Submission to the Productivity Commission
"The Social and Economic Benefits of Improving Mental Health"

Executive Summary

The Productivity Commission is seeking feedback from all stakeholders to assist with its challenge of improving the social and economic costs of mental health in Australia. Australian Kookaburra Kids Foundation is a unique, community-managed organised that provides evidence based mental health promotion and early-intervention services to an at-risk group of Australian young-people: those living in families affected by mental illness.

In this submission, we highlight the divide between the policy-level intent within the Australian mental healthcare system toward principles of early-intervention and person-centred mental health and the dominant model, system and processes that make these principles difficult to effectively implement. We highlight the opportunity for increased social and economic participation alongside improved mental health based that may arise from changes in approach.

The components of AKKF's relational, activity based peer early intervention approach are compared to a more conventional early-intervention for young people at risk, with the resultant opportunity for considerable economic and social cost-benefits based described. We suggest a complimentary investment in situational, dual approach early interventions for mental health alongside current mental healthcare initiatives, predicting a cost-shift in mental health service delivery and increased return on investment over time.

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Intent of Australian Kookaburra Kids Foundation (AKKF) Submission

AKKF makes this submission to provide an example of an innovative, combined clinical and non-clinical mental health early intervention and prevention initiative for at-risk young people that has demonstrated positive impacts on outcomes associated with improved mental health.

A further aim is to promote investment in relationally-based early intervention and preventative mental health interventions generally, and more specifically, within target populations who are greater risk of reduced social participation, life-skill development and compromised mental health. We speak to questions raised in the Commission's Issues Paper on pages 14-16 related to prevention and early intervention, particularly for young people.

We highlight the opportunity for improved wellbeing (socially, economically through increased participation and skills, and intra-personally) that can be realised within a reconceptualised framework of mental health; one which emphasises mental wellness (rather than reduced mental illness) as the central tenet. Here, we provide insight and opportunity relating to the Commission's questions about weaknesses in the healthcare system (page 13), and issues surrounding service-integration and reduced social participation and inclusion (pages 21-23).

Background to AKKF

AKKF is a non-government organisation (with charitable status) founded in 2002 by Dianne Madden. Through lived personal experience, Dianne identified the lack of support for children living in a family affected by mental illness.

Our organisation supports children aged 8-18 living in families affected by mental illness. The program provides mental health psycho-education and basic coping skills embedded within recreation camps and activity days.

Overview of Programs

During camps and activity-days, we empower young people with age-appropriate mental health knowledge and options for support, as well as the opportunity to form ongoing connections with new friends who share common experiences. We provide opportunity to practice newly developed coping skills within a supported environment, and equip each child with take-home resources that support ongoing implementation and have also been shown to promote a more positive approach to mental wellness within the broader family.

AKKF programs are an example of an evidence-based, preventative and early-intervention mental-health initiative undertaken in a peer-based, non-clinical format. In bridging the gap between clinical and non-clinical approaches, we aim to increase the relevance, accessibility and generalisability of the mental-health intervention, at the same time reducing barriers such as stigma.

Program aims include:

- Increase mental health literacy
- Improve help-seeking willingness and behaviour
- Increase self-help strategies for times of stress or sub-clinical emotional / psychological distress
- Triage and referral-on when young people are experiencing specific or clinical levels of psychological distress
- Provide opportunity and support to create effective and enduring peer-relationships with other young people on the program
- Allow young people to participate in developmentally-appropriate activities (i.e., social, recreational, physical, life-skills-oriented)
- Provide information and facilitate connection to other supports or relevant services
- Provide ongoing support to vulnerable young people for as long as they choose to remain within the program

The first "Camp Kookaburra" camp was held with 16 kids. Today, over 2300 children and young people are registered to the Kookaburra Kids program. We believe all children who are affected by parents or other family members with a mental illness deserve to be supported, valued, and provided with opportunities to reach their potential.

Impact of Family Mental Illness on Young People

Young people living with parents or other key family-member affected by mental illness are at risk of multiple adverse outcomes compared to their same-aged peers. These outcomes range from increased genetic predisposition toward mental illness themselves (e.g., twofold risk for anxiety-based disorders), higher risk of externalising behaviour problems, academic problems, difficulties socially and relationally, problems of self-regulation, and attention-related problems. (See Reupert, Mayberry & Kowalenko; 2013, for a review).

Evidence from a growing global research base suggests as many as 25% of young people are living in homes affected by mental illness (Howe, Batchelor, Bochynska, 2009; Mayberry, Reupert, Patrick et al., 2009). In addition to heredity, the proposed mechanisms of risk-transfer within vulnerable families include heightened overall stress/distress, increased family discord, compromised care including reduced parental responsivity and time spent together in connection, increased parental permissiveness, and reduced access to age-appropriate experiences across all of the five developmental areas (social, emotional, cognitive, academic, and physical) (Reupert et al., 2013).

While not all children living in homes affected by mental illness will be adversely impacted, nor will they be impacted in the same way, it is clear that this this category of young people are at particular risk when it comes to the complex social and economic costs of mental illness.

Policy and Program Context

Mental health and young People

The critical importance of health promotion in the area of children's mental health was highlighted in a large UK longitudinal study (Kingdom, Goodman, Joyce & Smith, 2011). This research found the mental health of children in the study to be far better predictor of lifetime health outcomes than physical health (Kingdom et al., 2011).

In the Australian context, targeting mental health interventions towards young people is clearly a priority of governments and policy makers. For instance, the Australian Government has acknowledged young people with additional risks to mental health as a priority group, including within the Access-to Allied Health Psychological Services (ATAPS) initiative managed nationally via the Primary Health Networks (Mental Health Services Australia, 2019). Furthermore, earlier this year, a $51.8 million boost to Headspace National Youth Mental Health was announced on top of the almost $100 million already committed, enabling service-provision to an estimated additional 14 000 adolescents (12-25 year olds) with mental illnesses.

For one in two adults diagnosed with a mental illness, evidence of the disorder can be traced back to childhood (Belfer, 2008). Therefore, the merit of intervention and support promoting the mental healthiness of young people appears well-established across research, policy and strategy, in Australia and beyond.

Early Intervention, prevention and mental health promotion

When it comes to mental health, there appears to be a general acceptance of the colloquial phrase "prevention is better than cure". Within research and anecdotally, there is also general agreement with the principle of "early-intervention", which involves intervening at a point earlier than full manifestation of symptoms, with the goal of averting disorder and a more successful return to full and symptom-free functioning. In the past two decades, the principle of early intervention has permeated the mental health literature, with the need for investment in this area recently emphasised as a priority within "Investing to Save" (KPMG & Mental Health Australian, 2018). This ground-breaking review of Australia's workplace mental health suggested that a purposeful shift in the focus of investment towards prevention and early-intervention was likely to "…generate a (positive) cost-shift in mental health service delivery over time" (p65) Within Investing to Save, and across the prevention and mental health early intervention literature more broadly, there is clear emphasis on the need and opportunity to reduce not only the economic burden resulting from mental illness, but also the significant and intangible human-losses such as reduced community participation, relationship and family disruptions, and unrealised potential (e.g., Access Economics, 2009).

Challenges to sustainable, effective mental health prevention and early-intervention initiatives

Despite considerable in-principle and strategy level commitment to health promotion, illness prevention and early intervention for mental health, the degree to which these principles and approaches have been effectively adopted within the Australian healthcare system is questionable (Ashfield, MacDonald, Francis, Smith, 2017). A fundamental problem, which is at

the heart of our mental healthcare system, is the reliance on a deficit-based medical model inherently focused on the reduction of illness-symptoms that are the hallmarks of psychiatric diagnoses. In short, we are continually focused on "reducing mental illness" at the expense of comprehensive, purposeful, strategic discussions that allow us to ask (individually, as families and as communities) "how does mental wellness look?"

Evidence of this illness-focused, reductionistic symptom approach to mental healthiness is found within the kinds of outcome measures mental health clinicians are required to utilise when services are being delivered under the Better Access (Medicare) and ATAPS programs. For example, the well-utilised Kessler-10 (K10) (Kessler, Barker, Colpe, Epstein et al., 2003) asks individuals to rate their experience over the last 4 weeks in terms of questions such as "About how often did you feel tired out for no good reason?", and "About how often did you feel worthless?", or "About how often did you feel so sad nothing could cheer you up?" The Depression Anxiety Stress Scale (DASS-21) (Lovibond & Lovibond, 1995) is another measure identified as an appropriate outcome measure in key government programs that is popular with treating clinicians across Australia. Its questions similarly ask the individual "over the past week, how much did the following statements apply to you" on 21 items, such as "I found it hard to wind down, I tended to over-react to situations, I was worried about situations in which I might panic and make a fool of myself, or I felt I wasn't worth much as a person".

There is no doubt that alleviation of symptoms is an important part of any treatment that seeks to bring about health. As practitioners of mental health, this over-emphasis keeps us focused on delivery of "up-stream" supports from within the moderate to complex needs categories depicted in the "Stepped model of care" (Figure 5; Productivity Commission Issues Paper, pg 13) with extremely little focus on the potentially health-creating interventions outlined in the down-stream in the early steps of this model. This is especially true when it comes to funding mental health initiatives; practitioners in both the primary and state-based mental health sector cannot resource these components of the stepped-care model via any of the established funding arrangements (e.g., Medicare, ATAPS, local health district interventions). Referral for services that can be claimed via such initiatives require a GP referral and some kind of identified "presenting mental health issue" (even if sub-clinical in severity).

Consequently, a growing number of prominent research-practitioners and mental health strategists appear to be expressing concerns about what has been called "the inherently stigmatising narrative" of our approaches to mental wellness, and a system that is promulgated with what some say is disempowering, illness-oriented "language that harms" by shifting the locus of control for wellness from the individual, to the medical "experts" (Ashfield et al., 2017). Over time, the accumulation of medical notes, referrals, mental health treatment plans, and indeed the self-definition applied by the individual who has been deemed "ill" becomes more solidified and known. Often, this "paperwork" arrives before the individual does, ahead of an appointment, as part of an application, to transition some kind of service. It can (and arguably does) adversely influence all manner of social and economic participation: ranging from access to insurance and other products, to some employment opportunities, as well as influencing the responses from service providers and professionals who see the illness-oriented words before they meet the individual (Ashfield et al., 2017). As individuals who are on the receiving end of

this process when young people and families are referred to our programs, and (if we self-reflect honestly) as practitioners who have been part of the co-creation of such potentially-harming illness-narratives, this is something we feel must be changed, and are committed to being part of that change. We will highlight the way AKKF is doing this in following sections.

We are, of course, beginning to speak here to the "questions on structural weaknesses in healthcare" raised by the Commission (page 13 of Issues Paper). We have highlighted already what we see to be the critical importance of early intervention and prevention activities within the mental health space (also acknowledged in Issues Paper on page 14). Unfortunately, it does not seem that a simple solution of investing more in the mental health early intervention generally is likely to lead to the kinds of impacts the Commission is seeking. The issue of mental health approaches being based inherently in a stigmatising narrative of mental illness (has also been levelled at key early intervention approaches that have experienced wide-scale roll-out in the past decade (e.g., Mental Health First Aide, Kitchener, Jorm & Kelly, 2017). The criticisms highlight the over-emphasis of mental health literacy campaigns on avoidance of illness, de-contextualising the human experience of "distress" to a series of symptoms (Ashfeld, et al., 2017). The prominent critics, representing a number of key Australian Universities and the Australian Institute of Male Health & Studies, highlight the need for a dual-focus approach that allows early intervention to address not only the situational distress (i.e., current experiences and symptoms) of the individual, but the "wider issues known to be contributing to or strongly implicated in their distress" (Figure 4, page 17; Ashfield et al., 2017).

An additional concern we have is that early-intervention, conducted in the absence of relevant context factors (such as supported relationships, or a framework where new ideas can be tested and refined), is likely to have limited relevance, generalisability and impact. These issues are identified as limitations of most psychological interventions and present an enduring challenge to mental health care (Williams, Oades, Deane, Crowe et al., 2013) We therefore agree that an urgent opportunity exists to focus on the second element of the Ashfield et al. (2017) dual-situational approach (address the wider issues known to be contributing to or strongly implicated in their distress), to early intervention initiatives are contextually-relevant, are able to be generalised beyond the intervention setting, and have a chance to take hold. We seek to demonstrate how our interventions approach this in the coming sections.

The concerns highlighted in this submission persist within the Australian mental healthcare system also despite a policy-level commitment to Recovery-Oriented approaches to mental health practice and service delivery by Governments (i.e., 2011, 2014). The concept of recovery-orientation places the lived-experience of the individual, the need for individual choice and empowerment, and the responsibility for services to ensure collaborative planning and service provision at the heart of healthcare (Williams, Deane, Oades, Crowe et al., 2017). If we truly embody the recovery-vision within our system of healthcare, all individuals impacted by mental health concerns would be supported by our practices, interventions, and services toward "…the creation of meaningful and contributing lives in a community of choice, with or without the presence of mental health issues" (Department of Health, 2014; page 2). When we are truly embodying this framework, adoption of interventions and supports that approach

individuals from an illness-aversion standpoint, and seek to measure "treatment outcomes" in terms of reduced symptoms, will not only be counter-intuitive, but unacceptable.

The Productivity Commission's Issues paper has called for comment on the current national approach to suicide-prevention. One of the most prominent and well-expounded models of suicidality is Joiners' Model (Joiner et al., 2005), which identifies "thwarted belongingness" (a social and engagement-related construct) and "perceived burdensomeness" (a construct related to participation and accomplishment) as the critical and common variables. Our approaches to suicide prevention currently focus on risk and symptomatology far more than these underlying variables and is an area suggested as possible focus of forthcoming alternate approaches.

Examples outside the Australian healthcare system that offer opportunity

Following on from this last comment, the Commission has asked respondents to identify examples where some of the healthcare system challenges are being managed well. We are able to identify examples of applied best-practice in the UK particularly in the area of true recovery-orientation in service provision (see https://www.reasearchintorecovery.com) Elsewhere, models of holistic, strengths-focused, wellness-oriented health care are being developed, implemented and researched with growing effect. One prominent model of wellness, developed and disseminated by Dr Martin Seligman, who ironically, was an initially a pioneer in psychological research quantifying and measuring the core components of depression (learned hopelessness and helplessness). For the past two decades or more, Dr Seligman has established himself as one of the leading minds and practitioners in the area of scientific Positive Psychology. This field of applied research seeks to explicate and make reproducible the factors that allow humans to function optimally; to lead vital, socially connected and meaningful lives. Within his current model of wellbeing and vitality, Dr Seligman has identified 5 components: Positive emotion, Engagement, Relationships, Meaning, and Accomplishment (Seligman, 2018) https://positivepsychologyprogram.com/perma-model) . The PERMA model presents an opportunity for mental health strategists and clinicians to reframe not only the kinds of interventions and programs offered to service participants, but to also re-orient the fundamental premise of what it is we have all set out to do: That is, to promote the mental healthiness and optimal functioning of individuals not only in terms of psychological and emotional wellbeing, but across the diversity of a lived human experience. Positive emotions, Engagement, Relationships, Meaning, and Accomplishment. Notably, these factors explicated within a positive psychology conception of wellbeing appear to overlap substantially with the very outcomes being sought via the Productivity Commission's inquiry.

We are not arguing that symptom reduction and increasing awareness of mental illness symptoms ought not be part of mental healthcare in Australia. In fact, increasing mental health literacy is a critical component of AKKF's programs, and has been positively associated with increased help-seeking (Perry, Petrie, Buckley, Cavanagh et al., 2014). Instead, we are proposing positive outcomes in social connectedness, engagement, productivity and mental healthiness will require at least equal focus and prioritisation of interventions that target these variables.

What has been done by AKKF: Evidence of Impact

Since 2018, AKKF has been evaluating the effectiveness of its relationally-based, peer-group early interventions in a pre-post format that utilised combined participant experience qualitative data and responses via empirically tested questionnaires (i.e., General Help Seeking Questionnaire; Wilson, Deane, Ciarrochi & Rickwood, 2005; Mental Health Literacy Questionnaire; Groves, Mayberry & Reupert, 2014). While data collection and analysis is in its foundational stages, we have strong indications that our camp chat-group interventions the at-risk group of young Australians we support has a positive impact on mental health literacy and help-seeking intentions. Recent data-collection at Activity Days supports our assertions that holding early-intervention within a relational and interactive framework extends the relevance and generalisability of such interventions. For example, participating young people report they have made new friends, re-connected with friends made previously, and participated in new activities and physical-skills, in addition to acquiring new knowledge about mental healthiness (Williams, unpublished evaluation report, 2019).

The full impact of our programs is best exemplified through case-examples and lived-experiences offered by young people. The following de-identified, brief examples are offered in the hope they can depict the breadth and scope of impact that can be achieved:

Katie*, aged 10 years, learning about anxiety and how to cope well

Katie attends a Kookaburra Kids camp for the first time and learns about anxiety, anxiety disorders, sources of information and ways she can help herself if she needs to. Katie participates in chat group with 6 other girls, and learns a little of their experiences of anxiety and stress. Katie notices herself feeling less alone.

Two weeks after camp, Katie is faced with a highly stressful social situation at school, which she feels unable to speak with anyone about. She remembers "chat group" at camp, and how her group practised calling Kids Helpline. Katie makes a call to the helpline, receives supported and develops a plan for how to manage her stressful situation.

Katie plans to share this news with her Kookaburra Kids leaders and friends when she sees them at the next activity day.

* not actual name

Joel came home raving about camp! He thought all the leaders were amazing and made some new friends. He also said he learned a lot about Daddy's PTSD and has even started communicating differently with his Dad. Thank you so much Kookaburra Kids! I haven't seen Joel so happy in a long time. We can't wait to come to the next camp.

Monique*, aged 22, is about to commence a post-graduate university course within the social sciences. Monique commenced in the AKKF program at age 9, eligible for inclusion due to both of her parents identifying with the major mental health disorder diagnoses. She contacts a member of the AKKF team whom to request they act as a referee on her study work-placement application. Monique reflects that she believes wholeheartedly that without the skills, ongoing support and safe-place to develop her confidence that she received from Kookaburra Kids, the accomplishments she has achieved would not have been possible.

Comparison to an alternate evidence-based early intervention for young people

A common early-intervention approach to meeting the needs of a young-person who is presenting as "at-risk" of mental illness would be to offer a series of Cognitive-Behaviour Therapy (CBT) sessions with a psychologist / clinical psychologist. The current recommended session rate for a psychology session (45-60minutes) is $251 (www.psychology.org.au). Within most government-funded psychology programs for early-onset or mild presentations, between 6 and 10 sessions of CBT are allowed per year. This approach has been acknowledged as a potential useful early intervention approach within the Investing to Save report (KPMG & MHA, 2018) and has been highlighted for consideration within the Productivity Commission's inquiry.

In Figure 1 below, we compare the modalities, targeted skills and areas of impact of the AKKF early-intervention approach alongside a standard CBT approach:

Figure 1

AKKF Program (left) modalities, targets and impact compared to CBT early intervention (right)

Referring back to the views we have expressed regarding the challenges within the current model of mental healthcare, the features and targets of the AKKF programs as outlined above can be seen to adopt core components of early-intervention in addition to a number of principles explicated in contemporary wellness-oriented models (e.g., PERMA; Seligman, 2018). The features of a typical CBT intervention as outlined here do include some relational components (e.g., liaison with referrers and parents), though adhere most closely to the symptom-reduction focus inherent within the medical model.

Potential cost-savings compared to treatment as usual

The cost of participation for a young-person in AKKF programs is (on average) approximately $2000 per annum, and involves an average 60 face-to-face engagement hours across multiple social, physical and recreational contexts for the participating child or adolescent.

The cost of participation for a young person who engages in 10 sessions of CBT with a clinical psychologist funded under Medicare (bulk-billed rate) is $2510 per annum, and involves a total 10 hours of face to face engagement hours within a clinic-setting (usually) for the participating child or adolescent.

Based on these estimations, there are considerable per-child cost-savings when AKKF programs are compared to the recommended costs of a CBT approach for similarly at-risk young people.

What can and should be done: potential impact on the social and economic costs of mental illness if we invest effectively in early-interventions

In 2009, Access Economics produced a report that investigated the economic impact of youth mental illness, with specific emphasis on the cost-effectiveness of early intervention. In that report, the costs of un-managed mental health concerns in our young-people was estimated to be $31 104 for every year that effective intervention is not provided. In 2018, AKKF provided service to over 350 children in its camp programs alone. From within this group, approximately 16% of young people were identified as at additional risk (over and above the vulnerability presented by family mental illness) and were linked to ongoing and specialised support. We provided evidence-based mental health psycho-education, help-seeking and resilience skills-building intervention to all of these young people, embedded within a social, relational and activity-based group format. A proportion of these young people, identified via our qualified team, were provided in the moment support and coaching, and referred on to specialist providers for ongoing, selective mental health interventions. If we dare to posit that at least 85% of these young people received the right service at the right time (which may actually be a conservative estimate), the cost-effectiveness of our programs last year was $9 253440 (350 children x .85 x $31 104). The actual cost of program delivery for 350 children who participated in camp and activity days was $700 000.

This represents an economic saving of $8 553 400, which is equates to a cost-benefit ration of 12.2 for every early intervention mental health dollar spent in our programs.

While these figures are estimates only, we believe they highlight the potential for “shifting cost-ratios” that were proposed by KPMG and MHA in their ground-breaking report (2018). When the observed and reported positive impacts of our programs on social participation, recreational and physical engagement, life-skill development and healthy relationships are considered, it appears the relational and peer-based format of our early intervention

approach may reduce the social costs of mental illness on children living within mental health affected families.

We are not suggesting that services and resources being expended "up-stream" in the stepped care model be ceased or redirected to early-intervention. Rather, a necessary and urgent shift needs to be made in the approach and mindset that underpins the mental healthcare system if improvements in the social and economic costs associated with problems of mental health are to be realised. In reality, what is likely to be required is a complimentary additional investment in the most-effective kinds of early intervention; those adopting a situation-dual focus as outlined by Ashfield et al., 2017. If we embrace early-intervention as a priority in mental healthcare, we will need to reconsider how to make this sustainable for agencies that are currently reliant on grants, philanthropy and other means and unable to access Better Access or other government funded programs targeting mental health. In the short-term, the costs of mental health service provision are likely to increase, but over time, aligned with the insurance model that has been adopted within the NDIS, program costs along with social and economic costs of mental ill-health are predicted to decline (KPMG & MHA, 2018).

In addition to adopting the principles and approaches that we have identified as exemplars (i.e., UK Recovery, Positive Psychology models) we hope the information we have provided about AKKF's novel approach to mental health promotion and early intervention can encourage further investment in this area, and contribute to our communal understanding of the mechanisms that make interventions effective.

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