2019 Grace Groom Oration

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Stephen King, Mental Health Inquiry Commissioner

Introduction

Dr Grace Groom was Chief Executive Officer of the Mental Health Council of Australia from 2002 to 2005.

She passed away in 2006, leaving an exceptional legacy of research and advocacy for mental health reform.

For example, I was reading back through a paper that Dr Groom wrote with Professor Ian Hickie and Ms Tracey Davenport in 2004 called "Investing in Australia's future: the personal, social and economic benefits of good mental health".[1] The paper presents both a critique of the mental health system and discusses the need for an economic approach to reform. It is testament to the insight shown in that paper, and the slow pace of reform, that many of the criticism remain valid today.

And what of the economic approach to reform canvassed in the paper?

Well, fifteen years later, the Productivity Commission is considering this approach, looking at both the economic costs of mental ill-health to Australia and formulating a range of reforms that can underpin a consumer-focussed mental health system that includes, but goes well beyond, clinical care.

2006, the year that Dr Groom passed away, was also the year that the Better Access program was introduced in Australia.

It is worth remembering that in the early 2000s services by GPs and psychiatrists attracted the bulk of Commonwealth government mental health funding. Psychological therapies were not covered by Medicare. In contrast, today "[a]pproximately 1.3 million people … receive MBS-rebated sessions of face-to-face psychological therapy … each year".[2] That is 1.3

1 Hickie, I., G. Groom and T. Davenport (2004) "Investing in Australia's future: the personal, social and economic benefits of good mental health", Mental Health Council of Australia, Canberra, December

2 Productivity Commission (2019) "Mental Health, Draft Report", Canberra, October, p.20.

million people each year who can thank Dr Groom, among others, for successfully arguing for this reform.

However, it was recognised in the 2000s, as it is recognised today, that preventing mental illness and promoting recovery extends well beyond adding psychological strategies to Medicare.

In a 2004 article in the Sydney Morning Herald, Jo Lammersma, at that time the secretary of the Royal Australian and New Zealand College of Psychiatrists, is quoted as saying that:

"*It is almost too difficult to grasp the enormous need out there ... the incredible burden of mental health on our population ... and the toll of that on patients, on their families, their friends, their workplaces, and the pressure they put on the health system*".[3]

The same article quotes Dr Groom reflecting on the economic benefits of consumer-centred care:

"*If people could access non-pharmacological care quite early in their disorder or illness, they won't be experiencing days out of the workforce ... there would be cost savings there for government, not just in the hospital system but also the welfare system*".[4]

Tonight, it is an honour for me to present the 2019 Grace Groom Oration.

The Productivity Commission's draft mental health inquiry report

The Productivity Commission released its draft report on mental health almost one month ago, on October 31st. Our focus is on consumer-centred care, on prevention and early intervention, and on providing support – both clinical and psycho-social support – for those who need it, not just through the health system, but where and when it is needed, with schools, tertiary institutions and workplaces providing effective gateways to support.

We have received significant feedback on our inquiry draft report, much, but not all, of it supportive. However, I want to emphasise the word 'draft'. We welcome feedback on the draft report and acknowledge that we still have significant work to do before presenting our final report to the Commonwealth Government in late May next year.

In this talk, I would like to consider some of the issues raised in the draft report.

Do not worry, I am not about to start reading through the one thousand two hundred and something pages. Even going through our draft recommendations and findings in full would

3 Sydney Morning Herald (2004) "Change of mind" January 15.

4 *Ibid.*

take far longer than my allotted time. But I do want to touch on some select areas raised in the feedback we have received so far.

Designing a consumer-centred mental health system

First, let me clarify where we, at the Productivity Commission, add value.

Our expertise is in system design, in incentives, and in the development of robust institutions that can underpin service provision, even when the relevant bits of the system cut across multiple sectors and reflect the approaches of multiple governments.

And that is what we have presented in our inquiry draft report.

Our draft recommendations start at the individual – the consumer – and build a system that will focus on that consumer. It builds outwards, including the support network for the consumer: family, carers and friends. It considers the range of services – both clinical and community – that can support the consumer, recognising that those services will differ between individuals and between regions. We consider the institutions to provide those services where and when the consumer requires them and the gateways to provide access to those services. We consider the institutions that can fund and govern those services, and the strategies and mechanisms to enable coordination across government.

Our draft report presents recommendations to build a consumer-centred mental health system.

Some organisations have been disappointed that the Productivity Commission – a group of people without significant clinical or psycho-social expertise – have not recommended specific clinical or psycho-social programs or approaches.

"The evidence is in" some claim.

"Good" we reply. "Then the evidence can be confirmed by an independent third party and the programs or approaches placed with a group of other verified approaches that can be implemented at a regional level *if* they are appropriate and best meet consumer needs".

So, we have recommended that the National Mental Health Commission be expanded to evaluate mental health programs. We have presented alternative regional approaches to make sure the right programs are funded and available at a local level. And our draft recommendations aim to make sure that local decisions are consumer-led.

We think that this approach needs to extend to all programs over time, including those that are currently funded. No program should be exempt from evaluation. And any current program that is effective and meets consumer needs has nothing to fear from that evaluation.

Others wanted more radical change. "Where is the revolution?" they ask.

The desire for revolution, to tear down the existing system and start again, is understandable, and reflects justifiable frustration at the pace of progress in mental health reform. But I would suggest that we want strong foundations, not revolution. We want the base on which to build a sustainable, consumer-centred mental health system. That is what the Productivity Commission has tried to do in the inquiry draft report. By design, it is a foundation for the future.

The vision of a consumer-centred mental health system

Let me turn to the Productivity Commission's vision.

In 2004, a remarkable economist, Jean-Jacques Laffont, passed away. I was fortunate enough to be taught by Jean-Jacques. He was an extraordinary technical economist who regularly provided policy advice to the EU.

I remember being in one of his classes. Jean-Jacques had just completed a board full of mathematics – and it was still blackboards in those days. A fellow student and I were sitting there puzzled. We had followed the mathematics and the result was startling. But we wanted more to help us understand the underlying principles of the result.

"Excuse me Professor Laffont" my colleague asked. "What is the underlying logic for that result?"

Jean-Jacques looked at us – brows furrowed. He looked back at the blackboard. He looked back at us.

"It is there," he responded.

Following the release of our draft report, I think I better understand Professor Laffont's reaction.

We have been asked on a number of occasions about our report, "Where is the vision?". Like Jean-Jacques, I turn to our report and say "It is there".

The vision is embedded in the two volumes of the draft report and summarised in the overview and recommendations.

But I think the question is a reasonable one. We should be clearer.

Let me try and rectify that.

Our vision is for a consumer-centred system. But what does this mean?

From an economics perspective, the answer is easy. Any service that is not valued by the consumer who uses that service has no value. Or to put it the other way, the only value of a service to support mental health is the value as perceived by the consumer.

That value can be reflected in measurable ways. For example, improved health, as perceived by the consumer, may be reflected through a lower need for health services in the future, by increased economic and social participation by the consumer and their support network, or by a measurable increase in quality of life. The value may be gauged by asking the consumer, for example by using patient-reported outcome and experience measures, PREMs and PROMs. Using some of these measures, the Productivity Commission estimated the cost of mental ill-health in Australia at around $180 billion per year, or $500 million per day.

But these are all imperfect measures. The value, the gain, is the outcome for the consumer.

For those outside economics, this approach can be confronting.

It means asking the consumers, and the carers who are chosen by the consumers, what they want. What are their aims and objectives? What do they want to achieve? It means advising rather than telling. It means ensuring that consumers have the information that they need about services, their effectiveness and quality, to enable them to make decisions.

And for people, often who have many years of training and experience, it means recognising that despite their expertise, their knowledge only has value to the degree that it achieves what the consumers want.

So how do we introduce consumer control and empowerment?

One approach would be to use an NDIS-style 'package' approach. But the NDIS experience shows the limitations with this approach, with the potential for significant transition issues. We have not recommended this approach for broader mental health – but are happy to hear from people who think that we should.

Instead, the approach the Productivity Commission has taken is to make draft recommendations that place the consumer at the heart of care.

This means recognising that consumers want a range of supports. A key element of these supports are carers, family and friends – the consumer's support network. This network centres on the consumer and itself needs appropriate support. So, we have made draft recommendations to improve this support, for example, through advocacy and carer and consumer payments.

The availability of psycho-social and clinical supports is another element. Consumers should be able to choose the approach to care that best meets their needs. The options cannot be unlimited. So, as already mentioned, through the NMHC and regional commissioning, we recommend an approach that will provide consumers with access to a range of evidence-based services. We have also developed a stepped-care model that can help match consumer requirements with the necessary psycho-social and clinical services.

Consumers can only choose if they have options. So, we have a range of draft recommendations to increase the options available to consumers across the health continuum. These include low intensity treatment options through different modes of access

including video, internet, text or face-to-face services. They include increased after-hours services – both peer-led and clinician-led — and service provision that takes account of the cultural diversity of Australians and the fact that many people who need help do not live within easy access of the necessary services and often need help outside of normal work hours. The draft recommendations also include increased options for in-community housing and supports to participate in education and employment.

Consumers can only choose if they are aware of the options and can access independent advice. So, we have recommended that consumers and carers have more information about their options. We have recommended formal care coordination, navigation and support to empower consumers. We have recommended consumer-centred care plans. And we would like more feedback as to whether consumers should have a formal right over their health data, to help them get independent advice.

Choice is only feasible if there is the workforce to deliver the services. So, we have a range of draft reforms covering workforce, including the clinical workforce and, more importantly, the peer workforce. And we recommend the creation of a workforce strategy, so that the development of tomorrow's culturally capable workforce will begin today.

Some groups of consumers have specific service requirements, and our draft report recognises this. In particular, we recognise that Aboriginal and Torres Strait Islander people often want the option to choose services delivered by indigenous providers. Where possible, that option should be provided.

The best designed health system will fail if it is not accessible. Consumers access the mental health system through many doors. Our draft recommendations aim to ensure that these doors are effective. For many consumers, their GP is the door, and we have draft recommendations to improve GP services, including clarifying consumer choice and providing the means by which family and carers could be included in the conversation. But schools, tertiary institutions and workplaces are also doors. And the doorways extend back in a consumers' life to perinatal and early childhood. Our draft recommendations consider each of these doors. These doors need to be responsive, focussing on prevention and enabling early intervention.

But doors provide no passage if consumers are dissuaded from using them. Unfortunately, that is exactly what occurs in Australian society. Stigma creates a barrier to care. It undermines choice and creates fear. It means that consumers who want care face explicit and implicit incentives not to seek that care. They will be labelled. They will face discrimination. They will be isolated. And through mechanisms such as our insurance system, they will carry these labels for life.

The Australian mental health system will never succeed if it is undermined by stigma and discrimination. So, our draft recommendations focus on stigma reduction at a national level, as well as raising awareness at a local level, for example through suicide awareness and workplace practices.

Are our draft recommendations perfect and complete? Of course not. It is a draft.

We thank the many people who have helped to identify gaps and limitations in our current draft recommendations. And we look forward to working together to improve those recommendations in our final report, with a shared vision of a consumer-centred mental health system.

The role of psycho-social supports

Finally, let me turn to the role of psycho-social supports in a consumer-centred mental health system.

Since the draft report was released, we have received feedback that our recommendations are too clinically focussed.

"Where are the in-community, psycho-social supports", we have been asked.

And going back through our draft recommendations and findings, I completely understand that perspective. But it has led to the perception that the Productivity Commission places clinical treatment above other supports. Let me state quite clearly – that perception is false.

The consumer-centred system that we have designed in our draft report recognises that clinical supports and psycho-social supports are inseparable and interdependent. They are two sides of the same coin. They must be balanced and one cannot and should not be placed above the other. It is not an 'either/or' choice. Without both clinical and psycho-social supports, and the ability of the consumer to choose the services that best meet their needs, there can be no consumer-centred care.

For example, hospital care will fail without the psycho-social supports to enable consumers to access the services that they need to flourish in the community. Without those supports the consumer will end up on a clinical merry-go-round with no choice, no empowerment and no recovery.

Similarly, therapeutic care in community will not succeed if the consumer simply leaves the clinician to return to the stress and trauma that led to them requiring care in the first place. But equally, in-community supports will fail unless clinical care is available when and where it is needed, to minimise the clinical symptoms of mental ill-health, when the consumer wants assistance. Housing first does not mean only housing. Employment assistance will fail without the clinical safety net.

The Productivity Commission has made draft recommendations around support services, but I recognise that there are fewer of these than those relating to clinical care. The reason for this is simple. There is a clinical care system in place for mental health. It has many gaps. It has numerous failings. But it does have the key components of a coherent system and we have made recommendations to try and fill the gaps and eliminate the failings.

By contrast, there is no coherent psycho-social support system in place for mental health in Australia. Rather there are a disparate group of services that are funded and defunded with little logic, where service providers face numerous funders all with differing reporting needs and the only consistency is the short-term nature of the contracts. There is no coherent system where we can make draft recommendations to fill gaps. There are gaps everywhere. And we cannot make recommendations to fix specific failings. The failure is the lack of the coherent system.

So, our recommendations around psycho-social supports are to establish a system. Establish a national strategy that can underpin regional service commissioning. Establish systematic evaluation so that the right services can be offered in the right places. Coordinate local funding and work with consumers, carers and service providers to offer a stable set of supports.

The Productivity Commission's draft recommendations for psycho-social supports are much broader than those for the clinical services. But they are at a different level and, as a result, they may be less obvious– because we need to establish, not simply reform, a system.

Conclusion

We are on a long journey to improve mental health in Australia. Tonight, we remember the work of Grace Groom and other pioneers who have been part of this journey. But there is much work to be done.

At the Productivity Commission, we are grateful to be part of this journey. We thank the many people who informed and inspired us as we prepared our draft mental health inquiry report. In particular, we thank the consumers and carers who have told us their stories, and in doing so, have helped us to understand both the many failings of Australia's current mental health system and how things can be improved. And we thank Mental Health Australia for providing assistance, guidance and support during our inquiry process.

But we are not done yet.

We have already heard from many of you about our draft report, but we need to hear from many more.

Through our draft recommendations, the Productivity Commission has worked to develop the strong foundations for a consumer-centred mental health system. Now we need your feedback. Let us know where we need to do more work before presenting our final recommendations to government in May next year. In particular, what are the implementable recommendations that we need to make to the government that are missing in our draft report? And why will they improve the outcomes for consumers?

Remember, however, that the final Productivity Commission inquiry report is not the end of the long journey. It is simply a step on the journey. It is an important step, but it will come to nought if our recommendations are not accepted and implemented by government. And reform will only occur if those who will benefit get behind the reform process.

So, my colleagues at the Productivity Commission and I look forward to the next part of our inquiry. We look forward to hearing from you, through hearings, roundtables and submissions. We look forward to learning more, from your experience and knowledge. And we look forward to refining our draft report to create a set of final recommendations to government that will lead to a consumer-centred mental health system.

Thank you.