Submission to the Productivity Commission Inquiry into Mental Health

April 2019

We would like to thank you for the opportunity to provide the following submission to the Productivity Commission's inquiry into Mental Health. EACH is heartened by the focus upon Mental Health and any endeavours to do more to support people who are living with or whose lives are impacted by mental ill-health and the intersection between mental health and economic participation.

As a community health organisation, we provide an integrated range of health, disability, counselling and community mental health services across Australia. Our services are underpinned by the social model of health and, as such, we recognise that health and wellbeing is significantly and negatively affected by factors such as unemployment, homelessness, financial difficulties, significant life transitions, social exclusion and addiction so we offer a wide range of supports to assist members of our community to lead happier, healthier lives.

As part of our strong organisational commitment to a co-design approach, we have spent time discussing this inquiry with our Consumer, Carer and Community Advisory Committee, workers from the industry and organisational leaders, and concluded there were 5 key aspects that we wanted to highlight for consideration: Early intervention; psychosocial supports and social inclusion; the importance of lived experience; services for families, carers and informal support networks; and, realistic funding models.

Early Intervention

It is well known that people living with mental health conditions experience poorer health outcomes than the general population. Difficulties with education and employment can lead to chronic disadvantage impacting upon access to basic life necessities, like secure and sustainable housing, healthy food, and social capital. This is also true in the reverse in that those experiencing difficult life transitions (unemployment, relationship or family separation, significant grief and loss, etc.), homelessness, financial difficulties, history of trauma, are at greater risk of experiencing mental ill health.

Being able to identify and address issues across these social determinants will be essential in ensuring a broader and more sustainable approach to mental health care and requires a focus on connecting the services that support people through these various difficulties. For those experiencing both mental ill-health and co-occurring health or other life difficulties, options for coordinated, multidisciplinary care (e.g. mental health, drug and alcohol, and homelessness supports that are co-located and seamlessly integrated) are essential to preventing a deterioration in mental health and/or circumstances.

Access to holistic services that can be responsive to engaging with people with a "no wrong door" approach is likely to prevent or reduce the impact of disengagement from social and economic participation.

For children and young people in particular, the need to intervene early for mental health, as well as to prevent school disengagement, is essential and well evidenced. There remains a shortage of appropriately skilled service providers who have capacity to offer the most appropriate interventions matched to the presenting needs of the child and that also have the capability to offer a systemic response to the child or young person's parents and schools. Funding models such as the current MBS items that restrict session numbers and do not support systemic (parent/carer, teacher) engagement make it difficult for service providers to offer evidence-based and best practice care to children and young people who are at risk of or already disengaging from education due to mental ill-health. More funding for services to offer holistic and coordinated care for young people, their parents/carers and the school to intervene early for mental health and school disengagement are essential and consideration should particularly be given to targeting these services at key transition periods – primary to secondary, year 10 to VCE, secondary to tertiary/employment.

Psychosocial Supports & Social Inclusion

The recent funding restructuring with the roll out of NDIS has had a significant impact within the community sector. There is currently a real lack of suitable community mental health support options for non-NDIS participants when they leave hospital-based Area Mental Health services with significant, and often complex, mental health recovery needs. The benefit and importance of brief interventions, small group trainings, informal support, drop in centres and partnering with other community supports and services cannot be overlooked. Having a safe place when issues start to emerge, or to commence interacting socially during recovery is extremely important and something that has been difficult to achieve within the current funding environment. These types of supports are often the first step towards engaging or re-engaging in education and training programs to support economic participation.

Further, social participation and inclusion needs to involve unconditional inclusion, not just putting users of the mental health system with other users of the mental health system. Mental health remains one of the most highly stigmatised health conditions in Australia, particularly within certain demographics and groups. Significant work is still required to educate the broader community and reduce the stigma associated with mental health conditions, not only to benefit the inclusion of people with existing mental health conditions, but also to support the early recognition of emerging/re-emerging mental health conditions that could reduce the need for acute care.

Sitting alongside this issue is that of mental health literacy. Whilst there has been much work in the area of health literacy over recent years, incorporating mental health literacy into these developments is essential to better equipping people to overcome barriers to discrimination and in order to aid with prevention, early intervention, management and recovery.

Further, social isolation and lack of inclusion is also major risk factor for mental ill-health and is therefore important for other groups such as refugees, CALD community, LGBTI and other marginalised groups. Funding models that support inclusive group and community connections, rather than those focused on individual service provision should be prioritised to address this growing need.

The Importance of Lived Experience

We acknowledge and support that the Commission is seeking direct feedback and examples from those with a lived experience who can contribute to this inquiry. We hope that this engagement continues throughout the process.

We would also like to take this opportunity to highlight the value of those with a lived experience as part of the workforce in the mental health sector. The importance of having workers that have the qualification of lived experience of mental health and recovery, and with it the understanding of what people with mental health conditions, their carers and family experience cannot be underestimated. EACH firmly believe that this part of the workforce requires better recognition and integration more broadly across all components of the system, from prevention to early intervention, through to complex care for AOD and mental health. Moreover, they also need better access to equitable remuneration, targeted training and development opportunities to enable them to fully engage with improved career paths and opportunities within the sector.

Services for families, carers, and informal support networks

Mental health conditions do not just impact those living with the condition, but also the families, carers, friends and workplaces of those people. In particular, children and young people who have parents living with mental health conditions can be significantly impacted, often having to take on caring roles and being isolated through these additional responsibilities and/or the stigma related to having a parent with a mental health condition. These children and young people are more likely to miss time at school, experience deteriorating performance and even disengage from their education altogether. It is essential that the education, as well as the mental health systems are able to recognise and be responsive to the needs of children of people experiencing mental ill-health without any need to label or stigmatise them.

Similarly, it is also essential that the system properly recognises the role carers have in supporting and improving the outcomes for people with mental health conditions and is able to adequately support and address the unique needs of these carers. Some carers may also need flexible work arrangements to care for their loved one, leading to potentially unstable employment if this is not well understood. Ensuring that carers have access to services that also do not require them to be labelled or stigmatised (e.g. through unnecessary diagnoses to receive a mental health treatment plan to support their access to a psychologist), but can support their wellbeing and economic participation is vital.

As indicated earlier, funding models that enable community capacity building activities that promote awareness, understanding and inclusion within local communities for those with a mental health condition, as well as for those who live with or care for someone experiencing mental ill-health, are particularly important to ensuring people remain connected and engaged with the informal supports that will aid their recovery.

Funding Models

EACH holds a strong belief in the delivery of quality, evidence-informed care delivered by appropriately skilled staff who are operating within their scope of practice. However, attracting and retaining staff who meet these requirements and are able to deliver services

to the most vulnerable within the community (e.g. those who cannot afford to pay co-contributions and gap fees) is becoming increasingly difficult under the current rates set for NDIS and MBS service provision. If we are to continue to provide these services, the set rates need to be reviewed, particularly in the context of ensuring that the most vulnerable members of the community can have access to them without compromising the quality of care they will receive. Where organisations receive block funding to employ "credentialed" mental health staff to deliver services, funding envelopes need to reflect the costs associated with employing and retaining credentialed staff on relevant Awards.

With the acknowledgement that many individuals with experiencing complex diagnosed mental health conditions may not be eligible for service under the NDIS, much needed psychosocial and mental health services are becoming established. However, access to some of these services appears confusing for customers who feel that they are being forced to test NDIS eligibility before they can access other services. The deficit-focused nature of the NDIS language is in stark contrast to the well-researched and supported Recovery Model utilised in the psychosocial mental health service space. Forcing individuals to step into a deficit-focused framework in order to access services, along with the need to repeat their story multiple times, could significantly impact their recovery journey.

Further, many customers express significant frustration and distress during times of funding changes. Where programs are funded for pilot initiatives or short-term contracts (i.e. 6-12 months), the service changes are confusing and can feel premature when they have not yet met the goals of their engagement with the service. Where staff have been employed on short-term or insecure employment contracts to align with funding commitments, customers can often also experience the loss of their worker prior to the funding ending, creating the possibility of multiple transitions of care and the risk of an escalation of their needs. Even where programs are re-funded or where new funding becomes available, customers experience gaps in service provision, changes of workers, and the need to repeat their story, all of which create setbacks in their mental health recovery and contribute to the likelihood they will need a longer period of engagement with services overall (based on internal service data). Funding security is required to ensure organisations can employ quality staff with longer tenures.

Summary

We are pleased to see that this particular inquiry has such a broad scope to consider the intersection between mental health and social and economic participation. We have chosen to focus on just 5 key aspects, but look forward to further engagement and encouraging our community to be involved in the Commission's inquiry as it evolves.

Peter Ruzyla
EACH CEO