could be done in this space. Consideration could be given for some sort of 'credentialing' for such organisations to legitimately incorporate them as service providers in part of the broader architecture of the health and mental health service system.

- ***Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?***

Particular sub-groups more at risk at risk of poor mental health include:

- Aboriginal and Torres Strait Islander communities
- Refugees, asylum seekers and migrants
- Culturally, linguistically and religiously diverse communities
- LGBTIAQ+ communities
- People with disabilities
- Young people
- People from low socioeconomic backgrounds

In order to better support these marginalized groups, preventative funding with a greater focus on breaking down barriers to participation, minimizing exclusion, and promoting equity and inclusion are important. In working towards achieving long term change it is also critical to embed these changes into systems and structures such as schools and workplaces, and to ensure they are supported by effective policy.

- ***What indicators are most useful to monitor progress in improving mental health outcomes through improved social participation and inclusion?***

A variety of existing indicators are available to measure improved social participation and inclusion such as; the Victorian Outcomes Framework and the Victorian Community Indicators. However these frameworks need to be strengthened to ensure data is consistent, particularly at a suburb-level, and has the ability to be analysed and understood by population groups. There are also several projects currently underway between the Scanlan Foundation and Community Indicators Victoria with the view to develop shared measures. Merri Health is also part of the Inner North West Primary Care Partnership project to develop shared Social Inclusion indicators for our region.

The use of outcome measurement tools, such as the Recovery Star, are also important in understanding the improvements people experience across a range of life domains when they are engaged and participating in the community.

9. Questions on Child Safety

- ***What aspects of the child protection programs administered by the Australian, State and Territory Governments are the most effective in improving the mental health of people in contact with the child protection system?***

Engagement of families and children by the child protection system can sometimes be the catalyst to support engagement in mental health and/or other relevant services or communities, and draw attention to children who are struggling with their psychological wellbeing.

The scope of the child protection system, which has the capacity to carry out exhaustive investigations and respond to acute risk as it emerges, is a positive mechanism in its ability to identify and support access to appropriate services. Furthermore, this provides an avenue for child related risk/concerns to be received and responded to and therefore allows for safeguards to be implemented that prevent further potential risks from diminishing a child's wellbeing/mental health.

- **What, if any, alternative approaches to child protection would achieve better mental health outcomes?**

The following issues need consideration and system change to achieve better mental health outcomes for children:

- Increased recognition of the impact of cumulative harm and the long term impacts on the developing mind of a child;
- Increased capacity across the spectrum of protective services inclusive of more staff, more experienced staff, smaller caseloads and better work conditions that would allow for increased staff retention. This would translate to more experienced staff that are better able to handle cases with more nuance and sensitivity taking the time to complete full assessments/investigations without the need to 'rush' decision making and planning;
- Adult mental health services, child protection and other community services (i.e. Integrated Family Services) need to work more collaboratively together with a focus on parental mental health and how this impacts the functioning of the whole family;
- Mental health services need more funding and support in the community. The shift to the National Disability Insurance Scheme has exacerbated an already 'bleeding' system with many clients losing access to services such as Personal Helpers and Mentors;
- Bulk billing access to psychiatric services is almost impossible to find and access, this service provision would support better mental health.

10. Questions on Education And Training

- ***What are the key barriers to children and young people with mental ill-health participating and engaging in education and training, and achieving good education outcomes?***

It is estimated that around one in seven Australian children experience mental health issues and about half of all serious mental health issues in adulthood begin before the age of 14, there needs to be more of a focus on early intervention. There are long wait lists for cognitive assessments to help better understand barriers impacting children feeling accepted and comfortable at school.

Our work with children and families leads us to identify the following barriers to children with mental health issues engaging in schooling and with the education system:

- limited access to specialist supports on campus, i.e. psychologists, social workers, counsellors, etc.;
- schools are overcrowded, stretched beyond their capacity and lack time and money to develop and/or implement specialist mental health initiatives;
- schools need more education and support for teachers and more funded wellbeing teams, to allow for modifications to be made to school environments and for supports to be implemented such as trauma-informed training;
- considerable work needs to be undertaken with families to support children to remain engaged in schools. The relationship between the school and family is a key determinant in school retention;
- inaccessibility of outreach based youth mental health services that are able to commit to children/young people on a long term basis and provide an intervention that is a combination of both casework and psychotherapy.

- ***Is there adequate support available for children and young people with mental ill-health to re-engage with education and training?***

There is a need for more proactive, outreach services to guide and encourage children to re-engage and negotiate and/or advocate for children in the education system and with training facilities.

Currently the system faces the following challenges:

- there are very few outreach supports, most supports are office based;
- there are a limited number of psychologists that will attend and work in the school setting with vulnerable and complex children. Psychological funding also needs to be funded to work systemically so work can take place with parents and care teams, not just a 10 session model focused on the child only;
- there are long waitlists for access to relevant and appropriate service assessments i.e. CAMHS, paediatricians, Autism Spectrum Disorder, and by the time diagnosis identify specific service needs (or qualifying for them) children presentations have often deteriorated. The navigation and service access to appropriate services is further compromised by the long wait lists.

School-re-engagement services like the 'Navigator' program where there is an outreach component are key; however they have long waitlists and strict eligibility requirements. This program can only accept children whose school engagement is down to 30%, research indicates that early intervention has the highest success. Thus eligibility needs to be reviewed and similar programs implemented to support school engagement.

13. Questions on Mentally Healthy Workplaces

- ***What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?***

  An intervention that has worked well for us is in developing a Mental Health and Wellness Framework that incorporates the proactive management for employees that have identified or shows signs of mental health in the workplace.

  This has resulted in us proactively partnering with our employees having a number of toolkits and templates available for managers and frontline staff such as a Discomfort Survey and Wellness Plans.

  Where we respond to an identified concern we work directly with the employee, their treating practitioner (where relevant) and their manager to create a wellness plan that identifies triggers, outlines supports/aids/modifications, and appropriate responses to enable the employee to safely return to work, know where to seek support and provide the manager the tools to be able to respond in the best way to their employee.

  An advantage of being able to take a proactive approach has led to the employee either not needing any time off from work or reducing the amount of leave they need. It has also been a positive experience for both the employee and manager to have open communication and understanding improving the levels of engagement in the overall employment relationship. Additional benefits have been in the maintenance of low workcover claims, low absenteeism rates against industry benchmarks, and high workforce retention rates against industry benchmarks.

- ***What differences between sectors or industries should the Commission take account of in considering the scope for employers to make their workplaces more mentally healthy?***

  The nature of the working environment and capacity for controls from a psychological risk perspective should be considered. Additionally the psychological vs physical inherent requirements from the role would significantly differ from one industry to the next. In the health and social services sector the psychological inherent requirements are greater in proportion to the physical inherent requirements. This present a challenge when developing proactive wellness plans and/or reactive return to work plans with frontline employees when the nature of their job requires them to have psychological stability to handle the situations they manage with clients that may have significant mental health, alcohol and other drug, family violence, victim of crime other circumstance requiring our services and support.

14. Questions on Regulation of Workplace Health and Safety

- ***What, if any, changes do you recommend to workplace health and safety laws and regulations to improve mental health in workplaces? What evidence is there that the benefits would outweigh the costs?***

Increased transparency on the average cost of a psychological claim to an organisation and the longer the employee is away from the workplace the less likely it is they will be able to reengage and their mental health improve. This evidence-based approach and improving the awareness across employers will potentially incentivised employers to take a more proactive approach and where responding to mental health in the workplace ensuring a timely response is undertaken.

Clearer guidelines on how workplaces can identify the psychological inherent requirements of a role to then identify if it is appropriate to not hire and/or manage an employee on the basis of them having a mental health condition.

Promoting positive case studies where employers have taken proactive approaches to mental health in the workplace and how this has benefited them through things such as attraction and retention of employees in having a more positive employer brand, and reduced absenteeism and turnover costs.

15. Questions on Coordination and Integration

- ***What are the barriers to achieving closer coordination of health, mental health and non-health services and how might these be overcome?***

Some of the main barriers to achieving closer coordination between health, mental health and non- health services are:

- **Time**. With increasing pressure on service providers, finding the time to develop relationships and work collaboratively with other parts of the service system is increasingly difficult. Work of this nature is often not a defined part of the funded work therefore making it challenging for service providers to build this into their work processes.

- **Funding requirements**. Rigid funding agreements also impact on the ability for service providers to engage in coordination and collaboration work with other parts of the service system. If this cross- sector work is not built into funding agreements, it will continue to not be prioritised.

- **Competitive, market-driven models**. Our service system is becoming increasingly competitive as market-models are introduced. Organisations that may have collaborated in the past are now being encouraged to compete with each other. This diminishes the value and positive consumer outcomes that could come from working together and providing an integrated and coordinated service response. There is an unquantified

economic value of this historical networked approach that is being lost to the service system with detrimental impacts on service access for clients.

16. Questions on Funding Arrangements

- ***What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?***

A number of factors have driven the growth in mental health expenditure in Australia. The most central of these factors has been the increasing need within the community for specific mental health supports. This increasing need is a combination of a higher prevalence of mental health issues within the community, as well as a general increase in the awareness of mental health issues and a normalising of seeking out support. As more people are acknowledging their need for support and seeking assistance, the need to fund more programs to address these needs has also increased.

Another key driver of the increase in expenditure has been the historic underfunding of mental health support services within Australia. It is possible to argue that the growth in expenditure is actually the system attempting to move closer to optimal levels of funding, rather than growing an already adequately funded system. With this is mind, this growth will need to continue to ensure support needs continue to be addressed.

Potential new drivers for growth in expenditure will be the continued roll out of the National Disability Insurance Scheme. As this system continues to grow, funding will need to be maintained and expanded to ensure the scheme is able to meet its aim. Similarly, increased funding will need to be injected into the system to fill the service gaps left due to the scheme's introduction.

- ***Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?***

A key example of sub-optimal policy outcome due to issues with existing funding arrangements has been the experience of community mental health services within Victoria. A State Government decision to commit all Community Mental Health funding to the National Disability Insurance Scheme, has resulted in a service system that is not able to adequately support the needs of people living with mental health issues. Whilst the system is slowly being rebuilt, this decision has had a significant impact on the experiences of people living with mental health issues, as well as service providers, many of whom have had to close their programs and divest a skilled workforce.

Another example of a sub-optimal policy outcome was the decision to cease the Commonwealth-funded mental health programs i.e. PHaMs, D2DL and PIR due to the introduction of the National Disability Insurance Scheme. Transition to the NDIS has not occurred as envisioned, with many existing clients of these services being found ineligible or

not wishing to engage with this new model of service. This is indicative that people experiencing mental health issues still require a service delivery model that is flexible, responsive and able to provide recovery-oriented interventions. The NDIS focus is on enduring disability and not necessarily congruent with a stepped approach or recovery oriented approach where individuals can 'recover' from episodic mental health conditions given appropriate supports.

- ***Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?***

  Current commissioning of mental health services has seen a shift from government departments to Primary Health Networks (PHN). A positive of this shift has been the localisation of the commissioning process, with each PHN able to tailor their service delivery to the needs of the community they represent. However, given the amount of new commissioning that has needed to occur, this has meant that PHNs have had to commission and tender many new services in short time frames. This rapid change in the service system may result in less than optimal outcomes for consumers as they seek to understand and navigate a new system.

  In terms of outcomes for consumers, it is possible that the large amount of change currently occurring within the mental health sectors may confuse or deter people from accessing services. As existing programs end, consumers will need to reorient themselves to a new and largely unknown service system. One way of mitigating this risk is to where possible re-commission existing service providers so that consumers are able to experience continuity in their care. In a system that is full of change, maintaining existing relationships may be one way to improve outcomes for consumers.

17. Questions on Monitoring and Reporting Outcomes

- ***Are decision-making forums for mental health receiving high quality and timely information on which to base strategic decisions?***

  As we are not part of any decision-making forums for mental health, we cannot speak to the nature of the information that is provided in order to make strategic decisions. However, given that a number of decisions have been made that seem mismatched with the experiences of consumers and service providers 'on the ground', it can be inferred that the most appropriate and insightful information is not being provided in these decision making forums. For example, decisions were made about the ceasing of Commonwealth funded programs based on information that suggested that at least 80% of current consumers would be found eligible for the National Disability Insurance Scheme. In practice, this has not eventuated with much lower rates of eligibility being found and has then left government departments needing to fill service gaps in the sector. Mechanisms for consumers and service providers to provide relevant information to decision-making forums may enhance

the ability to generate strategic decisions that reflect the current needs within the service system and strategically plan for better mental health service outcomes across both in service provision and supports but also in the early intervention arena.

- ***Does Australia have adequate monitoring and reporting processes to assure compliance with national standards and international obligations?***

  Victoria requires service providers to be accredited against the National Mental Health standards in order to provide services across both Commonwealth and State funded mental health programs.

- ***Is there sufficient independence given to monitoring, reporting and analysing the performance of mental health services?***

  At this stage the role of monitoring, reporting and analysing the performance of mental health services sits with the government departments responsible for funding particular programs. This process is part of the Grant Management process and is built into funding deliverables.

  This process could benefit from being more independent, and therefore allowing for greater consistency across the service sector.

- ***What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?***

  Consumers and carers wish to live the best life possible and engagement with meaningful activities is a vehicle to this desire, which is a basic human right. Meaningful participation encapsulates paid employment and volunteering, social connection and engagement with community, family and friends, and engaging with relevant components of the broader service system.

  Key outcomes that should be measured and reported on for consumers include:

  - Overall wellbeing (mental, social and physical);
  - Community connection and engagement;
  - Reduction in social isolation and;
  - Improved self-efficacy.

This submission is provided by Merri Health, www.merrihealth.org.au

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