Submission from Community Mental Health Australia (CMHA)

on the Productivity Commission Review of the Economic Benefits of Improving Mental Health

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations. Through them CMHA has a direct link and provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation.

The organisations represented through CMHA are:

1. Mental Health Coalition of South Australia
2. Mental Health Community Coalition of the ACT
3. Mental Health Coordinating Council NSW
4. Mental Health Council of Tasmania
5. Northern Territory Mental Health Coalition
6. Mental Health Victoria
7. Queensland Alliance for Mental Health
8. Western Australian Association for Mental Health

INTRODUCTION

Mental Health is more than "mental"[1] and more than a health issue[2]. The lens for this review should be multi-perspective and far-seeing. The Productivity Commission has a significant opportunity to nudge[3] the Australian people toward making **health and happiness key national objectives, equal with prosperity**[4].

Politicians[5] contest what is most important, the liberty of the individual[6], or the collective good[7]. Science[8] and clear thinking support their interdependence. Our fragile interconnected world and ecology now mandate that **the wellbeing of each person and the wellbeing of all, more than ever, require each other**.

This Productivity Commission's Issues Paper is well considered, and we are thankful for the opportunity to provide comment. In this submission we will (i) make some critical remarks on the Issues Paper (ii) respond to some of the questions, and (iii) put the case that:

   (a) Increased social equality for **the most disadvantaged** is a very powerful **long-term, high return** investment in national financial equity[9]

   (a) Our **mental health system** would be more effective if it was more **proactive and participatory**[10]**.** Participatory meaning greater **involvement of service users** in management and delivery of services

   (b) The historical commitment[11] to establish a comprehensive community mental health service network has not been realised. **Shifting "the centre of gravity" of mental health services to the community** is still required to effectively improve national wellbeing and productivity.

   (c) In the case of mental ill-health and disorder "help-seeking" is often absent or is a late stage occurrence[12]. This even more so for disadvantaged individuals and communities. A **proactive community embedded approach is required** for effective and early intervention.

   (d) Mental health, in **equal partnership with physical health**[13], is a key enabler of our capacity to learn, cooperate and contribute and requires a comparable amount of public investment.

   (e) **Sustainable employment** (and meaningful activity) is a significant measure of, and contributor to recovery[14]. Compared to other OECD countries our employment rate for people with severe mental illness is poor[15] and requires new thinking[16] and **should be a uniting goal for all MH services**.

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[1] Rethinking the biopsychosocial model of health: Understanding health as a dynamic system; Barbara J. Lehman; et al; Social and Personality Psychology Compass, Volume 11, August 2017: https://onlinelibrary.wiley.com/doi/full/10.1111/spc3.12328

[2] The social determinants of mental health: An overview and call to action. Shim, R *et al; Psychiatric Annals, 2014;* https://psycnet.apa.org/record/2014-05617-004

[3] https://en.wikipedia.org/wiki/Nudge_theory

[4] World Happiness Report; United Nations, 2019

[5] "There is no such thing as society" Margaret Thatcher, 1987

[6] https://en.wikipedia.org/wiki/Individualism

[7] https://en.wikipedia.org/wiki/Common_good; http://www.oecdbetterlifeindex.org/#/11111111111 and https://en.wikipedia.org/wiki/Collectivism

8 Prilleltensky I., Prilleltensky O. (2007) Webs of Well-Being: the Interdependence of Personal, Relational, Organizational and Communal Well-Being. In: Haworth J., Hart G. (eds) Well-Being. Palgrave Macmillan, London

[9] https://www.brookings.edu/book/productive-equity/

[10] The P4 Health Spectrum – A Predictive, Preventive, Personalized and Participatory Continuum for Promoting Healthspan; Sagner, Michael, et al; Progress in Preventive Medicine: January 2017

[11] See https://en.wikipedia.org/wiki/Community_mental_health_service

[12] Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour; Lucy Biddle, Jenny Donovan, Debbie Sharp and David Gunnell: Sociology of Health & Illness, Vol. 29

13 The Health and Productivity Cost Burden of the "Top 10" Physical and Mental Health Conditions Affecting Six Large U.S. Employers; Journal of Occupational and Environmental Medicine: January 2003 - Volume 45 - Issue 1 - p 5-14

[14] Employment and Mental Health; The Royal College of Psychiatrists Report, 2017.

[15] Connecting People with Jobs: Key Issues for Raising Labour Market Participation in Australia; OECD Report, 2017; "Of people 16 - 65, 67% are employed; 50% with mid-to-moderate mental illness are employed; 23% with severe mental illness are employed"

[16] For example: The Centre for Full Employment at Newcastle University; http://www.fullemployment.net/index.php

COMMENTS ON THE INQUIRY SCOPE

On page 5 of the Issues Paper it says

> *To give the inquiry focus, we intend to give greatest consideration to where there are the largest potential improvements in population mental health, participation and contribution over the long term. From the Commission's initial consultations, this seems likely to include:*
>
> - *people with a mild or moderate mental illness (such as anxiety and depressive disorders) because they account for the vast majority of Australians with a mental disorder (figure 2)*
>
> - *young people, because mental illness at a young age can affect schooling and other factors which influence opportunities over a person's lifetime — moreover, most mental illnesses experienced in adult life have their onset in childhood or adolescence (McGorry et al. 2011)*
>
> - *disadvantaged groups, such as individuals from very low socioeconomic backgrounds and people residing in remote areas because they may have more difficulty in accessing services which could improve their mental health (AIHW 2018d; Harris et al. 2010; Meadows et al. 2015)*
>
> - *suicide prevention, because the years of additional life lived, and associated social and economic participation and productivity years into the future, can be significant.*
>
> *We also intend to focus on measures that could improve the integration and continuity of support for particular groups, such as people with severe, persistent and complex mental illness, and which could better take into account the episodic nature of some mental illnesses.*

Comment: While the four areas for "greatest consideration" listed above seem reasonable, we believe there should be **more initial caution in deciding which areas or groups should be most focused upon until the cost and benefit data for all groups is collected and analysed**. For example, an alternative or additional group for "greatest consideration" could just as reasonably be put as:

- people with severe mental illness (figure 2), because they have the highest mortality, morbidity and unemployment rates and account for a disproportionately high amount of the human service costs.

It is this group that most overlaps with the disadvantaged groups mentioned in the third dot point above. It is also the case that this group (people living with severe mental illness) contribute disproportionally to the inequality measure in Australian society[17]. As it says in the 2014 OECD publication ***Trends in Income Inequality and Its Impact on Economic Growth***[18]

> *"Drawing on harmonised data covering the OECD countries over the past 30 years, the econometric analysis suggests that income inequality has a negative and statistically significant impact on subsequent growth. In particular, what matters most is the gap between low income households and the rest of the population" (Page 6)*

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[17] Productivity Commission Report on Inequality: A summation of the Evidence - https://www.pc.gov.au/research/completed/rising-inequality/rising-inequality.pdf

[18] Trends in Income Inequality And Its Impact On Economic Growth - http://www.oecd.org/els/soc/trends-in-income-inequality-and-its-impact-on-economic-growth-SEM-WP163.pdf

COMMENTS ON ASSESSMENT APPROACH

The Terms of Reference for this enquiry include "*examining the effect of supporting mental health on economic and social participation, productivity and the Australian economy*". In the definition of key terms Mental Health and Mental Illness are distinguished and mental health is defined as "*a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*". As it says in the March 2018 **WHO Statement on Mental Health – Strengthening our Response** (from which the above definition was obtained), "*Health is a state of complete physical, mental and social well-being and __not merely the absence of disease or infirmity__.*[19]"

In concurrence with the widespread understanding that has developed in the field of psychology over the past two decades, mental health is not just the absence of illness but is the presence of the characteristics of positive mental health. This understanding is now also a core feature of the recovery approach in mental health[20]. There is also a growing body of evidence that positive wellbeing improves productivity[21]. Another way of understanding this difference is to see mental illness and health as two separate dimensions[22] (Figure 1)

Optimal Mental Health

Optimal Mental Health with Mental Illness

Optimal Mental Health without Mental Illness

Serious Mental Illness

No Symptoms of Mental Illness

Poor Mental Health with Mental Illness

Poor Mental Health without a Mental Illness

Poor Mental Health

Figure 1: The Mental Health/Illness Continuum

It is thus **disappointing that the first Assessment Component steers the focus of the enquiry only onto the "Consequences of mental ill-health",** being made up of "*What it is costing individuals, their carers and Australia more broadly to forgo the participation and full contribution of those with mental ill-health*"

It may be more challenging to investigate the "**Consequences of the lack of positive mental health**", but it is not immeasurable, and as the research would indicate it is by no means insignificant in its potential contribution to improved individual, organisational and national productivity.

If this **dual focus on both the consequences of metal ill-health AND the lack of positive mental health** is included, then the three following Assessment Components still all apply:

- Effectiveness and cost of current programs and supports
- Gaps in current programs and supports available
- Likely effectiveness of alternative programs and supports

This more comprehensive dual approach will provide a more rounded balance sheet of national social capital that accounts both the liabilities and assets of our common mental health. This accounting of the full mental health continuum could provide evidence that not just (a) achieving stable normality (i.e. aiming for zero on the mental health scale) is sufficient, but also (b) building positive wellbeing (i.e. moving along the plus side of the continuum) are **both major contributors to improved productivity**.

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[19] https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response; WHO, 2018

[20] Mental illness and well-being: the central importance of positive psychology and recovery approaches; Mike Slade; Bio Medical Central Health Serv Res. 2010

[21] Happiness and Productivity. Oswald, Andrew J., Proto, Eugenio and Sgroi, Daniel. (2015) Journal of Labor Economics, 33 (4). pp. 789-822

[22] The Difference Between Mental Health and Mental Illness; Sherry Benton Ph.D. Psychology Today, 2018: https://www.psychologytoday.com/us/blog/reaching-across-the-divide/201804/the-difference-between-mental-health-and-mental-illness

COMMENTS ON CONTRIBUTING COMPONENTS TO IMPROVING MENTAL HEALTH AND WELLBEING

Structural Weaknesses in Health Care

Question asked in the Issues Paper: Why have past reforms of governments over many years had limited effectiveness in removing the structural weaknesses in healthcare for people with a mental illness?

Previous reforms had limited effectiveness because:

(a) Firstly, they were **inadequately funded** to provide the necessary and sufficient services required to assist all people in Australia that were within the target groups identified in previous reforms. That is, these were major **social infrastructure projects** and they failed because they were underfunded, **just as you cannot construct a physical bridge that will stay up if it is seriously underfunded**.

(b) The governance of the system is complex. Despite overall commitment to a common Plan (the 5th Plan), coordination is inconsistent and often poor between the commonwealth and states/territories, between different departments (e.g. health and social services - at both state and federal levels), between state department and local district/area services, between local district/area services and PHNs. This competitive political and bureaucratic governance arrangement, together with a competitive market-based approach to commissioning at the provider level, makes mental health system integration extremely difficult.

(c) Related to the above, continual restructuring and system change (see quote below[23]) has meant that **insufficient time** has been allowed to enable the organic evolution of the mental health service "chaos" into a "unified and coordinated system".

(d) Even with the above challenges the unification of the varying components of the mental health service system would have been more successful if a **universally accepted and mandated data set, including** most importantly **desired outcomes,** had been fully implemented.

Question asked in the Issues Paper: What, if any, structural weaknesses in healthcare are not being targeted by the most recent and foreshadowed reforms by governments?

(a) Firstly, as mentioned above, the **proposed investment (i.e. $$) is again way too low**. The investment in the promotion, prevention and treatment of mental illness, including effectively addressing the social determinants of ill-health and the promotion and development of positive mental health for people at each phase of the Stepped Care Model is insufficient and thus will not succeed.

(b) The most recent major reforms including the NDIS and the PHN commissioning in large part retain a structural inhibitor to connecting with a significant proportion of people who need assistance. To explain - the traditional approach to providing medical services is that the first move is made by a patient to approach a service (e.g. a GP) – "help-seeking behaviour". Lived experience[24], and research[25] finds that **a (1) more proactive** and **(2) a "consumer informed and involved culture" is required** to establish initial connections and maintain relationships with many people living with significant mental health issues who are not connected to a mental health service.

(1) Some evidence that a **more proactive approach can connect with people not previously connected** to a health services can be found in the "Sources of Referral" (see Table 5 in the downloadable Excel document here) for the Commonwealth Personal Helpers and Mentors (PHaMs) program. As can be seen in that table **ONLY 43% of referrals came from a health**

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[23] *"We trained hard—but it seemed that every time we were beginning to form up into teams we were reorganized. I was to learn later in life that we tend to meet any new situation by reorganizing; and what a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency, and demoralization."* Gaius Petronius Arbiter, circa A.D. 60 (apocryphal)

[24] The Way Ahead – Peer led recovery; https://wayahead.org.au/peer-led-recovery/

[25] Mental Illness Stigma, Help Seeking, and Public Health Programs; Claire Henderson, Sara Evans-Lacko, Graham Thornicroft; Am J Public Health. 2013 March

service, these being a Specialist mental health care service (26.5%), Community health centre (7.5%), Hospital (3%), Psychologist in private practice (2.8%), General Practitioner (2.3%), or Psychiatrist in private practice (0.9%). Further evidence that the traditional approach is not connecting with most people living with severe mental health issues is the gap between the number of people in this category (800K) and those currently receiving mental health services.

(2) *Consumer Informed and Involved Culture:* Culture is often invisible, like water is to fish, particularly for those who have been swimming in it all their working life. Implicit status is a key component of medically based mental health service culture[1]. This traditional implicit stratification, along with the trauma of involuntary hospitalisation for some, are major aversive factors that separate many mental health consumers from traditional mental health services. Status can be conceived of as power. Thus, there is a contradiction in the provision of traditional mental health services, which on the one hand wish to encourage self-direction, independence and empowerment of the people they are assisting, but at the same time disempower them though a treatment process that tacitly places them at a lower point. The word "patient" means to receive health care whereas the main route to mental health is self-activation.

There are at least two historical trends countering this traditional status hierarchy:

- The engagement of people with lived experience (both consumers and carers with their differing perspectives) in the design, delivery and management of all mental health services. Similar approaches are being adopted in many service areas supporting various "diversity" groups, such as in the delivery of health services to Aboriginal and Torres Stait Islanders (see Close the Gap Report – Our Voices Our Choices, 2019). Allied to this is the formation of organisations for the community, by the community (i.e. Community Based Services) that are strengths based, recovery oriented and trauma informed. There is a long history to this movement starting at least 1,300 years ago with St Dymphna (the patron saint of people living with mental illness), to the original foundation of "Mental Health America" by a long institutionalised "consumer" Clifford Beers.

- From a totally different direction is the movement towards **4P Health** with its focus of Participation as one of the cornerstones of its approach. It is participatory in that people shift "from being mere passengers to responsible drivers of their health", and in which providers encourage and value them as full partners (see The P4 Health Spectrum – A Predictive, Preventive, Personalized and Participatory Continuum for Promoting Healthspan; Sagner, Michael, et al; Progress in Preventive Medicine: January 2017).

(c) A related "structural weakness" not being targeted by the most recent and foreshadowed reforms is that **the new entry point for programs is generally via the need to have to obtain a formal diagnosis** and for PHN funded psychosocial support programs via an additional **full NDIS eligibility assessment**. The service intent here is to obtain evidence to ensure that the limited resources go to those most in need and those suitable for the program, but there are **three significant downsides** to this:

1. People who need services will stay away from and avoid those services (see reasons below)
2. Services will less able to connect and develop relationships with people who clearly need support if, at least at the early stage, obtaining a diagnosis is service entry
3. It limits the options for family and friends to encourage a person to connect with a service

Many people, whom a medical service may readily diagnose with a specific mental disorder, do not want to, or are reluctant to, define themselves as a person with either (a) that disorder/label or (b) indeed with a mental health issue at all. There are several reasons for this, including:

1. **Cultural differences** in understanding and describing mental health and ill-health[26]

2. People would rather not receive any assistance than accept the **stigma** associated with being defined as a person with mental ill-health[27]

3. Many people, particularly those with mental health issues, for various reasons **are distrustful of clinical mental health services**, and/or psychiatry, and/or psychopharmacology which they associate (correctly or not) with the process and outcomes of a formal mental health diagnosis

4. Within the nosology and symptomology of psychiatry itself, NOT accepting or describing oneself as a person with a mental health condition is itself a common **cognitive deficit** of several mental health disorders. Sometimes formally diagnosed at "**anosognosia**"[28]

5. Though somewhat fringe, there is a lively **debate** (in the world of disability) as at to what extent a "condition" (e.g. high functioning autism, or personality extremes) is **a disorder, or just a difference** (albeit often a significant deviation from the centre of the normal curve).[29]

6. **Many people who are not coping** and clearly need help **do not experience or define their situation as a health issue**, or indeed a disability issue (no matter how widely we may define these terms). In practice it is necessary to first develop a trusting relationship and in time, if necessary, a more formal assessment can be done. This was how the PHaMs program worked. The front door was open and the "eligibility screening tool" was applied over a 3-month period.

Question asked in the Issues Paper: How should the (Structural Weaknesses) be addressed and what would be the improvements in population mental health, participation and productivity?

(a) **Investing sufficiently** in the promotion, prevention and treatment of mental illness, including effectively addressing the social determinants of ill-health and the promotion and development of positive mental health for people at each phase of the Stepped Care Model (i.e. across the whole population).

There is have been a number of studies on the cost benefit of specific mental health interventions for specific groups[30] and analyses of the ROI on large scale investments on improving mental health[31], but it may be instructive to look at the long term direct and indirect improvements in population health, participation and productivity from other broad population health initiatives such as the lowering of the smoking rate in Australia over the past 30 years[32] or, even more ambitiously, the costs and benefits of the great changes to public sanitation particularly in the 19th century[33].

An indirect benefit of a large-scale initiative to improve population mental health (coupled with effective data collection and analysis) would be the discovery of new patterns in the epidemiology of mental ill-health that might reveal new insights into causes, preventive factors and treatments.

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[26] *Mental Health: Culture, Race, and Ethnicity: A Report of the US Surgeon General,* 2001*;* URL:

[27] *Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions;* Stephanie Knaak, et al; Healthcare Management Forum; Volume: 30

[28] Anosognosia; from National Alliance on Mental Health (US)

[29] *The Minority Body*, Elizabeth Barnes, Professor of Philosophy at the University of Virginia; 2016
https://elizabethbarnesphilosophy.weebly.com/book.html

[30] Worksite mental health interventions: a systematic review of economic evaluation; Heleen H Hamberg-van Reenen, et al;
https://pdfs.semanticscholar.org/dd91/95cf24d8b1f91822356c9eec868f14481da9.pdf

[31] Scaling-up treatment of depression and anxiety: a global return on investment analysis; Lancet, Volume 3, 2016
https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/fulltext

[32] The Economic Impact of Smoking and of Reducing Smoking Prevalence: Review of Evidence; Abraham K. Brown; July 14, 2015;
https://journals.sagepub.com/doi/10.4137/TUI.S15628

[33] "A History of the Public Health System" from the Future of Public Health; The Institute of Public Medicine; 1988
https://www.ncbi.nlm.nih.gov/books/NBK218224/

(b) The **unification of the varying components of the mental health service system** by:

- Ensuring that a single **shared data set[34]**, including most importantly desired **outcomes, is universally adopted.** This would assist in remedying the fragmentation of the current system. The foundations of this approach already exist in the work of the Commonwealth Institute for Health and Welfare, the National Mental Health Planning Framework, the National Mental Health Performance Framework, the Australian Mental Health Outcomes and Classification Network, and My Health Record, etc. Two barriers to implementing this are (a) providing sufficient resources to all parts of the system to enable this to happen and also (b) providing workarounds to the objections to such a system on the basis of privacy and confidentiality.

- Investing sufficiently in **services whose sole KPI was coordination of all parts of the mental health "system"**. *Note: This was the intention of the Partners in Recovery (PiR) program. One reason it did not fully achieve its coordinating goal (particularly in rural areas) was that there were significant service gaps (i.e. nothing to coordinate) and the PiR program, through necessity, had to itself become a provider of those psychosocial support services[35].*

Question asked in the Issues Paper: Should there be any changes to mental illness prevention and early intervention by healthcare providers?

There is evidence and argument that investing in early intervention with young people with mental health issues is prudent[36]. This has led to support and funding for the Headspace initiative. There also is evidence and argument supporting early preventative interventions with young children and their families[37].

As per the stages in the Stepped Care Model there is good evidence to show each person at each stage in the development of a mental health disorder has passed through the previous stages[38]. Even severe mental illness has its own progressive substages[39]. Thus, **intervention at every stage is an early intervention and prevention for slipping into the next stage**.

It is unfortunate that people will connect to services often only when in crisis or significant need. An effective approach to early intervention (for each stage and phase) is for health care providers to **promote the value of positive mental health**, to continue to **de-stigmatise mental illness** and to have services readily accessible with not only **no barriers to entry**, but **positive enablers to entry**. There are examples of service models that have moved in this direction, such as the **Recovery Café movement**[40], the **Recovery College movement**[41] and, indeed, the older and more established **international Clubhouse movement**[42]. Combined together their contribution to evidence for the value of attractive community based mental health preventive interventions for people with moderate to severe mental health issues is strong.

Question asked in the Issues Paper: Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered?

The number and skills level of the mental health workforce needs to significantly increase. Greater numbers are required to meet the **demand in the NDIS and non-NDIS services** (if they are to meet even a proportion of the need of 800,00 people living with severe mental illness). Significant improvements in

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[34] *Improving coordination through information continuity: a framework for translational research;* Karen Gardener et al, BMC Health Services Research 2014

[35] Evaluation of the Partners in Recovery program: http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir-eval-annual15

[36] Early intervention in youth mental health: progress and future directions; Patrick McGorry et al, 2018, https://ebmh.bmj.com/content/ebmental/21/4/182.full.pdf

[37] For example see the evidence for the Positive Parenting Program: https://www.triplep.net/glo-en/the-triple-p-system-at-work/evidence-based/key-research-findings/

[38] Staging of Mental Disorders: Systematic Review; Fiammetta Cosci a Giovanni A. Fava ; Psychother Psychosom 2013;82:20; https://www.karger.com/Article/PDF/342243

[39] Indicators of deterioration in young adults with serious mental illness: a systematic review protocol; Lindsay Dewa, Systematic Reviews (2018) 7:123; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6097392/

[40] See https://recoverycafenetwork.org/

[41] See https://www.researchintorecovery.com/recoverycolleges

[42] See http://clubhouse-intl.org/

average skill level is required if we wish to see people receiving services not just stabilised but **improving in recovery and productivity**.

For example: As per the recovery model[43] all people living with a mental health issue can live a full and contributing life[44]. This does not mean that there are times when a person simply requires support (emotional or practical) **but supporting the development of self-efficacy[45] should always be the default approach**. This should be the goal of all mental health services **and of every instance of service**.

The skills and ability to be able to achieve the above[46] should be **an essential component of the skill set for all people working in mental health services**[47,48]. Without this not only is it more likely that people **will not shift from dependence to independence** but also that, long term, non-advancing relationships of **mutual dependence** between workers and clients become the default.

An obvious source for a future workforce is people with the lived experience of mental illness and recovery themselves. Not just as peer workers (valuable though that role is) but as people with a **peer career**, able and supported to develop their skills to even more effectively support others on their recovery journey. In this regard mental health workers are **a bit like personal trainers in a gym**. They should (a) practice and apply **in their own life** the qualities and behaviours they wish to encourage in others and (b) undertake **ongoing training and education** to continue to develop their careers and the quality and safety of all they do.

A clearer map of the skills required, and thus current skill gaps, comes into sharp relief from a larger map of what the mental health service landscape could be/should be (see answer to the next question).

Question asked in the Issues Paper: How could non-clinical mental health support services be better coordinated with clinical mental health services?

The distinction between **clinical** and **non-clinical mental health services** is no longer helpful. Several separate dimensions/distinctions are being confounded in this duality, and this duality has **passed its use-by-date.**

Some of these dimensions include distinctions between:

- The recognised qualifications (and professional registration) of the workers
- The types of "interventions" used by those workers (e.g. psychotherapy vs assistance with work)
- The outcome focuses of the worker (e.g. Clinical Outcomes vs Recovery Outcomes [49])
- The location of service provision (e.g. in a "clinic" vs. at a "community centre", or at a person's home)
- The organisational type (e.g. government or private medical service vs not-for-profit NGO)
- The language[50] and status of the "client" (see previous statements about culture). In a medical setting

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[43] National Framework for Recovery Oriented Mental Health Services; http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovfra

[44] Contributing Lives, Thriving Communities: National Mental Health Commission; http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributing-lives-review.aspx

[45] Social cognitive theory of posttraumatic recovery: the role of perceived self-efficacy; Albert bandura, Behaviour Research and Therapy, (2004); https://pdfs.semanticscholar.org/63eb/a143b7fe18062c1a09e7ea2dd38314fa032b.pdf

[46] *REFOCUS-PULSAR recovery-oriented practice training in specialist mental health care: a stepped-wedge cluster randomised controlled trial;* Prof Graham Meadows, et al; The Lancet, Psychiatry, Vol 6, 2, 2019*;* https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30429-2/fulltext

[47] *Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial*. Slade, M., et al (2015). The Lancet Psychiatry, 2(6)

[48] Refocus – Research into Recovery: http://researchintorecovery.com/refocus#s2

[49] *The relationship between clinical and recovery dimensions of outcome in mental health; Rob McPherson, Mike Slade; et al; Schizophrenia Research; Volume 175, Issues 1–3, August 2016;* https://www.sciencedirect.com/science/article/pii/S0920996415300311#!

[50] The word clinical (from the Latic *Clinicus* meaning "physician that visits patients in their sick beds,") also carries the background baggage of its second meaning "very efficient and without feeling; coldly detached"

a "patient" is a recipient of a service and the requirement is that they are compliant with treatment. In contrast a "consumer" (a term whose use-by-date may also be passing) should be the initiator or collaborative partner with choice and control.

The problem is that now many of these dimensions no longer correspond with each other. For example, some NGOs employ Clinical Psychologists or OTs, or their workers have been trained in CBT or Mindfulness; Local Health Districts/Areas have client case managers who provide assistance with housing or employment with a recovery-oriented approach; a number of for-profit private companies now contract with PHNs, etc.

A more useful and accurate map of the constituents of mental health services is now required. Once this is done, we may better ask how the components should best work together. For example:
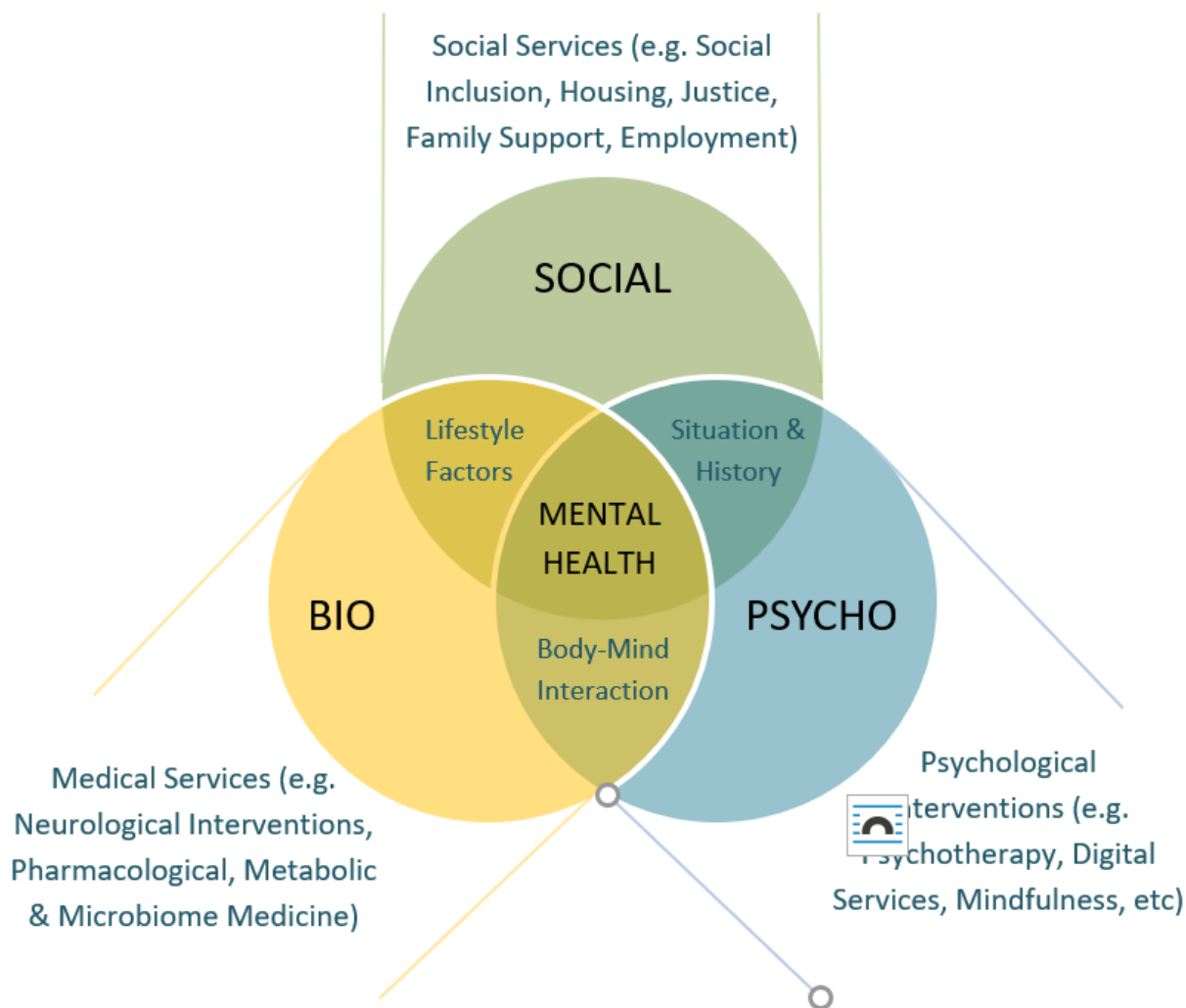

Figure 1: MAP OF MENTAL HEALTH SERVICES (based on Bio-Psycho-Social model)

Question asked in the Issues Paper: Are there significant service gaps for people with psychosocial disability who do not qualify for the NDIS? If so, what are they?

In the Issues Paper the number of people living with mental illness is 4.1m:

- 800,000 severe
- 1.1m moderate
- 2.2 mild

The total expected number of with a primary psychosocial disability is 64,000 (1.56% of the above figure).

A basic analysis reveals an enormous service funding gap. The major national initiatives to support people with psychosocial disability not in the NDIS are primarily going through Primary Health Networks. These national initiatives include:

1. The National Psychosocial Support Measure which includes a Commonwealth Government commitment of $80 million over four years, that must be matched by the States and Territories (thus a total of $160 million over four years – or $40m per year).

2. The Continuity of Support (CoS) commitment that will be available to people currently participating in PiR, PHaMs or D2DL programs (that were scheduled to close on the 30 June 2019) who are not eligible for NDIS. The CoS funding commitment is $109.8 million over four years. Importantly CoS funding is for 27,000 people with disability and only anticipated by DSS to include 8,800 psychosocial clients. Thus, the psychosocial component of CoS funding is more like $30 million over four years.

3. A further $ 121m over 14 months to support the many clients (75%) remaining in the PiR, PHaMs or D2DL who have not yet transitioned to the NDIS (many of whom are unlikely to do so).

From July 30, 2020 onwards the programs above have an ongoing commitment of **$47.5m per annum** to support non-NDIS clients with psychosocial disability.

In contrast even if assistance was provided to only half of the 800,000 people with severe mental illness (i.e. 400,000), with an average amount of funding per person per year that was equivalent to the average annual 2015/16 expenditure for each PiR, PHaMs or D2DL client (i.e. $6,500 per person[51]), the amount required would be **$2.6b per annum**.

There are of course some remaining State/Territory programs and a few on the drawing board. A comprehensive mapping of all services is required building upon the work already done by PHNs, the Australian Institute of Health and Welfare and the National Mental Health Service Planning Framework.

> Note: One common flaw in mental health service need mapping work is that demand for services is often based data coming from local mental health area/district (LHDs) service themselves, which in turn is based upon their service usage and unmet demand records. Given the propensity of many people with mental health issues not to engage in "help seeking" behaviour, this is a poor foundation and will always result is serious need underestimation. We don't work out the number of schools a district needs by getting data from librarians regarding how many parents enquired about books for their child's education, the requirement for schools is based upon total population numbers.

Question asked in the Issues Paper: How cost effective have the Australian Government's Disability Employment Service (DES) and Personal Helpers and Mentors service (PHaMs) been in enabling people with a mental illness to find and keep a job?

Disability Employment Service (DES) Performance

DES could be and should more effective, particularly for people living with mental health issues. In DES the success rate for obtaining **open employment for 6 months**, as a percentage of clients commencing and receiving up to **18+** months of support is **39%**[52].

Of course, it is difficult to judge **the real "effective" rate** for outcomes as there is **no reliable control group for comparison**. That is, we do not know what percentage of DES clients would have got employment anyway without DES.

This is not a good! **The significant majority of people who commence with an employment service should expect an employment outcome**. Employment is a good indicator of, and key contributor to,

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[51] See https://sarahhenderson.com.au/2018/11/01/speech-2nd-annual-ndis-and-mental-health-conference-melbourne/
[52] DES Outcome Rates by Disability Type:
http://lmip.gov.au/default.aspx?LMIP/Downloads/DisabilityEmploymentServicesData/DESOutcomeRatesbyDisabilityType

mental health recovery. That is, it is a **vital component of an effective mental health service system**. If employment services are not performing well, then **the other components of the sector are pulled down**.

On the other hand, if 80% to 90% of people with a psychosocial disability were able to obtain sustainable employment, **the long-term ROI would possibly be the most effective single action that could be taken in the whole mental health service sector**.

In addition, the 39% outcome rate hides a deeper failure (which is shared with JobActive). The employment **outcome rates for long term jobseekers is much poorer**!

Why is this so?

While there is always room for improvement it is **not because of the ineffectiveness of providers!** A large number of employment organisations (not-for-profit and for-profit) since 1996 when the Job Network was established, have been competing for two decades. Income increases when more outcomes are obtained, so if there was a way of consistently achieving high outcomes then **it would have been found[53]**. There is something **deeply systemically wrong,** that system tweaking will not remedy.

Question asked in the Issues Paper: What alternative approaches would better support people with a mental illness (whether episodic or not) to find and keep a job?

The **scientific evidence** of what does get better employment outcome rates for people living with significant mental health issues **gives some indication of what is required**. Several approaches have provided evidence of success, such as:

- The Individual Placement and Support model[54] - called Supported Employment in the U.S.[55]
- The Customised Employment and Discovery model[56]
- The Social Enterprise Model[57]

This not the place to explore the many components in the above models that contribute to their successes[58]. Combinations of all these components would be even more successful. But each of these comes at a cost in terms of staff time, skills and other investments.

That is one main reason why these models have not been fully implemented by DES providers broadly (albeit there have been several partial trails). The per person cost of doing these well (with full fidelity) is considerably more that the service and outcome fees in DES (or JobActive) allow. As per the following quote from a large IPS study in Britain, once the pilot grant had finished.

> "*The growth and maintenance of these services is difficult to achieve whilst the current cost pressures on the NHS continue.*"[59]

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[53] The exception being when some organisations bent the rules and employed people themselves through related entities (this is now clearly not allowed in DES)

[54] Experiences with the implementation of Individual Placement and Support for people with severe mental illness: a qualitative study among stakeholders; Miljana Vukadin et al, *BMC Psychiatry*2018**18**:145; https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1729-4

[55] Supported employment: Meta-analysis and review of randomized controlled trials of individual placement and support; Frederick DE, VanderWeele et al, (2019) PLOS ONE: https://doi.org/10.1371/journal.pone.0212208

[56] NDS Publication http://ideaswa.net/upload/editor/files/customised_employment_-_ndia_process_document.pdf

[57] Social enterprises as enabling workplaces for people with psychiatric disabilities. Buhariwala, P. et al(2015) Disability & Society, 30. https://www.tandfonline.com/doi/abs/10.1080/09687599.2015.1057318?journalCode=cdso20#.VjjqbbfhDcs

[58] Some of these include having trained team with necessary professional skills; going into the client's world and enlisting support from family and friends (Discovery process); working simultaneously on all the clients support needs ; having the resources to find suitable employers with suitable jobs; providing significant "Place and Train" supports" (IPS), etc..

[59] Implementing Supported Employment. Lessons from the Making IPS Work Project; Jan Hutchinson et al; International Journal of Environmental Research and Public Health; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6069163/

To significantly increase the employment outcome rate for people with mental illness a greater investment per person is needed, significantly more per person than the current system makes[60].

Rather than focusing on how to continuously improve current services, the focus should be on what is actually required to reach the objective (sustainable employment for almost all clients who commence in an employment service). A metaphor is the construction industry where if the outcomes of a project can be defined then quotes are obtained from builders/engineering companies to deliver those outcomes. Smart developers don't limit the size of the quote, but only pay on agreed outcomes.

Personal Helpers and Mentors service Employment (E-PHaMs)

E-PHaMs was a late addition to PHaMs (2012). We have not been able to find any published measures of its success. Anecdotally it achieved at least 3 positive outcomes by including developing employment goals as a key component of such a flexible mental health support service:

- It shifted many clients from a position of not wanting to work, because of fear or lack of confidence, to being motivated to begin an employment seeking pathway

- It provided an effective channel to link people on the Disability Support Pension (who had no compliance requirements) to volunteer to participate in employment services (DES or JobActive)

- By knowing about a person's life, home situation, family and carer supports, etc., as occurs in the Discovery Process in the Customised Employment model, E-PHaMs workers were able to better advise and assist employment service providers

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[60] "To put a man on the moon, we didn't start by asking Treasury how much" Neil deGrasse Tyson

COMMENTS ON FRAMEWORK TO ENHANCE MENTAL HEALTH AND IMPROVE PARTICIPATION AND WORKFORCE CONTRIBUTION

Question asked in the Issues Paper: How effective are the governance and institutional arrangements for mental health in Australia in achieving the objectives agreed by COAG Health Council in the Fifth Plan?

The current mental health system does not seem to be a system, in the dictionary sense, of "*a set of things working together as parts of an interconnecting network organized for a common purpose*". It is complex, fragmented and from a user perspective very hard to navigate.

The mental health service landscape is multi-cultural (e.g. consumer and carer empowerment verses professional/medical model cultures) and it has several "Great Houses", each with their own sub-houses: COAG and its committees, various Commonwealth and State and Territory Departments (+ Local Health Districts/Areas), the National Mental Health Commission (+ each of the State/Territory Commissions), Mental Health Australia and other National and State/Territory Peaks, Universities and mental health research organisations, NDIS, PHNs, the non-Government sector, the community, consumer and carer movements and organisations, etc.

Of course, this rich ecology sprouts innovation and effective local adaptations and there is some deep order in the apparent chaos, though it takes time to divine. There are several integrative factors such as the 5th Mental Health Plan (and its sub-derivatives); the spread and evolution of the recovery and wholistic approaches; the slow but steady de-stigmatising of mental illness, the shepherding of the Mental Health Commissions, the ideas and advocacy from the peak organisations, the ten thousand meetings, etc.

But still there are conflicting agendas and power plays, left hands not knowing what the right hands are doing, competition for limited resources leading to abandonment of many positive programs, duplications (occasionally) and gaps (mostly and big ones).

How can they [the governance and institutional arrangements] be improved?

The 5th Mental Health Plan (and its derivatives) provides the framework and its aims are broad:

- *promote the mental health and wellbeing of the Australian community and, where possible, prevent the development of mental ill-health*

- *reduce the impact of mental ill-health, including the effects of stigma on individuals, families and the community*

- *promote recovery from mental ill-health*

- *assure the rights of people with mental ill-health, and enable them to participate meaningfully in society*

While comprehensive, these aims should be more boldly stated allowing **measures of success to be derived from them at this this top level**, not just downstream at the action/tactical level. For example:

- *Increase the mental health and wellbeing and decrease of mental ill-health of the Australian community*

- *Eliminate the stigma of mental ill-health*

- *Increase recovery from mental ill-health*

- *Guarantee the rights of people with mental ill-health, and enable them all to participate meaningfully in society*

A plan is one thing, but like an engineering plan, its implementation requires adequate funding. The NDIS is a world leading initiative (with teething problems), its key strength is the quantum of funding allocated and quarantined for it.

A similar commitment needs to be made for people living with mental health issues (and their families) who will be outside the NDIS. Without this an environment of scarcity breeds conflict and not cooperation and this wonderful and significant social engineering project (captured in the re-statement of the above aims) simply cannot be done.

COMMENTS ON FUNDING ARRANGEMENTS

The calculation of mental health funding and expenditure is very important in this exercise. The sources from which the Australian Institute of Health and Welfare and other bodies derive the figures set out in Figure 9 in the Issues Paper are many and varied.

Regarding the item "Community mental health services" listed under State and Territory government expenditure ($2,000,000,000), we wish to state a concern about its reliability. We are assuming that this item applies to what is often called Public Community Mental Health, or Specialist Community Mental Health, or sometimes, Clinical Community Mental Health. We are also assuming that it is separate from funding to non-government organisations (not-for-profit or for-profit) which we presume is included in "Other Expenditure".

Public Community Mental Health when fully implemented may, for example, be used to fund:

- Crisis and Home intervention teams
- Case Management or Continuous care teams
- Assertive Outreach teams
- Youth mental health teams

Having consulted with people in the field, including staff and management of public community mental services, and while there are some significant differences across the country, it is a widely held view that over a considerable period of time these services have been cut back through natural attrition (not replacing staff as they leave). The "on the ground" view, for which we have no substantial evidence other than verbal reports from stakeholders, is that funding may be allocated at the top level for mental health services, but is subject to much internal competition at the local health level and is often moved into other areas of health.

As said, we have no strong evidence for this claim other that the observations and comments made by those who have long worked in the field. We have heard that in the process of their investigations the Productivity Commission can more closely investigate this matter. It may be the difference between reporting budgeted figures verses reporting actual expenditure.

COMMENTS ON MEASUREMENT AND REPORTING OF OUTCOMES

The measurement and reporting of outcomes have significant benefits. CMHA in partnership with AMHOCN has previously publicised a report and guidebook for Community Managed organisations on this matter[61].

Some of these **benefits** include:

- Providing a means of feedback to service users about their progress

- Using the data to improve service and individual worker quality and effectiveness

- Allowing individuals and organisations to better coordinate with others in the achievement of common or mutually dependant outcomes

- Improves accountability to funders and other stakeholders

The measurement of outcomes comes with **risks** such as:

- It is difficult to capture many of the subtle but important qualitative, subjective and specifically individual factors in quantitative measures. As the old saying goes "you cannot capture water in a net"

- When organisations or individuals are judged by their outcomes, these can become the sole goal, to the detriment of other important factors. This, for example, is often the complaint about NAPLAN

- In a situation of limited resources, where workers are stressed, outcome measurement can be viewed as a bureaucratic burden and may be done in a perfunctory way with limited reliability and validity

- Collaboration, choice and control are key principles of mental health service delivery. Having mandatory and standard measures can be seen by service users as conflicting with these principles.

- Similarly, the outcomes a service is measuring (and being held accountable for) may not align with the goals of each individual in its service

- The bulk mental health measures in standard usage focus mainly on mental illness and not sufficiently on the measurement of the development of positive strengths and characteristics

All these risks need to be managed. The Nous Group 2018, *Mental Health and Suicide Prevention Monitoring and Reporting Framework* moves the field on, but there is still more work to do.

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[61] *National Community Managed Organisation (CMO) Outcome Measurement Project Final Report*, 2013, CMHA and AMHOCN and *Implementing Routine Outcome Measurement in Community Managed Organisations*; 2015; CMHA and AMHOCN

ADDITIONAL COMMENTS

Increased social equality for the most disadvantaged

There is an increasing body of opinion and evidence[62,63] that productivity growth and reducing inequality are no longer competing objectives, but that now **increasing productivity requires reducing inequality**[64].

Currently on the OECD scale of relative income inequality **Australia is 23 out of 38**.
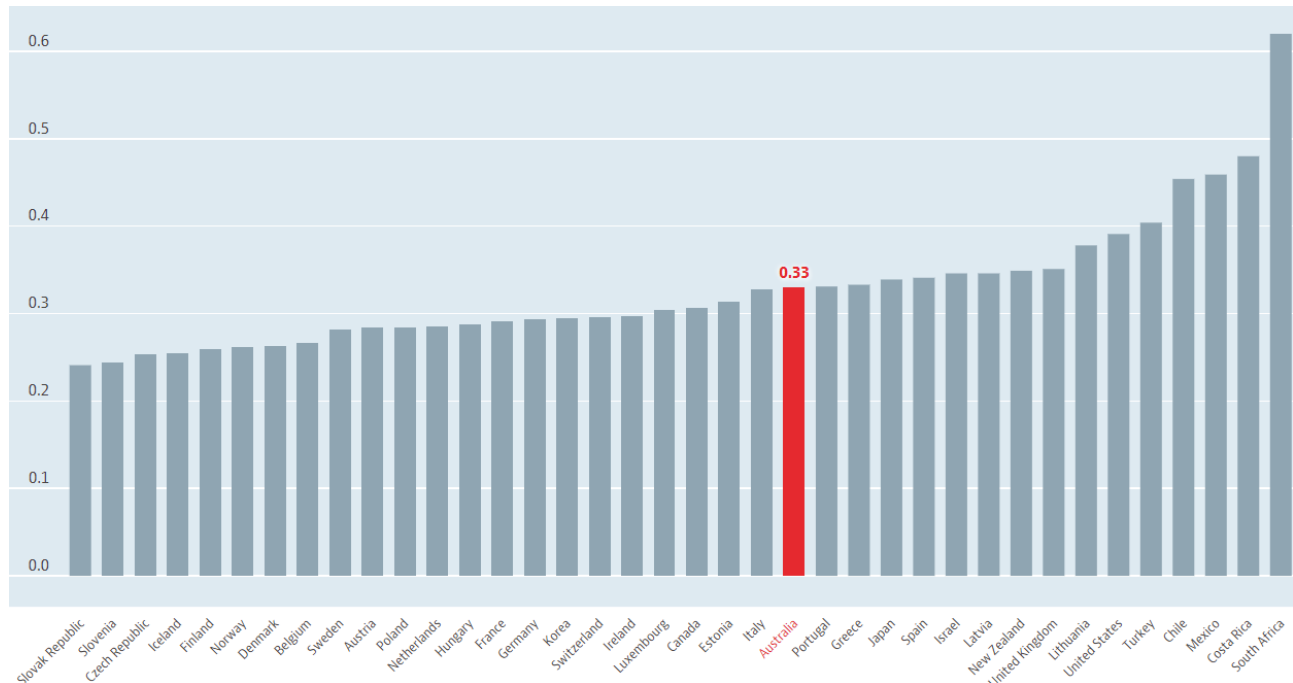
People living with **severe mental illness** (800,000) are some of the most disadvantaged and **poorest**[65]. members of society. Their **cost pressure** on the welfare and health system, justice, social housing is **very high**. As argued above, **this group should be those who attract the Commissions "greatest consideration"**.

A proactive community embedded approach

In the case of mental ill-health and disorder "help-seeking" is often absent or is a late stage occurrence[66]. This even more so for disadvantaged individuals and communities. A **proactive community embedded approach is required** for effective and early intervention.

Worldwide wide 75% of people with mental illness do not seek help and are connected to a mental health service[67]. The difference between true prevalence and treated prevalence is called "the treatment gap"[68].

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[62] In It Together: Why Less Inequality Benefits All, OECD Publishing; https://read.oecd-ilibrary.org/employment/in-it-together-why-less-inequality-benefits-all_9789264235120-en#page1

[63] Inclusive Productivity, OECD; http://www.oecd.org/inclusive-growth/#inequality-puts-our-world-at-risk

[64] *Productive Equity: The Twin Challenges of Reviving Productivity and Reducing Inequality*: Zia Qureshi, Joel Bell, and Kemal Derviş January 28, 2020; https://www.brookings.edu/book/productive-equity/

[65] Poverty and Serious Mental Illness: Toward Action on a Seemingly Intractable Problem. Sylvestre J, et al, American Journal of Community Psychology, 2018 Mar; https://www.ncbi.nlm.nih.gov/pubmed/29243829

[66] Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour; Lucy Biddle, Jenny Donovan, Debbie Sharp and David Gunnell: Sociology of Health & Illness, Vol. 29

[67] Mental Illness Stigma, Help Seeking, and Public Health Programs; Claire Henderson, Sara Evans-Lacko, Graham Thornicroft; Am J Public Health. 2013 March

[68] Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: summary of WHO recommendations Dua T, et al PLoS Med. 2011 [Link]

In this regard mental illness is **unlike most other health conditions**. The standard approach of waiting for a person to approach a service ("help seeking behaviour"), or to first connect to a service via an acute emergency is not sufficient. A more **embedded and proactive approach** is required.

There are many ways this can be done including:

- Embedding the services in the community and ensuring that their location and look are appropriate and attractive - **shifting "the centre of gravity" of mental health services to the community**
- Involving peers and members of the local community in the planning and delivery of services
- Using non-government organisations at this front line, as research[69] has shown that these services are seen as a more positive and comfortable entry point for mental health clients
- Utilising local community networks to find and connect to individuals and families in need
- Building upon any large-scale anti-stigma campaigns with local promotional initiatives (e.g. in shopping malls)
- Creating services whose KPI is locating and connecting with people with significant mental illness that are not receiving any assistance

Without such a proactive approach cycles of intergenerational suffering[70] are not broken[71], most people with mental health issues will not receive assistance and **population mental health initiatives will not succeed**.

The historical commitment[72] to establish a comprehensive community mental health service network has not been realised. This is still required to effectively improve national wellbeing and productivity.

Greater involvement of service users

Our **mental health system** would be more effective if it was more **proactive and participatory**[73]. Participatory meaning greater **involvement of service users** in management and delivery of services. This slow but significant shift in our understanding of how service for disadvantaged people and communities can be more much effective **has also been occurring in ATSI health services** – see "Our Choices, Our Voices"[74]

Across the world the involvement of peers in the delivery of mental health services is **both increasing and evolving**[75]. There is also a growing body of research[76] about the positive effects of peer workers on **improving mental health outcomes**.

In addition to the **credibility and perspective that having workers with lived experience brings**, training and certification such as the Certificate IV in Peer Mental Health Work and other forms of **ongoing career development are an evolving workforce capacity,** which can and will provide a significant component of the solution to the **emerging metal health workforce shortage issue** (including in the NDIS).

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[69] *Attitudes of people working in mental health non-governmental organisations in Australia: A comparison with other mental health professionals*; Grenville Rose, et al Health Psychol 2018; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5922491/

[70] *Intergenerational Transmission of Abuse: Implications for Parenting Interventions From a Neuropsychological Perspective*; Lisa J. DeGregorio; Journal of Traumatology; 2013; https://journals.sagepub.com/doi/abs/10.1177/1534765612457219

[71] *Trauma, Transgenerational Transfer and Effects on Community Wellbeing;* Atkinson, el al; in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice, Purdie, N. Dudgeon, P. et al (eds.), 2010

[72] See https://en.wikipedia.org/wiki/Community_mental_health_service

[73] The P4 Health Spectrum – A Predictive, Preventive, Personalized and Participatory Continuum for Promoting Healthspan; Sagner, Michael, et al; Progress in Preventive Medicine: January 2017

[74] *Our Choices, Our Voices*; Close the Gap Steering Committee; 2019 ; https://iaha.com.au/our-choices-our-voices-report/

[75] Peer delivered services in mental health care in 2018: infancy or adolescence? **Marianne Farkas World Psychiatry. 2018;** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5980530/

[76] *Effectiveness of one-to-one peer support for patients with severe mental illness - a randomised controlled trial.* Mahlke C; Eur Psychiatry. 2017; https://www.ncbi.nlm.nih.gov/pubmed/28364685

The Mental and Physical Health Connection

Mental health, in **equal partnership with physical health**[77], is a key enabler of our capacity to learn, cooperate and contribute requiring a comparable amount of public investment.

An enormous body of worldwide research demonstrates that **the causal pathway between mental and physical health is two way**[78]. This two-way causal relationship may also include dental health[79], as per the so-called **dental mental connection**[80].

Addressing the physical health (including dental) of people with mental health issues will have a synergistic benefit to both. From a broad perspective there is also evidence that this two-way cycle needs to be expanded into a **three-way cycle of poverty**[81]**, poor physical health and poor mental health**[82].

These interconnections can be taken advantage of and **vicious cycles turned into benign cycles**. Attending to and reducing any of these three, social inequity, poor physical health and/or poor mental health, will have benefits for each of the others.

Employment and Mental Health

As discussed above, for people seeking to navigate the mental health service sector, it is complex and fragmented. One means for **increasing cross service integration (both within and outside the NDIS**) would be the widespread adoption of **the common goal of seeking to prepare people for and to obtain and retain suitable meaningful employment**, or at least meaningful voluntary activity.

According to the recent OECD Report *Connecting People with Jobs: Key Issues for Raising Labour Market Participation in Australia*[83]*,* for **people aged between 16 -65**:

- 67% are employed
- 50% with mid-to-moderate mental illness are employed
- **23% with severe mental illness are employed**

Compared to other OECD countries in this report **Australia's employment rate for people with severe mental illness is very poor. Sustainable employment** (and meaningful activity) is a clear measure of, and significant contributor to recovery[84]. But **it is also very important to be aware of the risk associated with poor, inappropriate or stressful employment** as the following quotes from various studies attest:

- "Unemployment is not necessarily bad when compared to types employment which are **demoralising, degrading or 'noxious'"**[85]

- "**Precarious employment** can be very stressful and **negatively affect mental health** and can even precipitate mental health crises"[86]

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[77] The Health and Productivity Cost Burden of the "Top 10" Physical and Mental Health Conditions Affecting Six Large U.S. Employers; Journal of Occupational and Environmental Medicine: January 2003 - Volume 45 - Issue 1 - p 5-14

[78] The relationship between physical and mental health: A mediation analysis; Julius Ohrnberger; Social Science & Medicine; Volume 195, December 2017; https://www.sciencedirect.com/science/article/pii/S0277953617306639

[79] Possible Link Between Chronic Periodontal Disease and Central Nervous System Pathologies; Karol Ramírez Chan; 2015; https://revistas.ucr.ac.cr/index.php/Odontos/article/view/20325

[80] The Dental Mental Connection; edited by Henry Cotton; 2017; https://www.goodreads.com/author/show/6282245.Henry_A_Cotton

[81] Poverty & Mental Illness, WHO; https://www.who.int/mental_health/policy/development/1_Breakingviciouscycle_Infosheet.pdf

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[86] Precarious Employment: Understanding an Emerging Social Determinant of Health; J. Benach et al; Annual Review of Public Health; 2014; https://www.annualreviews.org/doi/10.1146/annurev-publhealth-032013-182500

At the same time the research on **the benefits of employment for people living with mental health** issues are significant:

- People with severe mental illness who were employed for more than 18 months had lower symptoms and better self-esteem - *Mueser et al. (1997)*

- Increased independence, an improved sense of self-worth and improved family atmosphere - *Baronet and Gerber (1998)*

- A significant improvement in social skills after 4 months of employment - *Lysakar and Bell (1995)*

- Significant symptom improvement and fewer hospitalisations - *Bell et al. (1996)*

- Improved physical and mental well-being - *Waddell & Burton (2007)*

- Employment has anti-stigmatising effects on people with severe mental illness - *McGurk & Mueser (2003)*

- Obtaining the rewards of mainstream living that most people take for granted can boost self-esteem and recovery - *Yankowitz (2002)*

- Particularly beneficial for people living with depression and general poor mental health - *van der Noordt (2014)*

Employment (and purposeful activity more broadly) is sometimes described as one of the four legs of the stable table of mental health, along with housing, health and social connection.

As discussed above in relation to the Disability Employment Services program, current approaches are at best marginally successful. Small improvements through tweaking current programs is an inadequate response. **What is required is new thinking**[87]. **A commitment to a Job Guarantee for all who want to work** would stimulate totally new initiatives. Very Importantly, this is NOT a universal "Work for the Dole" scheme, or a compliance-based approach, but a scheme whose **foundational principle is choice and control**. The right approach is for a civil society to respect and deliver on **an essential human right, the right to work**.

This would allow the realisation of the aim as imagined above in the restatement of the 4th Aim of the 5th Mental Health Plan.

- *Guarantee the rights of people with mental ill-health, and enable them all to participate meaningfully in society*

Hopefully the outcomes of this PC enquiry will help make this imagined scene a reality and, in so doing, nudge[88] the Australian people toward making **health and happiness key national objectives, equal with prosperity**.

We look forward to further participation as this enquiry continues.

Bill Gye
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Community Mental Health Australia

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[87] For example: The Centre for Full Employment at Newcastle University; http://www.fullemployment.net/index.php
[88] https://en.wikipedia.org/wiki/Nudge_theory

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